State of Minnesota

Reform 2020: Pathways to Independence

Section 1115 Waiver Proposal

Draft

Released for public comment on June 18, 2012

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1 Section One – Executive Summary

1.1 Introduction

Minnesota's Medicaid coverage levels for pregnant women, children and parents have historically been some of the highest in the nation. The state's Medicaid program, known in Minnesota as Medical Assistance, 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 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 reform 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 enrollee independence;
- 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.

DHS has developed a number of reform initiatives to better deliver the right services at the right time under Medical Assistance. 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.

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 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.

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. This waiver proposal will enable Minnesota 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. Such a system needs to be flexible, responsive 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 andensure the sustainability of the system through efficiencies achieved.

1.2 Demonstration Projects

Components of this waiver proposal include:

1.2.1 Accountable Care Demonstration

Minnesota seeks all necessary federal authorities to move forward with contracting with provider entities for the total cost of care. Minnesota requires a waiver of statewideness so that the shift to the new delivery system can be implemented as providers develop the necessary infrastructure to administer closed networks and contract for prospective risk-based global payments covering total cost of care. In addition, a waiver of freedom of choice of provider 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 authority to facilitate data sharing between the state and providers and among the health care and welfare systems. Payments will be calculated based on current spending and therefore will be budget-neutral.

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. As an adjunct to the new CFSS service, home care service coordination will be made available to those who haven't had access to service coordination.

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. 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.

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

Minnesota proposes a demonstration project with school districts to test a service coordination model that utilizes the existing school-based service structure (e.g. school nurse, school social worker, school psychologist) to provide more comprehensive coordination of services to address the child's needs in the community as well as in the school setting. The demonstration would include up to 1,500 eligible children enrolled in demonstration school districts.

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 information, counseling, 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.

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 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 income, increase independence and decrease public program utilization.

1.2.6 Housing Stability Services Demonstration

Minnesota proposes a demonstration project for single adults without children who also have serious functional impairments and housing instability to:

- Increase access to necessary and appropriate levels of health and other community living supports for people on Medicaid.
- 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.
- Improve consistency of care by helping to establish a relationship with a primary care provider.

1.2.7 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.

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.

1.2.9 Eligibility for Adults without Children

As part of this request, DHS seeks waiver authority to make eligibility rules consistent for adults at the same income levels, regardless of whether or not they are parents of dependent children, by imposing 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.

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. Three initiatives will be sought 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 early intervention services to support Medicaid eligible children ages 0-7 who have a diagnosis of Autism Spectrum Disorder (ASD). The primary goal of the program is to provide high quality, medically necessary, evidence-based therapeutic and behavior intervention treatments and associated services, such as respite, that are coordinated with other medical – and educational – services. Other goals of the program will be to make a smooth and effective transition into school programs and/or other community services, and demonstrate measurable gains and achievement of identified goals.

- 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.

1.3 Conclusion

With this waiver request, Minnesota seeks to move the service delivery system to a model that will better integrate medical, behavioral and long-term care services in patient-centered models of care, promote robust primary care, improve care coordination, and better align payment incentives to foster best practices. In addition, Minnesota proposes to modify existing long – term care services and supports to provide additional flexibility to match the right services with participants' needs, at the right time. 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 the long-term care system 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. These proposals 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. 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.

First, the Long-Term Care Realignment waiver proposes to modify the nursing facility level of care criteria to target services to those in greater need and manage utilization of high-cost services more effectively. In addition, Minnesota proposes to provide home and community-based services to people who do not otherwise qualify for home and community-based waiver programs but have some need for community support. The Alternative Care program provides an expansive home and community services benefit to people age 65 or older who need a nursing facility level of care but do not yet meet Medicaid financial eligibility requirements. Essential Community 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/dhs16_167144.pdf

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 seeks federal authority for the following activities:

Modify the Nursing Facility Level of Care Criteria

Minnesota proposes to modify 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. As noted above, state law directing DHS to adopt this modified NF LOC standard was first passed in 2009 (see Minnesota Statutes, section 144.0724, subdivision 11). 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 simplify the level-of-care decision and more precisely define the needs that must be present to meet the nursing facility level-of-care criteria.

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

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 State 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 (dual eligibles) 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 dual eligibles have three or more chronic conditions, and 61 percent have a cognitive or mental impairment.[1] 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 dual eligibles served in integrated Medicare and Medicaid Special Needs Plans and fee-for-service delivery systems.

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 dual eligibles. 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

[1] 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.

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 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. Through this waiver request, Minnesota seeks to build on these efforts and shift towards a delivery system based on partnerships with integrated care systems.

Minnesota seeks all necessary federal authorities to move forward with contracting with provider entities to for the total cost of care. Minnesota requires a waiver of statewideness so that the shift to the new delivery system can be implemented as providers develop the necessary infrastructure to administer closed networks and contract for prospective risk-based global payments covering total cost of care. In addition, a waiver of freedom of choice of provider 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 authority to facilitate data sharing between the state, providers, and among the health care and welfare systems.

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-fo- service and managed care delivery systems.

Minnesota is working with CMS to secure the federal authority needed for these projects under the state plan amendment process and does not expect that waiver authority will be required.

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 a safety net patient's 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 State 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 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 dual 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 other 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 and share in the savings with Medicare.

3.3.2 Vision for the future

Under this new waiver authority, organizations seeking to become 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 their populations they serve. This includes data analytic capabilities and storage capacity for reporting that potentially use a combination of health care claims, electronic medical records, and social service data to help providers better understand the care their populations are receiving and evaluate outcomes and care model strategies. Organizations must have the capabilities to stratify populations by need and develop appropriate models of care based on those needs.

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.

As noted above, the state will complete Health Care Delivery Systems Demonstration contracting in 2012, effective for calendar year 2013. For the next step in direct provider contracting with integrated provider organizations as described, the state anticipates an RFP to be released in early 2013 for contracts effective beginning January 1, 2014. The state will begin a stakeholder process prior to the release of the next RFP in the summer of 2012 to allow time for providers, counties, tribes, community organizations, public health agencies, and consumer advocates to provide input into the design and development process.

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
- recognizes developmental differences
- increases 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 the service meeting more needs, more appropriately, of more people, and at the same time, will reduce some 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 meet the gaps under current state plan personal care assistance services in what they need.

As an adjunct to the new CFSS service, home care service coordination will be available to those who haven't had access to service coordination, and there will be testing and a demonstration of an approach to assist others who provide coordination to incorporate CFSS into their service plans and on-going role with the individual to improve outcomes, increase their stability in the community and enable a single service coordinator to function across different funding and systems.

Finally, Minnesota seeks to test innovative approaches to service coordination for children receiving CFSS and also service coordination and other services through an Individual Education Plan. Minnesota proposes to contract with a limited number of school districts to demonstrate this service coordination model with a maximum of 1500 children.

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, 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, [2] Minnesota proposes to make CFSS available both to people who meet an institutional level of care and people who do not.

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 as appropriate across the program, we are requesting to extend the special eligibility rules that apply today under our home and community-based waivers to people who meet level of care and receive CFSS that today would only available under 42 CFR § 435.217. Minnesota is not proposing to extend these same eligibility rules to people who receive CFSS but who do not meet level of care.

[2] 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.

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 also has five home and community-based services waivers: Developmental Disability (DD)[3], Community Alternatives for Disabled Individuals (CADI)[4], Community Alternative Care (CAC)[5], Brain Injury (BI)[6] and Elderly Waiver (EW)[7]. Similar services to support individuals living in the community are offered under each waiver, but since each was were developed over time, under different constraints and

[3] 2011 unduplicated enrollment: 15,761
[4] 2011 unduplicated enrollment: 18,927 (reflects high turnover rate)
[5] 2011 unduplicated enrollment: 390
[6] 2011 unduplicated enrollment: 1513
[7] 2011 unduplicated enrollment: 29,291 (managed care and FFS)

opportunities and for different populations, they differ from one another in many ways, such as eligibility criteria and service limits.

There are many other components to the HCBS system, including: 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, to name a few examples.

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)[8]. 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 employment related activities as assigned by the individual. CDCS allows consumers to substitute individualized services for what is 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 state dollar only 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 consumer direction.

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

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[9], 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, in accordance to their educational plan, 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.

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.

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

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 who 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

(For concept graphic see Attachment C)

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.

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.

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 get 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 to 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 in the process of developing and rolling out a new comprehensive assessment and web-based support planning application for LTSS, called MnCHOICES. It will be used with individuals of all ages, any disability and all incomes. It will replace four existing assessments. A trained and certified assessor will identify a person's strengths, preferences, needs, and goals using a person-centered approach. It is designed to promote collaboration between the mental health and LTSS systems in assuring an appropriate assessment and service planning process for people who also benefit from mental health therapeutic services. We will use the launch of MnCHOICES in 2013 and the 1115 demonstration to learn how to use the assessment and support planning system to better identify the need for services, to shape the best service plan, to coordinate services, and evaluate outcomes.

We believe that having a single coordinated plan that works across systems 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 want to 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 children (0-7) with Autism
- Day treatment for adults with DD/serious cognitive impairment, serious mental illness and diagnosis of sexual disorder
- Inclusion of long-term care services and supports in Health Home demonstration (integration of mental and chemical health and physical health care)
- Alzheimer's Health Care Home Demonstration
- Evidence-based health promotion
- Universal Information and Assistance
- Implementing a HCBS report card
- Centralizing reporting for vulnerable adults
- Conducting gaps analysis, system needs determination and developing services
- New In-home supports service option

- Establishing access thresholds for certain residential services
- Redirecting nursing facility services to individuals with higher needs
- Creating an updated menu of waiver services and provider standards, including standards of positive practices, and prohibitions on restrictive procedures
- Revising Consumer Directed Community Services within the waivers
- Providing technical assistance to counties to divert commitments
- Money Follows the Person demonstration
- Redesign case management (service coordination), with interim steps that include:
    - Home Care Case Management: Currently, Medicaid recipients in Minnesota are able to access case management services if they are eligible for a Medicaid waiver or if they are eligible for certain targeted case managements. However, many people using home care services alone 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 home care service coordinator would help the individual access services and supports to promote the person's stability in the community based on that person's assessed needs. Service coordination 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. Service coordination 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 home care participants who are already receiving a case management service, approaches will be tested to assist an existing case manager(s) 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. Contracted provider(s) 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. They 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 the 1915(k) and 1915(i). 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 1915(i) and 1915(k) within the 1115 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 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 1915(k) regulations we are requesting to receive the enhanced federal participation. The funds that would be generated from this enable us to operationalize the entire plan.

We are using an 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.

- Offer service coordination, and in some certain limited circumstances require service coordination when it is needed to maintain the participant in the community, and, for those children receiving CFSS and educational services with required service coordination, give the service coordinator greater flexibility in accessing and coordinating the service package in a comprehensive support plan.

- Provide participants in home and community-based waivers with the option to receive CFSS services as part of their waivered services. To avoid duplication of services, HCBS waiver participants may not receive CFSS.

- Allow Minnesota to extend the special eligibility rules that apply today under our home and community-based waivers to people who meet level of care and are receiving CFSS that today would only available under 42 CFR §435.217. 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. For example, 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.

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)."

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 would have 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.

Development and 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 1115 submission. We will expand participation in the next phase of development and form a separate Development and Implementation Council during the summer of 2012 that will assist the Department in the more detailed planning and protocols 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.

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 may choose to purchase services through an agency-provider model, or choose to self-direct services. If they choose to direct their own services, financial management entities will provide functions 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.

Financial management entities will be selected through an RFP process conducted by the state with participation by members of the Development and 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.

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 minutes service units. 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. 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.

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 1915c 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 CLSS, 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).

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 Development and 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 [10]
- Have an assessed need for assistance with at least one activity of daily living (ADL), or, be identified as having complex behaviors such as physical aggression to self or others or destruction of property

The special eligibility rules (application of Special Income Standard and exemptions from spousal or parental deeming) that apply today under Minnesota's home and

[10] 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

community-based waivers will be extended to people 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 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.

New service description

See section above, *New service description*, under CFSS-1915(k).

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 is proposing a demonstration project with a limited number of school districts to test a service coordination model that utilizes the existing school-based service structure (e.g. school nurse, school social worker, school psychologist) to provide more comprehensive coordination of services to address the child's needs in the community as

well as in the school setting. The demonstration would include 1500 children of any age served by the school district who access CFSS, and meet the other eligibility criteria, whether they meet a level of care or not. There will be a process to select the participating school districts that includes their willingness to provide needed service coordination to include CFSS, and be available year round to support the person and their family in school and in their home and community. Children who are not participants in the demonstration may use a home care service coordinator. If they have another service coordinator, they will have access to assistance to coordinate CFSS into their existing service plan through the activities that are planned as related to reform but not included in this 1115 submission to test approaches to support existing service coordinators incorporate CFSS and outcomes into their activities.

Eligibility criteria

- Eligible for Medical Assistance
- CFSS recipient
- Under age 21 and have not graduated from 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)

Milestones

2012

- Convene Case Management reform group to develop framework and design for new 1115 system of case management
- Create subgroup of providers to react to and help design new system
- Create working group of primary care providers to provide on-going assessment and re-design of case management services
- Establish Development and Implementation Council
- Prepare legislation to end PCA and establish CFSS
- Prepare an implementation plan for CFSS

2013

- Case management report due to Legislature
- Create process for continuous assessment of what is being learned and working and adapting.
- Receive legislative authority for CFSS and related legislative changes

- Establish financial management structure
- Develop protocols and instructions for the implementation of CFSS
- Communicate, outreach and necessary training to participants, providers, lead agencies and others
- Begin transition according to implementation plan

2014

- Full implementation of CFSS and service coordination demonstration
- Take case management out of waiver services and creating targeted case management

5 Demonstration to Expand Access to Transition Supports

5.1 The challenge

Consumers who have complex care needs and are moving home or into different settings have been shown through several evidence-based programs to be vulnerable to experiencing serious problems that often result in readmission or institutionalization. These individuals are at high risk for spend down to Medicaid and are referred to as "pre eligible". The effectiveness of education and support in assisting consumers in avoiding a move from their home has been demonstrated in a number of different evidence-based initiatives for various populations. Transition supports that are prevention-focused, together with a modest amount of intervention and follow up, have been demonstrated to result in helping people remain in their homes, use less expensive services and to avoid risk of spend-down to expensive public programs.[11]

In addition, initiatives that assisted with medication education and that are used by Minnesota long-term care options counselors have been shown to reduce the risk of rehospitalization, another indicator of risk of nursing home placement and thereby spend-down. Minnesota seeks federal support to build on current state-funded initiatives with proven track records of success.[12] Current state initiatives make long-term care options counseling available to provide transition support to a wide range of pre-eligibles. With federal support, Minnesota could serve more consumers in nursing homes and expand access to 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 and use less costly services.

[11] 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-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.

[12] See references above.

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

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), and
- Have expressed a desire to return to the community, and
- Fit a discharge profile that indicates a high probability of community discharge, and
- Would otherwise become long stay residents based on the status of their peers, and
- Are Minnesota residents, and
- Are not yet eligible for Medicaid or Money Follows the Person Benefit, and

- 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 HelpNetwork™ for up to five years.

Once the individual has returned to the community, the CLS provides an in-person visit at 3 days from 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 the Department using an analysis using actual claims experience 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 from the Center for Aging Research at the Indiana University is currently evaluating the service and will be issuing a report that will document the availability of projected savings to the Medicaid program.

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

A second major transition support effort 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, 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 services), 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 support 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 caller receives an evidenced-based risk screen that determines risk of nursing home placement which was developed by Dr. Joseph Gaugler with the University of Minnesota School of Social Work. 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
- Risk of 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 was 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. The protocols will be implemented through the Minnesota Hospital Association and the Quality Improvement Organization. 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, 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, and
- Is 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 but they may be younger based on risks, and
- 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 Nursing Home admissions using MDS 3.0. 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 four RUG groups that will be targeted for the reasons cited below. 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. diabetes, oxygen, injections.

- Impaired Cognition- include those with short term memory loss and have difficulty making decisions but are still receptive to therapy.

- Reduced Physical Functioning- include those who have decreased ADL capacities and could benefit from therapy.

- Special Care- including those who may be suffering from pneumonia, dehydration, weight loss which 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 (Mittleman et al) 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. 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 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.

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 MA reform. These concepts were supported by Minnesota's Demonstration to Maintain Independence and Employment, Stay Well, Stay Working. http://staywellstayworking.com

By providing navigation, employment supports and benefits planning, Minnesota seeks 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
- Achieve personal goals

Minnesota has benefited 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 Minnesota Family Investment programs.

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 Medical Assistance Expansion recipients age 18-26 with a potentially disabling severe 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. Minnesota Family Investment Program (MFIP) recipients age 18-26 who are currently enrolled in an employment program OR MFIP parents who have turned to cash assistance as minor parents or because of the demands of caring for a seriously ill family member.
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 exiting foster care.

Additionally, eligible individuals must:

- Be employed
- Have been employed within the past year, or
- Have experience and employment shift within the past year

An employment shift is defined as a decrease in income or job loss.

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 6 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.

6.1.2 Outreach

Potential enrollees will learn about this project through the following strategies:

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). Navigators will be embedded in and 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. [13]

Navigators will provide:

- Guidance in accessing needed medical, mental health and employment support services.
- Phone assistance focused on person-centered employment and life planning
- Support to strengthen current 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 participant and Managed Care Organization when necessary
- Options counseling to recognize available support
- Referral to appropriate support
- Follow up to ensure people's needs are met and address new needs as they arise
- 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.

- 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

[13] Disability Benefits 101 can be found at the following website: http://mn.db101.org/

will be sought. Minimum qualifications are a Bachelor's degree in one of the above noted areas.

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
- 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

The Disability Linkage Line 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 and move people to the right service at the right time. 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
- Integrate planning an screening tools to build service delivery consistency

Funding

The state would also like to 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.

Budget Neutrality

Minnesota would like to demonstrate that there can be cost savings to the state and federal governments with the relatively low cost benefit set laid out in this demonstration. Three main areas have been identified as having potential to provide cost savings over the course of 5 years.

- **Reduced Social Security Disability Benefits Cost**
  DMIE 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.

- **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 2 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.

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. 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
- People transitioning from Medicaid to Exchanges and vice versa

Services are also being designed to potentially function as a wrap-around option in 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 and Next Steps

This element 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 and 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 implementation. DHS will also conduct further analysis of how these services and supports may interact with services and supports offered by other state agencies.

6.2 Housing Stability Services Demonstration

6.2.1 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 serious functional impairments and identified housing instability through a new benefit set of 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 Medicaid expansion, effective March 1, 2011, 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.

Among this high-need single adult population, some could have been appropriately assessed to qualify with a certified disability, but were not, due to existing barriers such as the nature of an individual's disability (paranoia, chemical dependency) and

difficulties in obtaining a certified medical opinion, lack of outreach/in-reach services, and lack of available services for people requiring less than an institutional level of care. On the other hand, many did receive some level of support services or health supervision services through the state's Group Residential Housing Program (GRH) program, and some received cash assistance through the state's General Assistance (GA) program. Now that Medicaid expansion has been implemented, we have a new window of opportunity to remove barriers and better support the health needs of single adults in Minnesota.

With this demonstration, and in alignment with other reform priorities of the Department, we aim to craft eligibility for the Medicaid service delivery system to be informed by functional needs of individuals rather than solely on diagnosis or population group. 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 three components: 1) Outreach/In-Reach, 2) Tenancy Support Services, and 3) Service Coordination. These services will be individualized and determined through a functional assessment and 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.

We recognize that our Demonstration of Housing Stabilization Services may require technical assistance from the Centers for Medicare and Medicaid Services (CMS) regarding allowable settings in which individuals may receive these services. Federal regulations regarding setting requirements for State Plan Home and Community-Based Services list the conditions that must be met in provider-owned or controlled residential settings. In Minnesota, some of our residential settings conform today, some will conform by July 1, 2014, and some will take longer to conform, or may never conform due to limitations of physical site or program structure (i.e., some Board and Lodge and homeless shelter settings).

A number of recipients of state Group Residential Housing services, in addition to some residents of institutional settings, reside in non-conforming settings today only to

maintain access to necessary services. We estimate that many would, with Housing Stabilization Services, have an opportunity to move into an independent community living setting of choice and receive services there.

Others, many recipients of state General Assistance for example, are un-housed and living in a place not meant for human habitation, which is also a non-conforming community living setting and ineligible for home and community-based services as defined by CMS.

We ask that CMS staff work with us to craft an appropriate structure for Housing Stabilization Services to be provided to the eligible target population in both conforming and non-conforming settings, as we believe the goals and outcomes would be shared.

Our goals of this demonstration, for a population of adults with serious functional impairments and housing instability 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 hospitalizations, emergency room visits, ambulance transports, and psychiatric hospitalizations.

4. Improve consistency of care by helping to establish a relationship with a primary care provider.

5. Increase opportunities for independent community living.

6.2.2 Proposed health care delivery system

Eligibility for Housing Stabilization Services will be determined by a functional assessment administered by a trained certified screen administrator. Certified screeners will be knowledgeable about indicators of functional impairments and housing instability, interviewing skills needed to gather information, conducting a holistic dialogue, Housing First best practices, and dialogue that include the person's strengths, values, goals and perspectives. In addition, screeners will have information and education about other local long-term care options and services that may be appropriate.

Eventually, we want to integrate this functional assessment within the MNChoices Comprehensive Assessment tool being developed for use by Minnesota counties. This tool will allow counties to use a common tool across populations to assess an individual's functioning in the context of all the factors that support them in the community and centered on their own values and goals.

Eligible service providers of Housing Stabilization Services must:

- Be at least 21 years of age, and
- Have at least a high school diploma or its equivalent, and
- Have the skills and knowledge typically acquired, and:

    - o through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience working with persons living with functional impairment and housing instability, or

    - o through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons living with functional impairment and housing instability, or

    - o through a minimum of four years' experience as a care coordinator, or

    - o through an equivalent combination of training and experience that equals four years of practice in care coordination, or

    - o as a certified peer specialist.

- The service provider shall be knowledgeable of person-centered planning, the service delivery system, the needs of persons living with functional impairment and housing instability, and the "Housing First" model of Housing Stabilization Services and resources or the need for such services and resources to be developed, and

- Providers of care coordination are subject to the criminal, caregiver and licensing background checks and hiring prohibitions as prescribed by the Department of Human Services.

6.2.3 Eligibility Requirements

The target population for Housing Stabilization Services would include adults, men and women, age 18 or older, who are enrolled in Medicaid who exhibit a serious functional impairment and housing instability.

Eligible individuals would be assessed to meet the following criteria:

- Enrolled in MA, and
- At least 18 year of age, and
- Functional impairment (one of following), and:

    - o Needs assistance with one or more activities of daily living (ADLs) (including getting around inside the home, getting in or out of bed or a chair, bathing, dressing, eating, and toileting)

    - o Needs assistance with one or more instrumental activities of daily living (IADLs) (including meal planning and preparation, managing finances, shopping

for food, communication by telephone and other media, getting around and participating in the community)

o Has a functional impairment that seriously interferes with everyday activities (frequently depressed or anxious, trouble getting along with others, trouble concentrating, or trouble coping with day-to-day stress)

- Demonstrates significant housing instability (one of following):

o Literally homeless: Lacks a fixed, regular and adequate nighttime residence, meaning the individual has a primary nighttime residence that is a public or private place not meant for human habitation or is living in a publicly or privately operated shelter designed to provide temporary living arrangements. This category also includes individuals who are exiting an institution where he or she resided for 90 days or less, and who resided in an emergency shelter or place not meant for human habitation immediately prior to entry into the institution.

o At Risk of Homelessness

☐ Will imminently lose (within 14 days) their primary nighttime residence provided that no subsequent residence has been identified and the individual lacks the resources or support networks needed to obtain other permanent housing.

☐ Currently resides in permanent supportive housing.

o Currently resides in or upon release from one of the following institutional settings, and no longer requires a hospital level of care, and discharge plan identifies lack of appropriate and stable housing in the community:

☐ Psychiatric inpatient, acute care inpatient, prison/jail, residential chemical dependency treatment, and nursing facilities

o Fleeing/Attempting to Flee Domestic Violence

☐ Fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking

6.2.4 Benefits for individuals who will be covered under the demonstration

The following are descriptions of Housing Stabilization Services that would be offered:

(1) 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

•(2)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
- Budgeting and financial education

(3) 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.

Individuals assessed to be eligible for other Medicaid services that include service coordination, would not be eligible for the Service Coordination component of Housing Stabilization Services in order to avoid duplication.

The operationalization of Housing Stabilization Services as part of the state's Medicaid plan will require further coordination with all Medicaid reform initiatives in Minnesota in order to establish a comprehensive and streamlined service delivery infrastructure.

6.2.5 Research hypothesis and evaluation design related to the demonstration proposal

The following hypotheses relate to a population of adults with serious functional impairments and housing instability for this demonstration:

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, and

2) Housing Stabilization Services will result in improved housing stability, as evidenced by an assessment of housing stability at enrollment, annually, and at termination, and

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, compared with usual care, and

4) Housing Stabilization Services will result in improved self-management of health and improved consistency of care by helping to establish a relationship with a primary care provider.

5) Housing Stabilization Services will encourage and increase opportunities for people to move from institutional settings, and other non-conforming community living settings (as defined by CMS rules for Home and Community Based Services) into independent conforming community living settings, as evidenced by a count of service

recipients residing in non-conforming community settings (i.e., Board and Lodge, homeless shelter) at enrollment, annually, and at termination.

We propose to demonstrate these hypotheses among a limited group of eligible individuals, not to exceed 5,000.

6.2.6 Supporting Research

These hypotheses are supported by research involving similar target populations and service interventions across the United States. We are encouraged by the evidence that suggests budget neutrality is possible through a demonstration of Housing Stabilization Services.

In Chicago, Illinois, persons experiencing homelessness who were receiving inpatient hospital care for chronic medical conditions were randomly assigned to receive usual care or access to recuperative care (respite) and supportive services in permanent housing settings. The intervention group had 29% fewer hospitalizations, 24% fewer emergency room visits, and 45% fewer days in nursing homes.

In Portland, Maine, during the year after receiving Housing First-type supportive services, formerly homeless persons with a diagnosis of a long-term disability (mental illness, chemical dependency, physical disability, co-occurring disorder) experienced:

- 77% fewer inpatient hospitalizations
- 62% fewer emergency room visits
- 60% fewer ambulance transports
- 38% fewer psychiatric hospitalizations
- 62% fewer days in jail
- 68% fewer police contacts

In Portland, Oregon, individuals who had been chronically homeless and living with a dual diagnosis of mental illness and chemical dependency were offered Housing First-type supportive services and experienced:

- 58% fewer days in inpatient medical hospitalizations
- 87% fewer emergency room visits

In Seattle, Washington, Medicaid costs were reduced 41% after single adults who had been chronically homeless, with chemical dependency, and identified as a high cost user of emergency services (emergency room, detox, and jail) had received case management services for one year in supportive housing.

In the federal Collaborative Initiative to Help End Chronic Homelessness, participants were placed rapidly into permanent housing and 95% were in independent community

living settings after one year. Average costs for health care and treatment were reduced by about half. The largest decline was associated with costs for inpatient hospital care.

6.3 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.

6.3.1 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) through outreach and in-reach contacted 3,820 individuals. 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 come, first served 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 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.

6.3.2 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.

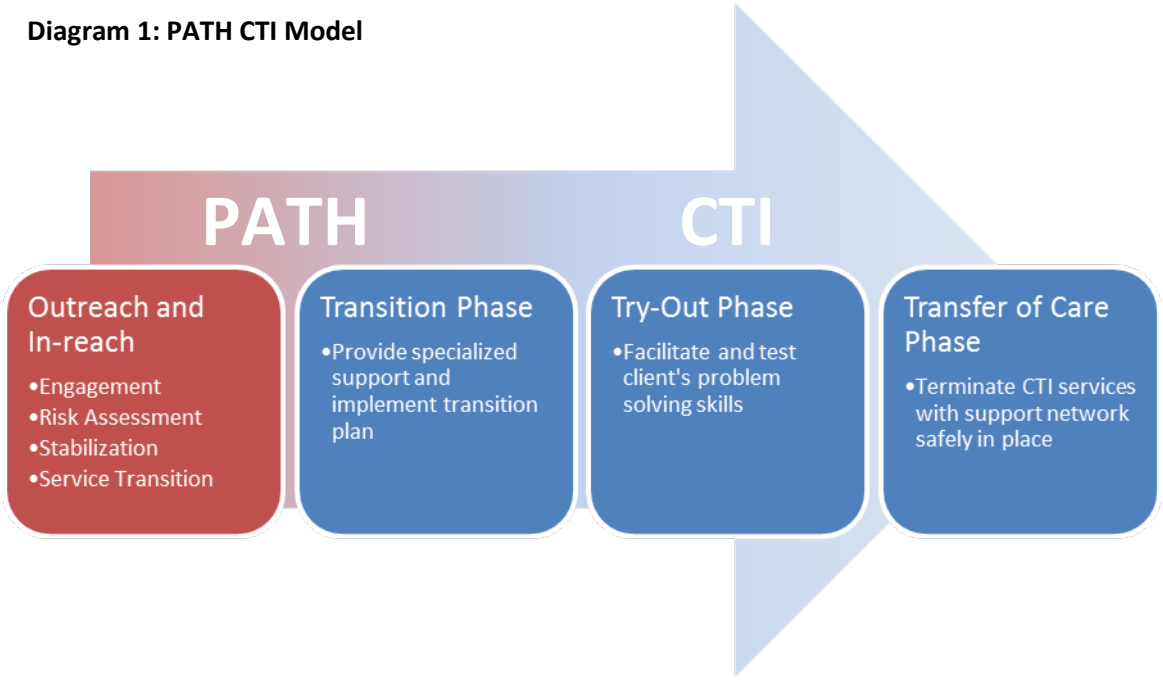
6.3.3 Population

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.

6.3.4 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 • Outreach • Case management	**Five Primary Areas of CTI Intervention**
• 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	

6.3.5 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.

6.3.6 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 FY 2012 PATH 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.

6.3.7 Evaluation

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[14]. 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.

[14] 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.

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6.3.8 Definitions

Outreach and In-reach

- 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.

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 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

Minnesota seeks a Section 1115 waiver to redesign the relationship of the AMRTC to the rest of the Medicaid system. Almost all people receiving treatment services at AMRTC would be Medicaid-eligible if the services were available in the community, and a majority are also Medicare recipients.[15] 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. Although AMRTC no longer functions as a long-term residential institution for people with a serious mental illness, it continues to serve discrete populations whose needs have not been met through the current service array in the community.[16] Almost every person admitted to AMRTC is under a civil

[15] 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.

[16] 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

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 plays an important safety net role for greater 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 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.

Given the significant transformation that has already taken place in Minnesota's State Operated Service system, wherein 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, the AMRTC demonstration seeks to enhance the continuum of care for some of the most psychiatrically disabled individuals who are receiving short-term treatment that would otherwise be covered by Medicaid if delivered in the community. By allowing MA 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 most complex patients being discharged to participate in, and help inform, the next phase of redesigning Minnesota's community supports and services.

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

7.1.3 Goals for the revised system

Those with serious mental illness and aggressive tendencies are especially challenging for smaller, more rural communities 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 are the specialized services required to keep this small sub-set of people with mental illness out of high acuity services? How much money is saved by avoiding judicial commitment proceedings, multiple emergency department visits and repeated involvement by law enforcement?
- What are the sub-populations that require specialized services to avoid formal civil commitment?
- What are the current evidence-based practices for serving these specialized populations, and what are the best mechanisms for assuring that patients receive them?
- For patients whose needs are so complex and unique that evidence-based practices do not provide adequate guidance for their care, what service and funding models should be adopted to assure the most appropriate care possible?
- How can providers, counties, tribes, law enforcement, courts, patients, and families all coordinate the transitions that patients make among levels of care to best promote patients' recovery?
- What models of care coordination are found to be effective in stabilizing this group over a longer period?
- How is health care reform likely to affect the populations being served by the current shared safety net? How can the state best assure that patients' mental health needs are adequately considered in state and federal health care reform planning?

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 make eligibility rules consistent for adults at the same income levels, regardless of whether or not they are parents of dependent children, by imposing 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 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 make eligibility rules more equitable for parents and adults without children in the Medical Assistance program by imposing 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 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 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

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 use the modified 1915(i) state plan amendment option to coordinate and streamline services for 3 groups with multiple and complex needs, many of whom are currently receiving services across several programs in the Department, resulting in uncoordinated services:

(1) children with an Autism Spectrum Disorder (ASD) diagnosis;

(2) people with a serious mental illness and other co-morbidities (DD/chronic addiction/complex medical conditions), including aggressive or assaultive tendencies AND have been committed to the State for treatment at Anoka Metro Regional Treatment Center (AMRTC) and are unable to return to the community within a reasonable time completing their medical and behavioral treatment, and

(3) adults with co-occurring developmental disabilities or cognitive impairments (e.g., brain injury, mental retardation) and serious mental health conditions AND also have a diagnosis of Sexual Disorders and/or Antisocial Personality.

9.1.2 1915(i) for Children with ASD Diagnosis:

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.

Despite the rise in the incidence of ASD reported at a national level, and despite claims by advocates in the Somali community here in Minnesota that there is a higher prevalence among Somali children, 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 Department of Education. Minnesota is a birth mandate state 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. Thus, in Minnesota, the healthcare system and education system share responsibility for early intervention for children with ASD.

A growing number of states are choosing to deliver autism specific services to young children through a 1915(c) home and community based waiver. These 1915(c) waivers provide specific services not generally available in the state's Medicaid plan to a broader population to a limited number of individuals. These waivers are generally targeted at those with significant functional impairments who are most at risk of being institutionalized long term. As a result, most 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 that are administered by separate areas of the Department: Home and Community based Waivers (DD or CADI); Personal Care Assistance (PCA); 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. Now, the 1915(i) option allows the state to provide coordinated services to a broader group of children with ASD who have significant functional impairments but do not otherwise qualify for a waiver or would be on a waiting list for a waiver.

Specifically, Minnesota will develop a 1915(i) to deliver early intervention services to support Medicaid eligible children ages 0-7 who have a diagnosis of Autism Spectrum Disorder (ASD). The primary goal of the program is to provide high quality, medically necessary, evidence-based therapeutic and behavior intervention treatments and associated services, such as respite, that are coordinated with other medical – and educational – services. Other goals of the program will be to make a smooth and effective transition into school programs and/or other community services, and demonstrate measurable gains and achievement of identified goals. As part of this 1115 waiver demonstration, Minnesota will seek technical assistance to ensure that no additional waiver of the 150% of poverty level income eligibility criteria for children will be necessary, as coverage for nursing facility services is currently available to all children who qualify for services at higher levels. The goal is to develop one service program 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.

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 are 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. In addition, symptom severity related to maladaptive or stereotypic behaviors, co-morbid behavioral health conditions (e.g. OCD, anxiety, depression, and others), current level of functioning and the intensity of services required to address the symptoms of ASD should all be considered when developing a treatment plan. Underlying this program model is the expectation that treatment providers demonstrate children are making progress as a consequence of treatment. Building on successful waiver models in other states, Minnesota will develop a time-limited early intervention service set that tapers off as progress is made, or that children age out of as they transition to school. The Department will work with providers, medical experts and clinicians to develop agreed upon standards, assessment tools and protocols for objectively measuring progress. The Department 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.

The benefit set (combination of services, supports, and coordination) to be defined and delivered though this 1915(i) will focus on interventions with support in the scientific and medical literature. Currently, Minnesota does not have established guidelines for medically necessary, evidence-based, early intervention 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 services to be covered by the 1915(i). However, because of the timelines needed to develop legislative budget proposals for 2013, the Department may initially propose benefit and service utilization criteria in advance of any recommendations by HSAC and will consider amending the submission to CMS if changes are deemed necessary when HSAC completes its work. In addition, services for children who are over age 7 would generally be included in the child's IEP and could be informed by HSAC's recommendations in this regard.

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

Integration of Public Health Care and Special Education Services. Minnesota is a birth mandate state under federal IDEA law; this requires that special education services be provided to children with assessed need from birth onward. Thus, in Minnesota, the

healthcare system and education system share responsibility for early intervention for children with ASD. Over the next 2 years, the Department intends to enhance the integration of Medicaid entitlement programs with the Free and Public Education (FAPE) entitlement. Integration would be operationalized through utilization of a comprehensive, multi-dimensional assessment protocol that will identify both medical necessity and education need using state-approved assessment instruments to maintain statewide assessment quality — along with a service coordination and authorization protocol that assigns coverage responsibility to the appropriate sector. Both healthcare providers and schools will make use of each other's assessments to avoid duplication of effort and the waste of public and family resources. The Comprehensive Multi-dimensional Diagnostic Assessment would identify and guide treatment planning for:

- existence of each of the various core Autism syndrome symptoms or conditions
- level or severity of an Autism Spectrum Disorder
- co-occurring developmental disabilities
- co-occurring psychiatric (mental health) conditions;
- co-occurring medical conditions: [e.g., fine motor; gross motor; gastro-intestinal; prosopagnosia (face blindness)].

Such integration builds on a foundation of health and education coverage for school-based services for children with autism, including those covered by:

- Special Education—IEP services (school-aged children)
- Infant and Toddler Intervention and Preschool Special Education (ECSE)—Part C and Part B
- Medical Assistance-IEP benefit (Medicaid services provided by schools to children with IEPs);
- School CTSS (Children's Therapeutic Services and Supports delivered by schools certified to provide children's mental health rehabilitation services;
- School-Linked mental health services (state-funded coordination and services to non-Medicaid-eligible students).

In addition, the Department 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 3, when infant and toddler intervention services cease being driven by federal IDEA Part C law (birth to 3rd birthday) to Part B requirements, which begin at age 3 and follow a child until age 21. By focusing on developing coordinated services and transitions for children aged birth-to-age 7, both state agencies could learn to bridge the first transition point. After age 7 it is expected that children would be enrolled in school and receiving any services they are entitled to under an IEP, which could include medically related services in addition to educationally necessary services.

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

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 for daily and longer visits that are need by this complex population. 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 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 this population. 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 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) Medicaid State Plan Amendment 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 1915i 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.

This MA reform element will dovetail with several other MA reform elements that Minnesota is requesting. 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 was an issue of great concern to mental health stakeholders. They also noted that while functional limitations of an individual who has a mental illness may appear the same or similar to those of individuals, the cause and, therefore, the services provided would be different. They expressed concern about the need to assure that the providers of services are skilled in working with people who have a mental illness.

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

1. A Serious and Persistent Mental Illness and
2. At least two of the following that is specifically related to symptoms of the person's mental illness
    a. assaults,
    b. verbal aggression,

c. c. active or recent chemical dependency that exacerbates mental illness symptoms,
d. past criminal behavior,

e. symptoms of mental illness that do not respond to treatment and require more than eight hours of supervision per day to assure safety.

f. the presence of another illness, condition or disability that, when combined with the persons mental illness, results in inability to function in the community or inability to find supportive services in the community as a result of similar or other issues and

3. 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.

This option would include additional services for individuals with the very high needs noted above. These services would include In-depth Assessment of Functioning; Clinical Direction of Services; Development of a Recovery-Oriented Service Plan; Tenancy Supports including in-reach services (e.g., engagement, risk assessment, transition services), assistance locating and retaining housing and other housing-related service coordination; Mental Health Symptom Management; Assistance with Substance Abuse and Dependency Issues; Family support and education; Supported Employment; Community integration services; Caregiver support and respite; Medication education, assistance and administration; Primary health care and dental care coordination; Financial and Health Care Benefits Navigation; Basic living skills; Transportation; Oversight, and supervision.

Services may be provided in any setting where the individual chooses to live or receive services and that conform to the settings requirement of the 1915(i) regulations. This may include family homes, single or shared apartments, or clustered apartments. The provider will not have a say in whether the individual can continue the live at the site selected. The provider will not have a financial interest in keeping the person in the housing setting or in removing them from the setting. The majority of the services must be provided in the individual's home and community instead of a provider office.

This 1915(i) service set would also allow flexibility in staffing that no other services allow. It would be designed to be provided by teams as small as three staff. These staff people may serve only one individual if that individuals needs are high enough or they may serve a small group of individuals. Individuals' budgets will be developed based on the needs of the individuals to receive the services.

9.2 1915(i) for adults with co-occurring developmental disabilities/cognitive impairments/serious mental health conditions AND diagnosed with a Sexual Disorders and/or Antisocial Personality.

There are approximately 134 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 Department including home and community based waiver services, adult foster care, and Adult Mental Health Rehabilitation Services. Because of the intellectual disabilities, these individuals have generally been removed from the criminal system and ordered to receive services from outpatient mental health day treatment programs. There are four providers located throughout the state that define themselves as "Sex Offender Day Treatment" programs.

Minnesota does not have a specific service developed to meet the unique needs of this small but complex group; therefore, the services for these sex offender treatment programs have been "pushed" into the day treatment model as the closest "fit." However, that program is not designed to meet the unique needs of this group and providers have engaged the Department in conversations about the limits of the current program in successfully developing and implementing new treatment services that are known to be more effectvi8e with this population. In particular, the Day Treatment model is an "all groups, all the time" model that does not include individual services beyond treatment planning and assessment. In addition, Day Treatment is meant to be a short-term service, which is not the need of this particular population of individuals.

The Day Treatment provider standards do not take into account the specialized needs and nature of the treatment being provided to this population. As a result, there has been limited oversight with regards to the effectiveness of the treatment being provided. The Department does not have defined expectations, treatment protocols, and expected outcomes other than what is defined for the overall Day Treatment program. It is also difficult to have any sense of whether the threat to the community has truly been diminished or even lessoned. There is also a long-term nature to the treatment needs of these individuals due to the nature of the sexual disorder as well as the co-occurring behavioral health issues, especially the intellectual disabilities. Due to the fact that services for these individuals are spread out across multiple providers and programs at the Department, providers who deliver services to these individuals outside of the sex offender treatment program have limited (or no) skills and knowledge regarding the treatment and support needs of sex offenders in order to keep the offenders and community safe. As the State explores provisional discharge of sex offenders under commitment to the State's care and custody, developing services and provider standards

to help evaluate successful treatment models for successful living in the community has become more of a priority.

Minnesota proposes to develop a 1915(i) for this population to better integrate services so all providers are following best treatment practices, not only for the sexual disorder but also the co-occurring disorders. Services for this group would include: Assessment and Testing (Diagnostic, psychological, neurological, functioning); Group psychotherapy;

- Group rehabilitative skills
- Individual psychotherapy
- Medication Management (psychiatry)
- Case Management
- Job training and Day Training and Habilitation opportunities (for those with developmental disabilities) uniquely tailored for this group to minimize the risk of re-offending while participating more fully in the community through a work experience

- Collaboration and treatment support with other mental health providers, developmental disability providers, caregivers, families, and/or legal system around the needs of an individual as it relates to the safety others due to the nature of the sexual disorder, as well as meeting the client's treatment needs.

The ideal would be for all treatment providers within the community to follow the same standards/treatment model following the principles below:

1) Integrated model with all service providers working with the individual to be trained on sexual disorders and sex offender treatment issues, with the ability to collaborate and provide interventions that are supported as best practices for sex offenders.

2) Treatment providers are using interventions that have been defined as best practice approaches

3) Treatment providers are knowledgeable about how to adapt interventions per individual with regards to any co-occurring diagnoses/needs that follow best practice/community standards

4) The use of appropriate assessments and outcome measures as it relates to sex offenders and the co-occurring concerns are defined and used.

9.3 Redesign Home and Community-Based Services

9.3.1 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 in the following pages.

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).

9.3.2 MnCHOICES

The Minnesota Department of Human Services (DHS), in collaboration with stakeholders, is developing a new web-based application referred to as MnCHOICES. MnCHOICES will implement a single, comprehensive assessment and support 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. Improved data collection 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
- Protocols and standards for ensuring reliable and consistent application of level of care criteria, program and service eligibility, support planning, and service authorization requests.

The MnCHOICES comprehensive assessment work process and software will allow Minnesota to move from paper documentation of assessments, care planning, and the determination of level of care to a single electronic format, which will help to ensure that assessments are complete, that care plans reflect appropriate services, and that professional determinations are supported by assessment information. This change will also allow Minnesota to maintain electronic documentation of assessment, care and support planning, and level of care information.

The expectation that the assessment is documented and that the determination of level of care is supported by the information contained in assessment is not new. It is reflected in Minnesota's practice of auditing the paper forms used to document level of care determinations during case file reviews. These audits are completed as part of the quality review process in the home and community–based waiver programs. For example, DHS reviews a random sample of case files for audit during the state reviews of county and tribal administration of waiver programs. Similarly, the case files of managed care enrollees are randomly selected and audited as part of the waiver quality review process. The change to the electronic format in the assessment, care planning, and level of care determination process will allow this audit function to be standardized and automated, and will allow the review of all cases rather than a sample of cases under both fee-for-service and managed care. Assessments and development of care plans will continue to be conducted face-to-face with applicants and enrollees.

Life Planning

MnCHOICES supports a person-centered approach to assessment and support planning, with a face to face interview to learn about a person's strengths, goals, family and friends, and community involvement, in addition to their assessed needs. In addition to the MnCHOICES assessment and community support planning, there are specialized, intensive planning processes designed to engage families and individuals in life planning for the long term future vision and steps to get there, which enable people and those closest to them to creatively plan and support their future. These planning processes may be funded through waiver services or as a case management activity; however, they often are helpful planning processes that draw on the support and involvement of family and friends regardless of whether the person receives an assessment, case management or a Medicaid funded service. A longer term objective of reform is to examine options for expanding options to life planning, and its outcomes, and possible ways to expand access, especially at critical points in a person's life, such as with young children as a disability is known, preparing for transition from school, or as people grow older and can't do as much for themselves as they once did.

9.3.3 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 consumer 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 (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 ripe 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 demonstrated 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 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 around 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 LinkAgeLine® 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 consumers 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 consumers 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.

9.3.4 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 Accountable Care Act 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.

9.3.5 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, there will be 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.

9.3.6 Enhancements to 1915(c) Waivers

Minnesota currently operates five 1915(c) Waivers:

- Brain Injury (BI) – for disabled individuals meeting a nursing facility or neurobehavioral hospital level of care

- Community Alternative Care (CAC) – for disabled individuals meeting a hospital level of care

- Community Alternatives for Disabled Individuals (CADI) – for disabled individuals meeting a nursing facility level of care

- Developmental Disabilities (DD) – for disabled individuals 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 our 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 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 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 will be amended provider standards that 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 1915c HCBS waiver plans will be submitted at the conclusion of the legislative session.

9.3.7 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.

9.3.8 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.

9.3.9 Crisis Intervention and Protection of Vulnerable Adults

With 94% of people with disabilities and the majority of seniors 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.

9.3.10 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

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

9.4 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 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.

9.4.1 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.

9.4.2 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.

9.4.3 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.

9.5 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.

9.5.1 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.

9.5.2 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.

9.5.3 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.

9.6 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 behavioral health needs of individuals receiving IRTS services, the Legislature directed DHS to develop a proposal for the improved integration of medical and behavioral 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 behavioral health needs.

9.7 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. Ironically, these current children's residential facilities might also be vulnerable to federal IMD designation, since federal guidelines defining the IMD are ambiguous; were Medicaid reviewers to make this determination, children and adolescents currently served through this mechanism could lose access to both critical and routine health care.

National Efforts – 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

Although research questions have been developed for the other demonstrations proposed in this waiver, evaluation planning for these demonstrations is not complete. Therefore, this section on focuses primarily on evaluation of the reforms made under the Demonstration to Reform Personal Assistance Services and Expanding Access to Transition Support described above, as well as reforms sought in the previously-submitted Long-Term Care Realignment Section 1115 waiver proposal.

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 school districts to test a service coordination model that utilizes the existing school-based service structure (e.g. school nurse, school social worker, school psychologist) to provide more comprehensive coordination of services to address the child's needs in the community as well as in the school setting. The demonstration would include 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 Processes and Outcomes

Initiative	Major Processes	Major 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	Major 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 Waiver "wait list" reduced No increase in Medicaid nursing home use No increase in hospitalizations and ED visits No increase in out of home placements for children

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. CFSS seeks to strengthen service coordination for individuals with complex needs, for more efficient delivery of services and improvement in personal health outcomes and community stability while avoiding potential adverse outcomes.

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 one service coordinator who is able to holistically plan and support the individual across all services and Innovative Approaches to Service Coordination for children with CFSS will address needs both in the community and in the school setting with a single care coordinator. 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" and 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 is slated to begin January 2014. 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 y 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	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	Period
	Target Populations: HCBS applicants who fail to meet NF LOC criteria and HCBS recipients who fail to meet PCA criteria on an annual assessment: Comparison Groups: 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	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 (dual-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 recommend 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

10.7 Next Steps

The proposed evaluation plan is very ambitious. It deals with a broad and diverse set of initiatives covering institutional and community long-term services and supports, older people and people with disabilities, and people covered by Medicaid only, dual eligibles, and other pay sources. The questions pursued in the evaluation extend beyond conventional concerns with aggregate Medicaid costs. The evaluation addresses health and functional outcomes, acute care service use and payments, transitions between settings and service packages, rates of Medicaid conversion, and other intended as well as potentially unintended outcomes from these interventions. Although we have gathered considerable information and dealt with numerous design issues, questions remain about the target populations for the intervention, the completeness and accuracy of data, and the capacity to draw valid before and after comparisons of major outcomes. Over the next several months we propose to continue to further refine the evaluation design, evaluation questions and objectives, measurement of key variables, data sources, incorporating changes in program policies or implementation plans, and data collection and analysis strategies.

11 Public Involvement

11.1 Work 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 the department'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.

11.2 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 Souix 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 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.

11.3 Public Notice and Comment

11.3.1 Minnesota State Register Notice

Minnesota State Register Notice Requesting Public Comment on Waiver

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 main web page for *Reform 2020* waiver request, http://www.dhs.state.mn.us/dhs16_169839, 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.

Minnesota State Register Notices Regarding Legislative Actions

A notice is published in the Minnesota State Register on an annual basis following the end of each state legislative session to inform recipients, providers of services, and the public of certain

statutory changes made to the Medical Assistance Program that the Minnesota Legislature has enacted. 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.

11.3.2 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 1115 waiver request and directing them to the Minnesota State Register notice published on June 18, 2012.

11.3.3 Public Hearings

Two public hearings will be held to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The first public hearing will be held at the Minnesota Department of Health on June 22, 2012. The second public hearing will be held at the Minnesota Department of Human Serves on June 25, 2012. Teleconferencing technology will be available at each site so that interested stakeholders would have the option to participate in the hearing remotely.

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.

David Godfrey is the state Medicaid director for the Minnesota Department of Human Services. He 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.

Maureen O'Connell is the Assistant Commissioner for Chemical and Mental Health Services Administration within DHS. She is responsible for the policy divisions of Adult Mental Health, Children's Mental Health, and Alcohol and Drug Abuse.

Regina Wagner is the Deputy Assistant Commissioner for Chemical and Mental Health Services Administration within DHS. She is responsible for providing leadership and operational direction to all the programs and divisions within Chemical and Mental Health Services Administration.

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 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:

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 to provide accountable care organizations only in certain geographical areas of the state.

Freedom of Choice. Minnesota requests a waiver of Section 1902(a)(23)(A) as implemented by 42 CFR 431.51 to the extent necessary to enable the State to restrict the freedom of choice of providers for demonstration participants to networks associated accountable care organizations, as well as to include integrated delivery system elements such as coordinated care teams that include non-traditional providers and other workers..

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 differing accountable care organization arrangements or in the absence of managed care arrangements.

Entities eligible for comprehensive risk contracts. Minnesota requests a waiver of 1903(m) of the Act as implemented by 42 CFR 438.6(b) to the extent necessary to enable the State to enter into full or partial risk arrangements with provider entities.

Actuarial soundness of payments under risk contracts. Minnesota requests a waiver of 42 CFR 438.6 (c)(5)(iii) to the extent necessary to enable the State to implement alternative provider payment methodologies and incentive structures to reimburse on the basis of outcome and quality.

13.1.2 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 Medicaid coverage for enrollees in accountable care organizations.
- Expenditures for payments in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement in order to provide incentive and resources to operationalize the accountable care model and shift the basis of payment from the provision of services to the attainment of health outcomes.

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:

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 Innovative Approaches to Service Coordination demonstration 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 for the Transition Eligibles population.

13.2.2 Costs Not Otherwise Matchable

Under the authority of Section 1115(a)(2) of the Act, Minnesota requests authority to regard the following expenditures demonstration populations 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:

- Be a nursing home resident who has been admitted for over 60 days but not more than 90, and
- Have expressed a desire to return to the community, and
- Fit a discharge profile that indicates a high probability of community discharge, and
- Would otherwise become long stay residents based on the status of their peers, and
- Are Minnesota residents, and
- Are not yet eligible for Medicaid or Money Follows the Person Benefit, and
- Could benefit from discharge planning assistance based on the Community Living Mini Assessment developed by Dr. Greg Arling, and
- Are Minnesota residents or planning a move to Minnesota, 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.

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 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:

13.3.2 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 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 severe 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 (MFIP) recipients ages 18-26 who are currently enrolled in an employment program OR MFIP 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

To be eligible under this demonstration, participants must be:

- Enrolled in MA, and
- At least 18 years of age, and
- Functional impairment, and
- Demonstrates significant housing instability.

Functional impairment is defined as one or more of the following:

- Needs assistance with one or more activities of daily living (ADLs) (including getting around inside the home, getting in or out of bed or a chair, bathing, dressing, eating, and toileting)
- Needs assistance with one or more instrumental activities of daily living (IADLs) (including meal planning and preparation, managing finances, shopping for food, communication by telephone and other media, getting around and participating in the community)
- Has a functional impairment that seriously interferes with everyday activities (frequently depressed or anxious, trouble getting along with others, trouble concentrating, or trouble coping with day-to-day stress)

Demonstrates significant housing instability is defined as one of following:

- Literally homeless: Lacks a fixed, regular and adequate nighttime residence, meaning the individual has a primary nighttime residence that is a public or private place not meant for human habitation or is living in a publicly or privately operated shelter designed to provide temporary living arrangements. This category also

includes individuals who are exiting an institution where he or she resided for 90 days or less, and who resided in an emergency shelter or place not meant for human habitation immediately prior to entry into the institution.

o At Risk of Homelessness

☐ Will imminently lose (within 14 days) their primary nighttime residence provided that no subsequent residence has been identified and the individual lacks the resources or support networks needed to obtain other permanent housing.

☐ Currently resides in permanent supportive housing.

o Currently resides in or upon release from one of the following institutional settings, and no longer requires a hospital level of care, and discharge plan identifies lack of appropriate and stable housing in the community:

☐ Psychiatric inpatient, acute care inpatient, prison/jail, residential chemical dependency treatment, and nursing facilities

o Fleeing/Attempting to Flee Domestic Violence

☐ Fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking

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% and at or below 250% 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

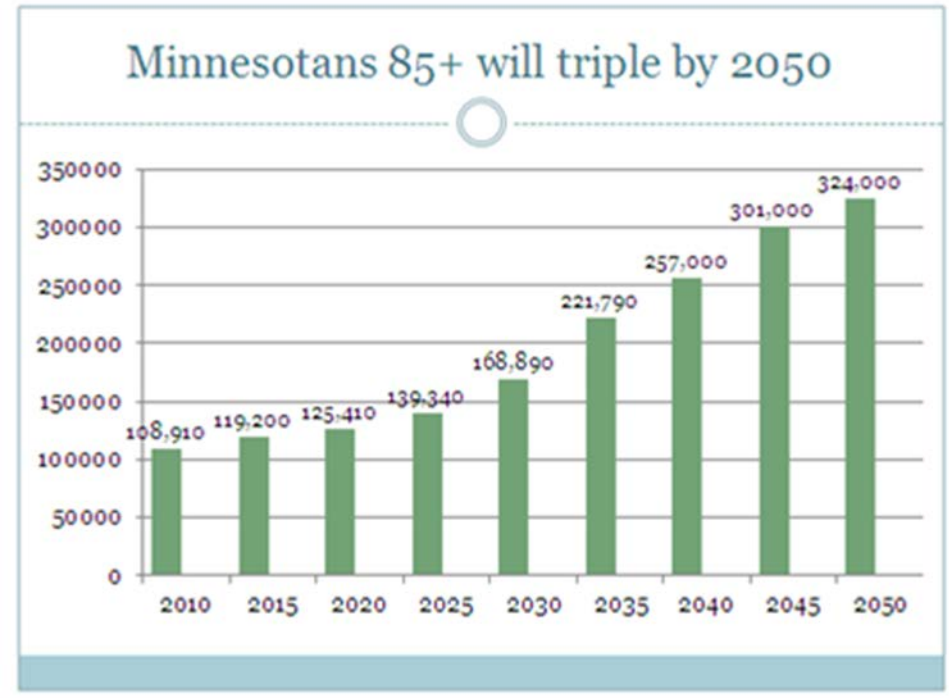
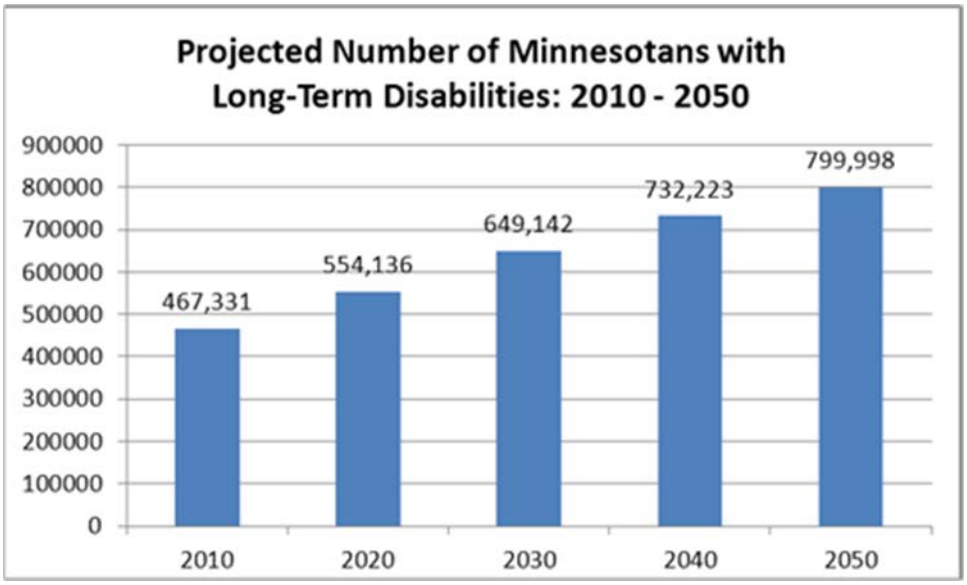
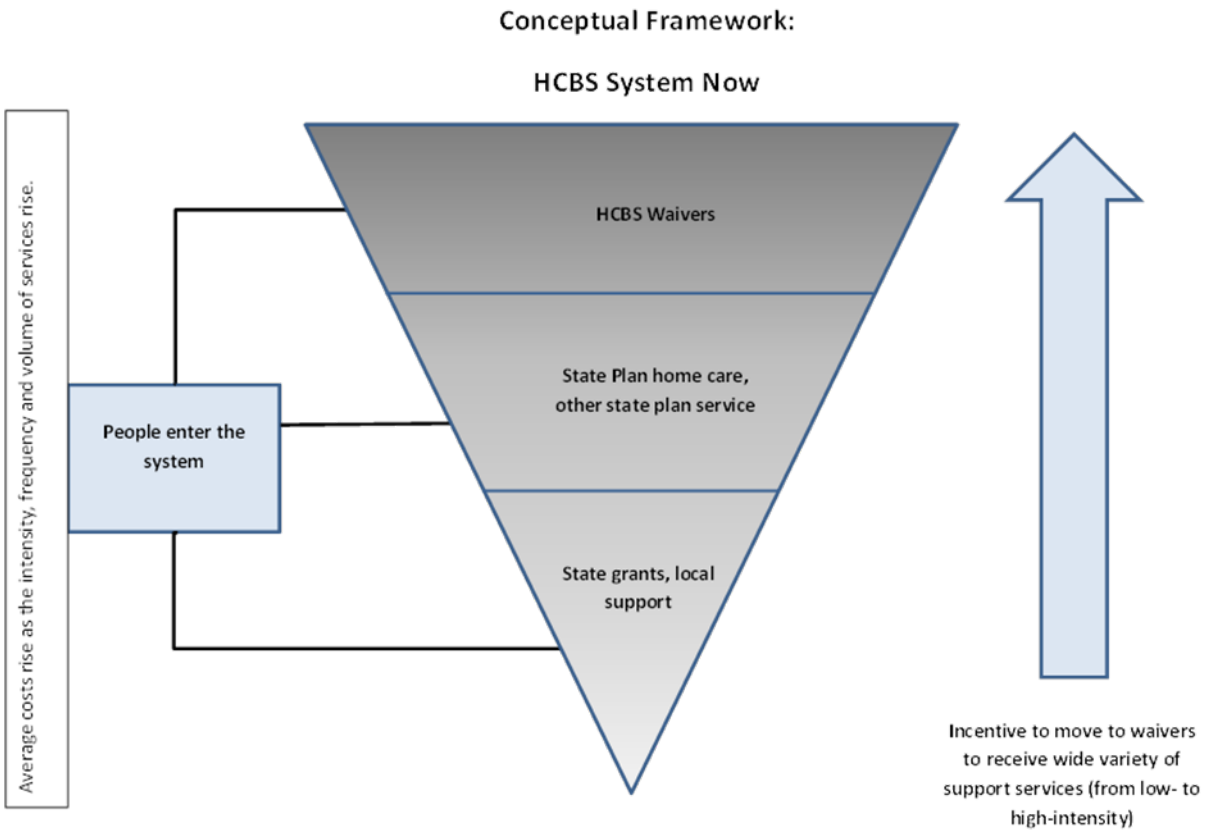


Chart 1: Projected number of Minnesotans with Long-Term Disabilities: 2010-2050

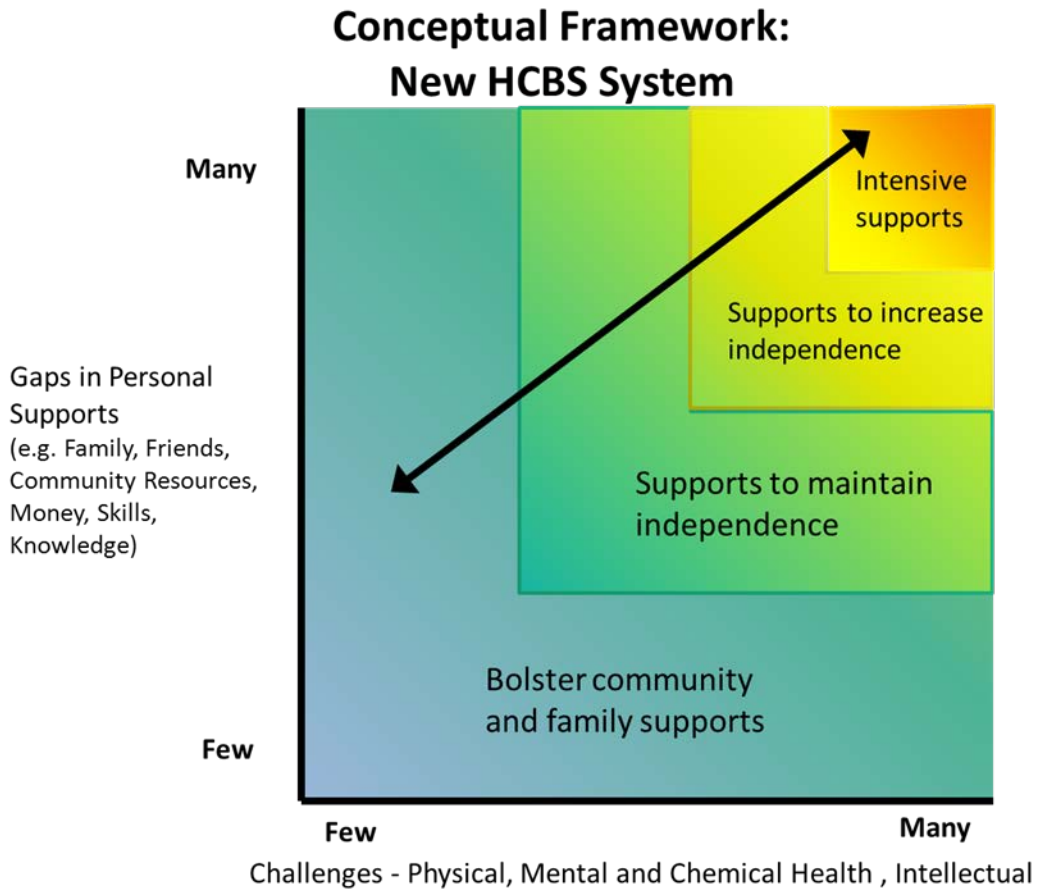


Attachment B: HCBS System "Now"



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: Stakeholder Work Groups and Meetings
Reform2020

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 (Planned)

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

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

Mental Health Stakeholders
May 1, 2012

Minnesota Interagency Council on Homelessness
Subcommittee on Medicaid and Support Services
Second Tuesday and fourth Wednesday of every month since April 2011

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.