Biennial Report on Long-Term Services and Supports for People with Disabilities

Minnesota Department of Human Services
Disability Services Division

January 2013

Minnesota Department of **Human Services**

Legislative Report

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $5,700.

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Executive Summary

This report has been prepared in response to legislation enacted in 2012 requiring the Minnesota Department of Human Services (DHS) to report, biennially, on the Department's overarching goals and priorities for persons with disabilities, including how programs administered by the commissioner are supporting them. The report also provides contextual information about the Disability Services Division's (DSD) placement within the Continuing Care Administration (CCA), particularly the relationship between DSD and the Aging and Adult Services Division.

In State fiscal year 2012, DHS expended $3.6 billion on long-term supports and services; of this, DSD administered $2.5 billion of services to support eligible Minnesotans with disabilities of any age.

The overall goals of the CCA are:

- To support and enhance the quality of life for older people and people with disabilities
- To manage an equitable and sustainable long-term services and supports system that maximizes value
- To continuously improve how CCA administers services
- To promote professional excellence and engagement in CCA's work

In terms of individual outcomes, CCA goals include:

- Increased stability in the community
- Better-informed decision-making about long-term services and support options
- Person-centered planning, both for long-term life planning and planning for crisis situations
- Improved transitions between settings and programs; preventing avoidable health crises

A rich network of partnerships and relationships is critical to carrying out DSD programs. The partnerships extend across CCA and other administrations within DHS, as well as across state agencies. DSD relies upon partnerships, including delegated and contractual administrative functions with counties, tribes and health plans to carry out its programs. DSD maintains other vital relationships with people with disabilities, their families and advocates, and service providers.

DHS currently supports people with disabilities with services beyond health care, through home and community-based waiver programs, state plan home care services, state grant programs that provide services and resources to individuals or their families, and services in institutional settings, such as intermediate care facilities for persons with developmental disabilities. This report gives a high-level overview of each of these components.

The Minnesota Medicaid system has continually evolved to meet changing needs of Minnesotans. For about 30 years, there has been steady focus on shifting long-term services and supports from institutional settings to home and community settings. A large majority of Medicaid-eligible people with disabilities (94 percent in 2010) and seniors (61 percent in 2010) who need long-term services are living in their communities rather than in an institutional setting.

Over time, as institutions have closed and the vast majority of funding is dedicated to supporting home and community based services, there is increased focus on helping people be meaningfully engaged with their communities. When people have more choice and flexibility in how they access and use supports and services, they also have more opportunity to lead lives that are personally meaningful and fulfilling.

Another policy direction that CCA has been moving towards is a quality-driven system. In 2006-2007, CCA engaged in a process of designing a framework ("quality architecture") for defining and measuring quality, and using quality to inform service design and delivery. Since 2007, CCA has been building and implementing components of that framework. One example of a component of the quality framework is the development of an enhanced assessment and service planning process. These improved processes help people make informed decisions about service options and put together services that respond to their strengths and individual goals, in addition to responding to their service needs.

Bipartisan legislation enacted by the 2011 Minnesota Legislature seeks to reform the Medical Assistance program—an effort called *Reform 2020*. The home and community-based services redesign portion of *Reform 2020* relates specifically to services for people with disabilities or other complex needs and older adults. The legislation identified the following outcomes for the reform effort:

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

This report describes the goals, strategies and initiatives that make up the home and community-based services redesign portions of *Reform 2020*.

Performance measurement data for waiver services is described in this report and can be accessed through the DHS Continuing Care Performance Reports webpage[1]. The report gives a

[1] http://www.dhs.state.mn.us/dhs16_166609#

statewide summary of participant counts, broken down by age ranges, for home care, institutional and waivered services. Annual spending for each waiver, state plan services and grants is also given, as well as waiver waiting lists information. It also provides performance data on areas such as earnings and people living at home with their families.

Purpose of this Report

The 2012 Minnesota Legislature required the Department of Human Services (DHS) to submit a biennial report, beginning January 1, 2013, on the overarching goals and priorities for persons with disabilities, including how programs administered by the commissioner are supporting the overarching goals and priorities. Specifically, Minnesota Statute 252.34 states:

> ***252.34 REPORT BY COMMISSIONER OF HUMAN SERVICES.***
>
> *Beginning January 1, 2013, the commissioner of human services shall provide a biennial report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and funding. The report must provide a summary of overarching goals and priorities for persons with disabilities, including the status of how each of the following programs administered by the commissioner is supporting the overarching goals and priorities:*
>
> *(1) home and community-based services waivers for persons with disabilities under sections Minn. Stat. §256B.092[2] and Minn. Stat. §256B.49[3];*
> *(2) home care services under section Minn. Stat. §256B.0652[4]; and*
> *(3) other relevant programs and services as determined by the commissioner*

This report also provides information regarding the policy intent of the Disability Services Division. It describes major initiatives underway, including status updates on those that have been in process for several years, and, identifies new initiatives.

Disability Services Division and the Department of Human Services

The Disability Services Division (DSD) is part of the Department of Human Services (DHS) Continuing Care Administration (CCA). DSD operates under the DHS mission—working with many others, to help people meet their basic needs so they can live in dignity and achieve their highest potential.

[2] https://www.revisor.mn.gov/statutes/?id=256B.092#stat.256B.092
[3] https://www.revisor.mn.gov/statutes?id=256B.49#stat.256B.49
[4] https://www.revisor.mn.gov/statutes?id=256B.0652#stat.256B.0652

For the past year, DHS used *Framework for the Future: 2012*[5] to guide and prioritize the Department's work. CCA and DSD's priorities follow this *Framework*.

- **People** – Provide smart care that keeps people healthy in their homes and communities

  CCA's many current initiatives all have at their core the intent to create a more person-centered service system that supports people with disabilities inclusively in their communities.

- **Innovation** – Redesign the Department's care delivery systems

  The 2011 legislature directed DHS to reform Medical Assistance, Minnesota's Medicaid program, to achieve multiple goals. This effort is called *Reform 2020*. In 2012, to address the goals related to people with disabilities and seniors, CCA continued work on current initiatives and designed many new initiatives to redesign Minnesota's home and community-based services system. Together, this package of initiatives is the home and community-based redesign portion of *Reform 2020*.

- **Equity** – Narrow disparities and improve outcomes

  CCA has several initiatives aimed at creating equal access and standards across the state, in particular, MnCHOICES, the Home and Community-Based Services Waiver Provider Standards initiative and the Disability Waivers Rate System initiative. CCA also has several initiatives and activities that will create a more person-centered outcome-driven system, including, MnCHOICES, the State Quality Council, the Participant Experience Survey and the Home and Community-Based Services Report Card.

- **Integrity** – Reduce fraud, waste and abuse

  CCA is strengthening the quality management system for home and community-based services. This includes a new state-administered approach to provider standards and monitoring, centralizing the vulnerable adult reporting system and greater transparency about outcomes.

Disability Services Division and the Continuing Care Administration

DSD supports people with disabilities in living the lives they want to live, pursuing personal goals and being active contributing members of their communities. DSD does this in partnership with many others including, people with disabilities, their families, advocates, service providers, and other administrative entities, including counties, tribes, and the federal government. DSD's role is to plan, develop, administer and evaluate home and community-based services for

[5] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464-ENG

Minnesotans with developmental disabilities, traumatic brain injuries, physical disabilities and chronic medical conditions who are in need of public services and supports.

Home and community-based services promote individual and family self-sufficiency and maintain an individual's or family's optimum level of independence in the community. Home and community-based services include home care services, in-home and family services, residential services and work-related services.

DSD also includes the HIV/AIDS Unit, which helps Minnesotans living with HIV/AIDS to access health care through its insurance, drug reimbursement, dental, nutrition and case management programs. The HIV/AIDS unit also consults with other parts of DHS and state government on HIV policy, statewide needs assessment, planning and evaluation.

While this report contains data specific to DSD programs, it is important to understand that these services exist within a broader, inter-related system of services and health care. DSD is part of the CCA which consists of four divisions:

- Aging and Adult Services
- Deaf and Hard of Hearing Services
- Disability Services
- Nursing Facility Rates and Policy

CCA functions are to:

- Administer Medical Assistance long-term services and supports programs (waivers and state plan services) which include developing, seeking authority for and implementing policies and projects
- Administer state and federal grants and contracts
- Provide information, education, assistance, advocacy and direct service
- Oversee the state’s adult protective services system
- Establish and manage provider payment rates
- Assure service quality, conducting evaluations and measuring results
- Staff the Minnesota Board on Aging; the Commission on Deaf, Deafblind, and Hard of Hearing Services; and numerous stakeholder work groups
- Provide administrative, financial, and operational management and support
- Provide technical assistance to CCA stakeholders

CCA programs serve more than 350,000 people each year, including older Minnesotans, people with disabilities of all ages and families. Many people need only a little help from public programs, for example, a home-delivered meal once a day, a phone consultation for information and assistance, or occasional respite from care giving. Others require extensive care, such as children who would otherwise live in a hospital (at greater cost) that can instead live at home

with care provided by skilled nurses and family members. Work of CCA is guided by the 2011-2015 Continuing Care Strategic Plan. (The Plan and the 2012 Plan Progress Report are included in Attachment A.)

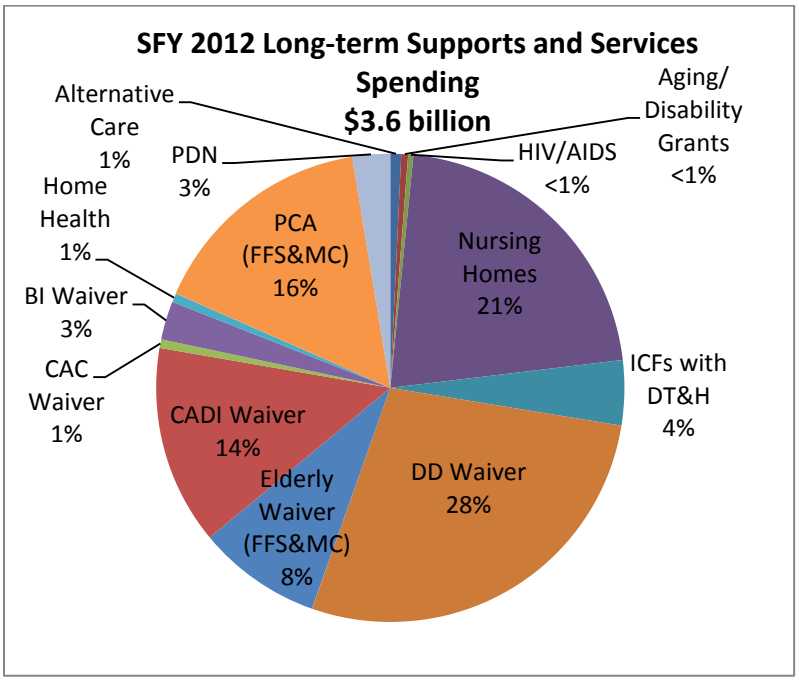

Figure 1: DHS Long-Term Supports and Services Spending, State Fiscal Year 2012: $3.6 Billion

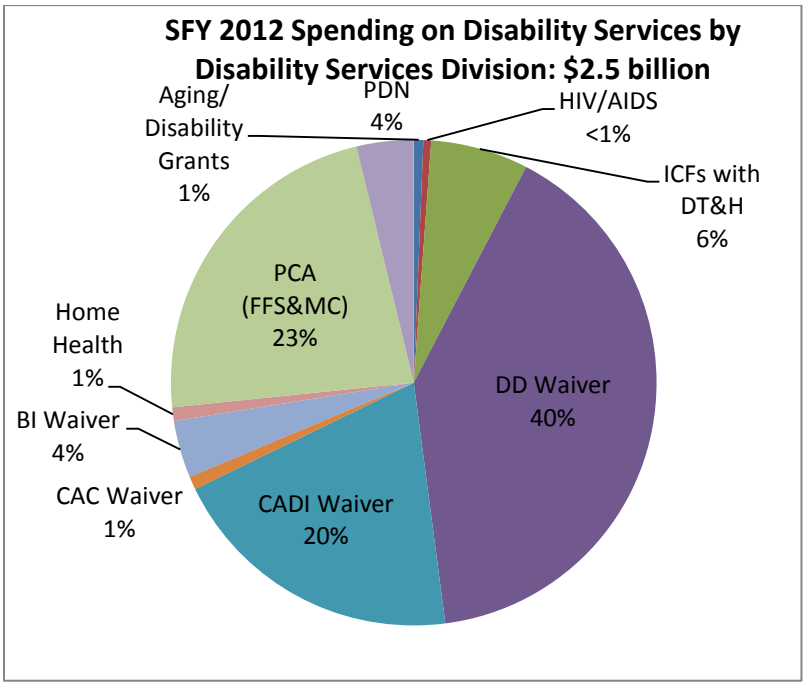

Figure 2: Disability Services Division Long-Term Supports and Services Spending, State Fiscal Year 2012: $2.5 Billion

CCA Vision, Values and Goals

The mission of CCA is to strive to improve the dignity, health and independence of the people it serves. CCA follows a common vision in designing, implementing and administering its programs. CCA sees a Minnesota where people have choices in how they receive services and how they live their lives. The domains of choice include:

- **C**ommunity membership
- **H**ealth, wellness and safety
- **O**wn place to live
- **I**mportant long-term relationships
- **C**ontrol over supports
- **E**mployment earnings and stable income

The values upon which the Administration's work is built are:

- **Choice & Independence** for the people CCA serves
- **Stewardship** of human service resources
- **Self-determination and personal responsibility** by the people CCA serves
- **Integrity** by CCA and others
- **Diversity** because our differences make us strong
- **Partnerships and collaboration**, with clear roles, responsibilities and accountability for ourselves and others
- **Accountability**

The goals of the CCA are:

- To support and enhance the quality of life for older people and people with disabilities
- To manage an equitable and sustainable long-term services and supports system that maximizes value
- To continuously improve how CCA administers services
- To promote professional excellence and engagement in CCA's work

CCA's goal for people with disabilities and older adults is to achieve better individual outcomes, including:

- Increased stability in the community
- Better-informed decision-making about long-term services and support options
- Person-centered planning, both for long-term life planning and planning for crisis situations
- Improved transitions between settings and programs; preventing avoidable health crises

Partnerships and Collaborations

CCA depends upon key partners in administering its programs and delivering services. In accordance with the CCA values, CCA works closely with its partners to plan for supporting Minnesotans as they age and those with disabilities, and to design and improve services. Among CCA partners are counties, tribes, health plans, the Minnesota Board on Aging, seven Area Agencies on Aging and their provider networks, other state agencies, enrolled home and community-based services providers, nursing facilities, intermediate care facilities for people with developmental disabilities, and Centers for Independent Living.

DSD State Government Relationships

People who turn to long-term supports and services[6] often have needs that span the organizational divisions of DHS and reach across state agencies. To support those people effectively, DSD fosters new relationships and maintains working partnerships across state government. DSD collaborates daily with the other Continuing Care divisions, particularly Aging and Adult Services.

Outside CCA, DSD has important relationships with the Chemical and Mental Health Administration, particularly the Adult Mental Health and Children's Mental Health divisions. *Reform 2020*, discussed later in this report, provides an opportunity for developing closer collaboration as DSD looks at how long-term services and supports reform could result in better outcomes for people with mental illness who have need for long-term services and supports to live in the community.

People who use long-term services and supports also use primary and acute health care services. Therefore, DSD has working relationships with the DHS Health Care Administration. These relationships came to the forefront as DHS worked on *Reform 2020*. One of the weaknesses of the current service system is poor coordination between these different sectors. DSD is working with the Health Care Administration as it builds new health care delivery and payment systems, including models of integrated primary care, acute care and long-term services and supports.

Reform 2020 also led DSD to develop closer relationships with the Children and Family Services Administration, particularly around housing and employment. DSD recognized that it is

[6] Notes on terminology:
The term *long-term supports and services*, or *LTSS*, can be used interchangeably with the term *long-term care*, or *LTC*. Both refer to on-going supports that an individual needs due to a chronic condition. These services can be delivered in the home, in another community setting or in an institutional setting. Over time, the term *long-term care* has become strongly associated with nursing facility services, even though the term has a wider meaning. In order to emphasize that these on-going support services can be delivered in both institutional and community settings, this report will use the *term long-term supports and services*.
The term *home and community-based services*, or *HCBS*, refers to long-term services and supports that are delivered specifically in homes or other community-based services, not in institutional settings. Home and community-based services are a subset of long-term services and supports.

fundamental to successful outcomes for people with disabilities that they have adequate, stable housing, and are prepared for and have access to competitive employment. Similarly, for people with a disability or a disabling condition, stable housing and employment are dependent upon having the right long-term support at the right time. Collaboration brings together the expertise and resources of each administration.

Working in collaboration with the Aging and Adult Services Division, DSD efforts on key initiatives that will transform how the division manages many of its core functions—MnCHOICES assessment and service planning, Disability Waivers Rate System, Home and Community-Based Services Waiver Provider Standards and several other initiatives related to managing quality—require collaboration with the DHS Licensing Division, Office of Inspector General, and cooperation with the Minnesota Department of Health Compliance and Monitoring Division.

DSD has relationships, partnerships and collaborations with numerous other state agencies and council, as well. These include:

- The Minnesota Governor's Council on Developmental Disability
- Minnesota State Council on Disability
- Minnesota Department of Health— Infectious Disease Epidemiology, Prevention and Control Division
- Minnesota Department of Employment and Economic Development—Vocational Rehabilitation Services and Office of Innovation
- Minnesota Department of Education—Special Education Division

DSD External Relationships

DSD relies upon numerous partnerships with groups outside state government, including counties, tribes, advocates and service providers to accomplish the Division's work. (Membership lists of the groups described in this section are included in Attachment B.)

In 2008, DHS initiated and became a member of the Home and Community-Based Services Partners Panel, which it continues to support. The Panel is a group that meets regularly and serves as a communication link among the system's stakeholders and as a means to support specific initiatives. Panel members are people with expert knowledge and experience with long-term services and supports, including representatives of consumer and family advocates, mental health and disability-specific advocates, county groups, existing advisory and policy groups, state agencies and other related groups. Members represent organizations that are engaged in statewide activities to support home and community-based services.

DSD is member of the CCA County-State Work Group. CCA established this group in 2010 as a forum for managing legislatively-mandated reform initiatives with counties, who are the Department's delegated local administrative agents to act on behalf of the Commissioner.

Membership is comprised of county and state staff that oversee the administration of home and community-based services; county representatives appointed by Minnesota Association of County Social Service Administrators, Local Public Health Association, and Association of Minnesota Counties; and, additional county members with particular expertise, as needed.

The University of Minnesota Institute on Community Integration is an on-going DSD partner, providing consultation and support for specific initiatives. The Institute on Community Integration is currently contracted with DSD to manage an autism stakeholder and planning process, which will inform the development of future long-term services and supports for people with Autism Spectrum Disorder. The Institute is also under contract with CCA through the Money Follows the Person grant to affect system-wide improvements in outcomes for people who use long term services and supports. Towards this end, the Institute will provide training in person-centered thinking and person-centered planning, and technical expertise. DSD recently established a new on-going Implementation Council for the Money Follows the Person Demonstration and the Community First Services and Supports Program. These two significant reform efforts aim to transition people out of institutions and support people to live and work in their communities.

At any one time, DSD, often in collaboration with the Aging and Adult Services Division, may have one or more temporary work groups with external stakeholders running to advise us on specific projects. Current and recent work groups include:

- MnCHOICES (collaboration with the Aging and Adult Services Division)
    - Policy
    - Private Duty Nursing
    - Experienced Assessor
    - Technology
    - First Implementer Lead Agencies
- Home and Community-Based Services Waiver Provider Standards (collaboration with Aging and Adult Services) and subgroups
- Disability Waivers Rate System and subgroups
- Case management reform
- Rule 40 Advisory Committee (final recommendations in January)
- State Quality Council (final recommendations in in January 2013)
- Reform 2020 workgroups
- Community First Services and Supports/Money Follows the Person Implementation Council and subgroups

Management of Current System

DHS currently supports people with disabilities in a variety of ways: home and community-based services waivers, state plan home care services, state grant programs, and services delivered in institutional settings. (More information about DHS services for people with disabilities can be found in the Disabilities section of the DHS website.[7])

Overview of Home and Community-Based Services Waiver Programs

The goal of home and community-based services waiver programs is to provide necessary services and supports to people living in their communities who would otherwise require the level of care provided in an institution. Home and community-based services waivers are federally approved options for states to put together various service options that are not available under regular Medical Assistance. These service options are available to people in addition to services covered by Medical Assistance. Congress first allowed waiver programs in 1982, and opened the door in Minnesota for deinstitutionalization, including the closure of state institutions for people with developmental disabilities. In the late 1990s, there were renewed efforts to provide home and community options for people with all types of disabilities choosing to move from nursing facilities. In 1999, the United States Supreme Court's Olmstead decision affirmed the right of people who are eligible for Medicaid services to receive those services in the most inclusive setting in accordance with the Americans with Disabilities Act.

Minnesota makes home and community-based waivers available with federal financial participation. To obtain federal participation, Minnesota submits waiver plans that the Centers for Medicare and Medicaid Services, the federal agency that administers Medicaid, approves initially and every five years.

Each of the home and community-based services waiver programs has been developed to meet federal guidelines, which include the obligation to meet specified federal assurances in six areas:

1. Level of care
2. Service plan
3. Qualified providers
4. Health and welfare
5. Administrative authority
6. Financial accountability

Services authorized under all waiver program plans must:

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

- Help a person avoid institutionalization and be an appropriate alternative to institutionalization
- Help a person function with greater independence in the community
- Be necessary to assure health, safety and welfare of the person
- Meet the unique needs and preferences of the person
- Have no other funding source
- Have a cost that is considered reasonable and customary

Status of Waiver Plans

Each of the home and community-based services waivers is authorized for a five-year period. There is a review at the midpoint of each approval period and a formal renewal request for continued federal financial participation every five years. At Minnesota's last review, the Centers for Medicare and Medicaid Services required a corrective action plan for the State to comply with what was determined a failure to meet federal requirements around free choice of qualified provider. The corrective action plan requires the State, by January 1, 2014, to:

- Eliminate county contracts with home and community-based providers as a criterion for authorization and service payment
- Enhance provider standards and enrollment with oversight at the state level
- Establish statewide rate-setting methodologies, including documentation of the basis of variation in the rates

The federal government will not approve further waiver plan renewals until there is assurance that Minnesota will meet its corrective action by January 1, 2014. The Developmental Disabilities Waiver plan, due for renewal in July 2012, is currently operating under an extension of the old plan, while the federal government monitors Minnesota's progress in meeting the timelines established in its corrective action plan. Legislative authority will be sought in the 2013 legislative session for the new standards, the licensing fee to enforce the standards, and the disability waiver rate methodologies.

Overview of State Plan Home Care Services

State plan home care provides medical and health-related services and assistance with day-to-day activities to people in their home. Home care services can be used to provide short-term care for people moving from a hospital or nursing home back to their home, or it can be used to provide continuing care to people with ongoing needs. Home care services are to be provided in a person's residence, not in a hospital or nursing facility. Home care services also may be provided outside the person's home when normal life activities take them away from home.

Home care services are available to people who are eligible for Medical Assistance or MinnesotaCare Expanded (serving pregnant women and children) who have needs that are medically necessary, physician ordered and provided according to a written service plan.

Medical Assistance covers the following home care services:

- Equipment and supplies, such as wheelchairs and diabetic supplies
- Home health aide
- Personal care assistant
- Private duty nursing
- Skilled nursing visits, either face to face or via tele-home care technology
- Therapies (occupational, physical, respiratory and speech)

Overview of State Grant Programs

The state grant programs provide support to people living in their own homes or with family members. These grant programs include:

- Consumer Support Grant
- Family Support Grant
- Semi-Independent Living Services

Consumer Support Grant

The Consumer Support Grant program is a state-funded alternative to Medical Assistance home care services. Consumer support grants can be used to purchase a variety of goods, supports and services beyond what is available through Medical Assistance, as an alternative to using traditional home care services. The services or items selected must relate to the functional limitation of the person and provide the supports needed for the person to live in their own home. (More information is available on the Consumer Support grant webpage[8].)

People are eligible for consumer support grant if they:

- Are eligible for Medical Assistance
- Are able to direct and purchase their own care and supports or have a family member, legal representative or other authorized representative available to purchase, arrange and direct care on their behalf
- Have a functional limitation that requires ongoing supports to live in the community
- Live in a home setting
- Are eligible to receive home care services from a Medical Assistance home care agency
- Are not participating in the Alternative Care program, home and community-based services waivers, managed care programs, Personal Care Assistance program, or receiving home health aide or private duty nursing services

[8] http://www.dhs.state.mn.us/main/id_004735

Family Support Grant

The Family Support Grant is a state-funded program that helps families access disability services and supports, prevents out-of-home placement of children with disabilities and promotes family health and social well-being. Family Support Grant program provides cash grants to eligible families with children who have certified disabilities. These grants offset the high expenses directly related to a child's disability and can be no more than $2,936 per calendar year for each eligible child.

To receive a family support grant, the child must live or will live in their biological or adoptive family home. Eligible children who would return to their family home if a grant were awarded are able to receive family support grant.

Family support grants are available to families of children who:

- Are certified disabled by a lead agency developmental disabilities screening or State Medical Review Team
- Are under the age of 21 years
- Live in or will live in their biological or adoptive family home
- Have a family annual adjusted gross income of $93,611 or less except in cases where extreme hardship is demonstrated.

Children receiving services through a home and community-based services waiver, the Personal Care Assistance program or a consumer support grant are not eligible to receive a family support grant at the same time. (More information is available on the Family Support Grant Program webpage[9].)

Semi-Independent Living Services

The Semi-Independent Living Services program helps adults developmental disabilities live successfully in the community. To be eligible for these services people must be 18 years of age or older and not at risk of placement in an intermediate care facility for persons with developmental disabilities.

The goal of semi-independent living services is to support people in ways that enable them to achieve personally desired outcomes and lead self-directed lives. Covered services include training and assistance to:

- Engage in activities that make it possible for an adult with developmental disabilities or related condition(s) to live in the community
- Exercise social, recreation and transportation skills, including appropriate social behavior
- Learn and exercise the rights and responsibilities of community living

[9] http://www.dhs.state.mn.us/main/id_004736

- Maintain personal appearance and hygiene
- Manage money, prepare meals and shop
- Obtain and maintain a home
- Perform first aid and obtain assistance in an emergency
- Self-administer medication
- Use the phone and other utilities

One-time housing allowances can be provided to cover some of the costs related to damage or security deposits for housing rentals, utility deposits and connection costs, household furnishings and other items necessary to enable participant to secure a home in which to receive semi-independent living services. (More information is available on the Semi-Independent Living Services webpage[10].)

CCA Policy Direction

Minnesota's Medical Assistance system has continually evolved. For about 30 years, there has been steady focus on shifting long-term services and supports from institutional settings to home and community settings. A large majority of Medical Assistance-eligible people with disabilities (94 percent in 2010) and older adults (61 percent in 2010) who need long term care services are living in the community rather than in an institutional setting.

It is increasingly evident that early intervention is a critical factor. The long-term services and supports system began in response to people at higher levels of need. However, by providing less intensive services to people at earlier stages, the need for higher level, intensive services can be delayed or avoided. CCA has been moving in the direction of early intervention.

In an effort to ensure the sustainability of the long-term services and supports system, the 2009 Minnesota Legislature directed the DHS to modify the nursing facility level of care criteria for public payment of long-term services and supports. Nursing facility level of care status affects eligibility for Medical Assistance payment of nursing facility services and home and community-based services waivers that provide alternatives to nursing facility services. This includes the Brain Injury-Nursing Facility, Community Alternative for Disabled Individuals and Elderly waiver programs. It also impacts eligibility for Alternative Care, a state-funded program that provides home and community-based services to people 65 and older but whose income and assets are above Medical Assistance eligibility thresholds. To meet nursing facility level of care, people must demonstrate one or more of the following characteristics:

- High need for assistance in four or more activities of daily living

[10] http://www.dhs.state.mn.us/main/id_003730

- High need for assistance in one activity of daily living that requires 24-hour staff availability
- Need for daily clinical monitoring; significant difficulty with cognition or behavior
- Qualifying nursing facility stay of 90 days
- Living alone with risk factors

This replaces a standard that allowed a determination of nursing facility level of care if a person needed ongoing or periodic assistance with any one activity of daily living. The modified nursing facility level of care criteria will be effective beginning January 1, 2014 for adults and October 1, 2019 for children. (More the waiver request submittal[11] and other information are available on the Modification of Nursing Facility Level of Care criteria webpage[12].)

The planned adjustment to Minnesota's nursing facility level of care standard will result in some people with low needs who are currently receiving long-term services and supports services losing Medicaid coverage for these services. Approximately 500 people with disabilities who have received services through the Community Alternatives for Disabled Individuals waiver will no longer be eligible for waiver services; there is a greater impact on older adults who had been receiving through the Elderly waiver or Alternative Care program. For some, this may also result in out-of-pocket costs in the form of a spenddown or ineligibility for Medicaid state plan services due to the financial eligibility rules. Minnesota proposes to provide a limited benefit package of low-cost, high-impact home and community-based services called Essential Community Supports to this group to ease the transition away from Medicaid payment of all long-term services and supports and to promote continued community living. (For more information about Essential Community Supports, see page 33.)

While work to move or support people in the community continues, there is also movement towards helping people who live in community settings to be meaningfully engaged with their community. When people have more choice and flexibility in how they access and use supports and services, they have more opportunity to lead lives that are personally meaningful and fulfilling. Minnesota has been increasing person-centered and self-directed options. Person-centered services revolve around each person's circumstances, preferences and goals. In this context, self-directed 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.

Another policy goal towards which CCA has been moving is a quality-driven system. In 2006-2007, CCA engaged in a process of designing a framework ("quality architecture") for defining and measuring quality, and, using quality to inform service design and delivery. Since that time CCA has been building and implementing the components of that framework.

[11] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6647-ENG
[12] http://www.dhs.state.mn.us/main/dhs16_147891

Reform 2020 provides an opportunity to greatly advance in these directions.

Reform 2020 (Home and Community-Based Services Redesign)

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

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

CCA has considerable responsibility for *Reform 2020* as many of its initiatives are focused on improving the long-term services and supports system to better support people in having a meaningful life at all stages, according to their own goals, providing opportunities to make meaningful contributions and building upon what's important to them. Such a system needs to be flexible, responsive and accessible. The goal of *Reform 2020* is to provide people with the right services, in the right way and the right time. These services should be driven by the person's functional needs, according to a person-centered plan. Services should be provided so that people can achieve better individualized outcomes. Services need to be designed and delivered efficiently and effectively to ensure the sustainability of the system. (A complete discussion of *Reform 2020* is available in *Reform 2020: Pathways to Independence*[13], the Section 1115 waiver proposal that was submitted to the Centers on Medicare and Medicaid Services on November 21, 2012.)

While this report highlights the initiatives that require federal authority and/or state legislation and are grouped together as the *Reform 2020* package, it is important to remember that other CCA initiatives, such as Money Follows the Person and performance measurement efforts, continue and serve as a foundation for many of the reform initiatives. It is also important to note that while the CCA is moving forward with plans for the various elements of *Reform 2020* it is responsible for, implementation will be dependent upon federal approval and/or state legislation for several of the proposals. *Reform 2020* is a collection of initiatives and actions staged to build on earlier activities, and inform further components of reform.

Current Environment for Reform

As discussed, CCA has been moving in certain policy directions for several years. Progress in these policy directions described is imperative as the changing demographics and economic

[13] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6535E-ENG

pressures faced by Minnesota and the rest of the country put the system at risk of not being sustainable. (Charts showing demographic trends are included in Attachment B.)

Past actions have laid the groundwork for the current reform environment. Starting in 2009, the CCA launched four significant transformation projects which provide the tools and framework from which to implement future reforms.

- MnCHOICES – a comprehensive assessment and planning tool (See page 24.)
- Elderly Waiver Customized Living Rate Development Tool - which is informing rate setting methodologies for customized living with the disability waivers
- Home and Community-Based Services Waivers Provider Standards (See page 26.)
- Disability Waivers Rate System (See page 28.)

Since then, opportunities have arisen on a federal level to support innovation and reform on the state level. Minnesota is pursuing several of these, including:

- Participating in the federal Money Follows the Person grant to help Minnesotans transition from institutions, such as nursing homes and intermediate care facilities for persons with developmental disabilities, and live and work with home and community-based services and supports
- Using federal funding to improve care for Minnesotans who are dually eligible for Medicaid and Medicare
- Taking advantage of enhanced federal financial participation and increased flexibility to increase consumer-directed options under new Medicaid authorities [e.g.: Community First Choice Option under the 1915(k) and 1915(i) authority]
- Innovating approaches to targeted populations with specialized services under Medicaid 1915(i) authority

Values and Vision

The values and vision that guide *Reform 2020* are aligned with the values and vision of the CCA.

DSD believes, as does CCA, that long-term services and supports should enable people to have a meaningful life at all stages of life, according to their own goals, providing opportunities to make meaningful contributions, and built upon what is important to them.

Minnesota's long-term services and supports system should be flexible, responsive and accessible by the people who have an assessed need for long-term services and supports.

The long-term services and supports system should be well managed to ensure its sustainability in order to be available to those who need it in the future.

Goals

Through redesign of home and community-based services, the CCA aims to achieve better individual outcomes, including:

- Increased flexibility to better meet the needs of each person
- Increased stability in the community
- Better-informed personal decision-making about long-term services and supports options
- Promotion of person-centered planning — life-long and crisis
- Improved transitions between settings and programs, preventing avoidable health crises
- Recognizing and addressing social determinants—factors that contribute to—health care need and cost

Another goal is to provide the right service at the right time, in the right way. This includes using low-cost, high impact services to reach people earlier and decreasing reliance on more costly services. Making services more flexible will enable many people to meet their needs without requiring a higher level of service. Helping people match up with providers that have the skills that are most helpful to them will make those services more effective.

An additional goal of *Reform 2020* is to deliver services in a more efficient and effective way in order to make the system sustainable and, thus, available for meeting the needs of Minnesotans today, tomorrow and into the future.

Strategies

There are four basic strategies underlying *Reform 2020*'s home and community-based services redesign. (A list of *Reform 2020* initiatives organized by strategy is included in Attachment D.)

Improve navigation and streamline access to services and support

Two important principles behind the reform effort are 1) people know what is best for themselves and their families; and, 2) early supports can mean better long-term outcomes, such as delayed or avoided need for costly interventions. The reformed system will provide more support for people to plan, prepare and direct their own services. The system will help people connect with supports earlier.

Redesign and improve services

Many services are being redesigned in accordance with the principle of early intervention. The long-term services and supports system was built to intervene at the most critical points in people's lives. While those supports still need to be available and improved in areas, DSD would like supports to be available for people *before* they are in crisis or have critical needs, including bolstering their informal support systems.

Increase service coordination and service integration

Through reform, DSD is working to bring together the care people receive from different people and places. DSD is working to eliminate unnecessary "specialization" that only serves to complicate the system, and to create specialization where it is needed but doesn't currently exist.

Increase efficiency and sustainability of administrative systems

In order to support the changes that make a difference in people's lives, administrative structures need to be adapted. A number of the reforms underway are rebuilding how the state administers the Medicaid system and evaluates its effectiveness.

Status of Current Priority Reform Initiatives

Three initiatives—MnCHOICES, Home and Community-Based Services Waiver Provider Standards and Disability Waivers Rate System—will transform the administrative structure for the delivery of long-term services and supports. These initiatives have been underway for several years and are nearing implementation. In 2011, Minnesota began a fourth initiative, Money Follows the Person, to develop, test and evaluate strategies to better serve people with the most complex needs through home and community-based services. The Money Follows the Person demonstration will run through 2020.

MnCHOICES

Description

The MnCHOICES initiative creates and implements a single, comprehensive, and integrated assessment and support planning application for long-term services and supports in Minnesota. MnCHOICES embraces a person-centered approach to ensure services are tailored to the person's strengths, goals, preferences, and assessed needs.

The key goal of the MnCHOICES initiative is to implement a new assessment and service planning process and application that will:

- Simplify and standardize assessments and streamline support planning
- Integrate community-based support options beyond what is reimbursed through Medical Assistance
- Improve consistency and equity in accessing home and community-based services
- Collect additional data for evaluating outcomes and enhancing quality assurance functions
- Automate the assessment process to support effective communication and administrative workflows, and make it accessible to lead agencies through the web

The MnCHOICES assessment will be used for people of all ages and with any type of disability or other long-term services and supports needs. It will replace current long-term services and supports assessment processes and forms, including:

- Developmental disability screening
- Long-term care consultation assessment
- Personal care assistance assessment
- Private duty nursing assessment (MnCHOICES will not replace the PDN assessment when first implemented; it will occur in a later phase of implementation)

Recent Milestones Met

- Built and tested the initial MnCHOICES prototype — the Alpha model—in 2011
- Started testing the second and final MnCHOICES prototype—the Beta model—in July 2012
- Completed pilot time study to define new activity codes for MnCHOICES assessments and evaluate the fiscal impact of implementing MnCHOICES
- Developed skills and competencies training for certified assessors
- Finalized DHS's expectations of lead agencies ("assurances") for implementing MnCHOICES

Current Activities

- Emailing frequent project updates to all lead agencies
- Testing the Beta model's business rules and offline functionality, with existing clients, in 16 lead agencies
- Integrating MnCHOICES with the Social Services Information System (SSIS)
- Establishing a new payment methodology for the MnCHOICES assessment
- Developing the standardized Community Support Plan and the Coordinated Services and Support Plan
- Operationalizing the three components of mandatory certified assessor training

How Implementation Will Occur

DHS will launch the first release of MnCHOICES in the spring of 2013, initially in the 16 "first implementer" lead agencies (the counties, tribes, and managed care organizations that have participated in testing the MnCHOICES models). Two months after the first release, additional lead agencies in the northern half of the state will implement MnCHOICES, followed, two months after that, by additional lead agencies in the state's southern half. This rollout process will be repeated for several future releases.

Who is Involved?

Representatives from lead agencies and advocacy organizations serve on the project's Steering Committee and a variety of advisory groups for various components of the project. (Membership lists of these groups are included in Attachment C.)

Home and Community-Based Services Waiver Provider Standards

Description

DHS is introducing a new, centralized, system for establishing and monitoring standards for providers of home and community-based services to improve the dignity, health and independence of people who use these services. A centralized system of provider evaluation, focused upon quality services, will drive consistency and quality outcomes in person-centered services. Centralized provider review will be more efficient and is required by the federal Centers for Medicare and Medicaid Services.

To accomplish this significant change to the service delivery system, DHS is building upon and combining the work of three CCA initiatives and closely aligned with a fourth activity.

1. *Provider Enrollment and Provider Standards Initiative*

   In 2008, Centers on Medicare and Medicaid Services reviewed Minnesota's home and community-based services disability waivers and directed several changes, documented in a corrective action plan. These changes are necessary to bring Minnesota in line with federal requirements. In response, CCA began this initiative to strengthen state provider standards and approval processes.

2. *Quality Outcome Standards Initiative*

   In 2009, the Minnesota Legislature directed DHS to develop a single set of provider standards for home and community-based services waiver services for people with disabilities. (MN Law 2009, chapter 79, article 8, section 8[14])

3. *Community Residential Setting/Residential Support Services Initiative* (combined with Quality Outcome Standards)

   In 2009, the legislature mandated that DHS create a single set of licensure standards (Minn. Stat. §245A.11, Subd. 8[15] and Minn. Stat. §256B.092, Subd. 11[16]), integrating corporate waiver foster care setting and service delivery. The new Residential Support Service requires a single Community Residential Setting license.

4. *Positive Support Strategies, Prohibitions and Emergency Use of Manual Restraint/Rule 40 Modernization*

   The intention of this work is to modernize Rule 40 to reflect current best practices. This entails a plan to eliminate the use of procedures that cause pain, whether physical,

[14] https://www.revisor.mn.gov/laws/?key=57560
[15] https://www.revisor.leg.state.mn.us/statutes/?id=245A.11
[16] https://www.revisor.mn.gov/statutes/?id=256b.092

emotional or psychological; prohibit the use of seclusion and restraints for programs and services licensed or certified by the Department that serve people with disabilities; advance the goal of serving all people in integrated community settings, using best practices that highlight positive, person-centered practices, and providing sufficient resources to enable providers to meet the new standard. Additionally, this work will fulfill the provisions of the 2011 Jensen settlement agreement.

The key goals of the initiative to build a centralized waiver provider standards system are:

- Expand consistent standards for those delivering home and community-based services waiver services to people age 65 and older and person with disabilities of all ages
- Improve home and community-based services provider enrollment, licensure and monitoring statewide
- Re-define county and tribe administrative function following the elimination of local waiver provider contracts

The scope of the initiative includes:

- Licensed and unlicensed providers of home and community-based services waiver services
- Minnesota Statute Chapter 245D (standards apply to service providers regardless of funding source)
- The new Residential Support Service – Community Residential Site license (a single license that combines the corporate waiver foster care service and facility standards)

Recent Milestones Met

- Stakeholders convened in the fourth quarter of 2012 to make comments, express concerns and give recommendations on the draft Minnesota Chapter 245D standards
- In the second half of 2012 DHS developed new online waiver provider training that will be part of enrollment requirements for all newly enrolled waiver service providers on March 2013
- Statutory language and a budget proposal have been developed for the 2013 legislative session

Current Activities

- Developing the technological infrastructure to support the electronic 245D licensure application, scheduled to begin in July 2013
- Working with representatives from more than 20 counties and tribes in exploring and defining local agency administrative functions following the elimination of waiver provider contracts
- Beginning re-enrollment of all currently enrolled waiver service providers with DHS

How Implementation Will Occur

- March 2013: All newly enrolling waiver service providers will need to complete a new online waiver provider training course. All waiver service providers will have access to the course and its individual modules.
- July 2013: Providers of home and community-based services identified in chapter 245D, will apply for DHS licensure in accordance with 245D requirements. January 1, 2014 is the effective date of the licenses issued.
- Fall 2013: DHS will provide training to lead agencies and providers in anticipation of the elimination of waiver provider contracts and movement to centralized operations
- January 1, 2014: Compliance monitoring, licensing inspections and licensing complaint investigations will begin for 245D-licensed services. Technical assistance for licensing compliance will be available to help providers new to regulation understand how to achieve and maintain compliance with licensing requirements.
- January 1, 2014: Elimination of county and tribal waiver provider contracts

Who is Involved?

- CCA consults with several external work groups on the various aspects of the project. The work groups include representatives from counties, tribes, health plans, provider organizations and advocacy organizations, program participants and family members. Some work groups have completed work; others continue to assist in the project development and implementation. (Membership lists are included in Attachment C.)

More information is available on the Home and Community-Based Services Waiver Provider Standards webpage[17].

Disability Waivers Rate System

Description

The Disability Waivers Rate System, the product of the Rate-Setting Methodologies Initiative, transfers the responsibility of setting rates for services within the four disability waivers from counties and tribes to the state. The four disability waivers include Brain Injury, Community Alternative Care, Community Alternative for Disabled Individuals and Developmental Disabilities waivers.

The goal is to create a statewide system for disability waiver services that:

- Establishes rates that are based on a uniform process but also capture the individualized nature of the services and clients' needs
- Is transparent, fair and generates consistent pricing across the state
- Promotes quality and participant choice

[17] http://www.dhs.state.mn.us/main/dhs16_172393

The scope of the rate system development process includes:

- Values for service components
- Compliance with federal home and community-based services waiver regulations to ensure Minnesota's continued participation
- Processes to standardize rates based on service components and individual needs
- Structural components of waiver services
- Streamlined purchasing and other administrative processes

Recent Milestones Met

- Convened monthly stakeholder advisory committee meetings to discuss process and progress
- Built an online software tool and gathered a sample of consumer-level data from lead agencies and providers
- Convened ten stakeholder workgroups, each meeting between three and ten times, to examine relevant data and make recommendations regarding the research areas in the 2012 legislation
- Built a simulation tool that models the characteristics of disability waiver participants and their service consumption behavior to understand the effect of policy changes on budget neutrality; trained a stakeholder group on use of the tool
- Conducted analysis using FY 2010 actual spending data on the impact of the different policy changes on budget neutrality and future payments to providers

Next Steps

In April 2012, the Minnesota Legislature enacted legislation (2012 Statutes 256B.4912 and 256B.4913[18]) that guides the research and development of the rate setting system. DHS is currently in a research period during which information is collected and analyzed in collaboration with stakeholders. The Centers for Medicare and Medicaid Services are expecting implementation to be effective as of January 1, 2014. Until then they are withholding approval of the Developmental Disabilities waiver and DHS anticipates they will withhold other future disability waiver renewals until assured that Minnesota will be implementing the statewide rate methodologies and eliminating the use of county contracts.

During the research phase, DHS collected and is analyzing data to adjust the rate frameworks. Counties and tribes will use a tool, the Disability Waivers Rate Management System, to enter client specific information for a limited number of services. This work will provide important data to DHS that does not exist elsewhere in the system. DHS is working with an advisory committee in order to gather input, discuss concerns and exchange ideas to prepare for the 2013

[18] https://www.revisor.mn.gov/laws/?id=216&doctype=Chapter&year=2012&type=0

disability waivers rate system legislative proposal and implementation and the 2013 Disability Waivers Rate System report, due February 15, 2013.

The information gathered during the current research phase will guide decisions for implementation of the disability waiver rate system in January 2014. Until then, providers continue to receive payments as authorized by counties and tribes.

Who is Involved?

The DSD has convened three major stakeholder groups to complete the work of the initiative. Selected applicants were chosen based on a set of criteria established by DHS to participate in either the Intensive or Expanded Workgroups (which ran concurrently in 2009 and 2010) or in the Advisory Committee. (Membership lists are included in Attachment C.)

More information can be found on the Disability Waivers Rates System webpage[19].

Money Follows the Person

Description

Minnesota already serves the majority of those needing long-term servicers and supports through home and community-based services, but there still remain people in institutional settings who would prefer to be in community settings. People who have the most complex needs and co-occurring conditions need sufficient support to make the transition and maintain stability in the community. The Money Follows the Person initiative was started, with a grant from the Centers for Medicare and Medicaid Services, to address this situation.

Money Follows the Person aims to decrease, and prevent reliance on, institutional care and increase the use of home and community-based services by supporting the transition of people eligible for Medical Assistance of all ages from institutions to the community, and increasing the capacity of community providers to serve people with complex and co-occurring conditions. Money Follows the Person also will identify and seize opportunities to simplify and individualize the way people with complex needs are served. Supporting people in community settings usually aligns with people's preferences and allows them to participate in their communities. It is also a more cost-effective approach, on average, that makes the entire system more sustainable.

Money Follows the Person is using four strategies to reach its objective:

1. Simplify and improve the effectiveness of transition services that help people return to their homes after lengthy hospital or nursing facility stays
2. Advance promising practices to better serve people with complex needs

[19] http://www.dhs.state.mn.us/dhs16_144651

3. Increase stability of people in the community by strengthening connections among healthcare, community support and housing systems
4. Decrease reliance on institutional care and increase use of home and community-based services by setting priorities to address specific institutional needs for reform, beginning with intermediate care facilities for people with developmental disabilities and children's psychiatric placements

DHS has projected transitioning approximately 2,000 people from institutional settings to more cost-effective home and community-based alternatives over the five-year grant period.

Recent Milestones Met

- DHS submitted its operational protocol for the grant. Once DHS's operational protocol is given final approval by Centers for Medicare and Medicaid Services, DHS will begin to implement Money Follows the Person.
- Established collaborative partnerships
- Established stakeholder relationships
- Created the Implementation Council

Who is Involved?

Collaborative partners include:

- Divisions within CCA: DSD, Aging and Adult Services, Nursing Facilities
- Community partnerships, including housing policy and planning
- State Operated Services
- Health care and manage care entities
- Adult and Children's mental health
- Children and Family Services

Stakeholders include:

- Counties, tribes and health plans
- Providers
- Consumers
- Families
- Housing organizations
- Advocacy groups

(A membership list for the Implementation Council is included in Attachment C.)

More information is available on the Money Follows the Person webpage[20].

[20] http://www.dhs.state.mn.us/main/dhs16_162194

New *Reform 2020* initiatives

The following new initiatives proposed under the umbrella of *Reform 2020* are being carried out by DSD (most are in conjunction with the Aging and Adult Services Division of the CCA).

Community First Services and Supports

The Community First Services and Supports program will replace the Personal Care Assistance (PCA) program. The Community First Services and Supports program is the same as the PCA program in many ways but will offer participants more flexibility in how they use the service.

The Community First Services and Supports program will have the same rules for eligibility as the PCA program. This means that everyone who is eligible for PCA services now will be able to get services through the Community First Services and Supports program. No one should lose service based on the change from the PCA program to the Community First Services and Supports program. Under the Community First Services and Supports program, direct care workers will be able to help the participant in all the ways they can under the PCA program. For example, workers will still help people with bathing, dressing, eating and other daily activities, and provide observation, redirection of behavior and assistance with health-related activities.

The Community First Services and Supports program direct care workers will also be able to help in new ways that aren't allowed under the current PCA program. Under the Community First Services and Supports program, they will be able to provide the things they currently do, as well as help people to do things for themselves or assist with acquisition of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health-related tasks.

Funds in a Community First Services and Supports program budget can be used to purchase equipment or technology that would increase a person's ability to do something on his own and reduce the need for having another person help him. Funds in a Community First Services and Supports program budget can be used to make a modification to the home that would increase a person's ability to do something on her own and reduce the need for having another person help.

The lowest number of minutes of service available will be raised. In the current PCA program people who are assessed at the lowest home care rating are eligible for 30 minutes of service a day. Under the Community First Services and Supports program the lowest number of minutes a day will be 75.

The fiscal management structure will change. In one of the models, fiscal management entities will help the Community First Services and Supports program participants handle the financial administrative activities connected with managing their services, such as processing timesheets and issuing pay checks to the direct service worker. Currently, there are approximately over 300 PCA Choice provider agencies and 15 fiscal support entities that manage the waiver consumer-directed community supports service. In the future, the fiscal management structure will be

consistent across all programs that offer an opportunity for people to choose to direct and manage their own services, including Community First Services and Supports and the waiver service Consumer Directed Community Supports. In the future, entities will bid on the chance to be a provider through a Request for Proposal process, and DHS will contract with them directly to provide the administrative support for those who choose to manage their own services instead of using a provider agency. DSD assumes there will be fewer agencies under contract to provide this service, but DSD is committed to ensuring that no matter where a person lives in the state, he or she will have at least two agencies from which to choose.

A smaller number of fiscal management entities will be less costly to the program. The State will be able to do a better job managing and ensuring the quality of this service. The traditional provider agency model will continue for those that would like to continue utilizing that model of support and assistance with receiving the Community First Services and Supports program services.

In conjunction with the new Community First Services and Supports program, DSD plans to launch a small demonstration project to test innovative approaches to service coordination for children with complex service needs. To be eligible to participate in the demonstration the child will have to be using the Community First Services and Supports program and meet other criteria. Through a request for proposal process DSD will select a few local entities to design models appropriate for their communities in relation to their resources and needs. Each model must include the involvement of a school. The demonstration will include up to 1,500 children.

Essential Community Supports

Essential Community Supports is a new program that will provide specific services for people of all ages who will not meet the new nursing facility level of care criteria, when implemented. Current statute provides Essential Community Supports to people age 65 years and older who are not eligible for Medical Assistance. In the Long Term Care Realignment Waiver submitted to Centers for Medicare and Medicaid Services, DHS proposes to expand Essential Community Supports to people of any age who lose eligibility for Medical Assistance payment of long-term care services due to implementation of the revised nursing facility level of care criteria. (The Long-Term Care Realignment Waiver submittal[21] is available on the DHS website.)

Services will support people with an assessed need for one of the Essential Community Supports to maintain their community living. As outlined in the Long Term Care Realignment Waiver request, Essential Community Supports will provide service coordination plus one or more of the following services most needed to maintain independence in the community:

1. Service coordination
2. Personal emergency response system

[21] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6647-ENG

3. Homemaker services
4. Chore services
5. Caregiver support and education
6. Home-delivered meals
7. Community living assistance

Eligible groups:

- Medical Assistance ineligible seniors (65 and older)
- Transition group: people of any age who were receiving long-term care services under Medical Assistance and lose eligibility for those services. To qualify, people must have received long-term care services under Medical Assistance prior to the implementation date of the revised nursing facility level of care criteria. There are 500 people under 65 with disabilities who will be affected by this change. It is a more significant change for older adults.

Planning and Service Development

CCA has many initiatives examining the current system, planning for changes in the system and developing services to address gaps. The gaps analysis and needs determination initiatives are discussed in the Quality section of this report, starting on page 39. Additionally, CCA is proposing a critical access study of the use and availability of home and community-based services across the state. Through this study CCA will determine what changes may be necessary to increase access to services, with particular focus on caregiver support and respite.

Consumer-Directed Community Supports Redesign

CCA will implement a new financial management structure for Consumer Directed Community Supports service, which is a self-directed option across the home and community-based service waivers, in order to have a more efficient system. Under this reform, fiscal support will switch from being a service to being an administrative function. DHS will issue a request for proposals and enter contractual arrangements with selected entities, giving DHS more direct oversight and quality management of these functions. Under the new arrangement participants will have a choice of at least two providers. This structure will be used both with consumer-directed community supports and the new Community First Services and Supports program.

Empower and Encourage Independence through Employment Supports

One component of *Reform 2020* is a demonstration project to test the effectiveness of services delivered over the phone to support people who are interested in employment, either starting to work or retaining work. The demonstrative builds off the successful practices Minnesota tested in the federal research grant, the Demonstration to Maintain Independence and Employment[22]. This demonstration will be available to limited numbers of people from specific groups. People will have a choice whether or not to participate.

[22] http://www.mathematica-mpr.com/disability/dmie.asp

The services that will be provided to people who participate in the demonstration are:

- Assistance in accessing needed medical, mental health, and employment support services
- Help in developing personal plans around employment and life goals
- Help in problem-solving in order to maintain or advance in their jobs, if they are already employed
- Assistance in understanding health care benefits and counseling to understand their options
- Referrals and follow-up

Minnesota proposes, initially, to limit services to the following targeted groups who are at a critical transition phase of life:

- People eligible for Medical Assistance Expansion, age 18-26, with a potentially disabling serious mental illness as identified used ICD-9 diagnostic codes (290-301 and 308- 319) and health care claims associated with these diagnoses within the past 12 months
- Medical Assistance for Employed Persons with Disabilities recipients, age 18-26
- Minnesota Family Investment Program parents who have turned to cash assistance as minor parents or because of the demands of caring for a seriously ill family member
- People eligible for Medical Assistance identified by the Department of Corrections as being in transition
- People eligible for Medical Assistance, age 18-26, who have exited foster care

Services for Children with Autism Spectrum Disorder Diagnosis

DSD is leading a collaborative effort between DSD, the Children's Mental Health Division and the Health Care Administration to work with people in the community to address the decidedly critical need for timely access to and coverage of a range of effective, responsive, family-centered and individually-derived screening, evaluation and treatment services for people with autism spectrum disorders and their families. DHS plans to develop a package of new and existing services to meet the needs of this unique population. The services will be based on available evidence and build additional evidence on the effectiveness and conditions supporting different approaches. DHS received and reviewed extensive community stakeholder input and performed a broad review of the literature as part of the process of developing a current best practice model for these new services.

The 2012 Minnesota Legislature asked the Health Services Advisory Council to recommend coverage for evidence-based treatments for people with Autism Spectrum Disorder (2012 Laws of Minnesota, Chapter 247, Article 1, Section 26[23]). The recommendations are due to the

[23] https://www.revisor.leg.state.mn.us/laws/?id=247&year=2012&type=0

Commissioner of Human Services by December 31, 2012. Council members discussed the issue at meetings from June through December 2012.

In addition to the Health Services Advisory Council's work, the Department convened an advisory council to provide input into two autism-specific initiatives: developing an early childhood benefit for children with an Autism Spectrum Disorder diagnosis, and, a study on housing with support for people with autism (2012 Laws of Minnesota, Chapter 247, Article 4, Section 50[24]). The Autism Advisory Council consists of 40 members who represent family members, advocates, providers, counties, health plans, and state agencies. The Council met monthly as a full Council and in small groups from October-December 2012. The Department will continue to convene the Council as needed to assist with developing specific benefit sets. By December 31, 2012, the Institute on Community Integration, under contract with the Department, will complete a report that includes a summary of the work of the Council, input from key stakeholder interviews, and findings from site visits and national research. (Membership lists for the various advisory bodies are included in Attachment C.)

Enhancing Protection of Vulnerable Adults

As the number of older adults and people with disabilities receiving services in the community grows, so does the need for a strong adult protection system that provides protection from abuse, neglect and exploitation.

Currently, Minnesota statute mandates the counties to designate a common entry point that is responsible for receiving reports of suspected maltreatment of vulnerable adults 24 hours a day, seven days a week [Minn. Statute §626.557 Subd. 9 (a)[25]]. The 84 counties and county collaborations designate a total of 168 different telephone numbers for citizens and mandated professionals to call to submit a report, based on the location of the incident and the time of day. This complexity significantly reduces the effectiveness of the system.

As part of *Reform 2020*, the Commissioner of the Department of Human Services will establish a statewide common entry point to receive reports of suspected maltreatment of vulnerable adults through a statewide, toll-free number. This will replace the current fragmented county-designated Common Entry Point system. A simplified reporting system will reduce impediments in making reports and provide a consistent response to reports of suspected maltreatment, facilitating investigation and interventions to protect vulnerable adults. The initiative will also include increased support for counties to investigate allegations of maltreatment and providing protective services.

[24] https://www.revisor.leg.state.mn.us/laws/?id=247&year=2012&type=0
[25] https://www.revisor.mn.gov/statutes/?id=626.557

Case Management Redesign

In 2012, the legislature required the DHS to submit a report in February 2013 proposing legislation to redesign the home and community-based services case management system (2012 Laws of Minnesota, Chapter 216, Article 11, Section 42[26]).

Over the past decade, several case management reports 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 home and community-based services waivers or by being part of 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 have been identified include the challenges of:

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

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

Home and Community-Based Services Waiver Enhancements

In tandem with the other *Reform 2020* initiatives, CCA proposes a package of enhancements to the five existing home and community-based services waivers with the goal of improving effectiveness of the waivers to provide the right service at the right time and to provide needed flexibility. The following are all changes to the waivers that are under consideration.

Technology

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. The service menu will be updated to keep current and increase access and effectiveness of option. This will make the home and community-based services waivers more flexible and more adaptable to individual needs.

[26] https://www.revisor.mn.gov/laws/?id=216&year=2012&type=0

Employment

Employment is a priority of the Governor, DHS and DSD. DSD, in collaboration with many partners, developed Disability Benefits 101 (DB101), a web-based tool with on-line assistance, which can be used by people with disabilities and those who help them to understand how employment earnings affect benefits. Too often people assume that working will mean a loss of necessary benefits. DB101 helps people learn how to use available benefits to support the pursuit of their chosen lifestyle, rather than having benefits act as a barrier to their goals.

The Division will use the experience gained from the Medicaid Infrastructure Grant, Pathways to Employment, to inform future changes to the service menu. DSD will propose policy changes that will encourage providers and support people in exploring and obtaining competitive employment (real work for real wages in integrated work conditions) and understanding their options. DSD will propose policy changes to incent providers to help people find and maintain competitive work.

Consumer-Directed Community Supports

Consumer-directed community supports are an option in the waiver programs for people to choose to direct and manage their own services, including hiring their own staff, rather than going through a provider agency. DSD is evaluating the current service to see if changes need to be made, specifically:

- Adjusting the definitions of what is allowable and unallowable
- Evaluating the budget methodology to determine strategies that may enable more people to participate in this option without increasing overall waiver spending

Home and Community-Based Services Report Card

CCA plans to launch a Home and Community-Based Services Report Card on www.minnesotahelp.info regarding the quality of home and community-based services to help people make informed purchasing decisions. The Report Card will be modeled after Minnesota's successful Nursing Home Report Card[27]. The Report Card will initially include three provider types: housing with services (including assisted living), corporate foster care (where the license holder does not reside in the residence), and day training and habilitation. The Report Card will help inform people about differences among home and community-based services and service providers; contribute to the DHS' response to federal assurances related to access, choice and systems improvement; and support home and community-based service providers in targeting improvements in their services.

Technical Assistance to Divert Commitments and Address Crises

DSD will offer enhanced technical assistance to create regional capacity for developing person-centered community-based crisis plans for people who have previously used psychiatric and/or

[27] http://www.dhs.state.mn.us/dhs16_173472

hospital services during crises, as well as to divert commitment and admissions to more restrictive settings, and to facilitate timely discharges to community services. The University of Minnesota will provide technical assistance under contract with DHS. DHS is also proposing to offer technical assistance through quality improvement triage specialists who will work with the crisis providers, counties, and community providers who are responsible to support people in successful community living. DHS will utilize tele-presence technology to bring clinical expertise anywhere in the state.

Other Reform Initiatives

The following initiatives, some of which fall under the umbrella of *Reform 2020* and others which do not, are listed here without description. These initiatives are not led by DSD but they intersect with home and community-based services. Complete descriptions of these initiatives can be found in the *Reform 2020: Pathways to Independence* Section 1115 Waiver Proposal submittal.[28]

- First Contact simplification
- Community-based services to address homelessness and barriers to housing
- Housing Stability Services
- Project for Assistance in Transition from Homelessness/ Critical Time Intervention (PATH/CTI)
- Planning and service development (in some cases, co-led by DSD)
- Mental health redesign
- Anoka Metro Regional Treatment Center demonstration
- Transition out of Anoka Metro Regional Treatment Center
- Intensive mental health recovery services
- Targeted clinical and community services
- Intensive residential treatment services
- Children under 21 in residential "institution for mental disease" (IMD) facilities
- Alzheimer's health care home
- Health home demonstration
- Budget methodology for high-cost seniors

Quality Management

Ensuring the quality of Minnesota's long-term services and supports is a central state goal. The Centers for Medicare and Medicaid Services Quality Framework, first published in 2002, underlies CCA's approach to quality and has the goals of achieving desired outcomes and meeting program requirements. The State's data-driven quality system is guided by the design,

[28] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6535E-ENG

discovery, remediation, and improvement model of continuous quality improvement articulated by the Centers for Medicare and Medicaid Services. The overall goal is to support and enhance the quality of life for older people and people with disabilities of all ages.

An in-depth description of the current quality management system can be found in the Quality Chapter of the Long-term services and supports State Profile Tool which will soon be published on the State Long-Term Care Profile page[29] of the DHS website. The chapter includes the measures and data sources used, and explains the bodies and processes that use this data to inform policy development and management and the administration of Medical Assistance home and community-based services programs.

Minnesota's quality strategy has evolved over time and is continuing to evolve. While DHS is pursuing reform options for the Medical Assistance program that are expected to change some of the mechanisms for delivering and funding home and community-based services, they are not expected to change the Department's commitment to quality outcomes and oversight, nor the fundamental approaches and data sources for measuring and monitoring home and community-based services quality. In fact, there are several initiatives related to quality management underway, with the intention of making Minnesota's long-term services and supports system more quality-driven towards person-centered outcomes.

In addition to several of the initiatives previously described in this report, the following initiatives are priority efforts currently underway that move Minnesota's long-term services and supports system further to support individual choice and deliver services in the most inclusive community settings, and to establish a system for monitoring quality of services from the perspective of achieving that goal.

Olmstead Plan

In the Americans with Disabilities Act of 1990, Congress described the isolation and segregation of people with disabilities as a serious and pervasive form of discrimination. In 1999, the Supreme Court issued a decision in *Olmstead v. L.C.*[30], a suit brought by two women in Georgia with developmental disabilities and mental illness who were unable to leave a hospital psychiatric unit even though they no longer required that level of treatment. In part, the Olmstead decision requires states to eliminate unnecessary segregation of people with disabilities and to ensure that people with disabilities receive services in the most integrated setting consistent with their desires and needs and subject to certain public resource considerations.

Minnesota has a public policy tradition to support people to live and work in communities of their choice. The last state hospital providing long-term residential care for people with developmental disabilities closed in 1999, and thousands of privately operated intermediate care

[29] http://www.dhs.state.mn.us/main/dhs16_141142
[30] http://www.law.cornell.edu/supct/html/98-536.ZS.html

facility beds for persons with developmental disabilities have closed over the past two decades. Nursing facilities have downsized and closed. Funding that supported people in these institutional settings was converted to home and community-based services.

Initiatives to support community living, such as the Options Initiatives, and later the Options Too, provided strategies to help people move from institutional settings, such as nursing homes and hospitals, and allow people to live and work in their communities. For example, relocation service coordination enabled people to request assistance from a qualified provider to help them plan and arrange for their move to community services. Another example is the change from using a case mix system in several of the disability waivers where people's community services were capped to not exceed the cost of their services in the institution, to an aggregate average cost of services managed by counties. The change to an aggregate average gave counties flexibility in managing the funds as necessary to support people, some of whom had higher cost needs and some, lower cost needs. Over the years, DHS expanded opportunities for greater community inclusion, including focused efforts to support those people remaining in institutional settings to relocate, efforts to help people live in their own homes and support for earning wages through community jobs. (See the Success Highlights section that begins on page 47.) The home and community-based services redesign portion of *Reform 2020* is the latest step in building a sustainable system that will provide appropriate community support for people, including those with complex and co-occurring conditions.

In 2009, a class action lawsuit was filed against the State of Minnesota and DHS, *Jensen v. Minnesota Department of Human Services, et.al*. The complaint alleged that the state and DHS unlawfully and unconstitutionally permitted one of the state's facilities to routinely impose seclusion and mechanical restraints upon plaintiffs and others similarly situated. After months of negotiations, the parties entered into a settlement agreement in June 2011. In December 2011, federal district court Judge Frank approved the settlement agreement.

One provision of the agreement is, within 18 months of the court's approval (due June 2013), the State and DHS will develop and implement a comprehensive Olmstead plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet people's needs in the "most integrated setting" and is consistent and in accordance with the U.S. Supreme Court's Olmstead decision.

To guide the development of this plan, DHS agreed to establish an Olmstead Planning Committee which would develop recommendations within ten months of the court approval (due October 2012). By March 2012, the member selection process was complete and the Committee convened. *The Promise of Olmstead: Recommendations of the Olmstead Planning Committee*[31] was presented to DHS Commissioner Lucinda Jesson on October 23, 2012 and made available

[31] http://www.dhs.state.mn.us/dhs16_172625.pdf

for public comment. While DHS will play a lead role in the development and implementation of the Olmstead plan, it is a responsibility spanning state agencies. DHS will be working to:

- Ensure that DHS programs and services are responsive to participant choice and support inclusive community work and living options
- Ensure that DHS programs and services are looked at through the Olmstead lens (i.e., people should decide how they want to be living their lives)
- Create measurable goals to increase the number of people with disabilities receiving services that best meet their needs in the most integrated setting and that will assess progress in achieving Olmstead plan goals
- Engage other state agencies to enable them to evaluate and, as necessary, transform their services to align with the principles of the Americans with Disabilities Act and Olmstead decision, according to an agreed upon plan

CCA, including DSD, will continue to be a key participant in the development and implementation of Minnesota's Olmstead plan.

Rule 40 Modernization

Minnesota Rules 9525.2700 to 9525.2810[32] (commonly referred to as "Rule 40") governs licensed facilities serving people with developmental disabilities in regard to use of aversive and deprivation procedures. The rule modernization stems from the Jensen settlement agreement, discussed in the previous section. At the same time, the Home and Community-Based Services Provider Standards initiative identified this rule and its underlying goals as an area that needed to be revised. (See page 28 for a discussion of the Home and Community-Based Services Waiver Provider Standards initiative.)

In the Jensen settlement agreement, in addition to developing and implementing an Olmstead plan, DHS agreed to utilize a rule advisory committee consisting of various stakeholders to study, review and advise DHS on how to modernize Rule 40. The Rule 40 Advisory Committee was convened in January 2012 to study, review and advise DHS pursuant to the Jensen settlement agreement. The Advisory Committee met ten times over the course of 2012, and will meet again in early 2013. The Advisory Committee's recommendations are in the final stages of completion and publication is expected in early 2013.

The Committee's recommendations cover:

- Person-centered planning
- Positive support strategies
- Permitted techniques
- Prohibited techniques

[32] https://www.revisor.mn.gov/rules/?id=9525

- Emergency use of manual restraint
- Staff training
- Reporting and notifications
- Monitoring
- Oversight
- Implementation

DHS intends to draw from the Advisory Committee's recommendations to eliminate the use of procedures that cause pain, whether physical, emotional or psychological; prohibit the use of seclusion and restraints for programs and services licensed or certified by DHS that serve people with disabilities; and, advance the goal of serving all people in integrated community settings, using best practices that highlight positive, person-centered approaches.

Needs Determination (Foster Care)

The purpose of this initiative is to assist the State in determining where foster care capacity is needed in the state and in reducing reliance on corporate residential services by developing supports for alternative arrangements and reducing corporate foster care capacity. The needs determination survey will enable DSD to get a baseline and subsequent data on the capacity within counties for residential services and alternative support services.

The scope of this initiative covers all residential services needed by people with disabilities, regardless of age, receiving services any of the four disability waivers, licensed or non-licensed. The survey will look at:

- Housing
- Identified barriers to corporate foster care closure
- Home-based support services

DSD will conduct the needs determination survey and produce a legislative report annually, with the first due to be delivered in February 2013. The purpose of the study and report is to:

- Report on the implementation of the foster care licensing moratorium
- Identify how foster care services will be used in Minnesota
- Identify how much foster care should be available
- Identify where foster care services should be located
- Identify what other services are needed as alternatives to foster care
- Recommend changes to the system
- Identify performance indicators
- Support the voluntary bed closure by providing data, closure priorities and incentives

The legislature has directed DHS (Minn.Stat. §245A.11, Subd.2a[33]) to begin bed closures as of July 2013, with a target to close 128 corporate foster care beds as of July 2014.

Gaps Analysis

The DHS is required (Minn. Stat. §144A.351[34]) to report to the legislature biennially on the effects of legislative initiatives to "rebalance" the State's long-term supports and services system. One of the tools to assess the status of long-term supports and services in Minnesota is the biennial gaps analysis survey. The gaps analysis survey originally focused on long-term supports and services for older Minnesotans, but in 2011 the legislature directed the CCA to expand the survey and analysis to include services for people with disabilities.

The purpose of this initiative is to better meet the preferences and needs of people with disabilities of all ages and older people and their families by collecting and analyzing data on services that can be used to support the development of home and community-based services, to provide policy-makers with data needed to make decisions about funding of home and community-based services, and to better match the distribution of services to areas of need.

The scope of the initiative is long-term supports and services, including residential and support services. Mental health services that intersect with long-term services and supports are included in the gaps analysis. The gaps analysis examines the availability of services, regardless of funding source. The gaps analysis (a biennial effort with report due in August) and the needs determination study (an annual effort with report due in February) are closely coordinated projects.

The legislation directs the CCA to include the following components in the report:

- Demographics and need for long-term supports and services in Minnesota
- Summary of county and regional reports on long-term services and supports gaps, surpluses, imbalances, and corrective action plans
- Status of long-term services and supports and mental illness services, housing options, and supports by county and region including:
    - Changes in availability of the range of long-term services and supports services and housing options
    - Access problems, including access to the least restrictive and most integrated services and settings, regarding long-term services and supports services
    - Comparative measures of long-term services and supports services availability, including serving people in their home areas near family, and changes over time

[33] https://www.revisor.mn.gov/statutes/?id=245A.11#stat.245A.11.2a
[34] https://www.revisor.leg.state.mn.us/statutes/?id=144A.351

- Recommendations regarding goals for the future of long-term services and supports services and support, policy and fiscal changes, and resource development and transition needs

Technology Grants

DSD administers the Assistive Technology Grants program according to the 2009 Laws of Minnesota, Chapter 79, Article 13, section 3, subd. 8(i)[35]. During state fiscal year 2013 $331,000 is available for qualified organization(s) to provide these consulting services in their region to teams of people, counties, tribes and others chosen by the participant. The technology grant program is part of a quality management strategy to increase the capacity of counties and others to provide people with high quality assistance in planning, acquiring and using assistive technology, and developing options as alternatives to corporate foster care.

Assistive technology is a tool which helps many Minnesotans with disabilities who are eligible for home care or home and community-based services waiver services increase their independence at home, at work, in their neighborhoods and across their lives. The purpose of these grants is to provide person-centered assistive technology technical assistance and case consultation to people, their case managers, and others chosen by the participants to be part of individual technical assistance teams. Consultations will include individual assistive technology evaluations and technical assistance, information and training. These activities will expand the number of people who avail themselves of assistive technology as one part of their individual support plans. Use of assistive technology aligns with many other efforts to support people in the community.

In 2009 the legislature placed a moratorium on corporate foster care (Minn.Stat. §245A.11, Subd.2a)[36] as well as restrictions on the use of personal care assistance services in provider controlled housing [Minn. Stat. §256B.0659 subd. 3(b)][37]. That same year, the legislature also authorized technology grants for case consultation, evaluation, and consumer information related to developing and supporting alternatives to corporate foster care. Technology grant funds were used in state fiscal year 2011 to develop training curriculum and conduct statewide training for counties, tribes, people and providers on how assistive technology is used to support people in their own homes.

Housing Access Services

Since 2009 over 620 people with disabilities have moved to homes of their own using Housing Access Services. People are now using these services to move into their own homes at a rate of one each day. This is expected to continue to increase as additional providers are enrolled. This service was originally an option only under the Developmental Disabilities waiver but has been

[35] https://www.revisor.mn.gov/laws/?id=79&doctype=Chapter&year=2009&type=0
[36] https://www.revisor.mn.gov/statutes/?id=245A.11#stat.245A.11.2a
[37] https://www.revisor.mn.gov/statutes/?id=256B.0659

expanded to be available to anyone who is eligible for home care or services under a home and community-based services waiver. By expanding this service to all waivers, creating new awareness and training materials and adding providers, DHS is increasing capacity to support people in moving into their own homes. (For more information about Housing Access Services, see the Success Highlights section on page 47.)

Participant Experience Survey

The 2007 Minnesota Legislature directed DHS to develop a survey tool that could be used with program participants to measure their experiences utilizing services (Minn. Stat. §256B.096, subd. 3[38]). The statutory goal for the DSD participant survey is to provide data for the state's quality improvement system, focusing on community-based services. It includes home and community-based services provided through waiver and state plan services. The Department of Human Services convened a broad group of stakeholders in 2008 to work on this task.

The statute specifies that the survey should include a random sample of five- to ten- percent of service recipients. Through face-to-face interviews, participants are asked about:

- Health and safety issues
- Provider capability
- Service access
- The CCA CHOICE domains (see page 11)

The information collected about consumer experiences is used by DHS and shared with counties, providers, and others to improve service quality. The Participant Experience Survey also provides evidence to the Centers for Medicare and Medicaid Services that the state is meeting the statutory and state plan assurances required for all Medicaid home and community-based services waivers.

The first survey and report were completed in 2010. The 2010 Participant Experience Survey final report (PDF) is available on the DHS website[39]. The 2012 report will be available in 2013.

State Quality Council

Early in 2012, DSD convened a State Quality Assurance Council, as directed by the legislature (Minn. Stat. §256B.097[40]). The Council is charged to improve the quality of services provided to people with disabilities. In collaboration with DHS, the Council will work cooperatively with consumers, providers, policymakers and the DHS Licensing division to achieve measurable positive outcomes in health and welfare for people with disabilities.

The Council is directed to do this by carrying out;

[38] https://www.revisor.mn.gov/statutes/?id=256B.096
[39] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6479-ENG
[40] https://www.revisor.mn.gov/statutes/?id=256B.097

- A community-based, person-centered, consumer driven quality improvement and assurance component
- Identifying and recommending the removal of barriers that prevent people from optimally exercising their right of choice within the community-based services system
- A comprehensive system for effective incident reporting, investigation, analysis, and follow-up

The Council will be making recommendations to the legislature regarding:

- Measurable outcomes
- Quality improvement priorities
- Region 10 transition to alternative licensing
- Creation of regional quality councils
- Participant survey
- Resources needed and funding sources
- Optimizing choice of community-based services
- On-going role of the State Quality Council

The Council met in December 2012 to adopt the preliminary recommendations, and will meet again in early January to finalize the legislative report that will be delivered in January 2013.

Success Highlights

The following three examples highlight some of the diverse ways DSD programs are making strides towards the CCA goals and priorities, in regard to services for people with disabilities. With the proper support, people are able to pursue their own goals, living lives built around what is important to them.

Housing Access Services Helps People Move to and Succeed in their Own Homes

John Lay enjoys shopping for his own groceries and learning to cook in his Mankato apartment, where he has lived for just over a year. It's a big change for the 26-year-old with mild developmental disabilities.

Housing Access Services, a partnership between the Arc of Minnesota and DHS, supports people with disabilities as they move to homes of their own. The demonstration project was authorized by the Minnesota Legislature in an effort to provide options to the use of corporate foster care when a moratorium on new settings was instituted.

The program serves adults assessed and determined eligible for Minnesota Medical Assistance home care or home and community-based waiver services, such as the Community Alternatives for Disabled Individuals waiver for which Lay is eligible. Since completing its first move in fall

2009 (as of the time of this writing), Housing Access Services has moved over 620 people to independent settings from corporate foster care, nursing homes and homelessness in 45 counties.

Arc Housing Access Services staff reach out to counties, community organizations and parent groups to inform them about the services and available financial resources. They then work with referred clients to locate safe, living arrangements within their budgets. When needed, the program also covers application fees and security deposits—a barrier for many—and helps clients find furnishings, pack and transport belongings.

With Housing Access Services' support, clients like Lay are realizing their desire to live on their own, make their own decisions and choose their support providers. Lay receives in-home support three days a week, is employed and is now working toward his goal of obtaining a driver's license and car. Housing Access Services also reduce costs and free up limited space in corporate foster care settings for those needing a high level of care.

The cost of providing disability-related services to clients living independently is drastically less than to those living in corporate foster care and assisted living settings. Based on 2007 numbers, disability-related services, not including housing and other living expenses, cost an average of $53,000 per person each year when provided in corporate foster care, compared with $25,000 in assisted living and $15,000 in independent settings.

The DHS contract with Arc runs through June 2013. DHS is currently working with the Money Follows the Person initiative on relocation housing supports for prospective participants, and is also developing online tools to train additional provider agencies as part of efforts to launch Housing Access Services as a service across all home and community-based long-term services waiver programs.

People with Disabilities Planning for and Finding Work

Sam, an individual with a disability, was working but did not get medical coverage through his job. He was at danger of having to choose between working and quitting in order to qualify for Medical Assistance. Sam turned to Disability Benefits 101 (DB101), Minnesota's interactive web-based tool that helps people with disabilities make work part of their plan, to see if there was a way to keep his job and still get access to the health coverage he needs. Through DB101 Sam learned about Medical Assistance for Employed Persons with Disabilities. Once he had the right information, he realized he could make work and benefits go together.

Darla was working a temporary job and was not aware that she could work a in a permanent position, increase her earnings from that job, *and* maintain the medical benefits she needs. After exploring her options and using the planning tools available through DB101, Darla decided to pursue a more reliable job with higher earning potential.

Sam and Darla[41] are two examples of people with disabilities who are making work part of their individual plans. Being able to work is an important part of living the lives they want to lead. But putting the pieces together isn't always easy. That's where DB101 is helping.

Minnesota's DB101 website[42] provides information on health coverage, benefits and employment. Benefits planning is critical to planning for employment. DHS is working to engage people who serve youth and adults with disabilities in any capacity so they understand that they have a role in supporting employment and benefits planning. DB101 is a tool that can be useful to people with a disability and to professionals.

DB101 has been in full swing in Minnesota since 2010 helping Minnesotan's with disabilities see their potential to work and maintain necessary benefits.

This year a new tool for youth, and information and a curriculum for professionals, were added to DB101. *Get a Smart Start to Work and Benefits* is a complete training package to help educators, employment planners, advocacy organizations, and others who work with youth in transition to incorporate benefits planning into their work. The video and activities of *Get a Smart Start* can also be used by parents and youth directly to help them plan for work goals and understand how to balance wages and public benefits. The toolkit was developed in collaboration with the Minnesota Department of Employment and Economic Development and the Minnesota Department of Education, and was tested throughout the state with special education teachers, school work coordinators, school social workers, and employment planners, including vocational rehabilitation youth counselors.

Now moving into its fourth year, DB101 helps more people every day and is gaining prominence as a useful tool for Minnesotans with disabilities.

Decreasing Stays at State Hospitals/Congregate Settings

Civil commitment and services provided in intensive congregate settings often are the result of the lack of appropriate services, interventions and housing to people with co-occurring conditions, due to their complex needs. People with complex needs often stay for longer periods of time, beyond what is necessary for their conditions, due to barriers that make discharge difficult. Data collected from the last five years show that hospital lengths of stay are increasing, averaging more than 14 months for people committed to Anoka Metro Regional Center and much longer when committed to St. Peter Security Hospital.

During the past year, DSD, the Chemical and Mental Health Services Administration, and State Operated Services have focused efforts to provide enhanced discharge planning to address the

[41] Identities have been altered to protect the identity of these individuals.
[42] http://mn.db101.org/

barriers which result in longer stays for people with complex conditions, including: challenging behaviors, intellectual disabilities, mental health and chemical health conditions.

Since introducing this enhanced technical assistance, 18 people with intellectual and other co-occurring disabilities who have met their treatment objectives have been successfully discharged from Anoka Metro Regional Center into stable community-based settings. Nine people with intellectual disabilities with other co-occurring disabilities have been discharged this past year from Cambridge Specialty Health System (prior to 2010 known as Minnesota Extended Treatment Options, or METO) into community-based services.

Beginning in February 2012, a triage team comprised of people from State Operated Services, Disability Services and the Ombudsman for Mental Health and Developmental Disabilities was established to assist counties by providing technical assistance for potential commitments so as to reduce unnecessary admissions to hospitals. Similar collaborative efforts, including work within the Department to address length of stay at Anoka, result in improved technical assistance and identification of system barriers that need to be addressed.

Program Data

The CCA provides performance measurement data for the people it serves and makes it available on the DHS website.[43] The performance measures used relate to specific goals in the CCA strategic plan and specific populations. New measures are added as they are developed.

The following data is collected for people in nursing homes:

- Percent of consumers living in nursing homes who would recommend their facility to others
- Quality of care
- Quality of life
- Percent of resident days for people with low needs

The following data is collected and reported separately for people with developmental disabilities and those with other disabilities:

- Average long-term supports and services spending
- Percent of long-term supports and services spending in home and community-based services
- Percent of people who receive home and community-based services
- Percent of people who receive home and community-based services at home
- Percent of people with low needs who receive waiver services in a residential setting

[43] http://www.dhs.state.mn.us/dhs16_166609#

- Percent of people with high needs
- Percent of people with high needs who receive services at home
- Working-age people with monthly earnings
- Working-age people earning $250 or more per month

For people with developmental disability, DSD also collects:

- Percent of people with low needs in intermediate care facilities

Caseload Summaries

DSD also tracks the number of people receiving various long-term services and supports. A statewide summary of this information is provided here. This information is also collected by county and can be provided upon request by calling DSD at (651)431-2400.

Case Load Summary Previous Fiscal Year (from 7/1/2011 to 6/30/2012) – Statewide[44]

Table 1: Unduplicated Count of Assessments Completed, by Age Range (7/1/2011-6/30/2012)

Unduplicated Assessment	All	Age 0-12	Age 13-17	Age 18-22	Age 23-39	Age 40-64	Age 65-84	Age ≥85
PHN Assessments for PCA	19,367	5,623	1,993	1,204	2,597	7,398	510	39
LTC Consultation	85,408	1,262	862	1,343	5,411	20,742	36,461	19,327
DD Screening	24,024	2,830	2,031	2,939	7,414	7,403	1,330	77

Table 2: Count of People Receiving Home Care Services by Age Range (7/1/2011-6/30/2012)

Home Care	All	Age 0-12	Age 13-17	Age 18-22	Age 23-39	Age 40-64	Age 65-84	Age ≥85
PCA - Waiver	5,538	475	368	450	996	3,062	186	0
PCA - Non-waiver	18,051	4,540	1,694	1,009	2,312	7,053	1,107	334
PCA - Total	**23,589**	**5,015**	**2,062**	**1,459**	**3,308**	**10,115**	**1,293**	**334**
PDN - Waiver	400	133	41	34	78	104	10	0
PDN - Non-waiver	422	189	28	22	47	76	42	18
PDN - Total	**822**	**322**	**69**	**56**	**125**	**180**	**52**	**18**
Sk. Nurse - Waiver	3,973	69	15	55	448	3,157	229	0
Sk. Nurse - Non-Waiver	8,951	2,075	143	376	1,316	2,814	1,381	846
Sk. Nurse - Total	**12,924**	**2,144**	**158**	**431**	**1,764**	**5,971**	**1,610**	**846**
HHA - Waiver	848	9	3	3	43	722	68	0
HHA - Non-Waiver	1,386	0	0	2	22	178	641	543
HHA - Total	**2,234**	**9**	**3**	**5**	**65**	**900**	**709**	**543**
Therapies - Waiver	612	34	20	28	78	424	28	0
Therapies - Non-Waiver	871	40	8	16	109	620	68	10
Therapies - Total	**1,483**	**74**	**28**	**44**	**187**	**1,044**	**96**	**10**

[44] Data Source: Medicaid Management Information System (MMIS) Screening & Service Agreement Data, Report run date: 1/2/2013

Table 3: Count of Individuals Receiving Institutional Services by Length of Stay or Facility Type and by Age Range (7/1/2011-6/30-2012)

Institutional Services	All	Age 0-12	Age 13-17	Age 18-22	Age 23-39	Age 40-64	Age 65-84	Age ≥85
NF Stays <= 90 days (MA funded)	5,365	0	0	13	164	1,863	1,516	1,809
NF Stays > 90 days (MA funded)	18,273	0	0	8	111	2,041	6,453	9,660
ICF / DD Stays	1,922	10	34	96	350	1,122	288	22

Table 4: Count of Individuals Receiving Waiver Services, By Age Range (7/1/2011-6/30/2012)

Waivers	All	Age 0-12	Age 13-17	Age 18-22	Age 23-39	Age 40-64	Age 65-84	Age ≥85
CADI	19,220	933	729	1,030	3,352	11,885	1,290	0
TBI - NF	1,071	8	17	49	243	699	55	0
TBI - NB	405	7	12	15	147	212	12	0
CAC	419	183	64	34	77	57	4	0
DD	16,006	587	1,187	1,873	5,679	5,572	1,042	66
AC	4,296	0	0	0	0	0	2,396	1,900
EW - Fee for Service	5,308	0	0	0	0	3	2,817	2,488
EW - Managed Care	25,387	0	0	0	0	9	17,040	8,338
EW - Total	**28,241**	**0**	**0**	**0**	**0**	**11**	**18,485**	**9,745**

Table 5: Count of Individuals and Families Receiving Grant Services, by Age Range (7/1/2011-6/30-2012)

Other Services	All	Age 0-12	Age 13-17	Age 18-22	Age 23-39	Age 40-64	Age 65-84	Age ≥85
Consumer Support Grant (CSG)	2,029	1,486	371	115	27	30	0	0
Family Support Grant (FSG)	1,628	0	0	0	0	0	0	0
Semi-Independent Living Services (SILS)	1,552	0	0	0	0	0	0	0

Home and Community-Based Services Waivers

In fiscal year 2012, there were a total of 37,121 people who accessed services through the four disability home and community-based services waiver programs. The total spending on the home and community-based waiver services was $1.63 billion[45]. The following table shows the number of participants and spending in fiscal year 2012 by waiver program, state plan services and grants.

[45] Does not include home care costs

Table 6: Total Participant Count and Spending by Waiver (7/1/2011-6/30/2012)

Program	Number of Participants in FY2012	Total Spending in FY 2012[46]
BI Waiver	1,476	$96,239,024
CAC Waiver	419	$21,780,587
CADI Waiver	19,220	$499,314,710
DD Waiver	16,006	$1,012,695,082

State plan services

Table 7: Total Participant Count and Spending by State Plan Service (7/1/2011-6/30/2012)

Program	Number of Participants in FY2012	Total Spending in FY 2012
Home Health (included Home Health Aide, Skilled Nursing Visits and Home Health Therapies)	16,641	$22,455,924
PCA (fee-for-service and managed care)	23,589	$574,331,581
PDN	822	$95,208,253

Grants

Table 8: Total Participant Count and Spending by Grant Program (7/1/2011-6/30/2012)

Program	Number of Participants in FY2012	Total Spending in FY 2012
Consumer Support Grant (CSG)	2,029	$571,000
Family Support Grant (FSG)	1,628	$4,364,500
Semi-Independent Living Services (SILS)	1,552	$8,490,500

Waiver Spending and Enrollment Trends

Home and community-based services waivers have shown continuous growth, although the growth has been controlled through growth limits established by the legislature. As an example, the Community Alternatives for Disabled Individuals waiver served 10,104 people in 2007, and grew to 16,483 in 2012 and is expected to serve more than 22,000 people in 2017. This growth is a reflection of Minnesota's history of public policy support for community living and cost effective services. These investments in home and community-based services allow continued reduction in institutional services and reduce the length of stay or substitute for more expensive and intensive services that would be required without these services.

[46] Does not include home care costs.

The Developmental Disabilities waiver experienced rapid growth at an earlier point in time, beginning in the mid-1980s when the closure of state and privately operated intermediate care facilities for persons with developmental disabilities converted funding from institutional services into home and community-based services. Another period of rapid growth in the Developmental Disabilities waiver occurred in 2001, when there was a time-limited expansion of the program authorized by the legislature. During this expansion, 5,500 people were added to the program, many of whom had been on the waiting list. Since then, the growth in the Developmental Disabilities waiver has been moderated due to legislative limits on growth. The program grew from serving 14,103 people in 2007 to 15,449 in 2012. It is expected to grow to serve 17,396 people in 2017. Any closure of beds in an intermediate care facility for persons with developmental disabilities will enable conversion of those funds to home and community-based services; these dollars are in addition to the legislatively authorized growth in the program.

Attachment E contains a table of the disability growth limits. Attachment F is the Continuing Care Long-term Care Programs November 2012 Update which contains data from the past five years and projections for the next five years for program enrollment and spending.

Waiting List Information

DSD collects information about people waiting to receiving services on home and community-based services waiver programs, including Brain Injury, Community Alternative Care, Community Alternatives for Disabled Individuals, and Developmental Disabilities waivers. Waiting list information[47] is available on the DHS public website in an interactive format.[48] Interested individuals can sort the information by county and a variety of individual characteristics or services.

DHS is working on adding more options to the waiting list information and will update the public website as information becomes available.

As of November 5, 2012, there were 3,602 people waiting to access the Developmental Disabilities waiver across the state, due to a lack of available funding. Nearly all of these people are accessing other services while waiting for the Developmental Disabilities waiver, including case management, educational services, and home care services. 66 percent of the people waiting for the Developmental Disabilities waiver are under 18, and 92 percent are currently living in the home of their immediate or extended family members.

As of October 1, 2012, there were 1,211 people waiting to access the Community Alternatives for Disabled Individuals waiver across the state, due to a lack of available funding. 64 percent were between the ages of 40 and 64.

[47] http://www.dhs.state.mn.us/main/dhs16_159977
[48] http://www.dhs.state.mn.us/dhs16_159977

There are currently no waiting lists due to a lack of available funding for the Brain Injury and Community Alternative Care waivers because there are no limits on the allocations available to these waivers.

There are criteria for managing waiting lists in statute (Minn. Statute 256B.092, subd. 12[49] and 256B.49, subd. 11a[50]). New people may be added to the waiver programs when there are new resources made available (new dollars authorized by the legislature) for growth, there is a conversion of institutional resources into home and community-based services, or when people leave a waiver program. There is also the ability to add new individuals without the availability of new resources, if the county or tribe is able to manage the costs of the services for the individual within their current allocation.

[49] https://www.revisor.mn.gov/statutes/?id=256B.092
[50] https://www.revisor.mn.gov/statutes/?id=256B.49

Attachment A: 2011-2015 Continuing Care Strategic Plan and Strategic Plan 2011 Review

CONTINUING CARE ADMINISTRATION

2011—2015 Strategic Plan

Vision

We see a Minnesota where people have choices in how they receive services and how they live their lives. The domains of choice include:

- **C**ommunity membership
- **H**ealth, wellness, and safety
- **O**wn place to live
- **I**mportant long-term relationships
- **C**ontrol over supports
- **E**mployment earnings and stable income

Values

- **Choice & Independence** for the people we serve
- **Stewardship** of human service resources
- **Self-determination** and **personal responsibility by** the people we serve
- **Integrity** by ourselves and others
- **Diversity** because our differences make us strong
- **Partnerships and collaboration,** with clear roles, responsibilities, and accountability for ourselves and others
- Accountability

Our Mission:

The Continuing Care Administration strives to improve the dignity, health and independence of the people we serve.

We administer/supervise about $3.5 billion annually in state and federal funds, serving over 350,000 Minnesotans annually. Our functions are to:

- Administer Medical Assistance long-term care programs (waivers and state plan services) which includes developing, seeking authority for and implementing policies and projects.
- Administer state and federal grants and contracts.
- Provide information, education, assistance, advocacy and direct service.
- Oversee the state's adult protective services system.
- Set and manage provider payment rates.
- Assure service quality, conducting evaluations and measuring results.
- Staff the MN Board on Aging, the Commission on Deaf, Deafblind, and Hard of Hearing Services, and numerous stakeholder work groups.
- Provide administrative, financial, and operational management and support.
- Provide technical assistance to our stakeholders.

We have about 250 staff in four divisions:

- Aging and Adult Services
- Deaf and Hard of Hearing Services
- Disability Services
- Nursing Facility Rates and Policy

We work with key partners in providing these services:
Counties and tribes; health plans; the MN Board on Aging, seven Area Agencies on Aging and their provider network; other state agencies; the Commission on Deaf, Deafblind, and Hard of Hearing Minnesotans; about 3,700 enrolled home and community-based service providers; 381 nursing facilities; 222 Intermediate Care Facilities for people with developmental disabilities (ICFs/DD); eight Centers for Independent Living and 235 Day Training and Habilitation (DT&H) settings.

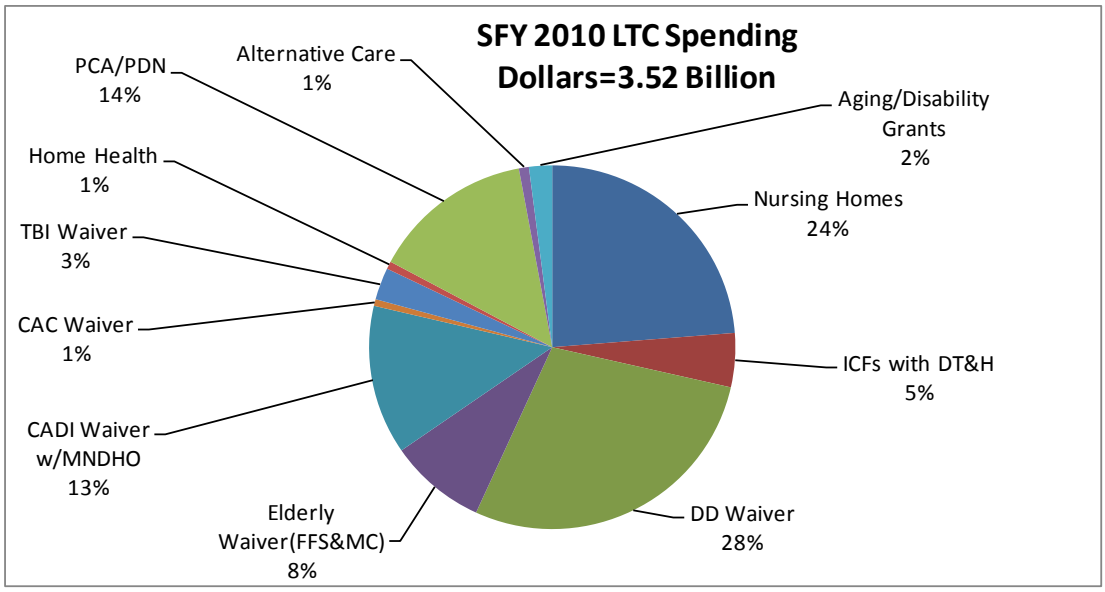
Minnesota Department of **Human Services**

www.dhs.state.mn.us

2011 – 2015 Continuing Care Strategic Plan

We are pleased to share this 2011 - 2015 Continuing Care Administration (CCA) strategic plan. This strategic plan describes four major goal areas and lists strategies and actions for achieving those goals over the next five years.

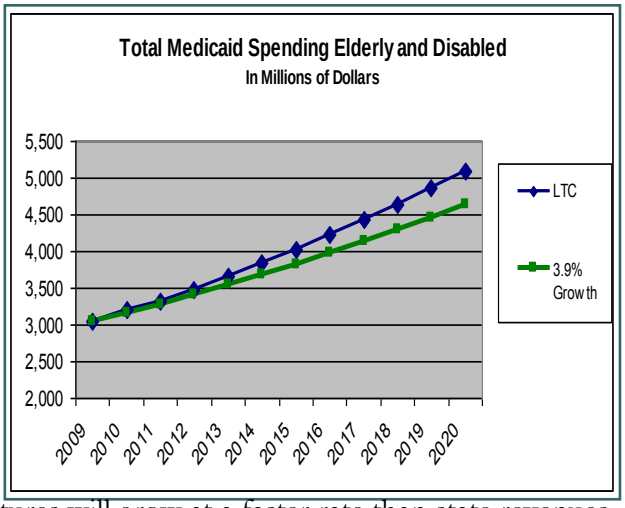
Continuing Care's programs serve more than 350,000 people each year. We serve older Minnesotans and children and adults with disabilities, and we provide help to families. Many people need only a little help from public programs: a home delivered meal once a day, a phone consultation for information and assistance, or occasional respite from care giving. Others require extensive care: children who would otherwise live in a hospital (at greater cost) that can instead live at home with care provided by skilled nurses and family members.



To help meet the needs of older Minnesotans and people with disabilities, the Continuing Care Administration manages a number of programs and services, including:

- **Managing and administering Medical Assistance waiver and state plan services.** These programs comprise over $2.2 billion annually in state and federal spending. They include:
    - Medical Assistance Home Care, Personal Care Assistance and Private Duty Nursing, which support more than 15,000 people per month.
    - Five waiver programs, which support more than 48,000 people per month who are at risk of placement in an institution.
- **Administering state and federal grants.** Continuing Care manages about 180 grants, which comprise 3% of total long-term care program spending, but serve more than 250,000 people each year. Many of these grants provide that little bit of assistance people need to keep them otherwise living independently.
- **Setting payment rates for public programs and nursing homes, intermediate care facilities for people with developmental disabilities (ICFs/DD) and Day Training and Habilitation (DT&H) providers.** Nursing facilities serve about 30,000 people per month, ICFs/DD serve 1,825 residents per month, and DT&Hs serve more than 13,000 people per year.

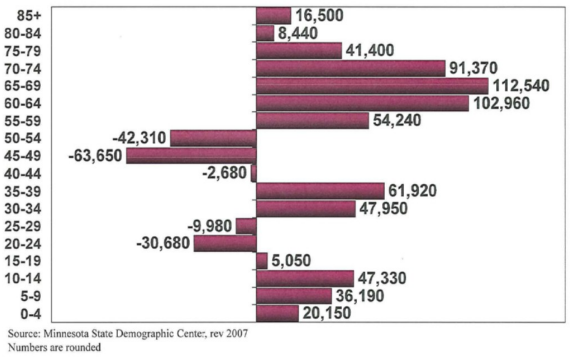
While developing this strategic plan we focused on our mission, vision, and values. Improving the quality of life for the people we serve is our mission. We work hard to ensure that Minnesotans who need long-term care have choices and can access services that enhance their quality of life.



At the same time, we are realistic about the fiscal constraints that Minnesota government faces. Long-term care is a large part of Minnesota's public health care spending. About 45% of Minnesota's total Medicaid budget is spent on long-term care. Currently, Minnesota spends about $3.5 billion dollars on long-term care services, and based on current trends, will spend $4.5 billion dollars by 2015.

Current projections show that, over time, long-term care expenditures will grow at a faster rate than state revenues. As a result, Minnesota faces a growing gap between demand for long-term care and the funding to pay for it.

From 2010 to 2020, Minnesota Will See Large Increases Age 50s and 60s



Source: Minnesota State Demographic Center, rev 2007
Numbers are rounded

Adding to the challenge are demographic shifts in Minnesota's population. The state demographer projects that between 2005 and 2035, the number of persons 65+ will double, from 600,000 to 1.3 million. The number of persons 85+ (who tend to need long-term care) will nearly double, growing to 163,000, and then double again by 2050, rising to 324,000 persons. By 2020, there will be more people 65 years or older than school-aged children in Minnesota.

These are challenging times. Ongoing budget deficits challenge policymakers to fund the long-term care system in a way that meets people's needs. We strive to shape and reshape policies and programs to help meet people's needs while also recognizing public funding's fiscal realities.

There is a tension between the goals of improving people's quality of life while also administering a long-term care system that must serve more people within limited budgets. Lawmakers will need to decide the types of programs and level of access Minnesota will provide for quality long-term care services.

Now is not the time to be discouraged, but to develop opportunities to advance our mission. Our staff and partners are creative and engaged. It's amazing to see what dedicated people can do when they work together on shared goals. It is within this context that we adopt this five-year strategic plan.

Goal: To support and enhance the quality of life for older people and people with disabilities.

Minnesota's long-term care service programs support older people and people with disabilities (children and adults) who do not have the resources to meet their own needs. These supports keep people safe and healthy so they can have a good quality of life and live with dignity.

State budget constraints make it difficult to support the growing numbers of people that are seeking services. That's why we must foster support from individuals, families and communities to help in achieving this goal.

Results

- Access to the right services in the right place at the right time
- Effective supports and training for families providing care for a family member
- High level of consumer satisfaction with their long-term care services
- Improved earnings by persons receiving long-term care services
- More people are able to remain in their own homes
- Reduced incidence of chronic and disabling conditions

Strategies and Key Actions
(Note: Many of the actions listed complement more than one goal although they may be listed only once.)

1. **Administer an array of home and community-based service options so that community-based care is the expectation.**
   - Continue to build better consumer transitions across health and long-term care settings for all populations and build on the Return to Community and Options Too initiatives.
   - Conduct statewide Gaps Analysis to identify critical service gaps across all populations and provide technical assistance to local providers and lead agencies to strategically fill those service gaps.
   - Develop new cost efficient models, some in collaboration with other administrations in the department, that increase consumer flexibility and independence.
   - Continue to encourage nursing facility bed closures.

2. **Provide information and assistance to seniors, people with disabilities, their families and our partners so that people needing services can make more informed choices.**
   - Manage and improve the MinnesotaHelp Network® which includes phone, web, print and face-to-face assistance provided through the Senior LinkAge Line®, Disability Linkage Line® , Veterans Linkage Line™, www.Minnesotahelp.info®, Long-term Care Choices Navigator online decision-support tool, and lead agencies.
   - Invest in technology and training to fully implement and support Disability Benefits 101 and Benefit Planning systems and resources throughout Minnesota.
   - Improve content quality and accessibility of DHS public web resources for CCA.
   - Implement MnCHOICES — a systematic and objective assessment of individual's needs, resources and options—for all income levels.
   - Sustain policy technical assistance and training systems and resources to service delivery partners.
   - Enhance the Minnesota Nursing Home Report Card and develop and implement a Home and Community -Based Services Report Card on provider performance; make this information available to the public via the MinnesotaHelp Network®.

3. Foster communities for a lifetime where older people and people with disabilities are contributors to their communities and where communities provide them with supports and services they need.

4. Partner with Area Agencies on Aging, Centers for Independent Living, and other federal initiatives to leverage state and local funds for strategic service development.

- Enhance stakeholder relations by partnering with cities, counties, Minnesota Council on Disabilities and other state agencies and specifically:
  - increase community development, including the Communities for a Lifetime Initiative, accessible and affordable housing and employment opportunities
  - promote strategies to implement and sustain person-centered access to services
  - create public awareness and education that promote community inclusion
  - increase transportation alternatives
- Encourage and select performance improvement projects that promote wellness and other livable community strategies.

4. Strengthen quality management strategies to improve the quality of long-term care services.

- Establish a continuous quality improvement system for home-and community based services that meets federal waiver requirements and identify improvement opportunities and remediation.
- Obtain data to establish and evaluate quality outcomes including participant experience indicators and provider performance that will enable promotion of best practices and positive approaches in service delivery and provide basis for provider incentives.
- Enhance public reporting to increase accountability, transparency and quality.
- Improve our delivery of consistent, timely and strategic training and technical assistance for providers.
- Provide nursing facilities and home-and community based providers with benchmarking data on quality and adopt robust methods of paying for performance.

5. Promote wellness for program participants to reduce instances and progression of adverse health conditions that lead to disability or prevent further disability.

5. Promote Medicare preventative benefits through the federally-funded Senior LinkAge Line® outreach initiatives.

- Ensure the inclusion of incentives for health promotion in managed care contracts (e.g., add-ons and with-holds).
- Implement evidence-based and "culturally competent" health promotion/disease prevention programs.
- Design wellness outcome measures and residential provider incentives.

6. Promote employment for all persons and economic security planning for later life.

- Create and promote resources that help individuals plan for economic security.
- Create incentives and supports that increase individuals' opportunities to achieve their employment goals and result in increased income earnings.
- Implement policy and legislative changes to remove barriers to employment for individuals.

7. Leverage opportunities provided by state and federal health care reform to focus on chronic health care management.

- Improve care transitions by using strategies such as the federally-funded Aging and Disability Resource Center (ADRC) Grant initiative and those included in the Money Follows the Person grant application.
- Partner with other DHS divisions and the MN Department of Health and in CMS demonstrations in integrated care innovations to further focus on chronic care management for Medicare beneficiaries, consistent with MN's new health reform.
- Work with internal and external partners to coordinate health care homes and community services.
- Position home and community-based management information systems to be HIPAA-compliant with new Medical Homes (aka Health Care Home) to improve coordination between health care and support providers.
- Continue interagency collaborations to improve system navigation and reduce progress of disabling conditions.

8. **Promote citizen/consumer rights and safety; protect vulnerable adults.**
   - Ensure rights of consumers to due process and access to proper legal resources/representation.
   - Improve adult protection by automating the "structured decision-making tool" and other best practices.
   - Use passage of Elder Justice Act to blend central/regional Common Entry Points and improve local investigation of Adult Protection Units—and other investigative lead agencies.
   - Promote greater awareness of health fraud, consumer fraud and related scams.

Goal: To manage an equitable and sustainable long-term care system that maximizes value.

What is an equitable long-term care system? Equitable means that people's needs are met and disparities are addressed. It means striving to do the most possible for as many with needs as possible. And it means ensuring the sustainability of key programs so that people with the greatest needs can count on essential services being there for them.

Results

- Access to the right services in the right place at the right time
- Sustainable growth in long-term care spending
- Increased reliance on private resources to provide long-term care
- Decreased reliance on expensive (high-end) LTC services
- Reduced rate of cultural disparities

Strategies and Key Actions

1. **Manage publicly-funded programs in ways that provide maximum benefit to people while meeting our mandates and staying within our budgets.**
   - Target services to people who need them the most; provide services/supports that are most essential and effective.
   - Develop alternative, cost effective strategies to more expensive service models. Invest in program options and community partnerships that encourage linkages to non-public and community based service options.
   - Increase technology and administrative capacity to leverage state information and staff resources to efficiently administer services.
   - Manage rate setting methodologies for all services.
   - Encourage development of provider consortia and regional administration of services.
2. **Promote personal responsibility to help people help themselves.**
   - Promote use of private resources (client fees and 3rd party) to pay for home and community based services (HCBS) and provide long-term care options counseling through resources such as the Senior LinkAge Line®.
   - Develop low-cost/high-demand strategic services that reduce use of expensive crisis services so that people can purchase services with their own funds.
   - Provide information to Minnesotans about the state's long-term care insurance partnership program and the CLASS Act.
   - Promote interventions that delay/mitigate dependency on higher levels of care and reduce reliance on public programs.
   - Provide information and education to promote the personal responsibility of individuals and families to assist in providing care and to plan for their futures.
   - Create individual service budgets that incent individuals and their families to be stewards of public resources.

3. **Utilize long-term care purchasing strategies to achieve desired outcomes.**
   - Change purchasing strategies by putting more decision making in the hands of consumers, increasing inter-provider competition and increasing the use of consumer directed options.
   - Explore financial incentives to help people stay at home.
   - Implement and evaluate enhanced provider enrollment standards and quality management.

4. **Promote an equitable long-term care system including equity across populations.**
   - Conduct an evaluation to identify and minimize barriers that prevent some facilities from competing successfully for Performance-Based Incentive Program (PIPP) contracts.
   - Cultivate a diverse workforce able to provide effective services, programs and policies that are culturally appropriate and accessible to all communities.
   - Evaluate the equity of costs and outcomes for populations we serve across all services/supports to inform policy decisions.
   - Invest in reducing nursing facility rate disparities.

5. **Support families/caregivers in giving care to people and prolonging their caregiving career.**
   - Provide long-term care options counseling through the Senior LinkAge Line®.
   - Increase support and education for caregivers including evidence-based caregiver models that provide respite and support statewide to all income groups, across the lifespan, and strengthen the capacity of family, informal and volunteer-based models along with self-directed models.
   - Create opportunities for families and children to work with mentors and role models (e.g., Deaf Mentor Program).

Goal: To continuously improve how we administer services.

Although our role at DHS is largely about administering public funding, our goal is much larger. Medical Assistance, state and federal grants, training, consultation, collaboration and technology are the resources we leverage to improve people's lives. We also provide direct services, advocacy and analysis. No matter which role each of us plays, how well we do our work and how well we leverage the resources available makes a difference for the people we serve. That's why we strive for excellence in what we do.

Transparency is important. How we manage Minnesota's programs and leverage public resources must be no surprise to others. We will be good stewards of these resources and manage them with integrity.

Results

- A long-term care service delivery system that is as simple as possible so that it is easier for our partners and consumers to understand and use
- Credibility through our actions and interactions with others
- Improved administrative efficiency and effectiveness
- Effective communication with stakeholders
- Strengthened results-based culture
- Streamlined business process & decision-making

Strategies and key actions:

1. **Provide reliable and efficient operations that simplify processes while meeting state and federal mandates.**
   - Redesign home and community-based services with consideration if doing so helps us to achieve our strategic goals.
   - Improve program administration to increase access, consistency, transparency and accountability.
   - Provide statewide training and technical assistance to ensure that all involved in administering and providing services across the state have access to standard training and skill-building, to promote Best Practices, and to recognize and honor excellence (staff, programs, initiatives).
   - Use technology options to implement streamlined processes, efficient operations, easy access and improved training and technical assistance delivery capacity.
   - Develop partnerships with stakeholders to share technology where possible.
2. **Use Continuing Care's Quality Architecture to make the service delivery system as administratively simple and effective as possible.**
   - Create a statewide long-term care service system that encompasses all Continuing Care services to support choice, independence, and employment through common administration, assessments, services, standards of performance, and supports to our local partners.
   - Use cross-agency and cross-divisional teams, external work groups, and internal governance structures to prioritize work with our partners, particularly providers, lead agencies and other areas in DHS, including mental health, to implement changes consistently across the administration and the agency to holistically support people.
   - Employ governance and project management principles in our approach to this work, particularly in implementing the 2009 program changes.
   - Partner with the mental health division to work on strategic issues that will improve mental health outcomes for people receiving public services.
   - Participate/cooperate in the department's efforts to establish an enterprise-wide architecture; utilize process improvement strategies to target improvement and simplify processes for those that administer, deliver, and receive public services.
3. **Enhance Stakeholder relations and collaboration.**
   - Use forums of external partners, including the people we serve, so that we may work together in developing and evaluating program changes (collaborations, panels, task forces and advisory committees).
   - Provide targeted briefings to legislators on the status of our programs and services.
   - Actively work with key stakeholders, including the HCBS Partner Panel, to ensure two-way communication; obtain their feedback regarding the effects of policy and program changes, identify potential unintended consequences, and achieve changes in the long-term care system that reflect the goals and strategies of this strategic plan.
4. **Be catalysts for change; provide leadership in using performance information to evaluate Minnesota's long-term care system and to guide change.**
   - Evaluate the impact of major program changes on access to public supports, quality of services, and value of Minnesota's long-term care services for consumers.
   - Pursue quality strategies including the Nursing Home Report Card and Provider Portal enhancements, expansion of pay for performance initiatives, nursing home access planning, refined electronic audits, and web-based performance initiatives/lead agency waiver reviews and follow up.
   - Apply Results Accountability tools to manage results on high priority initiatives and "tell the story."

Goal: To promote professional excellence and engagement in our work.

Results

- Continuing Care staff understand the administration's mission and goals and see how they directly contribute and impact results
- Continuing Care staff talent potential is understood and utilized

The Continuing Care Administration commits to provide staff development opportunities and supports that promote an engaged and productive workforce. We value the mentoring and coaching that our experienced staff passes on to those new to our organization. Together, we work to create a legacy we are proud of.

In 2006, Continuing Care launched the ExCEL (Examine, Create, Engage and Learn) initiative to improve employee commitment, involvement, and enthusiasm toward our work. We continue this commitment to our employees as part of this strategic plan.

Strategy and key actions:

1. Improve workplace culture and promote employee engagement.

- Support work teams and team champions to take actions that improve our workplace and promote a positive, engaging culture.
- Promote a resilient culture through times of change and ambiguity.
- Conduct reoccurring employee engagement surveys to measure our success and inform future actions.

2. Connect purpose and practice to ensure that employees understand how they impact the overall goals of the organization.

- Establish clear performance and behavior expectations for employees at every level of the administration.
- Enhance the administration's communication plan to provide greater consistency and understanding.
- Help managers to assist employees to realize their individual growth potential and reach the highest level of productivity.
- Provide ongoing training and staff development to support the workforce's success.
- Achieve succession planning by allowing and encouraging experienced staff at all levels to build their legacy by providing growth opportunities/knowledge transfer to others in the organization.

Department of Human Services
2011 – 2015 Continuing Care Strategic Plan
Progress Report: June 2012

The Continuing Care Administration, with the input of our stakeholders, developed and finalized its strategic plan about 18 months ago. Continuing Care's strategic plan dovetails with themes and key activities in the Department's Framework for the Future: 2012, promoting healthy people, stable families, and strong communities. We've worked to implement many of the strategies and key actions identified in the plan. Despite the challenges of state budget deficits and a recent government shutdown, we have made progress.

The purpose of this document is to highlight some of the efforts to date: to acknowledge the good work achieved, to highlight work still in process, and to help us refocus our efforts on the challenges ahead. Although we cannot cover every activity in this document, those included here provide a sample of the accomplishments and ongoing work to improve long-term care services and our operations.

People Goals

- **Provide smart care that keeps people healthy and in their homes and communities**
- **Support and enhance the quality of life for older people and people with disabilities**
- **Manage an equitable and sustainable long-term care system that maximizes value**

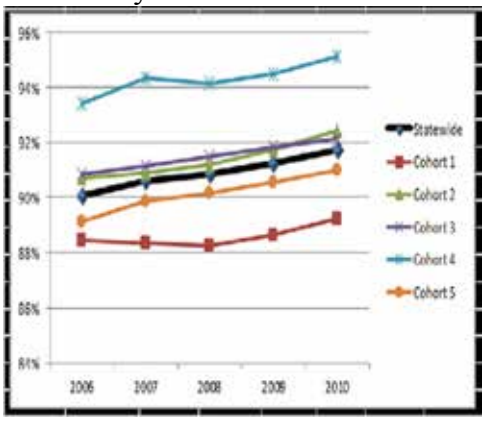
(Source: DHS Framework for the Future: 2012; CCA 2011-2015 Strategic Plan)

Minnesota's long-term care service programs support older people and people with disabilities (children and adults) who do not have the resources to meet their own needs. These supports keep people safe and healthy so they can have a good quality of life and live with dignity.

Accomplishments and Current Activities:

Administer an array of home and community-based service options so that community-based care is the expectation.

Percent of people receiving home and community-based services



To help track progress, counties that are similar in size are grouped together and called a cohort.

- Return to Community initiative – Since April 2010, Senior LinkAge Line® Community Living Specialists directly assisted 395 nursing home residents to return to the community. A total of 770 private-pay people are receiving follow-up in the community by Senior LinkAge Line®.
- The Veterans Directed-Home and Community-Based Services Program in the southwest region of the state was launched in August 2010 and is now implementing the Veterans Transportation Coordination Project through use of MNHelp.info tools.
- Housing Access Services increased access to housing for over 400 people. Through a DHS sponsored Housing Access Services grant, Arc of MN has developed tools and a practice that enables people eligible for home and community-based services (HCBS) waivers or home care to obtain or maintain their own housing. Additional outcomes include increased employment, creative

use of technology in lieu of staff and less than anticipated use of Medical Assistance (MA) Shelter Needy.

- Housing Access Services on-line curriculum is being developed to share lessons learned; waiver amendments to modify Housing Access Services and its rate structure are underway, and additional providers to be enrolled.
- Deaf and Hard of Hearing Services division is developing a pilot study in conjunction with DHS Children's Mental Health Division for a fulltime behavioral therapist to work in central MN.
- Money Follows the Person is being launched this year. The focus of this project is to "rebalance" the service system, making it less reliant upon institutional care and more focused upon community-based alternatives. The project will assist people to live in their own homes rather than serving them in nursing homes and other congregate settings. Staffs are being hired, the operational protocol was submitted in May and a participant handbook is being drafted.
- CCA is initiating an evaluation of long-term care service access. Truven Health has been hired to support this work.

Provide information and assistance to seniors, people with disabilities, their families and our partners so that people needing services can make more informed choices.

- The Senior LinkAge Line® One Stop Shop for seniors was launched in September 2011. To date, a total of 89,000 contacts have been made to the One Stop.
- Disability Linkage Line provided extensive support to people with disabilities through Special Needs Basic Care expansion; this is in addition to groundbreaking support they provided with Disability Benefits 101 (DB101), a web-based tool to assist people to understand options for employment and how earnings may affect benefits.
- MnCHOICES moved into implementation planning with alpha testing of the questions and through additional testing of the application; will begin its launch in summer 2012 and will be statewide by winter 2013. This is a collaborative process across DHS utilizing the business process workflow features of SSIS to add critical integrity and support lead agencies. Through work with 21 First Implementer Counties, we are finalizing the MnCHOICES application, curriculum and support to successfully launch its use. With MnCHOICES implementation, we will begin evaluation of the outcomes and conduct analysis of new data to inform individualized budgeting, quality management and MA reform policy decisions.
- Long-Term Care Options Counseling is being expanded to include high-risk older adults being discharged from a hospital and health care home.
- We are implementing, through appropriate phases, the First Contact model statewide that streamlines the preadmission screening process through a regional approach.
- A new nursing home report card will be released in June. It features enhancements to the current report card and relocates the host site from the MN Department of Health to DHS.
- We are developing curriculum and training individuals who are deaf, deafblind and hard of hearing to become Certified Peer Support Specialists to provide services to individuals with serious and persistent mental illness and hearing loss; we will begin offering Peer Support services fiscal year 2014.

Promote employment for all persons and economic security planning for later life.

- Pathways to Employment is concluding and we are embedding learnings from the grant into division activities and diligently taking steps to incorporate policies into the future of disability services including planned changes in services and incentives to support employment, changes to the MA Program for employed persons with disabilities (MA-EPD) and making employment part of the plan as MnCHOICES assessment and support plan rolls out.

- MA-EPD will include a new service menu and incentives for employment through home and community-based services with an outcome evaluation. The division has established a new maintenance of effort with the Minnesota Department of Education to focus on collaborative steps to increase employment for students as they graduate from school.
- CCA launched the next phase of the One Stop Shop for Minnesota Seniors, which includes SHARE Minnesota. This phase focuses on helping older adults find volunteer opportunities through a virtual network of agencies. In January 2013, the One Stop will be expanded to include linking older adults to employment.

Promote wellness for program participants to reduce instances and progression of adverse health conditions that lead to disability or prevent further disability.

- Over 1,000 high-risk older adults participated in the Chronic Disease Self-Management Program (CDSMP). Statewide capacity includes the delivery of CDSMP to Native elders through the Wisdom Steps Program, in partnership with all tribes in the state.
- The Aging and Adult Services Division expanded use of the Live Well at Home Rapid Screen and risk management tools to help older adults and family caregivers manage their risks, access evidence-based interventions and maintain safe, independent living.

Strengthen quality management strategies to improve the quality of long-term care services.

- The waiver review team completed county waiver reviews for all 87 counties and two tribes and also completed follow-up waiver reviews of 60 lead agencies. Waiver reviews begin again this summer with a renewed commitment to visit all counties in three years.
- The Performance-based Incentive Program (PIPP) increased MA payments for provider-initiated nursing facility quality improvement projects. Since introduction of the program in 2007:

    - PIPP facilities quality of care improved by 5% vs. improvement of 1% in other facilities. Similarly, quality of life scores improved 1% in PIPP facilities vs. 0.3% for other facilities.

    - Through PIPP, projects have been funded to reduce hospitalizations of nursing facility residents by improving care in the NF. Part of this effort entails work with the University of Minnesota to foster collaboration among the many NFs participating.

    - Several PIPP projects funded to address wellness, in general, and in specific ways such as culture of safety, falls prevention, exercise and improved sleep.

Nursing Facility Rates and Policy staffs are reviewing the newest round of PIPP including six mentoring proposals to enable new facilities to participate in PIPP by implementing projects with support of other PIPP providers. PIPP is undergoing an in-depth evaluation funded by the federal Agency for Healthcare Research and Quality (AHRQ).

- A minimum set of program integrity measurements was created to provide evidence of compliance and quality improvement within the quality framework relevant to the Elderly Waiver Program.
- The Nursing Facility Diversity mini-grant project was implemented. It enables facilities to implement programs or projects related to diversity and cultural competency to address issues either with the population they serve or staff of the facility.
- Future Stars Program provided free consultation on quality improvement to NFs with only one star on Quality Indicators (QIs) or Quality of Life (QOL). The program has been completed and an evaluation is underway.

- NFRP division is:
  - developing new clinical quality indicators for nursing facilities.
  - conducting a rate sufficiency analysis of the financial gains and losses of NFs. The analysis looks both at costs compared to total revenue and costs compared on a per diem basis to the MA rate to help us better understand the factors associated with financial performance.
  - collaborating with the Long-term Care Imperative to search for new ways to use the NF payment systems to encourage quality improvement leading to possible joint legislative ventures.
- In 2012, we are consolidating a series of provider and quality standards legislative initiatives into a HCBS Quality System. Practices include HCBS Provider Standards as well as five Quality System Practices:
  - Provider Enrollment and Provider Standards
  - quality outcome standards (single set of standards)
  - establishment of a Residential Support Service
  - new rule governing the management of disruptive behaviors as an alternative to Rule 40
  - quality assurance and alternative licensing standards by the State Quality Council

Next steps include further developing the HCBS Quality Systems Practices and design the regulations and fee structures to implement; create systems to integrate the information and workflow needed to manage across different partners (Licensing, Office of Inspector General, CCA, Mental Health, lead agencies, etc.); prepare for the elimination of county contracts; and, establish a "Quality Roadmap" that is understandable and functional to guide related work across CCA.

- CCA is undertaking a number of in-depth program evaluations. Under contract with the University of Minnesota, a study is underway to analyze the impact of personal care assistance and Home Care Reform, Return to Community Initiative and Community Consortium Grants. In addition, the Agency for Health Care Research and Quality is funding an extensive evaluation of the PIPP Program.

Foster communities for a lifetime where older people and people with disabilities are contributors to their communities and where communities provide them with supports and services they need.

- Transform 2010 provided Minnesotans with increased understanding of the demographic realities and changes that are needed to prepare for this shift. The project included developing a policy framework for what is needed to address aging of the workforce in Minnesota and developing a greater awareness of importance of communities for a lifetime through published success stories of specific communities and regular video conferences.

Manage publicly-funded programs in ways that provide maximum benefit to people while meeting our mandates and staying within our budgets.

- We are working to prepare for and implement the change in Nursing Facility Level of Care (NF LOC) to target services to those in greater need and manage utilization of high-cost services more effectively. We are also preparing for the Essential Community Supports Program to be implemented to provide a limited benefit set to individuals who would no longer be eligible for people of any age who are MA eligible but who would no longer meet the new NF LOC criteria and who are losing waiver services as a result of NF LOC implementation.
- The rate-setting methodology was revised for NF residents who are ventilator dependent to ensure that DHS is not paying too much.

- A new process has been established to ensure that NFs do not go more than two months past due on their bed surcharge payments; if two payments are missed, Health Care Operations will withhold from MA payments to collect current surcharge payments and any past due amounts.

Support families/caregivers in giving care to people and prolonging their caregiving career.

- Work is underway to expand the Self-Directed Services option through the Older Americans Act in-home, caregiver support and nutrition services programs.
- We are developing partnerships with state-certified health care homes and hospitals to connect high risk older adults and family caregivers to evidence-based interventions and in-home supports, facilitate care transitions and improve patient outcomes.

Promote citizen/consumer rights and safety; protect vulnerable adults.

- The Office of Ombudsman for Long-Term Care played an instrumental role in developing and promoting the passage of laws to address felony deprivation (neglect), Guardianship Bill of Rights and Bill of Rights for Wards.
- The Minnesota Board on Aging (MBA) and Office of Ombudsman for Long-Term Care launched a new participant data collection and reporting system, PeerPlace. The system supports the MBA and Area Agencies on Aging to target Older Americans Act services to those most in need.
- The Ombudsman Volunteer Program has targeted its focus to address complaints and concerns, rather than simply visiting residents in nursing facilities and assisted living settings.
- Based on work regarding the broader Adult Program initiative with the Governor's Office, we are continuing to strengthen the adult protection system and related legislation.
- CCA is implementing an online mandated reporting system for allegations of abuse or neglect to track the disposition of reports at the county level.

Innovation, Integrity and Operational Excellence Goals

- **Redesign our care delivery systems (Framework for the Future: 2012)**
- **Continuously improve how we administer services (CCA Strategic Plan)**

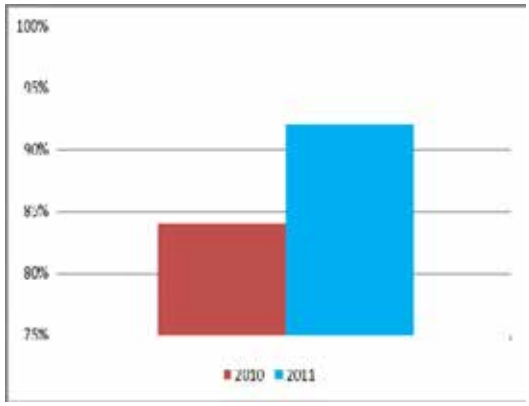
Although our role at DHS is largely about administering public funding, our goal is much larger. Medical Assistance, state and federal grants, training, consultation, collaboration and technology are the resources we leverage to improve people's lives. We also provide direct services, advocacy and analysis. No matter which role each of us plays, how well we do our work and how well we leverage the resources available makes a difference for the people we serve.

Accomplishments and Current Activities:

Enhance Stakeholder relations and collaboration

- Continuing Care administration held the "Building a Quality Future" Odyssey conference in June 2011. The conference attracted over 670 attendees.
- Continued collaboration through stakeholder participation in panels and progress on reform of long-term care services and supports:
  - HCBS Partners Panel participation in many long-term care services and supports reform

Percent of waiver review cases corrected after corrective action issued



  - Involvement with many groups (e.g., Citizen's League work group), has made long-term care financing a bigger priority and led to "Own Your Future" as a priority of this administration.
- DHHS regional office advisory committees planning town meetings in fall 2012 will provide feedback about accessibility needs in the community; broad range of stakeholders will be invited.
- Numerous advisory groups are shaping changes in service definitions, provider standards, rate methodologies, quality assurance, positive behavioral interventions, to name a few.

Be catalysts for change; provide leadership in using performance information to evaluate Minnesota's long-term care system and to guide change

- A new report/analysis function was implemented on the Provider Portal that allows nursing facilities to compare themselves and other facilities on a variety of financial ratios.
- Developed the Long Term Care Profile documenting Minnesota's system of services and supports for people with disabilities and older adults, and drafted performance indicators for home and community-based services.

Provide reliable and efficient operations that simplify processes while meeting state and federal mandates

- Through its MA reform effort, Reform 2020: Pathways to Independence, the department is redesigning home and community-based services to include amending 1915c waivers to consolidate and define a set of services and customize provider standards, create a new state plan service to replace PCA and serve people who previously had to use waiver services to get what they needed.
- A total of 27,000 customized living rate tools were completed with 26,300 rates generated allowing for data capture and process of rates for Community Alternatives for Disabled Individuals and Brain Injury Waiver Programs, enhanced reporting to lead agencies and increased consistency in the interpretation of rate-setting policy across lead agencies.
- Nursing Facility Consolidation Provisions were enacted, allowing special rate adjustments for facilities that want to undertake major capital projects in combination with complete closure of another facility.
- Hardship provisions were enacted to address areas with access concerns, replaced old criteria for allowing new beds to be added in with new criteria and a new process.
- Deaf and Hard of Hearing Services division staff collaborated with Office of Ombudsman for Long-term Care to pilot a specialist ombudsman position targeted to the needs of individuals with hearing loss in long-term care facilities. The division also:
  - Revised the Telephone Equipment Distribution (TED) Program statute was revised to modernize language and include standard programs practices into law.
  - Began promoting MN Relay outreach in July 2011. To date, the program has completed over 100 outreach activities.
  - Repurposed a portion of existing grant funding to re-create an outdated program that provided specialized and culturally affirmative psychological assessments and follow-up services to greater Minnesota children who are deaf, hard of hearing, or deafblind (ages 0 – 21).
  - Consolidated and redesigned the Deaf and Hard of Hearing Services (DHHS) regional offices to reduce operating expenses and create more effective onsite management of regional resources.
  - Expanded use of technology to improve communication and as a cost-saving strategy expanded use of SharePoint as a communication tool.
  - Transitioned DHHS Deaf Mentor Family Program to Lifetrack Resources and developed a new family mentor program to reach a broader range of families who need to learn communication strategies with their child.

  - Beginning July 1, 2012, is conducting the two-year National DeafBlind Equipment Distribution pilot program in MN (funded by the Federal Communications Commission)
  - Is conducting cost-benefit analysis in the TED program related to return of equipment requirement; the analysis will be done in preparation for business process mapping of three processes with the Office of Enterprise Architecture.
  - Is assessing current service delivery of interpreter referral services in Greater MN to design more cost-effective, outcome-based services for consumers, providers and interpreters.
  - We continue work on waiver provider rate-setting and waiver provider standards. Frameworks for establishing disability services rates have been developed and a research period is underway in preparation for legislation next session to implement the payment methodologies.
- DSD completed significant personnel and work changes. The focus on transformational projects such as MnCHOICES, provider standards and rate methodologies, required the realignment of staff, even as daily operations continue to remain complex and intensive. A structure and assignment of responsibilities that reflect the future needs of the division was created in response. Teams are updating work plans and clarifying roles and responsibilities. Collaborative work is being negotiated to establish effective ways to work together.
- We provided demonstrations of personal tele-presence and how the technology could improve client services and connect family caregivers to their older relatives – this is being implemented in many venues.
- DHHSD Mental Health Program conducted a consumer satisfaction survey and received an overall score of 4.63 (out of 5) for the quality of its services and the outcomes experienced by clients.
- DSD created a Policy and Technical Assistance Response Team that has successfully been piloted, expanded to the Metro and now being further expanded to provide timely, accurate information to counties.
- The role of regional resource specialist (RRS) staff was revised to bring their expertise about county operations and pressures to policy development, and to be a partner in managing change with counties as implementation occurs.
- The administration operationalized rate changes for Continuing Care program increases and decreases, managed the implementation of controversial and high profile initiatives such as PCA reductions, and conducted complex fiscal analysis of legislative requests.
- Minnesota's conversion to RUG -IV (Resource Utilization Groups used to determine both Medicare and Medicaid reimbursement rates) required special reporting by nursing facility providers, a cost-neutral set of payment rates to be computed and major payment systems changes; successfully completed effective 1/1/12.
- The Nursing Facility Rates staff implemented Equitable Cost-Sharing for Publicly-Owned Nursing Facilities; a new law that created a rate increase for governmentally-owned or operated nursing facilities if the governmental unit voluntarily pays the non-federal share of the increase. It required full-rebasing rates to be computed for all facilities, communication between DHS and providers and a method for accepting the non-federal payment from the owner; successfully implemented 10/1/11.
- The Disability Services Division and Appeals and Regulations sponsored a LEAN Kaizen event that looked at PCA program appeals and created an action plan that is in process of being implemented. Results include faster response times, an average of $75,000 savings/month, reduction in backlogs, and an ability for the MMIS Team in DSD to assume responsibilities vs. contracting for services at an annual expense of $150,000. The action plan includes a system to support the appeals process across DHS, implementing an expedited PCA appeal review process and other efficiencies to conduct due process activities.
- Nursing Facility Bed Relocation Provisions enacted to allow greater predictability and transparency in setting budget neutral rates.

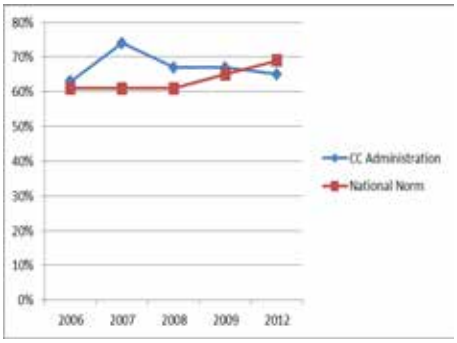
- Long-term care consultation (LTCC) assessors now have access to on-line training on working with persons with deafblindness.
- The administration increased use of technology to gain efficiencies in our work such as Service Desk Express, Go-to-Meeting, Microsoft Lync and the Disability Services Division On-Line Learning Module Development, including the use of Tegrity to develop training on rate setting.
- Through our efforts, technology is increasingly being used to support people with disabilities; e.g., hundreds of people who have moved to more independent settings thanks to the use of technology. We are continuing to expand the use of technology and develop a structured approach with TA and training, to support lead agencies, providers, families and individuals about its possibilities to support inclusive community living.
- Work is underway to expand the Gaps Analysis and Needs Determination to document services and supports that are available, identify where gaps or potential excesses exist and develop a plan to align services and supports across the State to meet the long-term service and support needs of older adults and people with disabilities.
- DSD is fully implementing the vision for the Policy and TA Response Team and updating all manuals and on-line tools to reflect current policy and instructions and address areas of potential misunderstanding.

Employee Learning and Growth Goals

- **Promote professional excellence and engagement in our work (CCA Strategic Plan)**

The Continuing Care Administration commits to provide staff development opportunities and supports that promote an engaged and productive workforce. We value the mentoring and coaching that our experienced staff passes on to those new to our organization. Together, we work to create a legacy we are proud of. Now in its sixth year, the ExCEL (Examine, Create, Engage and Learn) initiative serves to improve employee commitment, involvement and enthusiasm toward our work. We continue this commitment to our employees as part of this strategic plan.

Recognition and Career Advancement



Accomplishments and Current Activities:

Improve workplace culture and promote engagement

- CCA conducted the ExCEL employee engagement survey Jan. 9 – 24, 2012; 80% of CCA staff responded.
- Established 2012, the CCA Brown Bag series provides an opportunity for staff to increase their knowledge of each other and the work of each division.
- SkillSoft (on-demand, e-learning and performance support solutions) licenses were purchased for CCA staff. This training supports staff at all levels placing development initiatives in context of the needs of the individual employee.
- Current activities include:
  - Reviewing employee engagement survey data and providing feedback and consultation provided as needed. CCA is developing administration level action plans to address three priority areas for growing engagement levels in CCA; areas are related to employee

recognition and career advancement, and organizational effectiveness. Teams/units are also developing action plans and identifying resources to support staff where necessary.
  - Developing a 2012-2013 training agenda to support staff at all levels using employee engagement survey data to inform an agenda.
  - Planning a CCA retreat; reviewing and updating the strategic plan, documenting accomplishments and barriers, and beginning to build the 2013-2014 CCA legislative platform.
  - Preparing for a July 2012 Stakeholder meeting; engaging stakeholders re: CCA strategic plan progress and barriers; seeking input and advice from key stakeholders and recommending policy direction.

Connect purpose and practice to ensure that employees understand how they impact the overall goals of the organization

- The Continuing Care Hall of Results publicly showcases CCA population and program performance measures.
- The performance measures implementation team (PMIT) established to develop CCA performance measurement standards and measures.
- CCA launched its performance measures dashboard on DHS public website including 40 measures linked to strategic plan results. Additional dashboard measures are available on both DHS internal and external dashboards. In addition, web-based performance measures have been made available for lead agencies. CCA also developed "Is Anyone Better Off" outcome measures for DHHS regional offices core client work (case file clients) and creation of a survey tool and protocol for collecting outcome data.
- The Results Accountability (RA) community of practice was established to further develop performance measurement standards to be applied across the administration and to provide technical assistance to CCA programs.
- Current activities include:
  - Initiating a new fiscal analysis team.
  - Updating CCA Hall of Results summer 2012.

Attachment B: Minnesota Demographics

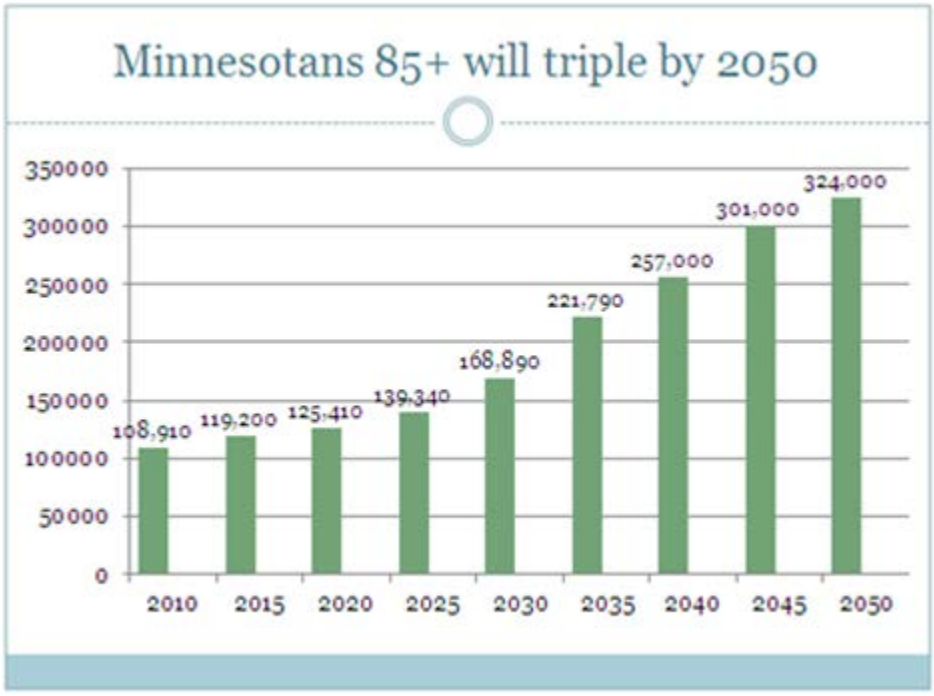


Figure 3: Projected Number of Minnesotans 85 years and Older: 2010-2050

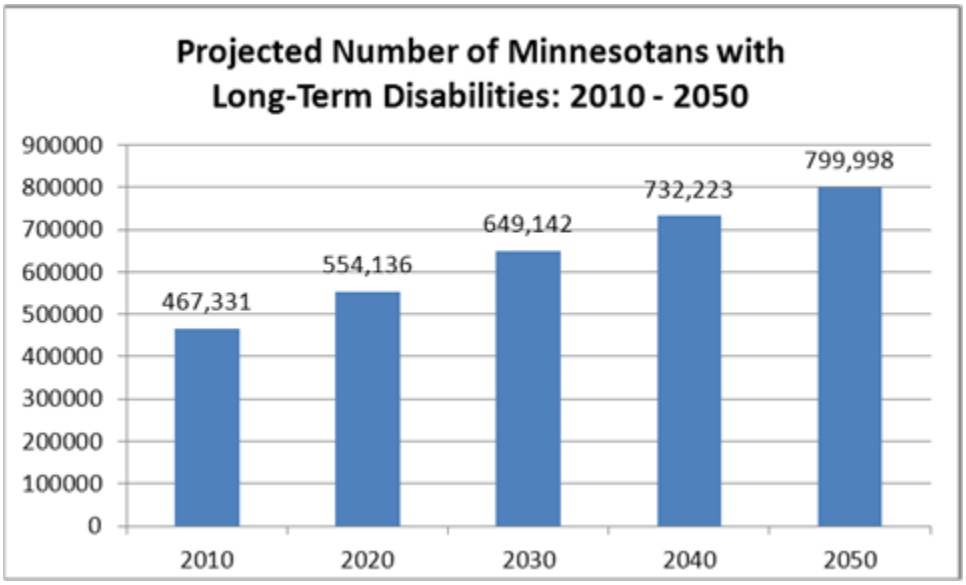


Figure 4: Projected Number of Minnesotans with Long-Term Disabilities: 2010-2050

Attachment C: Workgroups with External Partners

Home and Community-Based Services Partners Panel

Organizational Affiliation	Name
AARP	Mary Jo George
Advocating Change Together (ACT)	Mary Kay Kennedy
Aging Services of Minnesota	Mary Youle
Alzheimer's Association	Bob Karrick
Association of Minnesota Counties/CBP	Patricia Coldwell
Association of Residential Resources of Minnesota	Barb Turner
Brain Injury Association of Minnesota	Pete Klinkhammer
Care Providers of Minnesota	Patti Cullen
Courage Center	John Tschida
TBI Advisory Group (works at Dungarvin)	Dawn Smith
Governor's Council on Developmental Disability	Lynne Megan
Heading Home Minnesota	Laura Kadwell
Institute on Community Integration	Amy Hewitt
Minnesota Network of Hospice and Palliative Care	Michele Fedderly
Local Public Health Association (LPHA)	Kay Dickison
LTC Ombudsman	Deb Holtz
Lutheran Social Services	Mark Peterson
MACSSA - Anoka County	Jerry Pederson
Medica - representing MN Council of Health Plans	Julie Faulhaber
Minnesota Adult Day Services Association	Laura Philbrook
Minnesota Area Geriatric Education Center	Robert Kane
Minnesota Association of Area Agencies on Aging	Catherine Sampson
Minnesota Association of Centers for Independent Living	Victoria Dalle Molle
Minnesota Association for Children's Mental Health	Debora Saxhaug
Minnesota Association of Mental Health Centers	Ron Brand
Minnesota Board on Aging	Joseph Grant
Minnesota Consortium of Citizens with Disabilities	Steve Larson
Minnesota Consortium of Citizens with Disabilities	Christopher Bell
Minnesota Council of Child-Caring Agencies	Mary Regan
Minnesota Disability Law Center	Anne Henry
Minnesota Habilitation Coalition	Lynn Noren
Minnesota HIV Services Planning Council	Tim Sullivan
Minnesota Home Care Association	Jennifer Sorensen
Minnesota Leadership Council on Aging / Wilder Foundation	Bobbi Cordano
Minnesota Legislature, Chair House Health and Human Services Finance	Thomas Huntley
Minnesota Legislature, Chair House Health and Human Services Policy Committee	Tina Liebling
Minnesota Legislature, Chair Senate Health, Human Services Finance Committee	Tony Lourey
Minnesota Legislature, Chair Senate Health, Human Services Policy Committee	Kathy Sheran
Minnesota State Council on Disability	Joan Willshire
MNAPSE-The Network for Employment	Bob Niemiec
MnDACA	John Wayne Barker
NAMI Minnesota	Sue Abderholden
Ombudsman for MH/DD	Roberta Opheim
State Advisory Council on Mental Health	James Jordan
White Earth Home Health Agency	Jen Stevens

County-State Work Group

Name	Organization	County	Title
Chuck Amunrud	AMC	Filmore	County Commissioner
Malotte Backer	MACSSA	Clearwater	Social Services Director
Alex Bartolic	DHS		Health Care Program Mgr Sr
Krista Boston	DHS		State Prog Admin Manager
Julie Ring	AMC		Health and Human Services Policy Analyst
Nancy Dahlin	MACSSA	Chisago	Director, Health and Human Services
Kay Dickison	MACSSA	Dakota	Deputy Public Health Director
Pam Erkel	DHS		State Prog Admin Manager
Peggy Espey	LPHA	Dodge	Public Health Director
Bob Fenwick	AMC	Cook	County Commissioner
Peg Heglund	AMC	Yellow Medicine	Director, Human Services
Tom Henderson	MACSSA	Brown	Social Services Director
Nancy Hintsa	MACSSA	St. Louis	Waiver Coordinator
Mark Nelson	MACSSA	St. Louis	Division Director, Adult Services
Kate Lerner	DHS		Director, County Relations
Karen Jorgensen-Royce	LPHA	Wright	Public Health Supervisor
Eric Ratzmann	MACSSA		Interim Director, MACSSA
Meghan Mohs	MACSSA	Ramsey	Adult Services Division Director
Todd Monson	LPHA	Hennepin	Area Director, Human Services and PH
Britta Orr	LPHA		Director, LPHA
Jake Priester	DHS		Lead Agency Liaison
Laura Reid	LPHA	Sibley	Public Health Supervisor
Jamie Richter	LPHA	Cass	Adult Health Supervisor/Public Health
Lisa Rotegard	DHS		State Prog Admin Manager
Jean Wood	DHS		Health Care Program Mgr Sr
Bob Meyer	DHS		Director, Fiscal Analysis and Performance Mgmt

AMC – Association of Minnesota Counties
DHS – Minnesota Department of Human Services
LPHA – Local Public Health Association
MACSSA – Minnesota Association of County Social Service Administrators

Autism Spectrum Disorder Advisory Council

Name	Organization
Idil Abdull	Somali American Autism Foundation
Delores Alleckson	Rice Institute for Counseling and Education
Mike Amon	Alternatives for People with Autism
Jean Bender	Arc of Minnesota
Barb Dalbac	Minnesota Department of Health
Amy Dawson	Autism Advocacy and Law Center, LLC
Amy Esler	Amplatz Children's Hospital, University of Minnesota
Paris Gatlin	Arc Greater Twin Cities
Sheryl Grassie	End of the Spectrum
Kara Hall Tempel	Minnesota Department of Education
Diane Halpin	Lionsgate Academy
Anne Harrington	Celebrate the Spectrum
Anne Henry/Bud Rosenfield	Minnesota Disability Law Center
Carey Hodapp	Meeker County
Nancy Houlton	UCare
Jami Hughes	Alliant Behavioral Pediatrics
Kim Kang	Autism Society of Minnesota
Ginny Kistler	Parent
Peggy Kunkel	REM Minnesota
Traci LaLiberte	Center for Advanced Studies in Child Welfare, University of Minnesota
Istahill Malin	Parent
Kathryn Marshall	Minnesota Autism Center
Don McNeill	PACER
Bruce Nelson	Association of Residential Resources of Minnesota (ARRM)
AJ Paron-Wildes	Parent
Pat Pulice	Fraser
Teri Sanders	Residential Services, Inc.
Nancy Schussler	Behavioral Dimensions
Margaret Semrud-Clikeman	Pediatric Neurology, University of Minnesota
Phil Sievers	Minnesota Department of Education
Denise Steans	Washington County
Mike Stern	Governor's Council on Developmental Disability
Brad Trahan	ASD Task Force
Laurie Wabner	Creative Care Resources
Abbie Wells-Herzog	Minnesota Department of Employment and Economic Development
Rich Yudhishthu	Parent
Cary Zahrbock	Medica Behavioral Health
Andrea Zuber	Ramsey County
Timothy Zuel	Hennepin County
	Parent

Health Services Advisory Council

Name	Organization
Kathleen Brooks, MD, MBA, MPA	University of Minnesota Medical School
Don Brunnquell, PhD, LP	Children's Hospitals and Clinics
Amelia Burgess, MD, MPH	Park Nicollet Health Services
Craig Christianson, MD	UCare
Brendon Cullinan, MD	HealthEast Care System (council chair)
Lance Hegland, MBA	consumer representative
David Pautz, MD, FACP	Blue Cross and Blue Shield of Minnesota
Katie Pieper	COTA/L, Courage Center
Timothy Sielaff, MD, PhD, MBA, FACS	Allina Hospitals, Virginia Piper Cancer Institute
Tom Von Sternberg, MD	HealthPartners
Mark Willenbring, MD	United Hospital
Jeffrey Schiff, MD, MBA	DHS Medical Director for Minnesota Health Care Programs (non-voting member)

Community First Services and Supports/Money Follows the Person Implementation Council

Last Name	First	Organization affiliation
Aldrich	Jane	Hennepin County Human Services and Public Health Department
Bender	Jean	Participant or parent/family member of participant
Buckley	Lynn	Caring Connection Adult Day
Cardenas	Rick	Advocating Change Together
Christiansen	Barbara	Participant or parent/family member of participant
Crumley	Andrea	Caring Professionals
Giovanni	Antonietta	Participant or parent/family member of participant
Grisim	Shelia	Frasier
Hegland	Lance	Participant or parent/family member of participant
Hendricks	Charity	Participant or parent/family member of participant
Henry	Anne	Minnesota Disability Law Center
Holtz	Debra	Ombudsman Office
Jaszcak	Shantel	Consumer Directions Inc.
Jirik	Barbara	Participant or parent/family member of participant
Johnson	Tom	Mental Health Assoc.
Knutson-Kaske	Jill	MN Homecare Assoc.
Lackey	Shari	Participant or parent/family member of participant
Lowe	Janet	St. Paul Schools
Marrin	Maureen	Ombudsman MH/DD, State of MN
McCormack	Jacki	The Arc
McGeehan	Susan	Medica
Murrens	Jody	Participant or parent/family member of participant
Nelson	Jon	Residential Services, Inc.
Page	Justin	Minnesota Disability Law Center
Pathre	Rijuta	Participant or parent/family member of participant
Price	Scott	Participant or parent/family member of participant
Sams	David	Participant or parent/family member of participant
Smith	Galen	Participant or parent/family member of participant
Stensland	Barb	Lutheran Social Services
Thorne-Birt	Debra	Participant or parent/family member of participant
Tyler	Kim	Participant or parent/family member of participant
Velner	Teri	Participant or parent/family member of participant
Versailies-Hester	Esther	U Care
Vlasak	Karen	Participant or parent/family member of participant
Vogele	Stacey	Participant or parent/family member of participant
Ward	Tamara	Participant or parent/family member of participant

MnCHOICES Steering Committee

Name	Organization	Representing
Sue Abderholden	NAMI	Mental Health Advocacy
Connie Bagley	S.E. MN AAA	Area Agencies on Aging
Todd Bergstrom	Care Providers of MN	Aging Services Providers
Melody Bialke	Blue Cross/Blue Shield of MN and Blue Plus	MCOs
Jeff Bostic	Aging Services of Minnesota	Aging Services Providers
Rita Chamberlin	Hennepin County	Counties
Bobbi Cordano	Wilder Foundation	Aging Services Providers
Kris Flaten	Advisory Council on Mental Health	Mental Health Advocacy
Sandy Foy	Ramsey County	Counties
Janet Golden	Elder Care Rights Alliance	Aging Advocacy
Candy Hanson	Chisago County	Counties
Debbie Harris	ARC	Parent
Lori Hautajarvi	St. Louis County	MACSSA
Anne Henry	Disability Law Center	Disability Advocate
Barb Jacobson	ARRM	DD Providers
Christina Kallevig	Swift County Human Services	Counties
Michele Kimball	AARP	Aging Advocacy
Katherine Kreager-Pieper	Dakota County	Counties
Steve Larson	ARC	DD Advocacy
Susan McGeehan	Medica	MCOs
Jeanette Mefford	MHCA	Home Care Agencies
Becki Pender	PrimeWest Health	RN, CCP, Senior Care Mgr
Don Priebe	ARRM member/provider	ARRM
Diane Raff	Living at Home Network	Aging Services Provider
David Sams	MN State Council on Disability	Disability Advocate
Dawn Simonson	Metro Area Agency on Aging	AAAs
Robin Thompson	Minnesota River AAA	AAAs
Jill Tilbury	Brain Injury Association of MN	BI Advocacy
Beth Tollefson	Dakota Communities	DD Service Provider
John Tschida	Courage Center	Disabilities Advocate
Lori Vrolson	Central MN AAA	AAAs
Donna Walberg	Minnesota Board on Aging	Aging Advocate
Len Weiss	St. Louis County	Counties
Joan Willshire	MN State Council on Disability	Disability Advocate
Pam Zimmerman	Metro Area Agency on Aging	AAAs

MnCHOICES Policy Work Group

Name	Organization	Representing
Melody Bialke	Blue Cross Blue Shield of MN and Blue Plus	MCOs
Elaine Carlquist	PrimeWest	MCOs
Rita Chamberlin-Austin	Hennepin County	Counties
Barb Dietz	Brown County	Counties
Sandy Foy	Ramsey County	Counties
Candy Hanson	Chisago County	Counties
Anne Henry	Disability Law Center	Disability Advocate
Karen Jones	Leech Lake Band of Ojibwe	Tribes
Katherine Kreager-Pieper	Dakota County	Counties
Susan McGeehan	Medica	MCOs
Kara Temple (Hall)	MN Department of Education	Interagency
John Tschida	Courage Center	Disability Advocate

MnCHOICES Private Duty Nursing Work Group

Name	Organization
Edel Austin	Edelweiss Home Care
Angela Bieniek	Communities of Care
Carol Cantleberry	Accurate Home Care
Wendy Erlandson	New Dimensions Home Care
Lisa Flynn	Hiawatha Home Care
Lisa Fowler	Bayada Nurses Home Care Specialists
Sarah Frie	Edelweiss Home Care
Candy Hanson	Chisago County
Erin Livingston	Chisago County
Susan McGeehan	Medica
Lori Murray	Pediatric Home Service
Maureen Murray	South Country Health Alliance
Amy Nelson	Accurate Home Care
Becki Long	Pediatric Home Service
Kate Obert	Bayada Nurses Home Care Specialists
Margaret Patterson	Ramsey County
Amy Rewey	Anoka County
Joan Vaughn	Communities of Care
Tina Weiss	Crystal Care Home Health Companies
Megan White	Edelweiss Home Care
Kristy Wilfahrt	Medica
Susan Wingert	Pediatric Home Service
Maraloo VanDerWalt	Edelweiss Home Care

MnCHOICES Experienced Assessor Work Group

Name	Organization	Area Representing
Joel Bebeau	Leech Lake Band of Ojibwe	Tribes
Sherry Berde	Ramsey County	DD Waiver Assessor
Jill Boeson	McLeod County	Elderly Waiver Assessor
Roxanne Botz	Isanti County	DD Waiver Assessor
Wanda Breyer	U of MN	Elderly Waiver Assessor
Elaine Carlquist	PrimeWest	Health Plan/Elderly Waiver
Betty Christensen	Chippewa County	DD Screenings, LTCC
Kylie Eldred	Clay County	DD Waiver Assessor
Betsy Farley	Hennepin County	CAC, CADI, TBI Assessor
Sandy Feldman	Renville County	PCA/ Private Duty Nursing
Molly Fleming	Washington County	CAC, CADI, TBI Assessor
Rita Hanson	Winona County	DD Waiver Assessor
Betsy Hills	Douglas County	Elderly Waiver Assessor
Kim Holleschau	Hennepin County	CADI, TBI, EW, AC, MH-21
Naomi Jones	MNVA	PCA/ Minnesota Visiting Nurses Association
Steven Leslie	St. Louis County	PCA/ Private Duty Nursing
Ruth Lumley	Mower County	PCA/ Private Duty Nursing
Lynn McDermott	Keystone County	Elderly Waiver Assessor
Susan McGeehan	Medica	PCA/ Private Duty Nursing
Rachel Nice	Winona County	Elderly Waiver Assessor
Sandy Pinney	Le Sueur County	Elderly Waiver Assessor
Nancy Rector	Health Partners	Elderly Waiver Assessor
Anne Rooney	Scott County	CAC, CADI, TBI Assessor
Lana Sander	Watonwan County	CAC, CADI, TBI Assessor
Lisa Schultz	Chippewa County	DD Waiver Assessor
Laurie Snegosky	McLeod County	PCA/ Private Duty Nursing
Amy Springer	Morrison County	PCA/ Private Duty Nursing
Kara Temple (Hall)	MN Department of Education	Interagency advocacy
Rebecca Torbog	Meeker County	Elderly Waiver Assessor
Nikki Turenne	St. Louis County	Elderly Waiver Assessor
Lori Vigstol	Polk County	PCA/ Private Duty Nursing

MnCHOICES Technology Committee

First Name	Organization	Representing
Tom Barnd	Hennepin County	County
Charles Berg	Blue Earth County	County
Amy Bofenkamp	Medica	MCOs
Lori Bouchard	St. Louis County	County
Brad Brunfelt	St. Louis County	County
Emmett Davis	Hennepin County	County
Angie Dickinson-Palmer	Lake County	County
Jon Eckel	Chisago County	County
Candy Hanson	Chisago County	County
Jamie Hess	Prime West	MCOs
Sandra Hvizdos	Metropolitan Health Plan	MCOs
Scott Jara	Dakota County	County
Daniel Jensen	Olmsted County	County
Shannon Kennedy	Ramsey County	County
Susan McGeehan	Medica	MCOs
Lisa Menth	Anoka County	County
Tim Nix	UCare	MCOs
Judy Pearson	Dakota County	County
Shawn Pearson	Chisago County	County
Sayeed Reza	Blue Cross Blue Shield	MCOs
Laurel Rose	HealthPartners	MCOs
Gary Sprynczynatyk	McLeod County	County
Logan Strand	Washington County	County
Abbie Willis	Olmsted County	County
Glenn Wong	Hennepin County	County
Jim Wright	HealthPartners	MCOs

MnCHOICES First Implementer Work Group

Name	Organization
Thomas Barnd	Hennepin County
Anne Broskoff	Blue Earth
Elaine Carlquist	PrimeWest
Wendy Caslavka	UCare
Linda Erhardt	Swift County
Mary Grina	UCare
Kelley Haeder	Blue Earth County
Candy Hanson	Chisago County
Nancy Hintsa	St. Louis County
Jon Iwen	Becker County
Lori Jensen	Beltrami County
RaeAnn Keeler-Aus	Yellow Medicine County
Katherine Kreager-Pieper	Dakota County
Susan McGeehan	Medica
Alyssa Meller	Blue Plus
Lori Miller	Wadena County
Cindy Radke	UCare
Amy Rewey	Anoka County
Pam Selvig	Scott County
Susan Sommers	Metropolitan Health Plan
Jennifer Stevens	White Earth
Ronda Stock	Becker County
Bridget Vanderwal	Lac Qui Parle County
Sue Westrich	UCare
Kristy Wilfahrt	Medica
Caroline Woehle	Leech Lake
Kia Xiong	Ramsey County
Wendy Young	Wadena County

HCBS Waiver Provider Standards Stakeholders Group

Organizational Affiliation	Name
ARRM	Barb Turner
Day Provider	Lynn Noren
Counties (Metro)	Patricia Kuehn
Counties	Dennis Price
Counties (Out State)	Nancy Dahlin
Disability Law	Bud Rosenfield
NAMI	Sue Abderholden
Courage Center	Cindy Guddal
MDH	Janice Jones
U of M (ICI)	Derek Nord
Brain Injury Association of Minnesota	Jill Tillbury
TBI Advisory Committee	Sara Schlegelmilch
Hennepin County	Lynell Tanner
Ombudsman LTC	Sherilyn Moe
Ombudsman MH/DD	Amy Poehling
	Lisa Harrison-Hadler
Ombudsman DD/MI	Kay Hendrikson
Mount Olivet Rolling Acres	Susan Zeug-Hoese
Technology Provider	Sandy Henry
ARC of Minnesota	Anni Simons
Family	Lester Bauer
Family	Alice Hulbert
Self Advocate	Lance Hegland
Self Advocate	Patricia Winnick
MNDACA	Karen James
REM	Denise Miller
KandiWorks DAC	Deb TerWisscha
Ramsey County Contract Manager	Tim Hammond

Case Management Reform Work Group

Name	Organization
Kirsten Anderson	Lutheran Social Services
John Wayne Barker	MNDACA
Ron Brand	MN Assn of Community MH Provider
Elaine Carlquist	PrimeWest Health
Milt Conrath	ARC MN
Ed Eide,	MHAM
Anne Henry	Disability Law Center
Pete Klinkhammer	Brain Injury Association
Audrey Kolnes	White Earth
Matt Kramer	Advocate
Peggy Kunkel	ARRM
Catie Lee	PrimeWest Health
Susan McGeehan	Medica
Lynn Megan	MN Habilitation Coalition
Meghan Mohs	MACSSA
Annie Napoli	MACSSA
Laurie Snegosky	PH Assn
Traci Thompson	Washington Co

Rule 40 Advisory Committee

Name	Organization
Kay Hendrickson	Ombudsman for MH and DD
Colleen Wieck	Minnesota's Governor's Council on DD
Anne Henry	Minnesota Disability Law Center
Shamus O'Meara/M.Annie Santos	Plaintiff's Counsel
Patricia Kuehn	MACSSA representative – Ramsey County
Kelly Ruiz	MACSSA representative – Dakota County
Tim Moore	Independent Expert
Bonnie Jean Smith	Parents and Family Members
Barbara Kleist	Parents and Family Members, Advocate
Gloria Steinbring	Self-Advocate
Traci Lisowski	Provider
Leanne Negley	Provider
Andrew Pietsch	Provider
Steven Anderson	Provider
Dan Reed	Provider

State Quality Council

Organization/Affiliation	Name
ARC	Steve Larson
Assisted Living	Daniel Pakonen
Association of Residential Resources in Minnesota (ARRM)	Barbara Turner
Consumer Choice , Consumer Directed Community Supports (CDCS) Fiscal Support Entity (FSE)	Cara Benson
Consumer Directed Community Supports (CDCS) Support Planner	Gina Lecy
Dakota County	Dennis Price
DHS Licensing	Katherine Finlayson
DHS Regional Resource Specialist	Shannon Smith
Dungarvin Minnesota, LLC	Jason Flint
Family	Viola Smith
Family	Alice Hulbert
Family	Lester Bauer
Hennepin County	Ryan Marshall
Lifeworks Services Inc. (Resigned Nov 2012)	Andrew Pietsch
Lutheran Social Services	Debra Koop
Lutheran Social Services	Ann Lazzara
Metropolitan Center for Independent Living (MCIL)	David Hancox
Minnesota Department of Health	Janice Jones
Office of Ombudsman for Mental Health and Developmental Disabilities	Kay Hendrikson
Ramsey County	Pat Kuehn
Recipient	Lance Hegland
Recipient	Patricia Winick
Region 10 Quality Assurance Commission	John Jordan
Region 10 Quality Assurance Commission	Dennis Theede
Region 10 Quality Assurance Commission	LeAnn Bieber
Wright County	Debbra Swanson

Olmstead Planning Committee

Name
Christopher Bell (co-Chair)
Maureen O'Connell/Dave Hartford (co-Chair)
Phil Claussen
Loren Colman
Milt Conrath
David Godfrey/Ann Berg
John Hastings
Pamela Hoopes
Michele (Mickey) Kyler
Maureen Marrin
Maridy Nordlum
Shamus O'Meara/Annie Santos
Roberta Opheim
Lori Schluttenhofer
Colleen Wieck

Attachment D: Reform 2020 HCBS Redesign Initiatives by Strategy

Strategy One: Improve Navigation and Streamline Access to Services and Supports

- MnCHOICES
- First Contact Simplification
- Expanding access to transition supports
- Home and Community-Based Services Report Card
- Employment supports
- Statewide, centralized common entry point for vulnerable adult reports

Strategy Two: Redesign and Improve Services

- Planning and service development
- Community First Services and Supports
- Essential Community Supports
- Services for people with autism diagnosis
- Enhancements to home and community-based services waivers and home care
- Mental health redesign
- Community-based services to address homelessness and barriers to housing

Strategy Three: Improve Service Coordination and Integration

- Innovative approaches to service coordination - children with CFSS
- Case Management Redesign
- Alzheimer's Health Care Home
- Health Home Demonstration – Inclusion of long-term services and supports in the integration of behavioral and physical health care
- Technical assistance to divert commitments and address crisis

Strategy Four: Administrative Efficiency and Sustainability

- Nursing Facility Level of Care implementation
- Provider Standards
- Disability Waiver Rate System
- Consumer-Directed Community Supports: Redesign Fiscal Support Entities
- New budget methodology for vent-dependent seniors

Attachment E: Waiver Limits

Enrollment Limits for Brain Injury and Community Alternatives for Disabled Individuals Waivers

Table 9: Historical Limits for Brain Injury and Community Alternatives for Disable Individuals Waivers

Fiscal Year	BI waiver (new allocations per year)	CADI waiver (new allocations per year)
2004	150	1140
2005	150	1140
2006	150	1140
2007	150	1140
2008	150	1140
2009	No limits	No limits
2010	150	1140
2011	72	720
2012	No limits	720
2013*	No limits	720
2014*	No limits	1020
2015*	No limits	1020

* 2013, 2014 and 2015 limits were passed during the 2011 legislative session

Enrollment Limits for Developmental Disabilities Waiver

Table 10: Historical Limits for Developmental Disabilities Waiver

Calendar Year	DD (new allocations per year)
2004	50
2005	50
2006	50
2007	50
2008	50
2009	No limits (forecasted 300)
2010	180
2011	72
2012 (fiscal year)	72
2013 (fiscal year)*	72
2014 (fiscal year)*	180
2015 (fiscal year)*	180

* 2013, 2014 and 2015 limits were passed during the 2011 legislative session

Attachment F: Continuing Care Long-Term Care Programs, November 2012 Update

Continuing Care Long-term Care Programs
November 2012 Update

December 20, 2012

Section……Page

Quick Guide to what is included in the November 2012 forecast

What **IS** included in the forecast?

1) Current law, including:
   A) 20% PCA relative rate reduction, effective July 1, 2013
   B) Nursing Facility Level of Care, effective January 1, 2014
   C) 1.67% Provider rate reduction for 6 months (July 1, 2013-December 31, 2013)
   D) Enrollment limits for CADI and DD waivers
      - Currently 6 DD Waiver diversion allocations per month, increasing to 15 in FY14-15
      - Currently 60 CADI Waiver allocations per month, increasing to 85 in FY14-15
   E) Long-term care provider rate reductions
      - Beginning July 1, 2013 provider rate reductions for long-term care providers change from 1.5% to 1%, excluding nursing facilities
   F) Nursing Facility APS Operating Rate Adjustments
      - Roughly 2% per year

2) Assumes that changing demographics due to an aging population will increase demand for nursing facilities and elderly programs beginning in FY 2016. This becomes more noticeable in FY 2017.

What is **NOT** included in the forecast?

3) Reform 2020 waiver request items
4) Assumptions about the federal fiscal cliff

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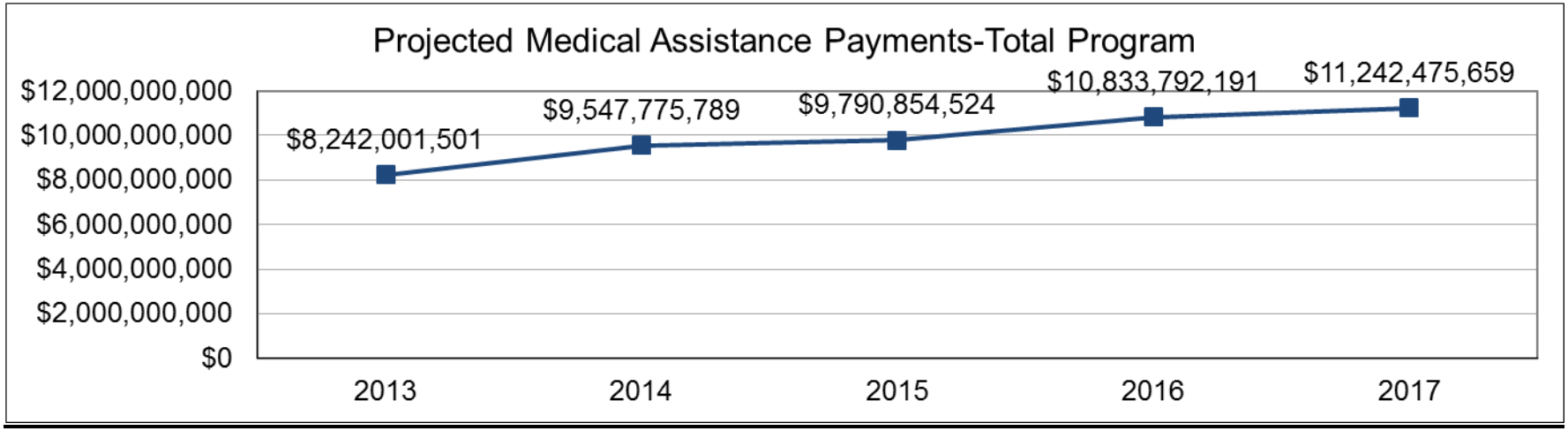
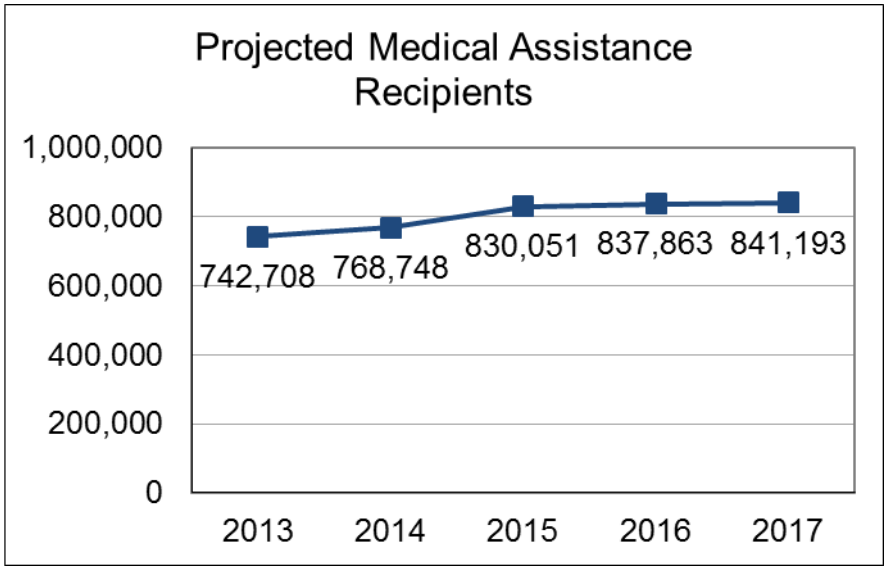
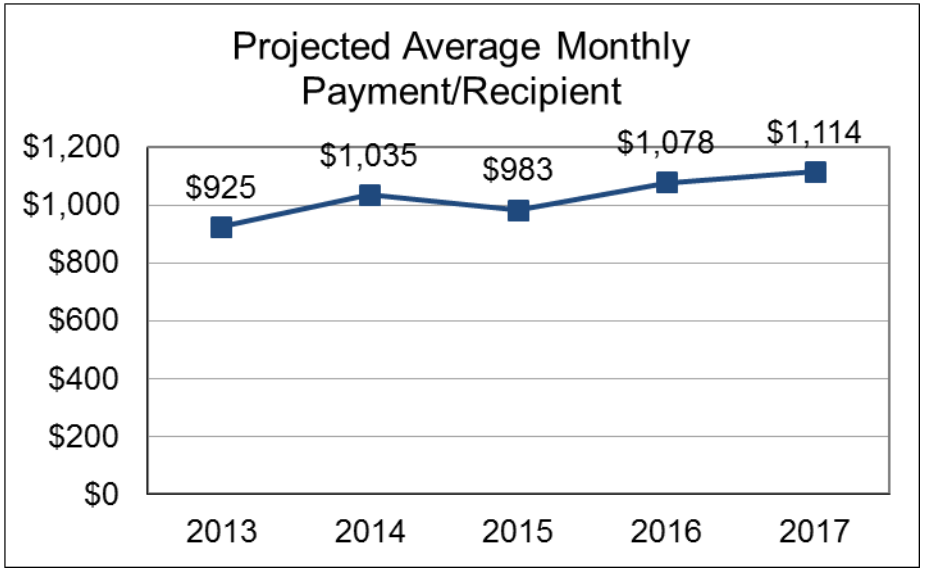
Total Medical Assistance Program



Total Medical Assistance spending is increasing at an average annual rate of 8.1% per year.



The average number of monthly recipients is projected to increase by 3.2% per year.



The average monthly cost per person will be increasing at a rate of 4.8% per year.

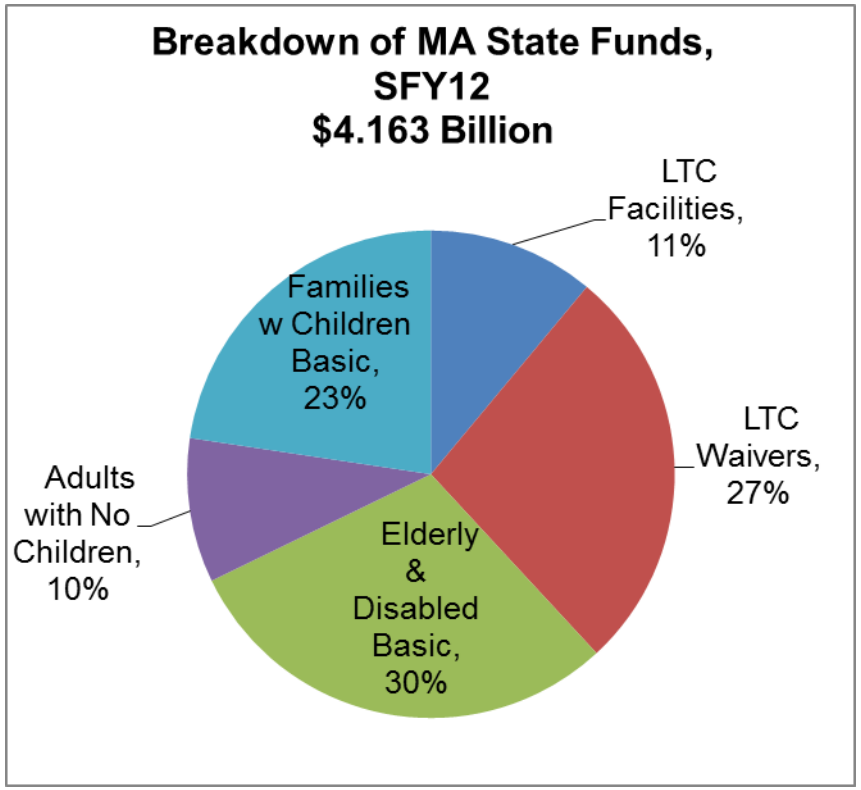
Total Medical Assistance Program, SFY13-17

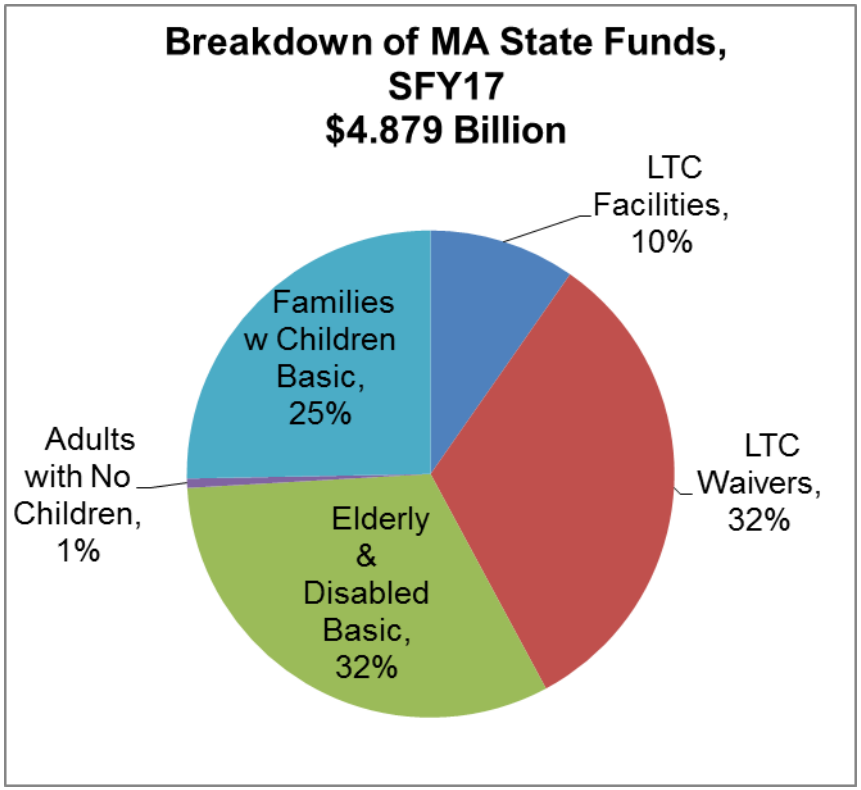
Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2013	742,708	$925	$8,242,001,501			
2014	768,748	$1,035	$9,547,775,789	3.5%	11.9%	15.8%
2015	830,051	$983	$9,790,854,524	8.0%	-5.0%	2.5%
2016	837,863	$1,078	$10,833,792,191	0.9%	9.7%	10.7%
2017	841,193	$1,114	$11,242,475,659	0.4%	3.3%	3.8%
			Overall Average	3.2%	4.8%	8.1%
			Drivers	40%	60%	

Historical Summary of Total Medical Assistance Program, SFY07-12

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2007	510,155	$955	$5,845,577,568			
2008	527,001	$991	$6,268,413,257	3.3%	3.8%	7.2%
2009	557,337	$1,014	$6,778,616,714	5.8%	2.3%	8.1%
2010	608,651	$991	$7,235,667,652	9.2%	-2.3%	6.7%
2011	665,483	$943	$7,528,982,006	9.3%	-4.8%	4.1%
2012	732,831	$937	$8,241,342,196	10.1%	-0.6%	9.5%
			Overall Average	9.5%	-0.5%	9.0%
			Drivers	95%	5%	

Breakdown of Medical Assistance State Spending





MA Spending by Category

			Annual Change
	FY 2012	FY 2017	12-17
LTC Facilities	11%	10%	-0.7%
LTC Waivers	27%	32%	8.9%
Elderly & Disabled Basic	30%	32%	6.0%
Adults with No Children	10%	1%	-47.5%
Families w Children Basic	23%	25%	7.0%
MA Total	100%	100%	4.0%
State Spending (000's)	$4,162,966	$4,879,432	4.0%

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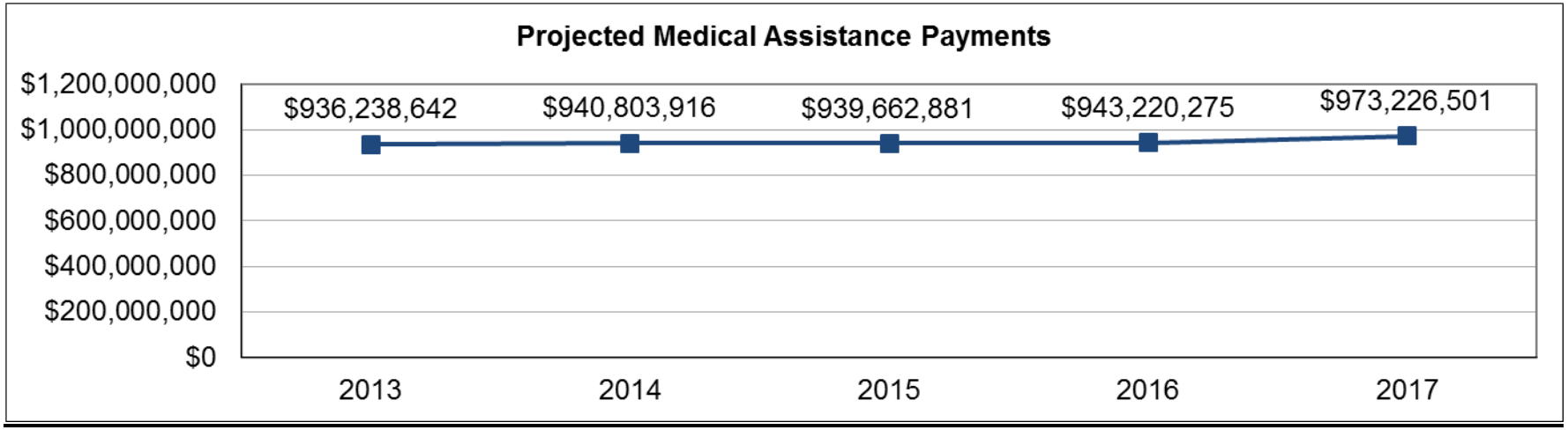
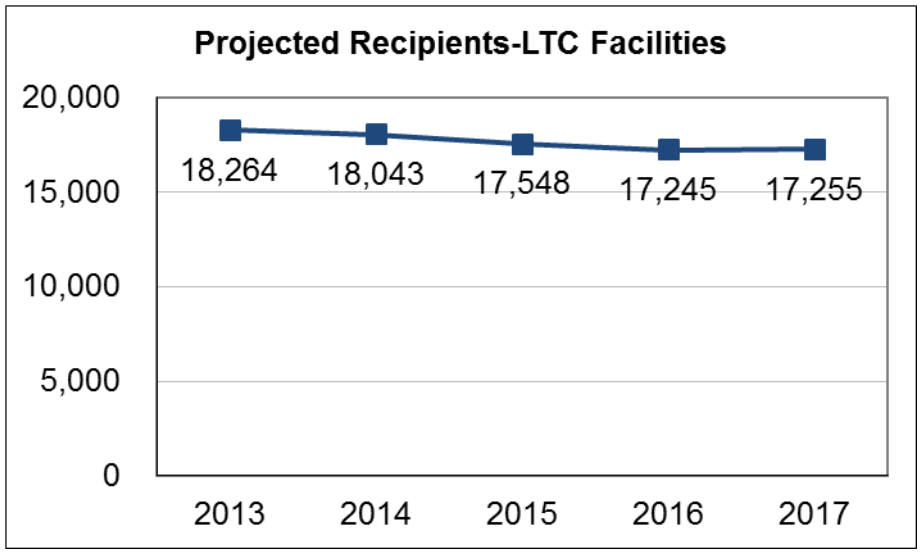
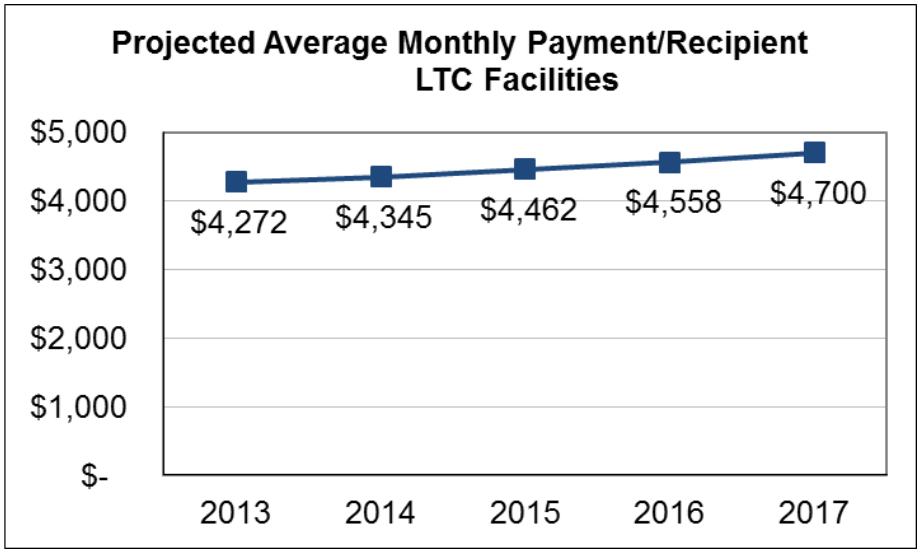
Long-term Care Facilities



Total Medical Assistance spending for long-term care facilities is increasing at an average annual rate of 1.0% per year.



The monthly number of recipients is projected to decrease by 1.4%.



Average monthly cost per person will be increasing at a rate of 2.4%.

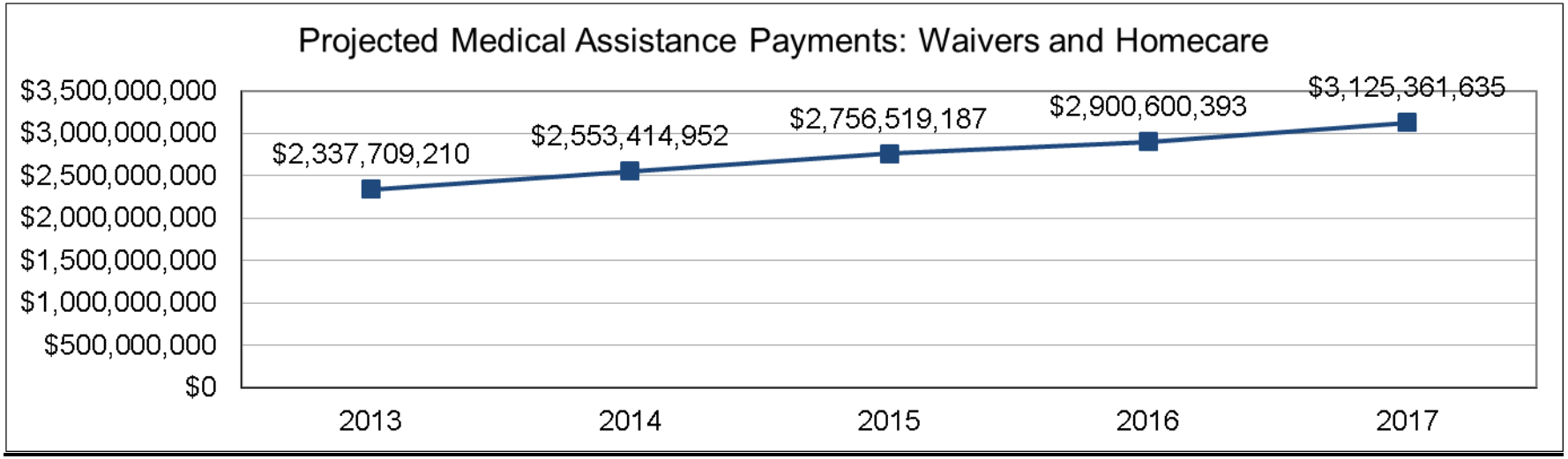
Total Medical Assistance Program – Long-term Care Facilities, SFY13-17

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2013	18,264	$4,272	$936,238,642			
2014	18,043	$4,345	$940,803,916	-1.2%	1.7%	0.5%
2015	17,548	$4,462	$939,662,881	-2.7%	2.7%	-0.1%
2016	17,245	$4,558	$943,220,275	-1.7%	2.2%	0.4%
2017	17,255	$4,700	$973,226,501	0.1%	3.1%	3.2%
			Overall Average	-1.4%	2.4%	1.0%
			Drivers	37%	63%	

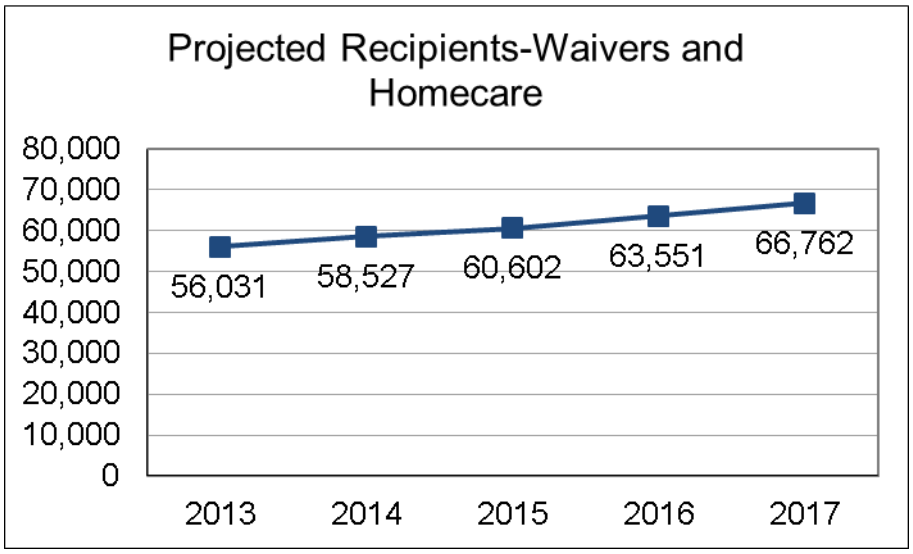
Historical Summary of Long-term Care Facilities, SFY07-12

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons		Percent Change Total Payments
2007	22,173	$3,865	$1,028,309,611			
2008	21,382	$3,967	$1,017,926,598	-3.6%	2.6%	-1.0%
2009	20,643	$4,104	$1,016,517,326	-3.5%	%	-0.1%
2010	20,030	$4,164	$1,000,836,209	-3.0%	1.5%	-1.5%
2011	19,305	$4,164	$964,666,727	-3.6%	%	-3.6%
2012	18,748	$4,203	$945,566,280	-2.9%	0.9%	-2.0%
			Overall Average	-4.1%	2.1%	-2.1%
			Drivers	66%	34%	

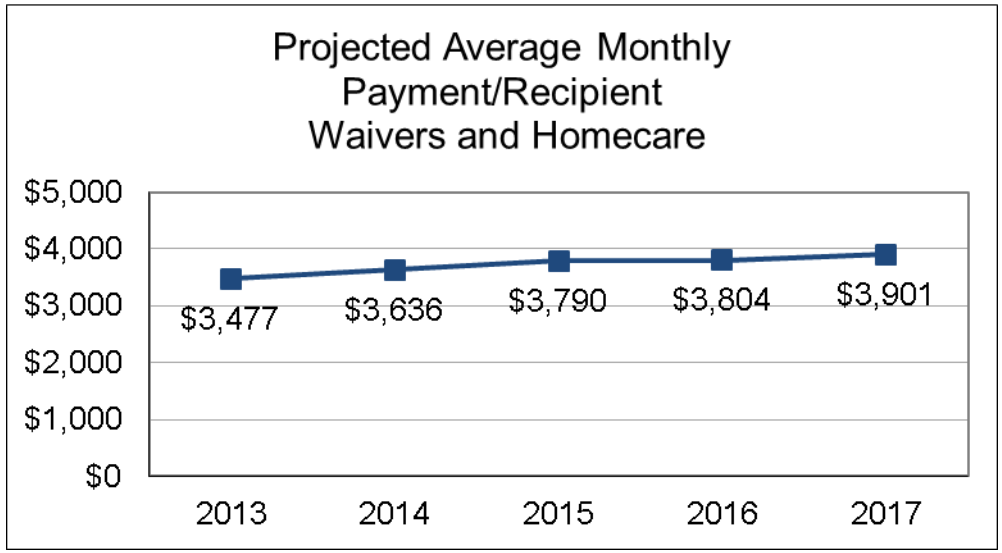
Waivers and Homecare



Total Medical Assistance spending for Waivers and Homecare (Fee for Service Only) is increasing at an average annual rate of 7.5%.



The average monthly number of recipients is projected to increase by 4.5%.



The average monthly cost per person will increase at a rate of 2.9%.

Total Medical Assistance Program – Waivers and Homecare (Fee for Service), SFY13-17

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2013	56,031	$3,477	$2,337,709,210			
2014	58,527	$3,636	$2,553,414,952	4.5%	4.6%	9.2%
2015	60,602	$3,790	$2,756,519,187	3.5%	4.2%	8.0%
2016	63,551	$3,804	$2,900,600,393	4.9%	0.4%	5.2%
2017	66,762	$3,901	$3,125,361,635	5.1%	2.5%	7.7%
			Overall Average	4.5%	2.9%	7.5%
			Drivers	61%	39%	

Historical Summary of Waivers and Homecare, SFY07-12

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2007	45,993	$3,065	$1,691,431,813			
2008	46,778	$3,257	$1,828,546,795	1.7%	6.3%	8.1%
2009	47,886	$3,462	$1,989,107,129	2.4%	6.3%	8.8%
2010	49,504	$3,456	$2,053,318,327	3.4%	-0.2%	3.2%
2011	52,474	$3,461	$2,179,651,151	6.0%	0.1%	6.2%
2012	54,050	$3,428	$2,223,655,096	3.0%	-1.0%	2.0%
			Overall Average	4.1%	2.8%	7.1%
			Drivers	59%	41%	

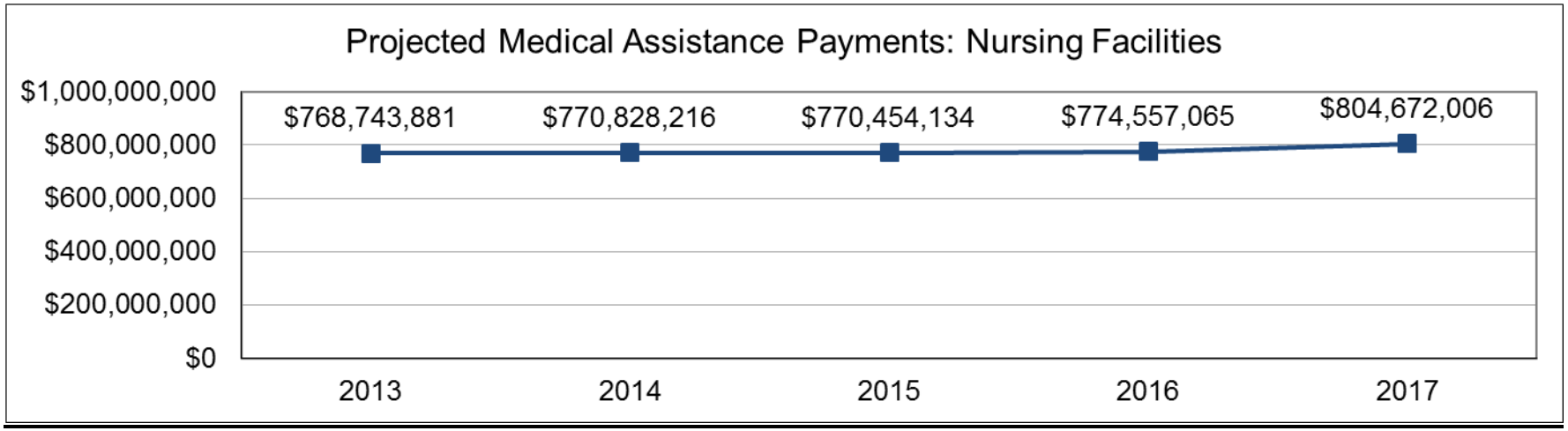
Total Cost by Category of Service (State & Federal), SFY13-17 (in thousands)

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	Avg. $ Change 13-17	Avg. % Change 13-17
LTC FACILITIES							
Nursing Facilities	768,744	770,828	770,454	774,557	804,672	8,982	1.1%
County Nursing Facilities	-	-	-	-	-		
ICF/DD	135,549	133,776	134,434	133,833	133,285	-566	-0.4%
Day Training & Habilitation (for ICF/DD)	33,220	33,585	34,775	34,830	35,269	512	1.5%
METO Program							
State Operated services MI	1,339	-	-	-	-	-335	
June 2013 payment delay	(2,614)	2,614				654	
Subtotal LTC Facilities	**936,239**	**940,804**	**939,663**	**943,220**	**973,227**	**9,247**	**1.0%**
LTC WAIVERS & HOME CARE							
DD Waiver	1,078,096	1,121,639	1,218,322	1,239,861	1,302,671	56,144	4.8%
Elderly Waiver	39,790	42,244	43,610	45,934	49,203	2,353	5.5%
EW Managed Care	277,227	299,043	308,722	336,862	366,896	22,417	7.3%
Disabled Waiver (CADI)	554,412	611,388	671,643	774,871	889,601	83,797	12.5%
Chronically Ill Waiver (CAC)	23,352	24,539	25,886	26,970	28,055	1,176	4.7%
Brain Inj. Waiver (BI)	99,505	105,600	113,462	120,673	128,137	7,158	6.5%
Home Health Agencies	22,976	27,099	29,547	30,561	31,163	2,047	7.9%
Personal Care	462,200	473,920	512,220	532,115	553,173	22,743	4.6%
PCA Managed Care	127,609	164,232	153,660	194,522	192,201	16,148	10.8%
Private Duty Nursing	103,483	117,070	127,992	140,355	151,278	11,949	10.0%
AC	28,102	29,714	29,186	31,774	32,960	1,215	4.1%
CSG	17,269	18,223	19,990	20,438	21,545	1,069	5.7%
June 2013 payment delay	(37,062)	37,062				9,266	
Subtotal Waivers and Homecare	**2,796,958**	**3,071,774**	**3,254,240**	**3,494,936**	**3,746,883**	**237,481**	**7.6%**
LTC Total	***3,733,197***	***4,012,578***	***4,193,903***	***4,438,156***	***4,720,110***	***246,728***	***6.0%***

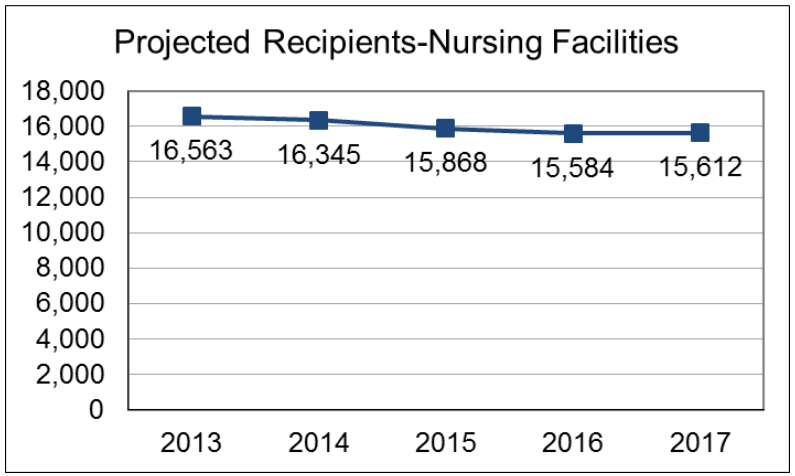
Historical Total Cost by Category of Service (State & Federal), SFY08-12 (in thousands)

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Avg. $ Change 08-12	Avg. % Change 08-12
LTC FACILITIES							
Nursing Facilities	812,796	833,075	824,532	795,963	782,480	-7,579	-0.9%
County Nursing Facilities	-	-	-	-	-		
ICF/DD	141,894	142,170	136,871	135,759	132,254	-2,410	-1.7%
Day Training & Habilitation (for ICF/DD)	31,793	32,932	31,699	32,256	30,736	-264	-0.8%
METO Program	2,604	1,025	-	-	-		
State Operated services MI	12,414	7,316	7,734	688	96	-3,079	-70.3%
Subtotal LTC Facilities	**1,001,500**	**1,016,517**	**1,000,836**	**964,667**	**945,566**	**-13,984**	**-1.4%**
LTC WAIVERS & HOME CARE							
DD Waiver	928,369	965,105	983,708	1,018,442	1,032,442	26,018	2.7%
Elderly Waiver	77,923	50,485	35,156	37,059	37,707	-10,054	-16.6%
EW Managed Care	178,324	232,175	266,291	274,757	273,339	23,754	11.3%
Disabled Waiver (CADI)	292,163	366,628	412,365	474,009	504,024	52,965	14.6%
Chronically Ill Waiver (CAC)	17,064	19,303	19,116	19,888	22,140	1,269	6.7%
Brain Inj. Waiver (BI)	88,152	95,819	96,378	96,593	96,475	2,081	2.3%
Home Health Agencies	25,247	23,849	23,088	23,347	22,456	-698	-2.9%
Personal Care	343,155	402,364	404,265	422,260	438,478		
PCA Managed Care	106,895	121,492	128,912	134,718	135,853	7,240	6.2%
Private Duty Nursing	65,317	70,416	81,378	92,507	95,208	7,473	9.9%
AC	29,592	30,304	29,833	28,467	27,447	-536	-1.9%
CSG	11,945	14,982	14,995	14,853	15,627	920	6.9%
Subtotal Waivers and Homecare	**2,164,147**	**2,392,923**	**2,495,487**	**2,636,900**	**2,701,197**	**134,262**	**5.7%**
LTC Total	***3,165,647***	***3,409,440***	***3,496,323***	***3,601,566***	***3,646,763***	***120,279***	***3.6%***

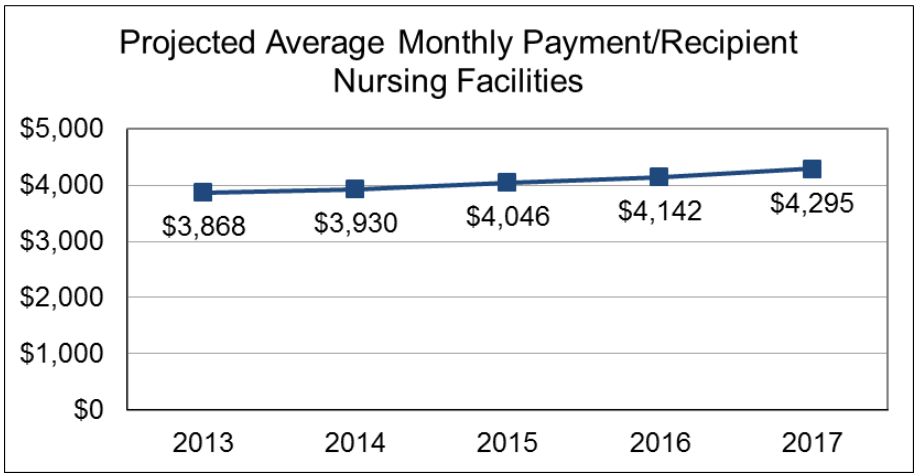
Nursing Facilities



Total Medical Assistance spending for Nursing Facilities is increasing at an average annual rate of 1.1% per year.



The average monthly number of recipients is projected to decrease by 1.5% per year.



The average monthly cost per person will be increasing at a rate of 2.7% per year.

Total Medical Assistance Program – Nursing Facilities, SFY13-17

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2013	16,563	$3,868	$768,743,881			
2014	16,345	$3,930	$770,828,216	-1.3%	1.6%	0.3%
2015	15,868	$4,046	$770,454,134	-2.9%	3.0%	0.0%
2016	15,584	$4,142	$774,557,065	-1.8%	2.4%	0.5%
2017	15,612	$4,295	$804,672,006	0.2%	3.7%	3.9%
			Overall Average	-1.5%	2.7%	1.1%
			Drivers	36%	64%	

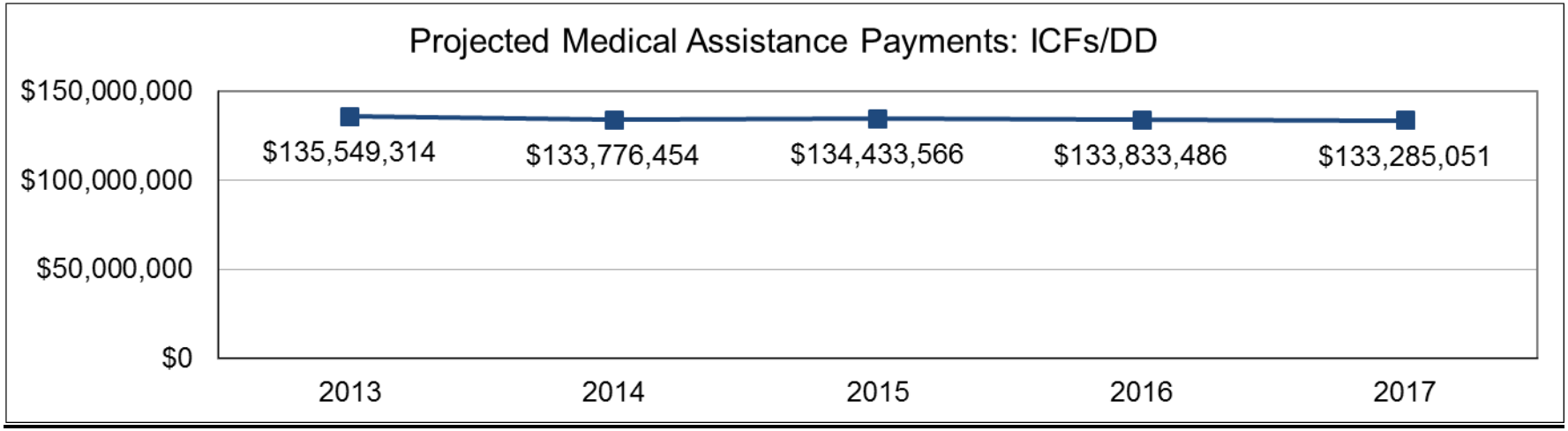
Historical Summary – Nursing Facilities, SFY07-12

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2007	20,233	$3,384	$821,582,971			
2008	19,468	$3,479	$812,796,052	-3.8%	2.8%	-1.1%
2009	18,783	$3,696	$833,074,698	-3.5%	6.2%	2.5%
2010	18,219	$3,771	$824,531,917	-3.0%	2.0%	-1.0%
2011	17,532	$3,783	$795,962,910	-3.8%	0.3%	-3.5%
2012	17,034	$3,828	$782,480,302	-2.8%	1.2%	-1.7%
			Overall Average	-4.2%	3.1%	-1.2%
			Drivers	57%	43%	

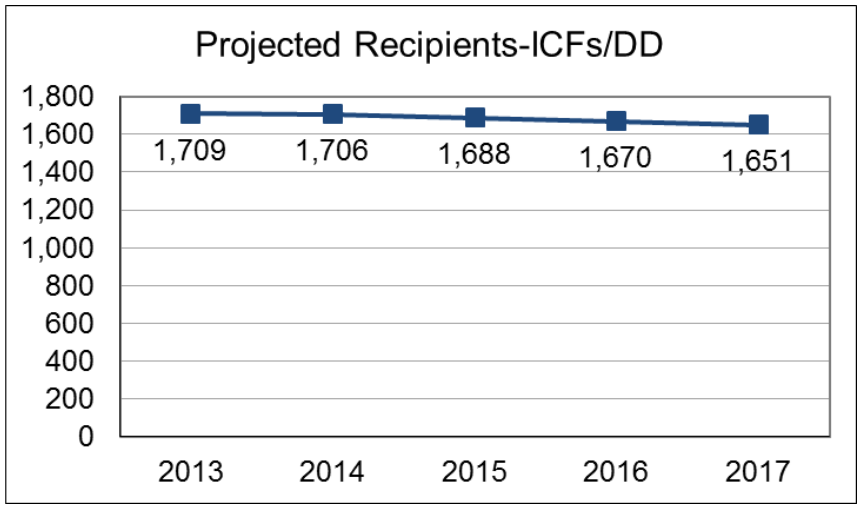
Trends in Nursing Facilities Forecast:

- On average, paid days have been declining about 2% per year.
- The increase in the average payment in SFY14 and SFY15 is due to the restoration of APS inflation.
- Beginning in 2017, the number of people served in nursing facilities is expected to begin growing as the population ages and demand for services increases.

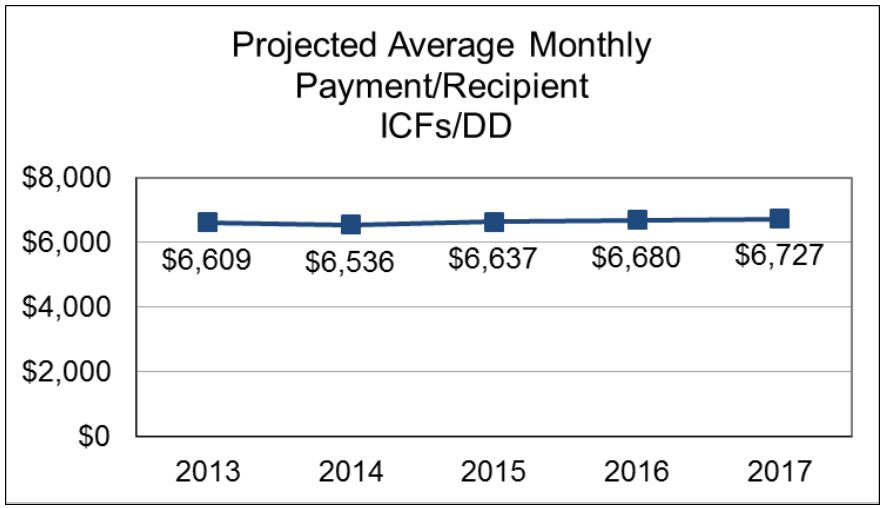
Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD)



Total Medical Assistance for ICFs/DD is decreasing at an average annual rate of 0.4% per year.



The average number of recipients is projected to decrease by 0.9% per year.



The average monthly cost per person will be increasing at a rate of 0.4% per year.

Total Medical Assistance Program – ICF/DD, SFY13-17

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2013	1,709	$6,609	$135,549,314			
2014	1,706	$6,536	$133,776,454	-0.2%	-1.1%	-1.3%
2015	1,688	$6,637	$134,433,566	-1.1%	1.5%	0.5%
2016	1,670	$6,680	$133,833,486	-1.1%	0.6%	-0.4%
2017	1,651	$6,727	$133,285,051	-1.1%	0.7%	-0.4%
			Overall Average	-0.9%	0.4%	-0.4%
			Drivers	66%	34%	

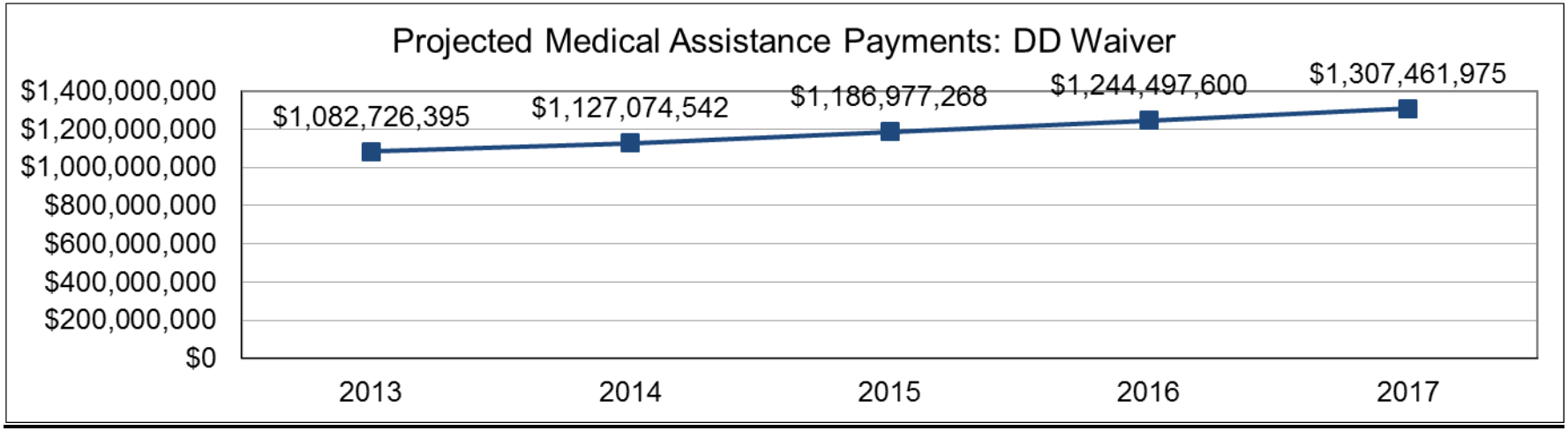
Historical Summary – ICF/DD, SFY07-12

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2007	1,864	$6,234	$139,409,634			
2008	1,850	$6,392	$141,893,823	-0.8%	2.5%	1.8%
2009	1,825	$6,491	$142,169,506	-1.4%	1.5%	0.2%
2010	1,779	$6,411	$136,871,265	-2.5%	-1.2%	-3.7%
2011	1,770	$6,390	$135,759,183	-0.5%	-0.3%	-0.8%
2012	1,720	$6,410	$132,253,830	-2.8%	0.3%	-2.6%
			Overall Average	-2.0%	0.7%	-1.3%
			Drivers	74%	26%	

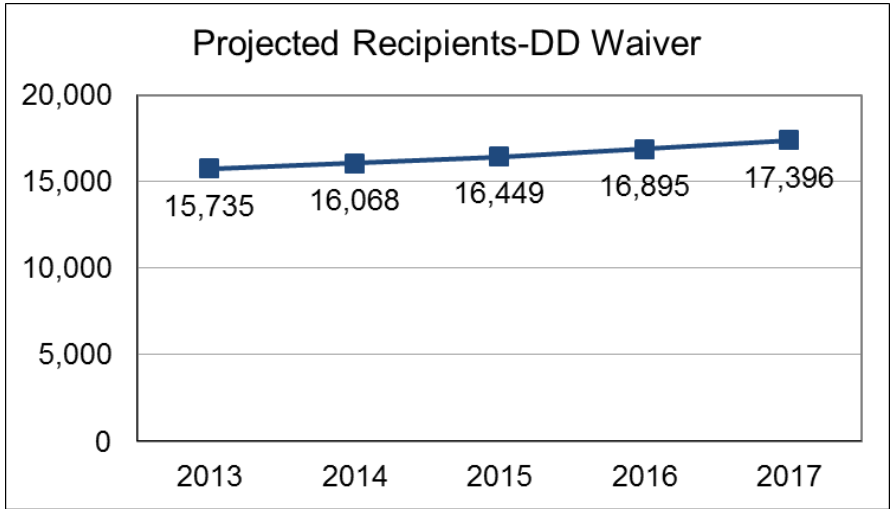
Trends in the ICF/DD forecast:

- The average number of monthly recipients continues to decline due to closing and unoccupied beds.
- The remaining recipients tend to be people with the highest needs, as a result, the average monthly cost increases.
- ICF/DD recipients also receive DT&H services. In 2013, the total cost of DT&H is expected to be $33,220,145.
- DT&H for ICF/DD recipients reflects similar trends to those in ICF/DD. As enrollment in ICF/DD declines, fewer people also receive DT&H services.

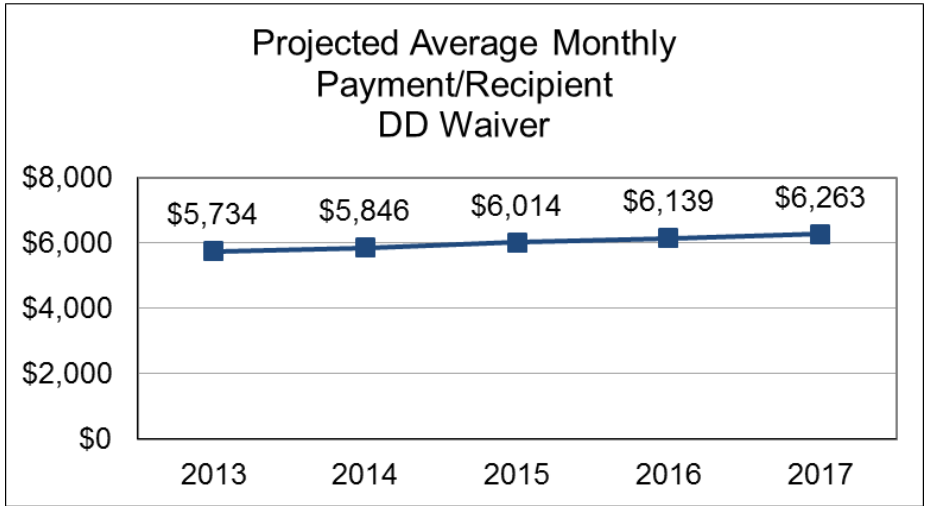
DD Waiver



Total Medical Assistance spending for the DD Waiver is increasing at an average annual rate of 4.8%.



The average number of recipients is projected to increase by 2.5% per year.



The average monthly cost per person will be increasing at an annual rate of 2.2%.

Total Medical Assistance Program – DD Waiver, SFY13-17

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2013	15,735	$5,734	$1,082,726,395			
2014	16,068	$5,846	$1,127,074,542	2.1%	2.0%	4.1%
2015	16,449	$6,014	$1,186,977,268	2.4%	2.9%	5.3%
2016	16,895	$6,139	$1,244,497,600	2.7%	2.1%	4.8%
2017	17,396	$6,263	$1,307,461,975	3.0%	2.0%	5.1%
			Overall Average	2.5%	2.2%	4.8%
			Drivers	53%	47%	

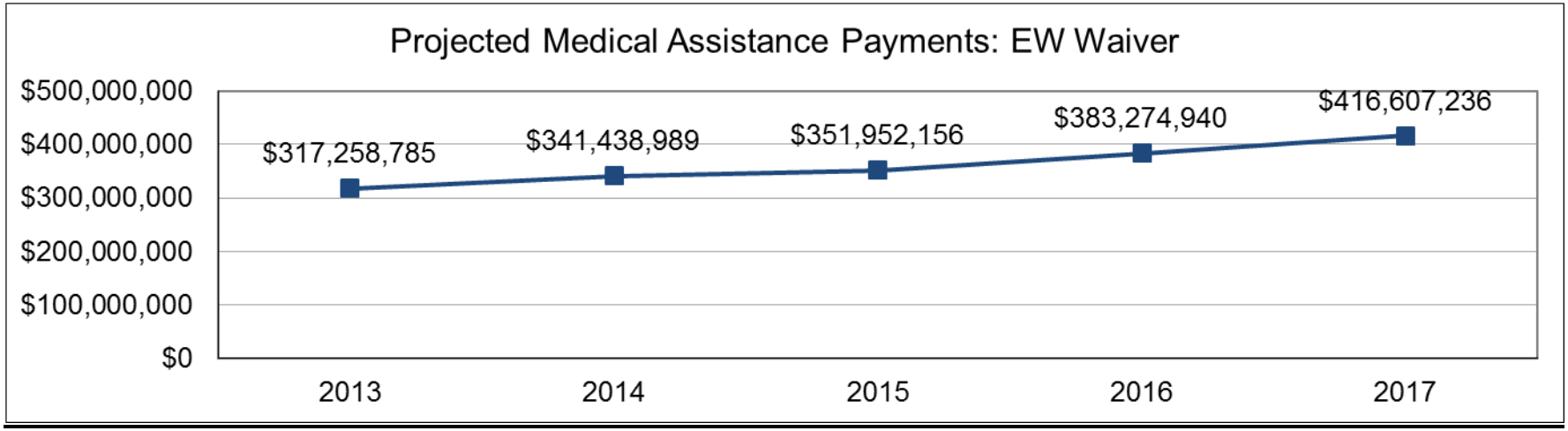
Historical Summary – DD Waiver, SFY07-12

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2007	14,103	$5,325	$901,129,015			
2008	13,971	$5,537	$928,369,470	-0.9%	4.0%	3.0%
2009	14,176	$5,673	$965,104,543	1.5%	2.5%	4.0%
2010	14,647	$5,597	$983,708,433	3.3%	-1.3%	1.9%
2011	15,165	$5,596	$1,018,441,737	3.5%	0.0%	3.5%
2012	15,449	$5,569	$1,032,442,037	1.9%	-0.5%	1.4%
			Overall Average	2.3%	1.1%	3.5%
			Drivers	67%	33%	

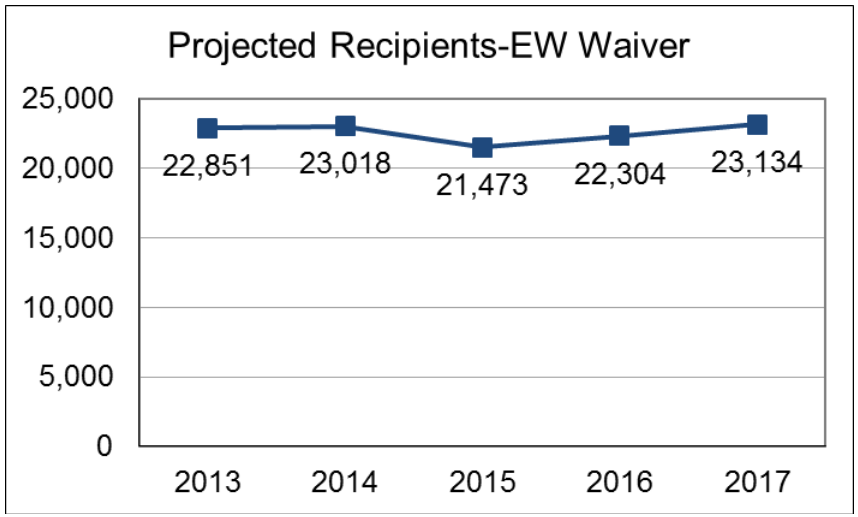
Trends in the DD Waiver Forecast:

- Costs do not include homecare and state plan services.
- The average monthly cost per recipient is slowing, in part due to the moratorium on foster care.
- In SFY14, enrollment limits are scheduled to increase to 15 per month.
- Currently, about 3,600 people are waiting for the DD waiver, although many of them are receiving other services in the meantime.

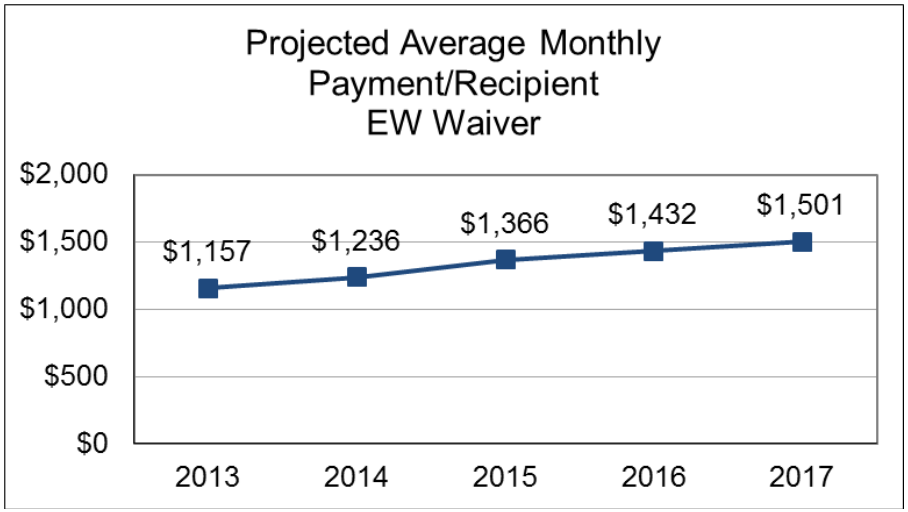
Elderly Waiver (Fee for Service & Managed Care)



Total MA for the Elderly Waiver (Fee for Service & Managed Care) is increasing at an average annual rate of 7.0%.



The average number of monthly recipients is projected to increase by 0.3% per year.



The average monthly cost per person will be increasing at an annual rate of 6.7%.

Total Medical Assistance Program – Elderly Waiver (Fee for Service and Managed Care), SFY13-17

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2013	22,851	$1,157	$317,258,785			
2014	23,018	$1,236	$341,438,989	0.7%	6.8%	7.6%
2015	21,473	$1,366	$351,952,156	-6.7%	10.5%	3.1%
2016	22,304	$1,432	$383,274,940	3.9%	4.8%	8.9%
2017	23,134	$1,501	$416,607,236	3.7%	4.8%	8.7%
			Overall Average	0.3%	6.7%	7.0%
			Drivers	4%	96%	

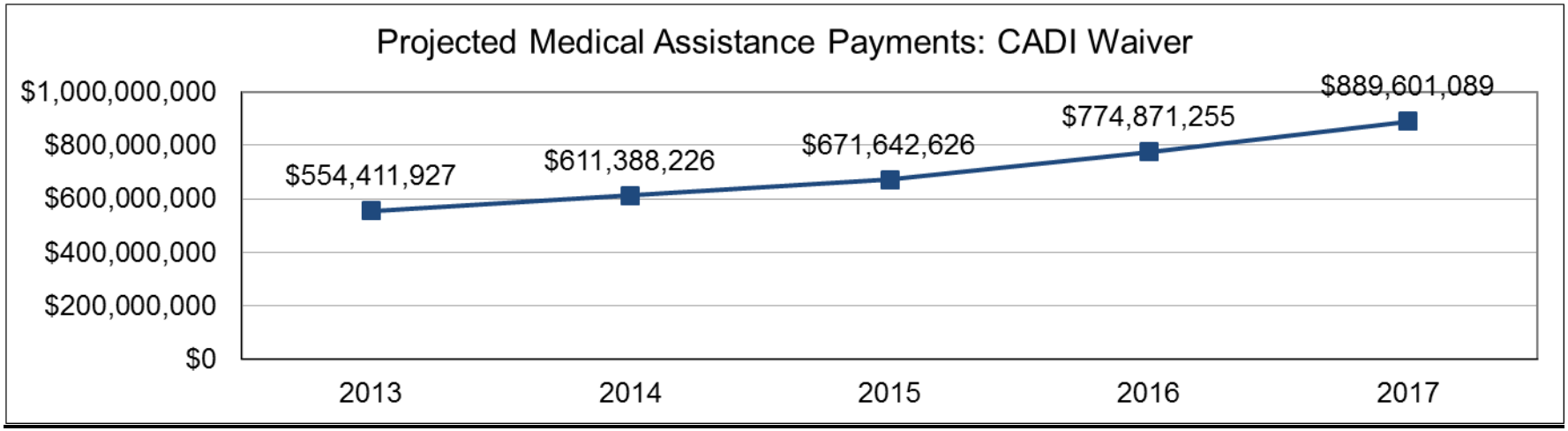
Historical Summary – Elderly Waiver (Fee for Service and Managed Care), SFY07-12

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2007	16,843	1,122	226,728,453			
2008	18,366	1,163	256,246,482	9.0%	3.6%	13.0%
2009	19,654	1,198	282,659,308	7.0%	3.1%	10.3%
2010	20,822	1,206	301,447,545	5.9%	0.7%	6.6%
2011	21,793	1,192	311,815,964	4.7%	-1.2%	3.4%
2012	22,357	1,159	311,046,392	2.6%	-2.8%	-0.2%
			Overall Average	7.3%	0.8%	8.2%
			Drivers	90%	10%	

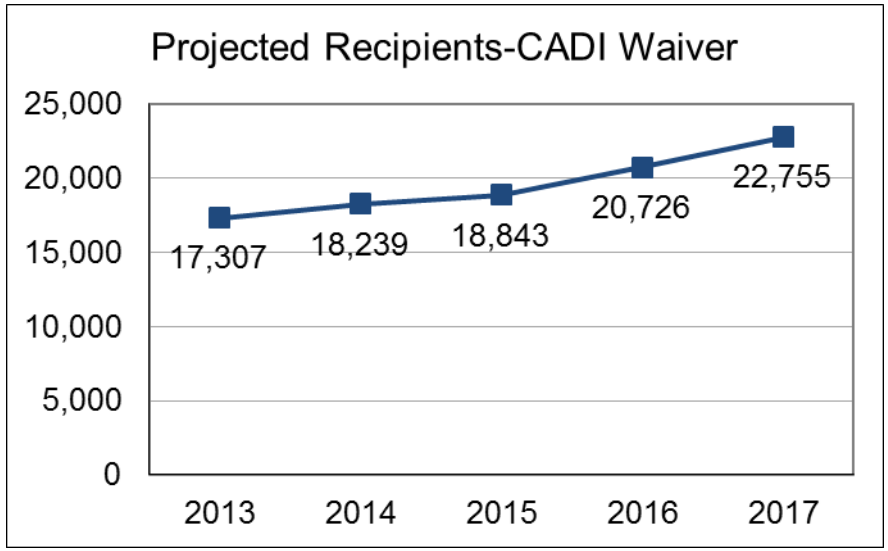
Trends in Elderly Waiver forecast:

- Costs do not include homecare and state plan services.
- Level of Care criteria, effective Jan. 1, 2014, are expected to decrease the number of EW recipients by roughly 13%. Since the people leaving the program tend to have lower needs and lower costs, the average cost of individuals remaining on the program will increase.
- In addition, long-term care counseling has slowed growth in enrollment as people are able to choose other options.
- Over 90% of recipients are served in the EW managed care program.

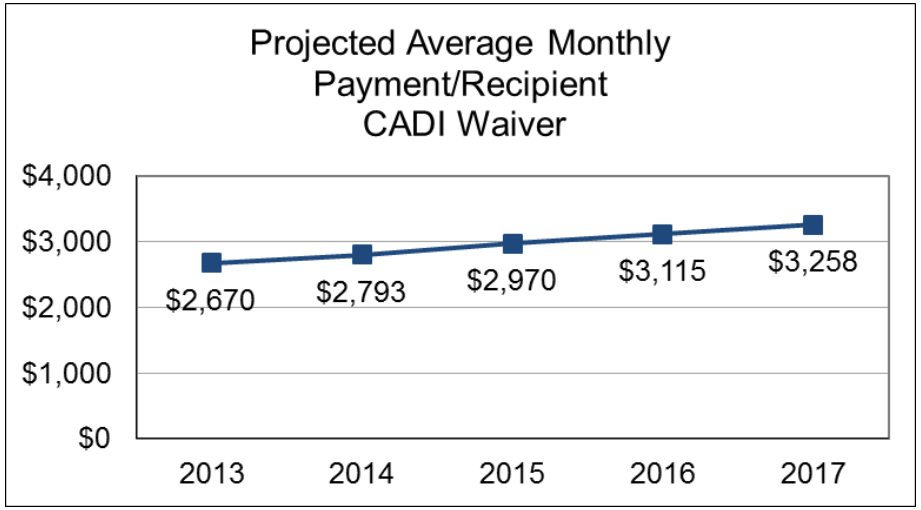
CADI Waiver



Total Medical Assistance spending for the CADI Waiver is increasing at an average annual rate of 12.5%.



The average monthly number of recipients is projected to increase by 7.1% per year.



The average monthly cost per person will be increasing at an annual rate of 5.1%.

Total Medical Assistance Program – CADI Waiver, SFY12-17

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2013	17,307	$2,670	$554,411,927			
2014	18,239	$2,793	$611,388,226	5.4%	4.6%	10.3%
2015	18,843	$2,970	$671,642,626	3.3%	6.3%	9.9%
2016	20,726	$3,115	$774,871,255	10.0%	4.9%	15.4%
2017	22,755	$3,258	$889,601,089	9.8%	4.6%	14.8%
			Overall Average	7.1%	5.1%	12.5%
			Drivers	58%	42%	

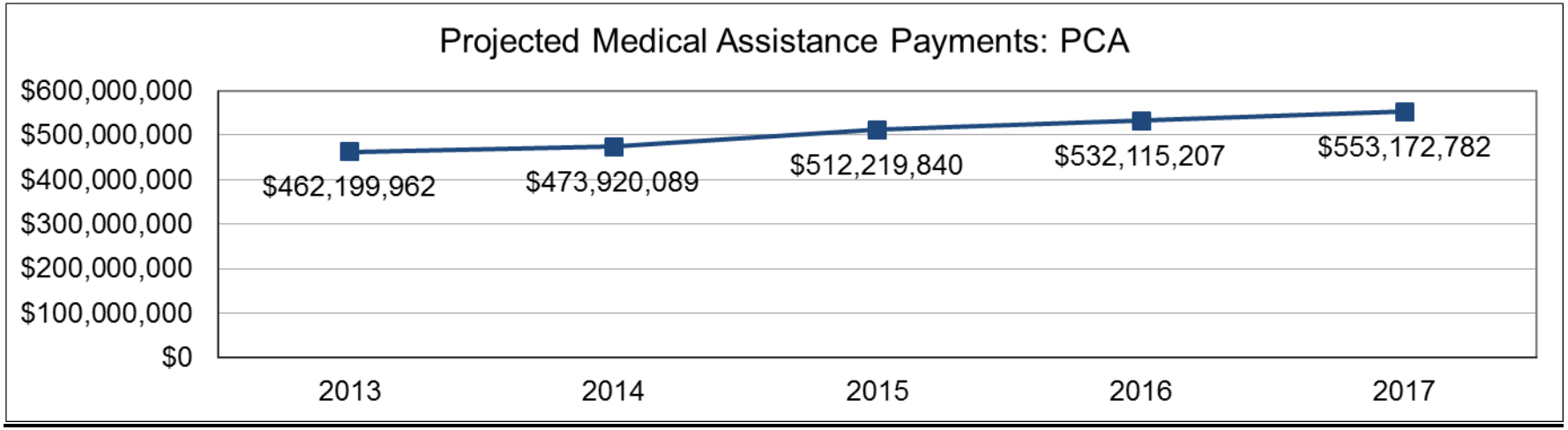
Historical Summary of the CADI Waiver, SFY07-12

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2007	10,104	$1,843	$223,404,268			
2008	11,763	$2,070	$292,163,020	16.4%	12.3%	30.8%
2009	13,320	$2,294	$366,627,944	13.2%	10.8%	25.5%
2010	14,226	$2,416	$412,365,390	6.8%	5.3%	12.5%
2011	15,692	$2,517	$474,008,596	10.3%	4.2%	14.9%
2012	16,483	$2,548	$504,023,987	5.0%	1.2%	6.3%
			Overall Average	13.0%	8.4%	22.6%
			Drivers	61%	39%	

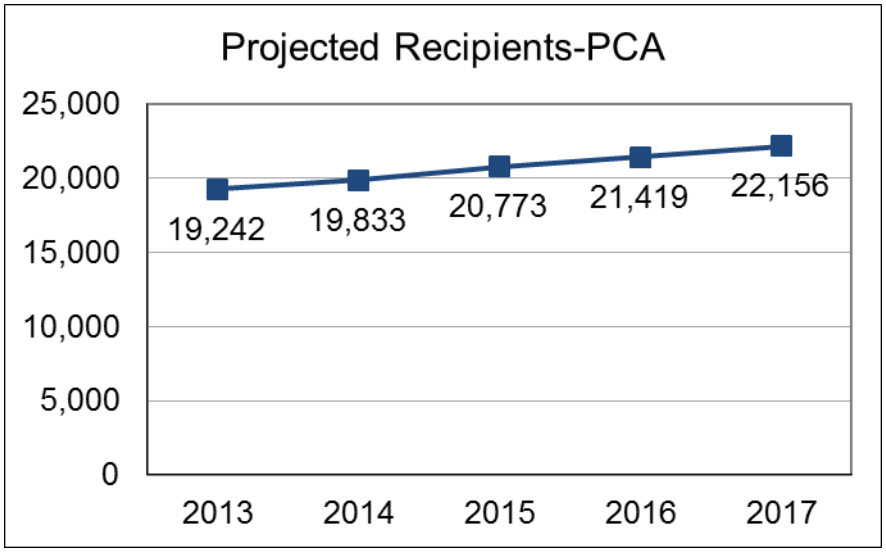
Trends in the CADI Waiver Forecast:

- Costs do not include homecare and state plan services.
- Growth in CADI recipients has been slowing due to enrollment limits. Enrollment is expected to pick up slightly in SFY13.
- The average monthly cost per recipient is slowing, in part due to the moratorium on foster care.
- In FY14, enrollment limits are scheduled to increase to 85 per month.
- Currently, there are about 1,200 people on the waitlist for a CADI, CAC, or BI waiver, although many of them are receiving other services in the meantime.

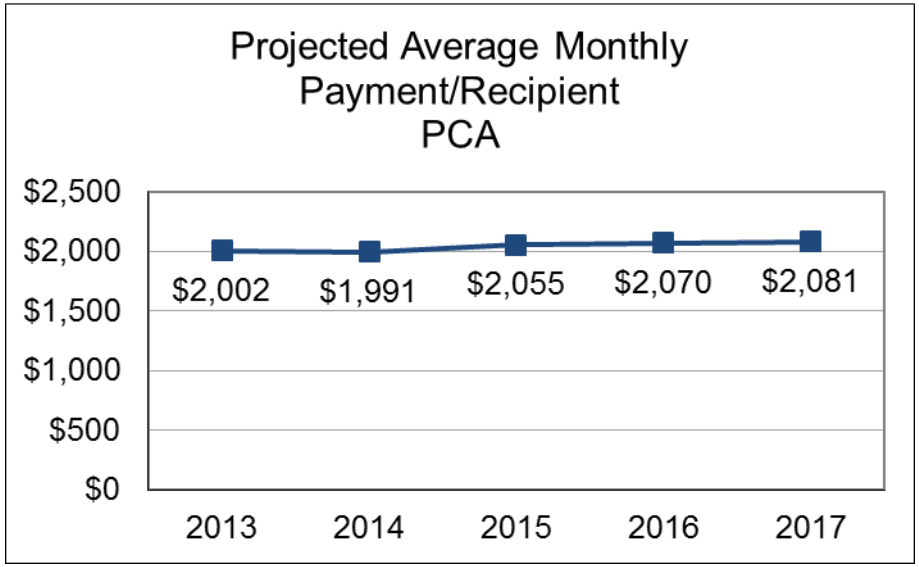
Personal Care Assistance (Fee for Service)



Total Medical Assistance for Personal Care Assistance (Fee for Service) is increasing at an average annual rate of 4.6%.



The average monthly number of recipients is project to increase by 3.6% per year.



The average monthly cost per person will be increasing at a rate of 1.0% per year.

Total Medical Assistance Program – Personal Care Assistance (Fee for Service), SFY13-17

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2013	19,242	$2,002	$462,199,962			
2014	19,833	$1,991	$473,920,089	3.1%	-0.5%	2.5%
2015	20,773	$2,055	$512,219,840	4.7%	3.2%	8.1%
2016	21,419	$2,070	$532,115,207	3.1%	0.7%	3.9%
2017	22,156	$2,081	$553,172,782	3.4%	0.5%	4.0%
			Overall Average	3.6%	1.0%	4.6%
			Drivers	79%	21%	

Historical Summary of Personal Care Assistance, SFY07-12

Fiscal Year	Persons Served	Average Monthly Payment	Total Payments	Percent Change Persons	Percent Change Average Monthly Cost	Percent Change Total Payments
2007	11,298	$2,253	$305,442,337			
2008	12,769	$2,240	$343,155,151	13.0%	-0.6%	12.3%
2009	14,808	$2,264	$402,364,206	16.0%	1.1%	17.3%
2010	16,477	$2,045	$404,264,975	11.3%	-9.7%	0.5%
2011	17,384	$2,024	$422,260,288	5.5%	-1.0%	4.5%
2012	18,077	$2,021	$438,478,479	4.0%	-0.1%	3.8%
			Overall Average	12.5%	-2.7%	9.5%
			Drivers	127%	-27%	

Total Medical Assistance Program – Personal Care Assistance (Managed Care), SFY13-17

Fiscal Year	Elderly MC	Families w/ Children MC	Total Payments	Percent Change Elderly	Percent Change Families w/ children	Percent Change Total Payments
2013	$111,141,416	$16,467,148	$127,608,564			
2014	$143,752,585	$20,479,765	$164,232,350	29.3%	24.4%	28.7%
2015	$133,473,577	$20,186,054	$153,659,632	-7.2%	-1.4%	-6.4%
2016	$170,078,423	$24,443,812	$194,522,235	27.4%	21.1%	26.6%
2017	$169,162,288	$23,038,744	$192,201,032	-0.5%	-5.7%	-1.2%
			Overall Average	11.1%	8.8%	10.8%
			Drivers	56%	44%	

Historical Summary of Personal Care Assistance (Managed Care), SFY08-12

Fiscal Year	Elderly MC	Families w/ Children MC	Total Payments	Percent Change Elderly MC	Percent Change Families w/ Children	Percent Change Total Payments
2008	$93,691,117	$13,203,666	$106,894,783			
2009	$106,071,211	$15,421,247	$121,492,458	13.2%	16.8%	13.7%
2010	$111,273,520	$17,638,690	$128,912,210	4.9%	14.4%	6.1%
2011	$115,820,767	$18,897,066	$134,717,834	4.1%	7.1%	4.5%
2012	$117,627,462	$18,225,639	$135,853,102	1.6%	-3.6%	0.8%
			Overall Average	5.9%	8.4%	6.2%
			Drivers	41%	59%	

Trends in the PCA (Fee for Service and Managed Care) Forecast:

- This forecast includes recipients of waiver and non-waiver services.
- About 55% of people served by Elderly Managed Care also receive waiver services.
- Nearly 25,000 people are served in the PCA Fee for Service and Managed Care programs each month.