Welcome

Jodi Harpstead
Commissioner
Department of Human Services

Jan Malcolm
Commissioner
Department of Health
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
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<tbody>
<tr>
<td>9:00 a.m.</td>
<td>Welcome and agenda review</td>
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<tr>
<td>9:20 a.m.</td>
<td>Follow-up topics from prior meetings</td>
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<tr>
<td>9:30 a.m.</td>
<td>Stakeholder engagement update</td>
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<tr>
<td>9:50 a.m.</td>
<td>Background presentation</td>
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<td>10:30 a.m.</td>
<td>Break</td>
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<td>10:40 a.m.</td>
<td>Long-term services and support for older adults cost savings strategy presentation and discussion</td>
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<tr>
<td></td>
<td>• Add an Enhanced Home Care Benefit in Medicare Supplement Plans (initial submissions #190, #357)</td>
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<td>• Guidelines to Access Customized Living Services (initial submission #427)</td>
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<tr>
<td>12:10 p.m.</td>
<td>Public comment</td>
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<tr>
<td>12:40 p.m.</td>
<td>Break to pick up lunch</td>
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<tr>
<td>12:50 p.m.</td>
<td>Long-term services and support for older adults cost savings strategy presentation and discussion</td>
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<td>• Value-based Reimbursement in Nursing Facilities (initial submissions #388, #131)</td>
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<td>• Repeal Nursing Facilities’ First 30 Days Rate Adjustment (initial submission #428)</td>
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<tr>
<td>2:30 p.m.</td>
<td>Public comment</td>
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<tr>
<td>2:50 p.m.</td>
<td>Wrap-up and next meeting</td>
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Follow-up Topics from Previous Meetings
Follow-up topics

1. Improving compliance with TPL strategy – request to determine if opportunity to enlist courts earlier
   • Weekly flat file data exchange with courts offers potential solution

2. MCO competitive price bidding strategy
   • State staff are updating the strategy to include more information about the quality and access assurance methods that occur in the competitive bidding process

3. Request to discuss DHS’ managed care strategy
   • State staff will be discussing purchasing strategies when we get to the transformation focus area

4. State staff is assessing the following requests and will share modified strategies at future meetings:
   • Additional services for potential volume purchasing and financial impact
   • Potential impact of extending DME strategies to MCOs
Stakeholder Engagement Update
Stakeholder Engagement

Stakeholder Toolkit
• Toolkit drafted and under review
• Anticipated distribution March 13

Community Engagement
• Locations
• Partner outreach

Commission Member Updates – what are you hearing
Background Presentation
Long-Term Services and Supports for Older Adults
Blue Ribbon Commission – March 6, 2020

Daniel Pollock, JD | Assistant Commissioner
Continuing Care for Older Adults Administration
Agenda

• Deinstitutionalization - long-term care for 65+, historical perspective
• Nursing Facility Rates and Utilization
• Elderly Waiver/Alternative Care/Essential Community Supports
• Senior Linkage Line/Older Americans Act
• Moving Home Minnesota/Return to Community
• Own Your Future – Alternatives to Medicaid
Pre-1995 nursing facility care was norm for adults 65+

- Prior to the 1980s, older Minnesotans had few choices for long-term services and supports other than nursing homes.

- Bed count and utilization declined dramatically after 1983 moratorium on new nursing facilities –
  o From 30,465 people in 1993 down to fewer than 14,000 people in 2020.

- 1995- Minnesota’s system of long-term care services and supports (LTSS) shifts from majority institutional settings to majority home and community-based services.

- In 2018, 74 percent of people age 65+ receive LTSS get them in a home or community-based setting.

Source: MN Historical Society, 1959
Minnesota has innovated on long term services and supports since 1995

- 1994 - Senior Linkage Line started and Disability HUB in 2005 – Free, statewide resource networks to help people solve problems, navigate the system and plan for the future
- 2001 – Long-term care consultation, shorter nursing home stays, and relocation assistance
- 2005 – Managed care plans integrate health care and long-term care through Minnesota Senior Health Options and Minnesota Senior Care Plus
- 2006 – Minnesota Nursing Home Report Card implemented
- 2011 – Return to Community Initiative and Moving Home Minnesota
- 2013 – MNCHOICES Assessment tool launched
Hello on wheels: In western Minnesota, help comes to those who need it

Pioneering effort uses retrofitted bus to bring services to seniors.

By Editorial Board Star Tribune SEPTEMBER 6, 2019 - 5:38PM

Provided by Prairie Five Community Action

The Mobile Community Center for Older Adults serves five counties in western Minnesota.

About one in three seniors experience loneliness according to the latest “National Poll on Healthy Living.” But a program that’s sweeping the world is looking to socialize and uplift the elderly, all while taking them on a trip down memory lane.

**LTSS for older adults today looks very different**

- **By the numbers:**
  - ~$1.5 billion in spending on LTSS
  - 400,000+ older adults served
  - 34,000 (EW)
  - 22,000 (SNF)
  - 300,000 calls (Senior Linkage Line)

- Prioritizing equity for underserved minority, tribal and rural communities

- Strengthening county/tribal adult protective services amidst 82,000 allegations of abuse

- Making Minnesota an Age-Friendly state
The age wave has arrived...

- 65+ will double by 2030
- 70% will need long-term care
- Unpaid caregivers would cost $8 billion to replace
- Maltreatment of vulnerable adult allegations have tripled since 2012
- What should we do?

Source: MN Department of Human Services, Aging Profiles, 2018
Costs of Medicaid-paid long-term services and supports continue to grow.

Medical Assistance and Alternative Care Spending for HCBS & Facilities
Source: November 2019 Forecast

Thousands of dollars

Facilities  Total HCBS


Minnesota Department of Human Services | mn.gov/dhs
Minnesota’s older adult population is booming

- Two-fold growth in proportion of those 65+ over a century
- Proportion of those under age 18 dropping by nearly half during the same time period

Source: U.S. Census Bureau, decennial census, and Minnesota State Demographic Center Projections.
Offering a spectrum of Long-Term Care Services and Supports

MBA
- Older Americans Act
  - Essential Community Supports
  - Alternative Care
  - Elderly Waiver
  - Nursing Home

DHS
- Senior LinkAge Line®
- Office of the Ombudsman for Long-Term Care
Shifting from nursing homes to assisted living...

Projected State Medical Assistance Spending for Nursing Facilities

- 2015 - Value-Based Reimbursement changed payment system for nursing facilities
- 362 nursing homes (60% non-profit), but recipients declining by 0.6% per year
- 86 changes in ownership in 5 years
- Spending increasing by 5.7%/year, to over $600 million (state share)—but ~4 nursing homes still closing every year
- Assisted living providers increased from 870 in 2007 to 1,300 in 2018 (72% for-profit)
2015 VBR Legislation Resulted in Wage Increases

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Prioritizing Nursing Facility Quality

- VBR has dramatically increased payments to nursing homes while also improving direct-care staff salaries and benefits.

- 2019 independent evaluation requested by the Legislature found that VBR does not provide effective financial incentives for facilities to improve quality.

- Performance-based Incentive Payment Program (PIPP) – 5% add-on

- Quality Improvement Incentive Payment (QIPP) - $3.50/resident day for improving clinical or quality of life

- $1m in new 2020 funding for moratorium exception projects, plus $250k for clean energy pilot
Elderly waiver faces challenges

EW challenges:
- Workforce shortages for in-home services
- Growth in higher-cost/higher-income assisted living market
- Increasingly complexity of EW participants (43% have a mental illness; 36% behavioral concerns)
- Spending increasing by 10% per year
- $1m in elderly waiver quality improvement grants available

Evaluation of rates in January 2019:
- Recommended rates require substantial increase in spending for in-home services, adult day, and customized living
- Chore services would increase 81% and homemaker services would increase 39%
Who are we serving through customized living?

• Customized living:
  o One of the services available to EW participants
  o Package of regularly scheduled health-related and supportive services provided to a person who lives in a registered housing with services establishment
  o Many of these settings meet the definition of assisted living

• 42% of EW participants receive customized living (2017)

• Customized living represents about 62% of overall EW program spending (2017)
Who are we serving through customized living?

<table>
<thead>
<tr>
<th>Case Mix</th>
<th>Case Mix Description</th>
<th>Not Receiving Customized Living</th>
<th>Receiving Customized Living</th>
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<tbody>
<tr>
<td>L</td>
<td>Very Low ADL</td>
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<td>8.5%</td>
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<td>A</td>
<td>Low ADL</td>
<td>10.6%</td>
<td>5.6%</td>
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<tr>
<td>B</td>
<td>Low ADL + Behavior</td>
<td>13.7%</td>
<td>26.4%</td>
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<td>C</td>
<td>Low ADL + Special Nursing</td>
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<td>1.4%</td>
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<tr>
<td>D</td>
<td>Medium ADL</td>
<td>16.6%</td>
<td>9.0%</td>
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<td>E</td>
<td>Medium ADL + Behavior</td>
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<td>22.9%</td>
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<td>F</td>
<td>Medium ADL + Special Nursing</td>
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<td>1.6%</td>
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<tr>
<td>H</td>
<td>High ADL + Behavior</td>
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<td>9.4%</td>
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<td>I</td>
<td>Very High ADL + Feeding</td>
<td>3.6%</td>
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<td>J</td>
<td>High ADL + Severe Neurological Impairment/Behavior</td>
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<td>5.2%</td>
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<tr>
<td>K</td>
<td>High ADL + Special Nursing</td>
<td>1.0%</td>
<td>2.4%</td>
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100.0% 100.0%
Evaluating HCBS Assessments for Racial and Ethnic Disparities

- Data suggests clear differences in waiver enrollment, service use and satisfaction by race/ethnicity
- PCA/homecare much likely to be used by non-white clients than elderly waiver and alternative care
- DHS multi-stage research project will use quantitative and qualitative methods to inform and reduce disparities in HCBS for communities of color and American Indians

Source: DHS Data Warehouse, State Fiscal Years 2015; Integrated Public Use Microdata Series data, 2014
• Partnership between DHS and Minnesota Board on Aging
• Creation of an assisted living report card, modeled on the MN Nursing Home Report Card
• Gives consumers more information about the quality of assisted living facilities.
• Quality metrics are based on 60,000 family member and consumer surveys every two years
Alternative Care and Essential Community Supports

Minnesota’s strategy: Reaching people early, before they require Medical Assistance

• Alternative Care (AC): provides HCBS to people 65+ who have modest income and assets, need nursing home level of care, but choose community services
  • AC does not pay for residential services such as assisted living

• Essential Community Supports: provides a limited HCBS benefit set to people 65+ who have modest needs. Same income and asset requirements as AC.

• The programs help participants avoid or delay nursing facilities and/or spenddown of middle-class families’ assets.
### Who

- Help at home
- New to Medicare
- Living in nursing home
- Can’t afford medications
- Tired caregiver

### How

- Research options
- Explain benefits
- Develop a support plan
- Apply for Rx programs
- Find support and respite
Older Americans Act services

U.S. Administration for Community Living

Minnesota Board on Aging

Area Agencies on Aging

Service Providers

<table>
<thead>
<tr>
<th>Senior LinkAge Line</th>
<th>Nutrition</th>
<th>Supportive Services</th>
<th>Disease Prevention &amp; Health Promotion</th>
<th>Caregiver Services</th>
<th>Elder Rights Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach, Information and Assistance, Options Counseling and Care Transitions</td>
<td>Congregate and Home-Delivered Meals</td>
<td>Chore, Homemaker, Transportation, Home Modification</td>
<td>Evidence-based Healthy Aging Programs</td>
<td>Caregiver Education and Supports, Respite</td>
<td>Long-Term Care Ombudsman Prevention of Elder Abuse, Neglect, and Exploitation, Legal Assistance</td>
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</table>
Moving Home Minnesota helps people on Medical Assistance (MA) move out of institutions

- Helps pay for services that MA or waivers will not pay for, provides counseling, and makes sure that individual’s transition to living in the community goes smoothly.

- Moving Home Minnesota will continue to provide services for up to a year after a person moves out of an institution and into the community.

- 625 people moved from institutional level of care back into the community
• Return to Community helps people not eligible for Medicaid move out of institutions
  • State-funded program using the free Senior LinkAge Line to connect older Minnesotans and their families with the help they need.
  • Senior LinkAge line provides services to help Minnesotans to remain independent in their community.
  • After a person returns to a community setting, Senior LinkAge Line provides follow-up in-person and over the phone for up to five years.
  • Caregiver support grants of $250 available in 2020
Executive Order 19-38: An Age-Friendly Minnesota Council

AARP/WHO 8 domains of community living

- (1) Outdoor spaces and buildings
- (2) Housing
- (3) Transportation
- (4) Social participation
- (5) Respect and inclusion
- (6) Civic participation and employment
- (7) Communication and information
- (8) Community support and health service
Own Your Future – Alternatives for Financing Long Term Services and Supports

- 2019 survey of 1,848 State Fair attendees found that 22% of respondents don’t know how they will pay for long-term care
- 34% do not have paid leave to care for family members
- 54% would take more than 6 months off to provide care to older relatives if they did have access to paid leave
Alternatives to Medicaid (LTSS) to reduce costs and improve options for care

LifeStage Insurance product

- Offer term life insurance products which convert to long-term care insurance at age 65
- Targeted middle income families $50k to $125k
- Employer Group market is priority

Enhanced Medicare Home Care Benefit

- Non-medical services to avoid institutional care
- State could require for MediGap (supplemental)
- Homemaker services; chores; training for caregivers; delivered meals; service coordination
Why Aren’t More Women Working?
They’re Caring for Parents

Aisha Adkins in the Atlanta area with her mother, Rose, whose dementia was diagnosed six years ago.

Lynsey Weatherspoon for The New York Times

By Eduardo Porter
Aug. 29, 2019

DUNWOODY, Ga. — Aisha Adkins would rather have her own place, instead of living with her parents. She would also like a job, a

Universal Family Care is a new social insurance program to which everyone contributes and from which everyone benefits to access affordable childcare, elder care, supports for people with disabilities, and paid family and medical leave.

Alternatives to Medicaid (LTSS) to reduce costs and improve options for care
QUESTIONS?

Daniel Pollock, JD
Assistant Commissioner
Continuing Care for Older Adults Administration

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651-431-3132
Twitter: @DanPollockMNDHS
Morning Break
Reminder: The Commission is Charged to Create an Action Plan

The statute charges the Commission to create an action plan that will, at a minimum, include strategies to:

1. **Transform the health and human services system** to a) improve program efficiencies, b) produce savings, and c) promote better outcomes for all Minnesotans;

2. **Increase administrative efficiencies and improve program simplification** within health and human services public programs, including: examining the roles and experience of the State, counties and tribes in delivering services, and identifying any conflicting and duplicative roles and responsibilities among the health and human services agencies, counties, and tribes;

3. Identify evidence-based strategies for addressing the significant cost drivers of State spending on health and human services, including the medical assistance program, in order to **reduce health and human services expenditures with net savings of $100M in the next biennium** (July 1, 2021 – June 30, 2023);

4. **Reduce waste** in administrative and service spending in health and human services through, including but not limited to misuse and overuse of health care services, fraud reduction, and improved program integrity; and

5. **Advance health equity** across geographies and racial and ethnic groups, in part, by addressing disparities in access, and disparities in outcomes
Reminders

• Strategy selection was determined using the approved criteria with the goal of advancing strategies that would meet the Commission’s charge.

• Selection of strategies for development does not indicate State agency advocacy, endorsement or support.

• State staff have helped develop strategies as technical assistance, similar to what they provide for legislator-initiated proposals.
• As a reminder, our objective for this portion of the meeting is for you to receive an explanation of the strategy, and then have an opportunity to:
   • Ask questions
   • Debate the merits of the strategy relative to the Commission’s charge

• You will be asked to indicate your degree of support for the strategy. If there is strong support or opposition, we will so note. **You need not come to agreement today.** We will revisit these strategies in the spring.

• As another reminder, the Commission’s charter indicates that:
   • Inclusion of a specific strategy into the final Action Plan will be made by consensus without vote, unless a vote is requested.
   • The complete Action Plan will require majority approval.
Long-term Services and Support for Older Adults
Cost Savings Strategy Presentation and Discussion
Add an Enhanced Home Care Benefit in Medicare Supplement Plans
I. Problem Statement

• There is limited access to insurance policies that would provide coverage to allow older adults to receive long-term services and supports (LTSS) in the home and community rather than in facilities.

• Use of private long-term care (LTC) insurance is rare in middle and lower-income older adults.

• Lack of insurance leads to a quicker spend down of assets and eligibility for Medicaid benefits.

• For those on Medicaid, it is only offered to certain beneficiaries based on enrollment in waiver programs.
II. **Recommended Strategy**

- Require Medicare supplemental plans (Medigap policies) to include a nonmedical, enhanced home care benefit. This would potentially reach 120,000 Medicare beneficiaries.

- Specific services would include:
  - Personal emergency response system
  - Homemaker services
  - Chore services
  - Training and education of family caregivers
  - Home-delivered meals
  - Adult day care services
  - Services coordination
  - Community living assistance
II. Recommended Strategy (continued)

• Benefit limits proposed:
  • Available coverage would be capped at $100/per day.
  • There would be a lifetime cap of $36,500.

• Estimated cost of $8.49/month in increased premium for each Medigap policy
  • A new actuarial study should be completed based on current assumptions.
  • The estimated cost here is based on a 2017 actuarial study.
  • Question: Should the strategy include subsidy support from the State to cover all or part of the increased cost of the premiums?
III. Anticipated Benefits

• Increase number of Medicare beneficiaries living independently in their homes without need for Medicaid-funded LTSS.
  • Expect that this will occur over the next decade

IV. Supporting Evidence

• Actuarial analysis from 2017 hypothesized potential long-term savings for state spending on long-term care
• Medicare Advantage plans have the option of including these benefits today.
V. Administrative Implications

• The strategy would benefit from an updated actuarial analysis.

• The strategy requires a state legislative mandate for Medigap policies to include the enhanced home care benefit.

• MN Department of Commerce would need to approve product designs, rates and regulatory steps needed to implement the mandate.

• MN DHS would need to develop an evaluation plan, track the cost of providing the services and assess whether there is a corresponding delay to Medicaid eligibility.
VI. Equity Review Considerations

**Key Questions**

• How does the strategy determine the set of nonmedical services?

• Are there other programs/services that could be potentially impacted by this strategy?

• How does this strategy define low income older adults?

• What is the provider impact on health plans providing Medigap services and products?

• What is the inter-agency impact?
VI. Equity Review Considerations (continued)

Key Questions (continued)

• How would the strategy make provisions for accountability?
• How does the strategy address the impact to Medigap policy take up rates and the potential for adverse selection?
• How does the strategy assess for community conditions and population impact?
• Establish a needs assessment of different population groups for those receiving services.
• Perform a cost savings analysis comparing long-term benefits for investing in home care benefits.
VII. Anticipated Challenges

• Potential unintended consequences:
  • a negative impact on Medigap policy take up rates due to increase in rates
  • Adverse selection
Guidelines to Access Customized Living Services
I. Problem Statement

• Customized living is a residential service and is relatively expensive compared to other Elderly Waiver service options.

• People on the Elderly Waiver can access customized living or 24-hour customized living, which provides 24-hour supervision and staff support.

• Under current law, there is criteria for eligibility for 24-hour customized living. People who receive 24-hour customized living have a larger budget for customized living services.
II. Recommended Strategy

• People on the Elderly Waiver who are assessed as Case Mix A will only be able to receive customized living services. They will no longer be able to receive 24-hour customized living services.

  • Individuals in Case Mix A are at the lower level of acuity of those within the Elderly Waiver, and have low levels of need for assistance with activities of daily living (0-3 needs) and don't have behavioral needs.
III. Anticipated Benefits

• The State will play less for customized living services for Elderly Waiver participants with relatively low needs (Case Mix A).

IV. Administrative Implications

• Upon enactment of the legislation, DHS staff will need to:
  • Submit an amendment to the State's waiver plan
  • Make system changes
  • Provide training and information to case managers and providers
V. Equity Review Considerations

• Establish an equitable lens and needs assessment in the customized living tool.
• What population groups are accounted for under Case Mix A?
• What is the population and geographic impact?
• How are Elderly Waiver participants going to be impacted?
• What is the provider impact?
• What steps are being taken to ensure that there is an equity lens embedded in the process?
V. Further Equity Review Considerations

• What accountability measures are going to be implemented?

• Will there be a continuous process to perform a gap analysis across population groups?
VI. Anticipated Challenges

• While this change is aimed as a rate cut for providers of customized living who are serving a low-level case mix in 24-hours care, some providers may not be willing to provide less than 24 hours care due to the current rates.

• There are approximately 400 individuals at this level who will need re-assessments based on this change; some may not be able to stay in existing residence if the provider is not willing to provide less than 24 hours of customized living. This may result in some individuals moving to a nursing facility or receiving care through alternative services.
Public Comment Period #2
Break to pick up lunch
Long-term Services and Support for Older Adults Cost Savings Strategy Presentation and Discussion – Cont’d
Value-Based Reimbursement in Nursing Facilities
1. Problem Statement

- Value-Based Reimbursement (VBR) was passed by the Legislature in 2015 as a major overhaul to nursing facility rates aimed at addressing workforce issues and to create incentives to invest in direct care and improved quality.

  - Key features of VBR: care-related costs based on actual costs subject to a quality limit; other operating costs reimbursed based on a pricing model; health insurance costs are pass-through costs.

- Now that there is some experience with VBR, there are areas of improvement to the rate methodology to limit future spending growth and strengthen the quality incentive.
II. Recommended Strategy

The strategy consists of a number of modifications to the rate setting formula including:

1. Redesign the rate-setting formula to create a stronger quality incentive while at the same time rewarding cost efficiencies.
2. Establish a cap on the growth of the other operating costs from year to year tied to a published inflation factor (Skilled Nursing Facility Market Basket inflation adjustment), or some other percentage increase established in law.
3. Suspend the Critical Access Nursing Facility Program (CANF) funding, as it has no value under VBR.
II. Recommended Strategy (continued)

4. Suspend the Alternative Payment System automatic property inflation adjustment.

5. Eliminate a hold-harmless clause which states that facilities at least receive the rate they had for the year prior to the implementation of VBR.

6. Add an assessment when therapy services are discontinued, which will result in a decrease in the resident’s daily payment rate because the assessment will reflect that the service is no longer needed and no longer being provided.
III. Anticipated Benefits

• Revising the VBR methodology will provide nursing facilities with greater incentive to improve quality by linking it more strongly to reimbursement.

• By slowing the rate of growth in the operating cap components, the State will appropriately target its limited resources and promote operational efficiency.

• The continued suspension of CANF appropriately recognizes that VBR is cost-based and removes need for the CANF.

• Removing the inflation rate for property (which has been suspended for several years) also appropriately recognizes that VBR is cost-based.
III. Anticipated Benefits (continued)

• Removing the VBR hold harmless clause is appropriate since VBR has been in place for 4 years, and facilities have had time to adjust to cost-based reimbursement.

• By requiring an assessment when individuals’ clinical and functional ability change so as to no longer need therapy, this will ensure that facilities are appropriately paid based on individuals’ need for services.
IV. Administrative Implications

• There are limited administrative implications to these proposals.

• DHS would provide technical assistance to the Legislature in drafting legislation.

• Once enacted, DHS would inform nursing facilities about change to ensure they are aware of them.

• For the therapy assessment, DHS would also provide education and training to facilities about the new requirement. MDH would also need to be involved.
V. Equity Review

• The VBR reform proposed changes do not impact any identifiable racial or ethnic group differently than the general population of nursing facility residents.
• The proposal supports modification to the formula that limits the reimbursement of care-related expenditures in ways that are more sensitive to individual nursing facilities.
• The impact will be positive if the revised formula incentivizes poorer performing nursing facilities to improve the quality of care and quality of life they provide to residents.
V. Equity Review (continued)

Key Questions

• What is the population and geographic impact?

• What equitable mechanisms are being used in the modification of the rate setting formula?

• How does this strategy impact consider stakeholder engagement?

• How is this strategy impacting wages?

• How will this strategy promote equitable access?

• What accountability measures will be built in the assessment process?
VI. Anticipated Challenges

• Nursing facilities will see this as a rate cut.

• Most of the components of this strategy was included in the Governor’s 2019 budget and were met with strong resistance.

• The requirement for a new therapy assessment when no longer needed is a new activity for nursing facilities, and may result in reduced revenues because they would not be able to continue to bill at the same rate for entire quarter.
Repeal Nursing Facilities’ First 30 Days Rate Adjustment
I. Problem Statement

• This enhanced rate was established prior to Value-Based Reimbursement (VBR) to help nursing facilities receive reimbursement for costs associated with new admissions.

• Since VBR is a cost-based system, these costs are incorporated in the overall rate. The enhancement, therefore, is no longer needed.
II. Recommended Strategy

• This strategy recommends the repeal of 256R.42, which is the provision of law that allows for the 20% rate adjustment in the first 30 days following admission to a nursing facility.

III. Anticipated Benefits

• The strategy will remove the enhanced rate and thereby produce a rate that more accurately reflects facility costs.
IV. Administrative Implications

• There are limited administrative implications to this proposal.

• DHS would provide technical assistance to the Legislature to draft legislation to repeal the provision.

• Once enacted, DHS would modify its system to remove the 20% rate enhancement.
V. Equity Review

Key Questions

• What are the cost trends associated with the rate adjustment since its implementation?

• What is the impact to those entering the nursing facility with a MH or SUD need?

• How does the strategy impact nursing facilities?

• Establish the equity impact for the strategy.
VI. Anticipated Challenges

• Nursing facilities will see this policy change as a rate cut.
Recommendation to Commission: Removal of Strategy 145 from Future Consideration

• Strategy 145: Consolidation of the State’s HIV Prevention and Care Administration
  • Submitted by Hennepin County and prioritized as one of 47 strategies for development
  • MDH administers federal and state HIV prevention funding and programs, and DHS administers Ryan White HIV/AIDS Program Part B funding for HIV care programs
  • Strategy stated that having HIV programs and funding at two state agencies leads to complications for counties, clinics and agencies that receive funding from both MDH & DHS for HIV services

• MDH and DHS recommend that this strategy now be removed because:
  • MDH and DHS have strengthened collaboration, and are streamlining inter-agency processes to eliminate duplication of service funding and reduce burden of RFP process on clinics
  • DHS, MDH and Hennepin County are near completion of system-wide process change to centralize eligibility for Ryan White services
  • A recent evaluation recommended keeping administration of Ryan White Part B services at DHS
  • This is a budget neutral strategy, with some potential administrative costs
  • Removing this strategy will allow staff to focus on other priority strategies
Wrap-up
Friday, March 20, 2020

BRC Meeting 10

9:00 a.m. - 3:00 p.m.

Orville L Freeman Building

625 Robert Street North, St. Paul

Focus: Waste, including fraud and program integrity
Thank you!

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