

# STATE OF MINNESOTA

## Office of Governor Mark Dayton

130 State Capitol ♦ 75 Rev. Dr. Martin Luther King Jr. Boulevard ♦ Saint Paul, MN 55155

July 19, 2017

The Honorable Thomas E. Price, M.D.  
Secretary of U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

Re: Renewal of Minnesota's Section 1115 Medicaid Waiver-- Reform 2020

Dear Secretary Price:

This is a request to renew Minnesota's section 1115 waiver entitled Reform 2020, effective July 1, 2018. This waiver provides federal authority to implement components of Minnesota's initiatives to promote independence, increase community integration and reduce reliance on institutional care for older adults and people with disabilities.

Specifically, the waiver provides federal support for the following efforts.

- The Alternative Care program, which provides community-support for seniors who are near but not yet eligible for Medicaid to divert nursing home admissions and help people stay in their homes.
- Making use of the Community First Choice option by ensuring that people who are eligible for personal care supports in Minnesota do not lose those benefits as we convert to the Community First Choice option.
- Continuing to cover children under the age of 21 who do not meet the state's definition of institutional level of care, which was revised on January 1, 2015, preserving their eligibility for Medicaid.

Extending this waiver authority will help us continue to move away from reliance on institutional settings and promote community integration. I look forward to working with you toward approval of this renewal.

Sincerely,

A handwritten signature in black ink that reads "Mark Dayton".

Mark Dayton  
Governor

cc: Brian Neale, Deputy Administrator of Centers for Medicare & Medicaid Services and Director of Center for Medicaid and CHIP Services  
Ruth Hughes, Associate Regional Administrator of Region V, Centers for Medicare & Medicaid Services, Division of Medicaid and Children's Health Operations

**Reform 2020 Section 1115 Waiver  
Renewal Request**

Project No. 11-W-00286/5  
June 30, 2017

## Table of Contents

Section I – Program Description .....	1
Section II – Demonstration Eligibility .....	3
Section III – Demonstration Benefits and Cost Sharing Requirements.....	8
Section IV – Delivery System and Payment Rates for Services .....	10
Section V – Implementation of Demonstration .....	14
Section VI – Demonstration Financing and Budget Neutrality .....	17
Section VII – List of Proposed Waivers and Expenditure Authorities .....	18
Section VIII – Public Notice.....	19
Section IX – Demonstration Administration .....	22

### Attachments

Attachment A	Alternative Care Program Operational Protocol
Attachment B	Proposed Reform 2020 Evaluation Plan for 2018-2021
Attachment C	Reform 2020 Interim Evaluation Report 2013-2017
Attachment D	Budget Neutrality Worksheets
Attachment E	State Register Notice - Public Comment
Attachment F	Tribal Consultation Policy
Attachment G	Tribal Letter May 22, 2017
Attachment H	Public Comment

## **Section I – Program Description**

### **1) Provide a summary of the proposed demonstration program, and how it will further the objectives of Title XIX and/or Title XXI of the Social Security Act (the Act).**

On October 18, 2013, the Centers for Medicare & Medicaid Services (CMS) approved Minnesota's section 1115 demonstration project, titled Reform 2020. The five-year demonstration provides federal authority to implement three key components of Minnesota's reform initiative to promote independence, increase community integration and reduce reliance on institutional care for older adults and people with disabilities.

The Reform 2020 waiver specifically provides: (1) Medicaid funding for the Alternative Care program, which provides community-supports to elders not yet financially eligible for Medicaid; (2) expanded self-directed options under the Community First Services and Supports program for people who would otherwise be ineligible under the 1915(i) and 1915(k) state plan options; and (3) Medicaid funding for covering children under the age of 21 who do not meet the state's required institutional level of care as of January 1, 2015 and, therefore, would lose Medicaid eligibility without the demonstration.

Through these efforts the state seeks to further the objectives of Title XIX of the Social Security Act to improve health outcomes of low-income Minnesotans, specifically older adults and people with disabilities, by increasing their access to community-based providers and supporting service delivery networks for care provided in the community.

The current waiver for this demonstration is in effect through June 30, 2018. The state seeks a renewal of such waiver authority to continue this demonstration through June 30, 2021.

### **Alternative Care Program**

Medicaid funding for Minnesota's Alternative Care Program was authorized under the Reform 2020 waiver beginning November 1, 2013. Alternative Care provides home and community-based services to people ages 65 and older who are: 1) in need of a nursing facility level of care; 2) not yet eligible for Medical Assistance (MA) coverage because their income and assets exceed the MA eligibility limits; and 3) their excess income and/or assets are insufficient to pay for 135 days of nursing facility care.

The Alternative Care Program connects seniors with community services in an effort to divert them from nursing facilities and encourage more efficient use of services when full Medicaid eligibility is established. Minnesota has a 1915(c) home and community-based services (HCBS) waiver, known as the Elderly Waiver program, for people over age 65 who need the level of care provided in a nursing facility. Unlike the Elderly Waiver program, full Medicaid benefits are not covered under the Alternative Care program.

The Alternative Care program requires services to be delivered by qualified providers enrolled in the state's Medicaid program. A detailed description of this program's delivery system and

requirements is provided in the Alternative Care Program Operational Protocol at Attachment A. We have revised the protocol to reflect changes in the program since the last revision in December of 2016.

### **Community First Services and Supports (CFSS).**

Minnesota is redesigning its personal care assistance (PCA) benefit to expand self-directed options for beneficiaries under a new service called Community First Services and Supports (CFSS). The service is modeled after and is designed to comply with federal regulations for the Community First Choice option under section 1915(k) of the Social Security Act (SSA). The CFSS program allows for consumer-directed care and reduces pressure on the health care system by allowing people to use CFSS to address their needs, instead of enrolling in one of the state's five HCBS waivers.

Two types of federal authorities are necessary for the state to implement CFSS—both state plan and waiver authorities. Minnesota is seeking federal approval of two state plan amendments related to this initiative to avoid a reduction in services for people currently using PCA services in Minnesota. Due to systems modernization efforts, implementation of this benefit has been delayed. Once approved, CFSS will be available under the state plan to people who meet an institutional level of care via the 1915(k) state plan option and to those who do not meet institutional level of care via the 1915(i) state plan option.

Appropriateness of services will be based on CFSS eligibility criteria. Services authorized under 1915(i) will be the same as those authorized under 1915(k), yet the available federal Medical Assistance percentage (FMAP) rate for these services will differ. For example, for 1915(k) services, the enhanced FMAP rate will apply, while the state's regular FMAP rate will apply to the 1915(i) services.

Waiver authority under section 1115 allows Minnesota to receive Medicaid funding for two additional groups of people who would otherwise be ineligible under either the 1915(k) or 1915(i) state plan benefits. The first group are people with income above 150 percent of FPL who will receive the reformed PCA service (CFSS) but do not meet an institutional level of care, referred to hereinafter as the "1915(i)-like" group. The second group are people who meet an institutional level of care and will receive the reformed PCA service (CFSS), not the HCBS benefit, but would have been eligible under the financial eligibility rules for HCBS waivers, referred to hereinafter as the "1915(k)-like" group.

The state's regular FMAP rate will apply to CFSS benefits provided to these two waiver populations.

CFSS will be implemented for all populations—state plan and waiver—upon CMS' approval of Minnesota's 1915(i) and 1915(k) state plan amendments.

## **Children Under 21 with Activities of Daily Living (ADL) Needs**

This waiver also provides federal expenditure authority for children under the age 21 who are eligible under the state plan and meet the institutional level of care criteria as of March 23, 2010, but under state law do not meet the current institutional level of care criteria established as of January 1, 2015, and, therefore, would otherwise be ineligible for Medicaid or HCBS benefits.

### **2) Include the rationale for the Demonstration.**

This demonstration is designed to support the following goals:

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

### **3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.**

Please refer to Attachment B for the Reform 2020 Evaluation Plan for the waiver renewal period July 1, 2018 through June 30, 2021.

### **4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions; within the State.**

The demonstration will operate statewide.

### **5) Include the proposed timeframe for the Demonstration.**

Minnesota seeks to renew the Reform 2020 waiver under section 1115 of the Social Security Act for the period of July 1, 2018 through June 30, 2021.

### **6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.**

N/A

## **Section II – Demonstration Eligibility**

**Eligibility for Alternative Care:** The Alternative Care is a program that provides limited home and community-based services to people who meet the specified eligibility requirements. People enrolled in the program must:

- Be age 65 or older;

- Meet the institutional level of care;
- Have income and/or assets exceeding the standards for the categorially needy aged, blind, and disabled groups covered in the state plan;
- Have a combined adjusted income, as defined in section 3 of the Alternative Care Operational Protocol, and assets that are not more than the projected nursing facility cost for 135 days of care, based on the statewide average rate;
- Not be within a penalty period for uncompensated transfers under Minnesota Statutes, Section 256B.0595
- Be within the limit on home equity in Minnesota Statutes, Section 256B.056;
- Choose to receive HCBS benefits instead of nursing facility services;
- Pay the assessed monthly fee; and,
- Either have no other funding source available for HCBS services (such as long-term care insurance), or have long-term care insurance that pays for only a portion of the beneficiary's assessed needs.<sup>1</sup>

**Eligibility for Community First Services and Supports:** CFSS is modeled after the Community First Choice Option under section 1915(k) for people who meet an institutional level of care. The component of the program for people who do not meet an institutional level of care is modeled after the 1915(i) state plan option. The program is designed for people in need of PCA services to maintain and increase independence by directing and managing their care. This waiver allows the state to extend this benefit to two additional populations who would have otherwise been ineligible under the state plan options for CFSS. These populations are eligible as follows:

The 1915(k)-like population must:

- Meet non-financial requirements for Medical Assistance;
- Not meet financial eligibility factors for a Medicaid state plan group;
- Have income and assets that meet the requirements of the special HCBS waiver eligibility group under 42 C.F.R §435.217;
- Meet one of the following eligibility factors for Medicaid payment of long-term care services:
  - age 65 or older, eligible without a spenddown, have income at or below 300 percent of SSI and meet spousal impoverishment rules if applicable;
  - disabled and under the age of 65, but over the age 21, eligible without a spenddown, have income at or below the relevant state plan standard with special institutional rules, including an exemption from spousal deeming; or
  - Under age 21, eligible using special institutional rules, including exemption from parental deeming rules.
- Not be currently receiving services under an approved 1915(c) HCBS waiver;
- Meet an institutional level of care for a nursing facility, a psychiatric residential treatment facility (PRTF), an intermediate care facilities with intellectual disabilities (ICF-IID) or hospital; and

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<sup>1</sup> The Alternative Care program is a payor of last resort and other insurance is primary. If other benefits and/or payments are sufficient to meet the beneficiary's assessed needs, the beneficiary is not eligible. If insurance only pays a portion of the beneficiary's assessed needs, the Alternative Care program could pay for other assessed needs that are unmet.

- Meet the PCA criteria, defined as having an assessed need for assistance with at least one activity of daily living or demonstrating physical aggression toward oneself or others or destruction of property that requires immediate intervention by another person.

The 1915(i)-like population must:

- Be enrolled in Medical Assistance under a state plan eligibility group that includes eligibility for persons with incomes above 150 percent of the FPL and at or below the relevant state plan limit;
- Not meet an institutional level of care;
- Not meet the Medicaid financial eligibility criteria to be eligible for the 1915(i) state plan benefit; and
- Meet the PCA criteria, defined as having an assessed need for assistance with at least one activity of daily living or demonstrating physical aggression toward oneself or others or destruction of property that requires immediate intervention by another person.

**1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration.**

Populations whose eligibility is affected by the Demonstration are outlined below in a chart summarizing each group and its coverage authority, funding stream, and eligibility and expenditure groups for reporting purposes to CMS.

<b>Demonstration Expansion Group</b>	<b>Federal Poverty Level (FPL) and/or other Qualifying Criteria</b>	<b>Funding Stream</b>	<b>Expenditures and Eligibility Groups Reporting</b>
1915(i)-like	People under the state plan, with incomes above 150 percent of the FPL and at or below the relevant state plan limit (includes pregnant women and children). These individuals meet the programmatic criteria of 1915(i) including PCA criteria but do not meet the Medicaid financial eligibility criteria to be eligible for the 1915(i) state plan benefit.	Title XIX Title XXI	1915(i)-like
1915(k)-like	People who meet all Medicaid eligibility factors except the financial requirements of a state plan group, meet income and asset criteria for Medical Assistance as if qualifying	Title XIX	1915(k)-like

<b>Demonstration Expansion Group</b>	<b>Federal Poverty Level (FPL) and/or other Qualifying Criteria</b>	<b>Funding Stream</b>	<b>Expenditures and Eligibility Groups Reporting</b>
	<p>using the rules of the special HCBS group under 42 C.F.R § 435.217 and meet one of the financial eligibility factors for payment of Medicaid long-term care services described in STC 18(c)(i). People eligible for this benefit are not receiving an HCBS service through a 1915(c) waiver, yet they meet the institutional level of care for nursing facilities and the PCA targeting criteria. Therefore, they would not be eligible for the 1915(k) state plan benefit under a group covered in the state plan.</p>		
Alternative Care	<p>Age 65 and older, income and/or assets exceeding state plan standards for the aged, blind and disabled for any groups covered in the state plan [100 percent FPL for the aged, blind and disabled], combined adjusted income, assets do not exceed projected nursing facility cost for 135 days of care, no asset penalty period, and home equity is within the limit defined under Minnesota Statutes, Section 256B.056.</p>	Title XIX	AltCare
Children under 21 with Activities of Daily Living (ADL) Needs	<p>Children under 21 who are state plan eligible, who meet the institutional level of care in effect on March 23, 2010, but do not meet the institutional level of care in effect on January 1, 2015 and</p>	Title XIX Title XXI	ADL Children

Demonstration Expansion Group	Federal Poverty Level (FPL) and/or other Qualifying Criteria	Funding Stream	Expenditures and Eligibility Groups Reporting
	who would otherwise be ineligible for Medicaid or HCBS services.		

**2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.**

Standards and methodologies for eligibility are set forth under the state plan, and eligibility for the state’s HCBS waiver programs is set forth in the approved 1915(c) waivers.

**3) Specify any enrollment limits that apply for expansion populations under the Demonstration.**

No enrollment limits apply.

**4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.**

Please see the budget neutrality worksheets at Attachment D for the projected eligible member months for each population under the demonstration. Eligible member months may be divided by twelve to approximate the number of unique individuals who will be eligible under the demonstration.

**5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).**

People in the 1915(k)-like group will be determined eligible using the rules that apply to the eligibility group under 42 C.F.R. § 435.217 for a 1915(c) waiver. Eligibility and post-eligibility rules will follow the rules of the applicable 1915(c) waiver. For a person age 65 and older, the eligibility and post-eligibility rules for that group in the Elderly Waiver will apply; for a person under age 65 and disabled, the eligibility and post-eligibility rules for that group in the CADI, BI or DD waivers will apply.

**6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority**

(such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

N/A

**7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.**

N/A

### **Section III – Demonstration Benefits and Cost Sharing Requirements**

**1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:**

**Yes**       **No (if no, please skip questions 3 – 7)**

The Alternative Care program benefit set differs from the benefit set under the Medicaid state plan in that the benefits are limited to home and community-based services. The benefits available under this program are similar to Minnesota’s Elderly Waiver program, except that transitional support services, customized living services, adult foster care services, and residential care are not covered. People enrolled in the Alternative Care program can receive nutritional services and discretionary benefits. Please refer to section 2 of the Alternative Care Program Operational Protocol for a detailed description of program benefits and service definitions.

Unlike the Medicaid state plan benefit, individuals in the Alternative Care program pay cost-sharing fees of up to 30 percent of the average monthly cost of the individual’s services in this program. Please refer to section 3 of the Alternative Care Operational Protocol for a detailed description of fee.

**2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:**

**Yes**       **No (if no, please skip questions 8 - 11)**

Enrollees pay cost-sharing fees of up to 30 percent of the average monthly cost of the individual’s services for the program. Please refer to section 3 of the Alternative Care Operational Protocol for a description of how fees are determined. .

**Yes**       **No (if no, please skip questions 8 - 11)**

State plan cost-sharing requirements will apply to CFSS participants. Cost-sharing requirements are described in Attachment 4.18-A of the state plan.

**3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration.**

The benefit package for CFSS populations affected by the Reform 2020 demonstration will mirror the benefit package provided to CFSS populations under the 1915(i) and 1915(k) state plan options. The benefit package for the 1915(i) and 1915(k) groups are set out in Minnesota's amendments to its State Plan. See TN 13-32 and TN 13-08.

**4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:**

N/A

- Federal Employees Health Benefit Package
- State Employee Coverage
- Commercial Health Maintenance Organization
- Secretary Approved

**5) Demonstration Benefits for Expansion Populations**

Benefits are the same as those listed under Section III item 1) above.

**6) Indicate whether Long Term Services and Supports will be provided.**

Yes (if yes, please check the services that are being offered)       No

The "Long Term Services and Supports" for Alternative Care recipients are described in section 2 of the Alternative Care Program Operational Protocol at Attachment A.

These services will mirror those provided to CFSS populations under the 1915(i) and 1915(k) state plan option. The "Long Term Services and Supports" for the 1915(i) and 1915(k) groups are set out in Minnesota's amendments to its State Plan. See TN 13-32 and TN 13-08.

**7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.**

Yes (if yes, please address the questions below)       No (if no, please skip this question)

For the 1915(i)-like and 1915(k)-like groups, the state plan requires coordination with cost-effective group insurance under section 1906 of the Social Security Act.

**8) If different from the State plan, provide the premium amounts by eligibility group and income level.**

N/A

**9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan.**

N/A

**10) Indicate if there are any exemptions from the proposed cost sharing.**

N/A

## **Section IV – Delivery System and Payment Rates for Services**

**1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:**

**Yes** - for participants in Alternative Care program

**No (if no, please skip questions 2 – 7 and the applicable payment rate questions)** - for waiver participants in CFSS and the ADL children group

Minnesota uses both fee-for-service and managed care delivery. Coverage for a large portion of enrollees on Medical Assistance is purchased on a prepaid capitated basis. The remaining recipients receive services from enrolled providers who are paid on a fee-for-service basis. Most of the fee-for-service recipients are individuals with disabilities. Individuals affected by the demonstration will receive services from enrolled providers who are paid on a managed care or a fee-for-service basis.

The Alternative Care program services are provided fee-for-service and are administered by counties and tribal health agencies. The service definitions and provider standards for Alternative Care services are the same as the service definitions and provider standards specified in the federally approved Elderly Waiver plan, to the extent the services are the same. Approved services are prior authorized in the MMIS system. Services are provided by qualified providers who are enrolled as Medicaid providers. The delivery system used to provide benefits to Alternative Care recipients under the Reform 2020 demonstration is described in section 1 of the Alternative Care Program Operational Protocol at Attachment A.

CFSS populations affected by the Reform 2020 demonstration will receive services through the delivery system options described in the 1915(i) and 1915(k) amendments to the state plan. The delivery system for the 1915(i) and 1915(k) groups is described in TN 13-08 and section TN 13-32.

The delivery system used to provide benefits to the ADL children group will not differ from the state plan.

**2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration’s expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.**

CFSS populations affected by the Reform 2020 demonstration will receive services through the delivery system options described in the 1915(i) and 1915(k) amendments to the state plan. The delivery system for the 1915(i) and 1915(k) groups is described in the pending state plan amendments TN 13-08 and section TN 13-32.

**3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:**

- Managed care**
  - Managed Care Organization (MCO)**
  - Prepaid Inpatient Health Plans (PIHP)**
  - Prepaid Ambulatory Health Plans (PAHP)**
- Fee-for-service (including Integrated Care Models)**
- Primary Care Case Management (PCCM)**
- Health Homes**
- Other (please describe)**

**4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option.**

**Delivery System Chart**

<b>Eligibility Group</b>	<b>Delivery System</b>	<b>Authority</b>
1915(i)-like	Self-directed service delivery models	42 C.F.R. § 441.545(a) and (c)
1915(k)-like	Self-directed service delivery models	42 C.F.R. § 441.545(a) and (c)
Alternative Care	Fee-for-service	Section 1115
Children under 21 with Activities of Daily Living (ADL) Needs	Election of fee-for-service or managed care enrollment	Minnesota Statutes Section 256B.69, subd. 4(b), (6) and (8)

**5) If the Demonstration will utilize a managed care delivery system:**

**a) Indicate whether enrollment will be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?**

Managed care enrollment is mandatory for population groups covered by Minnesota's state plan who are not otherwise exempt from managed care. Certain populations are excluded from enrollment into managed care. The federal authority to require managed care enrollment for certain groups that would otherwise be exempt from managed care is contained in the Minnesota Senior Care Plus (MSC+) 1915(b) waiver.

**b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.**

Managed care is statewide.

**c) Indicate whether there will be a phased-in rollout of managed care.**

Managed care is statewide. Minnesota intends to continue to operate managed care purchasing and service delivery for Medicaid recipients on a statewide basis.

**d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.**

All enrollees who are potential enrollees in a managed care organization (MCO) are notified about the requirements and options to enroll in a MCO, and provided a deadline for enrollment. The deadline is no less than 30 days from the date the enrollee is mailed educational materials. To ensure consistency, all counties are required to use a standard set of educational materials developed by the Department of Human Services.

County staff provides information to enrollees about their options, including if enrollment in an MCO is required or voluntary. All enrollees eligible to enroll in an MCO are encouraged to choose an MCO. If the enrollee does not make a choice, the Department of Human Services assigns them to an MCO.

When an enrollee has either chosen or been assigned to an MCO, the enrollee is mailed an enrollment notice. This notice informs the client of the effective date that coverage begins and the name of the MCO. After enrollment, there are opportunities and options for changing enrollment between MCOs. The enrollment notice includes a detailed list of circumstances under which an enrollee may choose a different health plan.

**e) Describe how the managed care providers will be selected/procured.**

Minnesota law places a five-year limitation on grant contracts, including managed care contracts. DHS has adopted a rolling cycle of procurements that result in one-year contracts that can be renewed. Procurement is conducted for each geographic region at least once every five years.

**6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.**

Federally Qualified Health Centers (FQHCs) and Indian Health Service (IHS) providers are carved out of the MCO contract and are paid fee-for-service. MCO's are still responsible for contracting with these providers and assuring enrollees access. Room and board for certain types of mental health stays is paid by county government.

**7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.**

CFSS populations affected by the Reform 2020 demonstration will receive services through the delivery system options described in the 1915(i) and 1915(k) amendments to Minnesota's State Plan. The delivery system for the 1915(i) and 1915(k) groups is described in TN 13-08 and section TN 13-32.

**8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.**

Any fee-for-service provider payment rates for any services under this waiver will be consistent with the approved rates in Minnesota's State Plan.

**9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.**

**General Rate Setting Methodology**

The Department of Human Services does not negotiate individual rates with each MCO. Base capitation rates are developed on a statewide basis, using data from all of the plans, adjusted for various factors such as changes in benefits and pricing. Capitation rates vary based on age, gender and geographic location of recipients, along with the health status of members in the plan.

**Risk Adjustment**

The state uses a risk adjustment mechanism that is diagnosis based called Chronic Illness and Disability Payment System (CDPS+Rx) in accordance with Minn. Stat. § 256B.69, subdivision 5(b). Minnesota began making risk-adjusted payments in 2000. Rates for pregnant women and newborns are not risk-adjusted.

**10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.**

The contracts with MCOs include payment incentives to promote access, efficiency and quality. The payments for 2018 are described in Article 7 of the 2017 Families and Children model contract, posted on the DHS public web site under [Managed Care Contracts](#).

## **Section V – Implementation of Demonstration**

### **1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.**

The Alternative Care portion of this Reform 2020 waiver was implemented statewide on November 1, 2013. This waiver extension requests continuing authority for a program that is already in effect. Therefore, an implementation schedule is unnecessary.

The Reform 2020 waiver authority for the CFSS benefit will be implemented for all populations upon CMS' approval of Minnesota's 1915(i) and 1915(k) state plan amendments. Operational and system changes required to implement the PCA reform initiative are underway.

The Reform 2020 waiver authority for children in need of "activities of daily living" (ADL) was implemented January 1, 2015. This waiver extension requests a continuation of expenditure authority that is already in effect. Therefore, an implementation schedule for this component is unnecessary.

### **2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.**

Alternative Care Program & Process. Applicants must submit applications to lead agencies. Lead agencies must redetermine financial and service eligibility, annually. Applicants may be required to provide all information necessary, including the client's Social Security Number (SSN), to determine eligibility for the program and potential eligibility for Medical Assistance. Applicants who appear to be categorically eligible for Medical Assistance may receive services through the Alternative Care program for up to 60 days while Medical Assistance eligibility is being determined.

Please refer to sections 1 and 5 of the Alternative Care Program Operational Protocol at Attachment A for additional information on the administration and enrollment processes for this program.

1915(k)-like Benefit & Eligibility Process. The eligibility process for the 1915(k)-like benefit will be very similar to the one used for the HCBS waivers, except that the participants eligible for the 1915(k)-like benefit will receive their HCBS benefits through CFSS instead of both CFSS and HCBS waiver services. Lead agencies (which may be a county or tribal entity) administer the HCBS waiver program today and will administer the CFSS benefit for the 1915(k)-like group, once the necessary federal authority is received.

- Each applicant will receive a comprehensive assessment known as a long-term-care consultation process. The certified assessor or case manager will discuss the option of receiving benefits through CFSS as an alternative to an HCBS waiver. If individuals who are eligible for the 1915(k)-like benefit meet the required institutional level of care and are using the special institutional rules to qualify, CFSS will be treated as a long-term-care service. Long-term-care eligibility rules applicable under HCBS waivers will apply.
- If the applicant selects the 1915(k)-like benefit, the assessor or case manager will develop a service plan that is person-centered and that documents the amount, frequency and duration of services and, where appropriate, assigns caregiver supports needed. Services will receive prior authorization through the state's MMIS system. Reassessments will be done at least annually, or earlier if an individual experiences an event that changes their condition.

1915(i)-like Benefit & Eligibility Process. Eligibility for the 1915(i)-like benefit will be identical to the eligibility procedures for 1915(i) state plan benefit.

**3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.**

The state will continue to contract with MCOs in the same manner as it has for many years. Minnesota law places a five-year limitation on the procurement of grant contracts, including MCO contracts. DHS has adopted a rolling cycle of procurements that results in one-year contracts that can be renewed. Procurement is conducted for each geographical region at least once every five years.

**The following information is provided in response to the extension application requirements under 42 CFR 431.412 (c)(2)(iv):**

**Quality Assurance and Monitoring**

To ensure the level of care provided by an MCO meets all of the standards, the state monitors the quality of care provided by each MCO through an ongoing review of their individual quality improvement systems, grievance procedures, service delivery plans, and summaries of health utilization information.

**Quality Strategy**

In accordance with 42 C.F.R. § 438.202(a), the state's quality strategy was developed to monitor and oversee the Minnesota's Prepaid Medical Assistance Program (PMAP) and other programs that use managed care to deliver publicly funded health care services to beneficiaries in Minnesota. Minnesota.

This strategy assesses the quality and appropriateness of services provided by MCOs for all enrollees in managed care. It incorporates elements of current MCO contract requirements, state health maintenance organization (HMO) licensing requirements (Chapters 62D, 62M, 62Q of

Minnesota Statutes), and federal managed care regulations (42 C.F.R. Part 438). The combination of these requirements (contract and licensing) and standards (quality assurance and performance improvement) are at the core of DHS' quality strategy. DHS assesses the quality and appropriateness of health care services, monitors and evaluates the MCO's compliance with state and federal requirements and, when necessary, imposes corrective actions and appropriate sanctions if MCOs are not in compliance. The outcomes of these quality improvement activities are included in the Annual Technical Report (ATR).

### **External Review Process**

Each year, as the single state Medicaid agency, DHS must conduct an external quality review of managed care services. The purpose of this review is to produce an ATR that includes:

- Determination of compliance with federal and state requirements;
- Validation of performance measures, including Health Care Effectiveness Data and Information Set (HEDIS) Measures and Consumer Assessment of Health Plans Survey (CAHPS®), and performance improvement projects; and
- An assessment of the quality, access, and timeliness of health care services provided to Medicaid beneficiaries enrolled in managed care.

Where there is a finding that a requirement is not met, the MCO is expected to take corrective action to come into compliance with the requirement. The external quality review organization (EQRO) conducts an overall review of Minnesota's managed care system. The charge of the review organization is to identify areas of strength and weakness and to make recommendations for change. Where the technical report describes areas of weakness or makes recommendations, the MCO is expected to consider the information, determine how the issue applies to its situation and respond appropriately. The review organization follows up on the MCO's response to the areas identified in the past year's technical report. This report is published on the DHS website at [Managed care: Quality, outcome and performance measures](#).

### **MCO Internal Quality Improvement System**

MCOs are required to have an internal system for quality improvement that meets state and federal standards set forth in the contract between the MCO and DHS. These standards are consistent with state licensure requirements for Health Maintenance Organizations (HMOs). MCOs submit annual updates regarding their quality improvement programs and efforts to identify, monitor and improve service or clinical quality relevant to their enrollees. Information on each MCO's quality program activities can be found at [Managed care: Quality, outcome and performance measures](#).

### **Performance Improvement Projects**

All MCOs that contract with DHS must conduct projects for performance improvement, designed to improve care provided to enrollees. The performance improvement projects summary report for 2016 is published on the DHS website at [Managed care: Quality, outcome and performance measures](#).

## **Summary of Managed Care Grievance System Information**

The Ombudsman for Public Managed Health Care Programs at Department of Human Services collects data about enrollee grievances and appeals filed with managed care plans; notices for denial, termination or reduction sent by the plans; and related fair hearings. A summary of the grievance system information for MCOs during calendar years 2012-2014 is published on the DHS website at [Managed care: Quality, outcome and performance measures](#).

## **Consumer Satisfaction**

DHS sponsors an annual satisfaction survey of enrollees in managed care using the CAHPS® instrument and methodology to assess and compare their satisfaction with services and care provided by MCOs. DHS contracts with a certified CAHPS vendor to administer and analyze the survey. Survey results are published on the DHS website at [Managed care: Quality, outcome and performance measures](#).

## **Update on Comprehensive Quality Strategy**

Minnesota's comprehensive quality strategy is an overarching, comprehensive and dynamic continuous strategy integrating all aspects of the quality improvement programs, processes and requirements across Minnesota's Medicaid program, Medical Assistance. Minnesota has incorporated measures and processes related to the programs affected by this waiver. An initial draft was submitted to CMS in February 2015. DHS is currently updating its Comprehensive Quality Strategy in an effort to streamline quality measurement across all Medicaid populations served by Minnesota's managed care and fee-for-service delivery systems.

## **Reform 2020 Evaluation Activities**

### **Interim Evaluation Report**

DHS has contracted with researchers at the University of Minnesota and Purdue University for development of an evaluation design and analysis plan that covers all elements outlined in paragraph 60 of the current Special Terms and Conditions for the Reform 2020 waiver. Please refer to Attachment C for an interim report on evaluation findings for the period November 1, 2013 to June 30, 2015.

### **Reform 2020 Evaluation Plan 2018 to 2021**

The current evaluation plan for the Reform 2020 waiver renewal period July 1, 2018 through June 30, 2021 is included at Attachment B.

## **Section VI – Demonstration Financing and Budget Neutrality**

### **1) Budget Neutrality**

The budget neutrality projections for the Alternative Care program component of the Reform 2020 waiver are determined using a nursing facility and Elderly Waiver diversion model. The waiver budget neutrality projections for the CFSS program and children with ADL need are calculated using a PM/PM method. The budget neutrality worksheets are provided at Attachment D.

## Section VII – List of Proposed Waivers and Expenditure Authorities

Minnesota seeks CMS guidance to determine which, if any additional waivers of state plan requirements under the authority of section 1115(a)(1) of the Social Security Act are necessary to enable the state to carry out the demonstration.

### Expenditure Authorities

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) will be regarded as expenditures under the State's Title XIX plan for the period of this extension.

1. **Population 1: Expenditures for Alternative Care program services for individuals age 65 or older who have income and/or assets exceeding the state plan standards for the aged, blind and disabled for any group covered in the state plan.** This population has a combined adjusted income, as defined in section 3 of the Alternative Care Operational Protocol, and assets that do not exceed projected nursing facility (NF) costs for 135 days of NF care, based on the statewide average NF rate. The beneficiary must not be within a penalty period for uncompensated transfers and home equity must be within the limit specified in state law. This authority is intended to include expenditures for the state to continue to operate the Alternative Care program.

This includes, but is not limited to, alternate methods for determining eligibility, limited benefit package, and alternate treatment of resources and annuities. These operations are described in Attachment D of the current Special Terms and Conditions (STC) for the Reform 2020 waiver. The State must provide fair hearings consistent with requirements at 42 C.F.R. § 431.200.

2. **Population 2: Expenditures for coverage provided under the Community First Services and Supports (CFSS) Program to the population eligible for the 1915(k)-like benefit, which includes individuals who meet non-financial requirements for Medical Assistance.** This group consists of individuals who do not meet the financial eligibility factors under the Medicaid State Plan, but who meet the income and asset criteria for Medical Assistance, when applying the rules of the special HCBS waiver group described in 42 C.F.R. § 435.217. This population also meets: (1) one of the financial eligibility factors for Medicaid payment of long-term care services as described in STC 18(c)(i); (2) the institutional level of care on January 1, 2015; and (3) the requisite targeting criteria for Personal Care Assistance (PCA) services. This population is not receiving an HCBS benefit through a 1915(c) waiver.

This waiver authority is contingent upon the state receiving CMS approval of a 1915(k) state plan amendment to authorize the CFSS program.

3. **Population 3: Expenditures for coverage provided under the Community First Services and Supports Program to the population eligible for the 1915(i)-like benefit, which includes state plan eligible individuals with incomes above 150 percent of the FPL and at or below the relevant State Plan limit (including pregnant women and**

**children).** These individuals meet the criteria for PCA services, but do not meet the criteria for NF level of care for adults.

This waiver authority is contingent upon the state receiving CMS approval of a 1915(i) state plan amendment to authorize the CFSS program.

- 4. Population 4: Expenditures for children under 21 who are state plan eligible but do not meet the institutional level of care as of January 1, 2015, and therefore would lose Medicaid eligibility without the demonstration.**

## **Section VIII – Public Notice**

**Please include the following elements as provided for in 42 CFR § 431.408 when developing this section:**

### **1) Start and end dates of the state’s public comment period.**

A notice requesting public comment on this proposal was published in the *Minnesota State Register* on May 22, 2017. The comment period ran from May 22, 2017 to June 21, 2017. The notice informed the public on how to access an electronic copy or request a hard copy of the waiver request. Instructions on how to submit written comments were provided. In addition, the notice included information about two public hearings scheduled to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The time and location for the two public hearings, along with information about how to arrange to speak at either of the hearings, was provided. Finally, the notice provided a link to the Reform 2020 waiver web page for complete information on the Reform 2020 waiver request including the public input process, planned hearings and a copy of waiver application. A copy of the notice is provided as Attachment E.

### **2) Certification that the state provided public notice of the application, along with a link to the state’s web site and a notice in the state’s Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.**

The Department’s public web site provides the public with information about this request.. The web site is updated on a regular basis and includes information about the public notice process, opportunities for public input, planned hearings and a copy of the waiver application. After submission, this page will be updated to alert web visitors of the upcoming federal comment period on the Reform 2020 waiver extension request and to provide the link to the federal website for comment when it is available. A copy of the final draft of the waiver request that includes any modifications made based on public input will be posted on the web page.

### **3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.**

The State certifies that it convened two public hearings regarding this waiver to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The hearings were held at two different buildings in downtown St. Paul. Teleconferencing was available at each hearing to allow interested stakeholders the option to participate in the hearing remotely. The first public hearing was held on May 31, 2017. There was one member of the public in attendance. No public testimony was offered. The second hearing was held on June 1, 2017. There were no members of the public in attendance.

**4) Certification that the state used an electronic mailing list or similar mechanism to notify the public.**

The State used an electronic mailing list to notify the public. On May 22 2017, an email was sent to all stakeholders on the electronic mailing lists for “Medicaid Waivers, Disability Services Division, and Aging and Adult Services Division Community Support for Seniors,” informing them of the intent to submit this request and directing them to the web page. A second email will be sent to provide notice that the final submitted version of the waiver is on the web site and to alert stakeholders that a federal comment period is expected soon.

**5) Comments received by the state during the 30-day public notice period.**

DHS received one written comment from a stakeholder. A copy of the comment is provided at Attachment H.

**6) Summary of the state’s responses to submitted comments, and whether or how the state incorporated them into the final application.**

The one comment that was submitted is included as Attachment H.

**7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state’s approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.**

In Minnesota, there are seven Anishinaabe (Chippewa or Ojibwe) reservations and four Dakota (Sioux) communities. The seven Anishinaabe reservations include Grand Portage located in the northeast corner of the state, Bois Forte located in extreme northern Minnesota, Red Lake located in extreme northern Minnesota west of Bois Forte, White Earth located in northwestern Minnesota; Leech Lake located in the north central portion of the state; Fond du Lac located in northeastern Minnesota west of the city of Duluth; and Mille Lacs located in the central part of the state, south of Brainerd. The four Dakota Communities include: Shakopee Mdewakanton Sioux located south of the Twin Cities near Prior Lake; Prairie Island located near Red Wing; Lower Sioux located near Redwood Falls; and Upper Sioux whose lands are near the city of Granite Falls. While these 11 tribal groups frequently collaborate on issues of mutual benefit, each operates independently as a separate and sovereign entity – a state within a state or nation within a nation. Recognizing American Indian tribes as sovereign nations, each with distinct and

independent governing structures, is critical to the work of the Department of Human Services. The Health Care Administration within DHS maintains one position in the Medicaid Director's office to act as a liaison to the Tribes related to the public health care programs. Attachment F is Minnesota's tribal consultation policy from its State Plan.

The Tribal Health Work Group was formed to address the need for a regular forum for formal consultation between tribes and state staff. Work group attendees include Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, and the state consultation liaison. The Native American Consultant from CMS and state agency staff attend as necessary depending on the topics covered at each meeting. The DHS liaison attends all Tribal Health Work Group meetings and provides updates on state and federal activities. The liaison will often arrange for appropriate DHS policy staff to attend the meeting to receive input from Tribes and to answer questions.

On May 22, 2017 a letter was sent to all Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, the Indian Health Service Area Office Director, and the Director of the Minneapolis Indian Health Board clinic informing them of this request. The letter also informed Tribes of the public input process and provided a link to the Reform 2020 waiver web page. Please refer to Attachment G for a copy of the letter.

The State's intent to submit a request to extend the Reform 2020 waiver was also included in a summary of federal waiver activity provided to Tribal Chairs and Tribal Health Directors at the Tribal Health Work Group meeting on May 11, 2017.

#### **8) Summary of the state's compliance with the post-implementation forum requirements in the transparency regulations**

In accordance with paragraph 32 of the special terms and conditions, the State held a public forum on December 16, 2016 to provide the public with an opportunity to comment on the progress of the Reform 2020 demonstration. A summary of the forum including comments and issues raised by the public was included as Attachment A of the quarterly report for quarter two of demonstration year IV. DHS plans to hold the next public forum in December 2017.

**If this application is an emergency application in which a public health emergency or a natural disaster has been declared, the State may be exempt from public comment and tribal consultation requirements as outlined in 42 CFR 431.416(g). If this situation is applicable, please explain the basis for the proposed emergency classification and public comment/tribal consultation exemption (if additional space is needed, please supplement your answer with a Word attachment).**

N/A

## **Section IX – Demonstration Administration**

### **Contact**

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**Attachment A**  
**Alternative Care Program**  
**Operational Protocol**

Table of Contents

1.	Delivery System.....	1
1.1	Alternative Care Delivery System .....	1
1.2	Alternative Care Program Allocation to Lead Agencies.....	1
2.	Benefits .....	1
2.1	Benefits under the Alternative Care Program .....	1
2.2	Service Definitions and Provider Standards .....	2
2.21	Nutrition Services Definition.....	3
2.22	Nutrition Services Provider Standards and Qualifications .....	4
2.23	Discretionary Services Option.....	4
3.	Cost Sharing .....	4
3.1	Alternative Care Program Cost-Sharing.....	4
3.2	Determining Fees .....	4
3.3	Billing and Non-payment of Fees.....	5
4.	Eligibility.....	6
4.1	Alternative Care Eligibility.....	6
4.2	Alternative Care Eligibility Process .....	6
4.3	Roles.....	7
5.	Alternative Care Enrollment .....	7
5.1	The Long-term Care Consultation (LTCC).....	8
5.11	Access.....	9
5.12	Assessment .....	9

5.13	LTC Assessments .....	10
5.14	Citizenship and Immigration Status .....	10
5.15	Consumer Information.....	16
5.16	LTCC Support Plan.....	16
5.2	Financial Eligibility.....	17
5.21	Determination of Financial Eligibility.....	17
5.22	Fee Schedule .....	18
5.23	Income and Assets .....	18
5.231	Income and Asset calculation for married applicants with a community spouse Form DHS-2630A.....	18
5.232	Income and Asset calculation for all other applicants..... Form DHS-2630.....	19
5.24	Transfer of Assets.....	20
5.25	Trusts.....	21
5.26	Home Equity Limit.....	21
5.27	Liens and Estate Recovery .....	21
6.	Alternative Care Program Participant Rights.....	21
6.1	Notice to Beneficiary.....	21
6.2	Appeals.....	22

## **1. Delivery System**

### **1.1 Alternative Care Delivery System**

Alternative Care program services are provided fee-for-service and are administered by lead agencies, which may be a county or tribal entity. Counties may contract with the public health nursing service to be the lead agency. Federally recognized Indian tribes with a reservation in Minnesota may contract to serve as the lead agency responsible for the local administration of the Alternative Care program. Most service definitions and standards for Alternative Care services are the same as the service definitions and standards specified in the federally approved Elderly Waiver.

### **1.2 Alternative Care Program Allocation to Lead Agencies**

Alternative Care program funds are authorized in the state's budget as a major program appropriation.

Lead agency Alternative Care program allocations are maintained within the state's Medicaid Management Information System (MMIS) and are distributed in the form of payments to Alternative Care service providers for authorized services delivered to eligible persons.

Local lead agency activities occur under an Alternative Care program plan that ensures compliance with program policies and procedures.

The local Alternative Care program administrator is responsible for tracking, monitoring, and effectively managing the local Alternative Care program. Technical resources such as the MMIS InfoPac reports, the MMIS provider file and the MMIS payment and claim calendar are available to support lead agencies in the local administration of the program.

Alternative care funding will be determined in accordance with program eligibility and service cost projections based on the State forecast.

## **2. Benefits**

### **2.1 Benefits under the Alternative Care Program**

The Alternative Care program provides an array of home and community-based services based on assessed need and as authorized in the coordinated service and support plan (care plan)

developed for each beneficiary. The monthly cost of the Alternative Care services must not exceed 75 percent of the monthly budget amount available for an individual with similar assessed needs participating in the Elderly Waiver program. The benefits available under Alternative Care are the same as the benefits covered under the federally approved Elderly Waiver, except that Alternative Care covers nutrition services and discretionary benefits, and Alternative Care does not cover transitional support services, assisted living services, adult foster care services, and residential care and benefits that meet primary and acute health care needs. Alternative Care benefits include:

- Adult day service/adult day service bath;
- Family caregiver training and education, family caregiver coaching and counseling/assessment and family memory care;
- Case management and conversion case management;
- Chore services;
- Companion services;
- Consumer-directed community supports;
- Home health services;
- Home-delivered meals;
- Homemaker services;
- Environmental accessibility adaptations;
- Nutrition services;
- Personal care;
- Respite care;
- Skilled nursing and home care nursing
- Specialized equipment and supplies including Personal Emergency Response System (PERS); and,
- Non-medical Transportation.
- Tele-home care
- Discretionary Services
- Individual Community Living Supports (ICLS)

## **2.2 Service Definitions and Provider Standards**

Service definitions and provider standards for the Alternative Care program are the same as the service definitions and provider standards specified in Minnesota's federally approved Elderly Waiver, CMS control number 0025.R07.02, to the extent the services are the same. Please see [MHCP Provider Manual Elderly Waiver and AC](#) for more information on Elderly Waiver and AC service definitions and provider standards. Definitions and provider standards for the additional

services provided by the Alternative Care program (but not included in the Elderly Waiver) are described below. Approved services are prior authorized in the MMIS system based on a long-term care needs assessment. Services are provided by qualified enrolled Medicaid providers.

## **2.21 Nutrition Services Definition**

Nutrition services include nutrition education and nutrition counseling to address a recipient's nutritional needs. The goal of this service is to improve or maintain a recipient's nutritional status, and to improve management of the older adult's chronic diseases or conditions.

Nutrition education is one or more individual or group sessions which provide formal and informal opportunities for recipients to acquire knowledge and skills in managing their diet and nutritional needs. Examples include:

- Shopping
- Food selection
- Meal Preparation
- Menu Planning
- Preparing normal therapeutic diets
- Cooking for one or two
- Tips for eating well on a limited budget

Nutrition counseling is one or more individual sessions to advise and assist individuals on appropriate nutritional intake. Nutritional counseling includes assessment of a recipient's nutritional needs that results in an individualized plan with goals and follow-up on established goals. Nutrition counseling can assist recipients with:

- Managing therapeutic diets (e.g. diabetic, low sodium, low cholesterol, renal, or gluten free);
- Providing weight management strategies for recipients who are chronically underweight or overweight;
- Severe weight loss gain;
- Difficulty chewing or swallowing;
- Other nutritional care issues.

Nutrition services are tied to a specific goal and are authorized in the person's community support plan. All services are consistent with the recipient's cultural background.

## **2.22 Nutrition Services Provider Standards and Qualifications**

Nutrition Services are provided by enrolled Medicaid providers that meet the following qualifications:

- Licensed dietitians
- Licensed nutritionists
- Registered dietitians who meet education and practice requirements specified in Minnesota Statutes, section 148.621 and Minnesota Rules Chapter 3250.
- Other professions who are exempt from licensure, as per Minnesota Statutes, section 148.623, and perform service incidental to their practice, such as a diabetic educator or registered nurse.

## **2.23 Discretionary Services Option**

Discretionary services allow lead agencies to utilize a portion of Alternative Care program funds to address special or unmet needs of a client or family caregiver that are not otherwise defined in the Alternative Care program service menu. These services may be used to improve access, choice and/or cost effectiveness of the Alternative Care program in order to address chronic care needs of the client and that do not duplicate other services or funding streams.

Discretionary services, as with other Alternative Care services, are necessary to delay or prevent nursing facility admission and are identified in the individual community support plan. Lead agencies who wish to use the discretionary services option must complete the application process described in [DHS-5815-ENG](#).

## **3. Cost Sharing**

### **3.1 Alternative Care Program Cost-Sharing**

A fee is required for most Alternative Care program eligible clients to help pay for the cost of services provided under the program. Individuals in the Alternative Care program pay cost-sharing fees up to 30 percent of the average monthly cost of the individual's Alternative Care services.

### **3.2 Determining Fees**

Client fees are assessed based on adjusted income and gross assets and the average monthly amount of services authorized for the beneficiary. Adjusted income for a married applicant who has a community spouse is calculated by subtracting the following amounts from gross income:

- the monthly spousal income allowance to the community spouse (which is calculated using the spousal impoverishment rules applicable under the Elderly Waiver);
- recurring and predictable medical expenses; and
- the federally indexed clothing and personal needs allowance.

Adjusted income for all other applicants is calculated by subtracting the following amounts from gross income:

- recurring and predictable medical expenses; and
- the federally indexed clothing and personal needs allowance.

<b>Alternative Care Adjusted Income</b>	<b>Gross Assets</b>	<b>Monthly Fee Charge (percentage of average monthly Cost of services)</b>
Less than 100% of the FPL	Less than \$10,000	No monthly fee
At or greater than 100% of the FPL up to 150% of the FPL	Less than \$10,000	5 percent
At or greater than 150% of the FPL up to 200% of the FPL	Less than \$10,000	15 percent
At or greater than 200% of the FPL	At or greater than \$10,000	30 percent

### **3.3 Billing and Non-payment of Fees**

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

## **4. Eligibility**

### **4.1 Alternative Care Eligibility**

Alternative Care is a program that provides limited home and community-based services to people who meet the following eligibility requirements. People enrolled in the Alternative Care program must:

- Be age 65 or older;
- Meet the nursing facility institutional level of care;
- Have income and/or assets exceeding the state plan standards for aged, blind, and disabled categorical eligibility for any groups covered in the state plan;
- Have combined adjusted income, as defined in STC 23, and assets that are not more than projected nursing facility cost for 135 days of NF care, based on the statewide average NF-rate.
- The beneficiary must not be within an uncompensated transfer penalty period, and home equity must be within the Home Equity limit;
- Choose to receive home and community-based services instead of NF services
- Pay the assessed monthly fee; and,
- Either have no other funding source available for the home and community based services (such as long-term care (LTC) insurance or other insurance), or have LTC insurance that pays for only a portion of the beneficiary's assessed needs. Alternative Care is a payor of last resort and other insurance is primary. If other insurance benefits and/or payments are sufficient to meet all the beneficiary's assessed needs, the beneficiary would not be eligible for Alternative Care. If the LTC insurance only paid for a portion of the beneficiary's assessed needs, the Alternative Care program could pay for other assessed unmet needs.

### **4.2 Alternative Care Eligibility Process**

Applicants must submit applications to lead agencies. Lead agencies must annually re-determine both financial and service eligibility. Applicants may be required to provide all information necessary to determine eligibility for Alternative Care and potential eligibility for Medical Assistance, including the client's Social Security number. Applicants for Alternative Care who appear to be categorically eligible for Medical Assistance may receive Alternative Care for up to 60 days while MA eligibility is determined. The state is authorized to maintain a waiting list any time it is not enrolling people into Alternative Care.

### 4.3 Roles

A recipient approved for Alternative Care will receive case management from a public health registered nurse or social worker who implements and monitors the coordinated service and support plan and coordinates reassessment of the individual's level of care and the review of the coordinated service and support plan. The lead agency must ensure that the health and safety needs of the recipients are reasonably met under their coordinated service and support plans.

**Lead Agency.** For the Alternative Care program the lead agency can be a county social service department, local public health agency or a tribal entity. The lead agency provides access to Long-term Care Consultation (LTCC) and case management functions. The lead agency also authorizes service delivery and monitors local access, provider capacity and cost effectiveness.

**Lead Agency Financial Worker.** The financial worker conducts asset assessments as needed for determination of Alternative Care financial eligibility.

**Lead Agency Case Manager/Certified Assessor.** The case manager/certified assessor determines financial eligibility, assesses fees, assists with collection of overdue fees, monitors needs and facilitates transitions between care settings, services and providers.

**Long-term Care Consultation (LTCC) Team.** The LTCC team:

- Certified assessors conduct a LTCC assessment to determine Nursing Facility level of care
- Conducts a community assessment of the person's needs
- Assures informed choice and consent
- Assists with the application process
- Develops a person-centered coordinated service and support plan based on assessed needs
- Develops a coordinated service and support plan that reasonably ensures the person's health and safety
- Makes necessary referrals
- Arranges and coordinates service delivery

## 5. Alternative Care Enrollment

Enrollment procedures for Alternative Care are very similar to Medicaid HCBS waiver enrollment, except that Alternative Care enrollees do not need to select a health plan. Lead agencies administer both Alternative Care and the Elderly Waiver. Lead agencies determine financial and program eligibility. Each individual will receive a comprehensive assessment under the Long-term Care Consultation process/MnChoices. The certified assessor/case manager also evaluates financial eligibility. Applicants who would be eligible for Medical Assistance (MA) under State Plan categorical eligibility standards are referred for MA. The certified assessor/case manager also discusses with applicants the option of qualifying for MA under a medically needy basis.

### **5.1 The Long-term Care Consultation (LTCC)**

The LTCC is designed to help people make decisions about long-term or chronic care needs and choose services and supports that reflect their needs and preferences.

The intention of the LTCC program is the following:

- Ensure persons are made aware of available home and community-based options
- Prevent long-term placement of persons in nursing facilities, hospital swing beds and certified boarding care facilities
- Provide options to persons so they can make informed decisions about where they want to live
- Assist in the development of a person-centered coordinated service and support plan for individuals choosing to live in or return to the community

Upon request, any person with long-term or chronic care needs is entitled to receive LTCC services regardless of their age or eligibility for Minnesota Health Care Programs. The county where the person is located at the time of request or referral for LTCC service is responsible to provide the LTCC services.

Individuals, families, human services and health professionals, hospital and nursing facility staff may make referrals for LTCC services.

LTCC incorporates four main components. The components may be provided in any combination.

- Consumer information and education about local long-term care services options.
- Face-to-face assessment and person-centered support planning to determine program eligibility for people considering home and community-based programs (AC and CAC, CADI, DD, EW, and BI waivers).

- Transition assistance to relocate people currently in nursing facilities to community settings.
- Initial and annual LTCC assessments to determine and re-determine program eligibility are always the responsibility of the certified assessor/LTCC staff in the lead agencies. As these are administrative functions, lead agencies cannot delegate them to contracted case managers.

County or tribal entities may serve as lead agencies. If the lead agency is a county, the county boards of commissioners establish LTCC teams. Two or more counties may collaborate to establish a joint local consultation team or teams. Each team member is responsible for providing consultation with other team members upon request. The team is responsible for providing long term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs. The team of certified assessors must include as a minimum: (1) a social worker and (2) a public health nurse or registered nurse. The commissioner shall allow arrangements and make recommendations that encourage counties and tribes to collaborate to establish joint local long term care consultation teams to ensure that long term care consultations are done within the timelines and parameters of the service. Certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or a closely related field with at least one year of home and community based experience, or a registered nurse with at least 2 years of home and community based experience who has received training and certification specific to assessment and consultation for long term care services in the state.

### **5.11 Access**

To initiate LTCC services, a person or their representative may contact the certified assessor/LTCC team in the county which they are located at the time of their request.

### **5.12 Assessment**

The assessment process identifies:

- Level of care
- Need for supports and services
- Natural and informal caregiver supports
- Person's preferences and goals
- Strengths and functional skills
- Service options and alternatives in support of informed choice
- Financial resources including all third party payers

LTCC assessment includes the following activities:

- Inform and educate the general public regarding availability of LTCC services for individuals.
- Conduct the intake process.
- Schedule the assessment.
- Travel to and from assessment.
- Assess individual health, psychosocial, functional needs, strengths and preferences.
- Assess level of care.
- Assess for vulnerability issues and services that address them.
- Assess environmental needs for safety and access.
- Determine the natural supports and informal providers who are able to meet the assessed needs of a person.
- Identify services to maintain the person in the most integrated living environment.
- Provide options and resources in support of informed choice including financial resources.
- Provide information regarding Minnesota Health Care Programs (MHCP).
- Review the requirements for MHCP eligibility
- Make a referral for final determination of MHCP eligibility.
- Provide written recommendations regarding available cost-effective community services.
- Develop a person-centered coordinated service and support plan.
- Prepare and approve the Long-Term Care Screening Document.
- Record LTCC screenings into MMIS.

### **5.13 LTC Assessments**

LTCC assessments are conducted in the same way that assessments are conducted for people with Medical Assistance. The assessment is conducted using the LTCC Assessment [DHS-3428-ENG](#) or MnCHOICES during a face-to-face visit with the individual being assessed, the individual's legal representative as required by legally executed documents, and other individuals as requested by the person.

People requested to be present at the visit may provide information on the needs, strengths and preferences of the person necessary to develop a support plan that ensures health and safety. However, they cannot be a provider of service nor have any financial interest in the provision of service.

### **5.14 Citizenship and Immigration Status**

AC program applicants must attest to their citizenship or immigration status at application and have an additional 90 days to provide acceptable supporting documentation. Most enrollees are confirmed to be citizens or qualified noncitizens in the course of determination of eligibility for Medicare and other programs they are currently receiving

The following process will be used to verify citizenship or immigration status.

First, the LTCC team will attempt to verify citizenship or immigration status based on whether the AC applicant is currently enrolled in or receiving benefits from a program that would have already verified their citizenship or immigration status. Eligibility for the following programs requires verification of citizenship or immigration status so the agency would not need to request verification:

- Medicare
- Medicare Savings Programs (including Qualified Medicare Beneficiary (QMB), Service Limited Medicare Beneficiary (SLMB), Qualified Individuals (QI))
- Supplemental Nutrition Assistance Program (SNAP)
- Nutrition Assistance Program for Seniors (NAPS)
- Supplemental Security Income (SSI) benefits
- Social Security Retirement, Survivors, and Disability Insurance (RSDI)

AC applicants with current or past enrollment in one or more of the programs listed above have already verified their citizenship or immigration status in order to receive benefits. As a result, they are not required to verify their citizenship or immigration status again. Enrollment in the above programs will be verified by checking the MAXIS system and when possible, through an interface with the Social Security Administration. If a recipient has SSI or RSDI, and documentation of benefits cannot be obtained electronically, documentation of current program enrollment will be requested in lieu of requesting paper verification of citizenship or immigration status.

If an AC applicant who indicates he or she is a U.S. Citizen, U.S. National or lawfully present noncitizen and is not enrolled in one of the programs listed above or is unable to provide verification of receipt of Medicare, SSI or RSDI benefits, paper documentation of U.S. citizenship or immigration status will be requested. Verification of U.S. citizenship or immigration status must be submitted within 90 days of the approval notice for the AC program:

### **Stand-Alone Documentation of Citizenship**

The following documents are acceptable documentation of citizenship without any other supporting documentation. Original documents are not required; copies are acceptable:

- U.S. passport, including a U.S. passport card issued by the Department of State, without regard to any expiration date as long as such passport or card was issued without limitation.
- Certificate of Naturalization.
- Certificate of U.S. Citizenship.
- Valid State-issued driver's license if the State issuing the license requires proof of U.S. citizenship, or obtains and verifies a social security number from the applicant who is a citizen before issuing the license. (Note: Minnesota does not require verification of U.S. citizenship, only requires verification of immigration status).
- Documentary evidence issued by a Federally recognized Indian Tribe which includes the:
  - Name of the Federally recognized Indian Tribe that issued the document
  - Individual by name; and
  - Confirms the individual's membership, enrollment, or affiliation with the Tribe.

Documents that meet these requirements include, but are not limited to:

- A Tribal enrollment card;
- A Certificate of Degree of Indian Blood;
- A Tribal census document;
- Documents on Tribal letterhead, issued under the signature of the appropriate Tribal official, that meet the requirements above.

### **Documentation of Citizenship that Requires Identity Documentation**

Individuals who are unable to provide one of the stand-alone documents listed above may submit one of the following documents accompanied by an identity document:

- U.S. birth certificate showing birth in one of the 50 states, the District of Columbia, Guam, American Samoa, Swain's Island, Puerto Rico (if born on or after Jan. 13, 1941), the Virgin Islands of the United States or the CNMI (if born after Nov. 4, 1986). If the document shows the individual was born in Puerto Rico or the Northern Mariana Islands before the date referenced in this paragraph, the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:
  - *Puerto Rico*: Evidence of birth in Puerto Rico and the applicant's statement that he or she was residing in the United States, a U.S. possession or Puerto Rico on Jan. 13, 1941.
  - *Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI))*:
    - Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986,

(NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time);

- Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975, and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time);
  - Evidence of continuous domicile in the NMI since before Jan. 1, 1974, and the applicant's statement that he or she did not owe allegiance to a foreign State on Nov. 4, 1986 (NMI local time). Note: If a person entered the NMI as a nonimmigrant and lived in the NMI since Jan. 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.
- Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.
  - Report of Birth Abroad of a U.S. Citizen.
  - Certification of birth of a U.S. citizen.
  - U.S. citizen ID card.
  - Northern Marianas ID card, issued by the U.S. Department of Homeland Security.
  - Final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a Statement from a State-approved adoption agency that shows the child's name and U.S. place of birth.
  - Evidence of U.S. Civil Service employment before June 1, 1976.
  - U.S. Military Record showing a U.S. place of birth.
  - Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000 (8 U.S.C. 1431).
  - Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth. Life, health, or other insurance record that indicates a U.S. place of birth.
  - Life, health or other insurance record that indicates a U.S. place of birth
  - Official religious record recorded in the U.S. showing that the birth occurred in the U.S.
  - School records, including preschool, Head Start and daycare, showing the child's name and U.S. place of birth.
  - Federal or State census record showing U.S. citizenship or a U.S. place of birth.
  - Affidavit. If the applicant does not have one of the documents listed above he or she may submit an affidavit signed by another individual under penalty of perjury who can

reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

## **Identity Documentation**

The following documents may be used to document identity, provided that such document has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

- Driver's license or ID card issued by a state or territory of the U.S.;
- School ID card;
- Voter's registration card;
- U.S. military card or draft record;
- U.S. military dependent's ID card;
- ID card issued by federal, state, or local government;
- Native American tribal documents;
- U.S. Coast Guard Merchant Mariner Card;

Two documents containing consistent information that supports an applicant's identity. Such documents include, but are not limited to:

- Employer ID card;
- High school and college diploma (including high school equivalency diplomas);
- Marriage certificate;
- Divorce decree;
- Property deed or title.

Affidavit. If the applicant is not able to verify identity using any of the above methods, the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity (age, sex, race, height, weight, eye color, or address). The affidavit does not have to be notarized.

## **Immigration Status**

Because all AC enrollees are 65 and older, AC follows the immigration requirements for Medical Assistance for noncitizens age 21 or older and who are not pregnant. To be eligible for AC, lawfully present noncitizens who are 21 or older (and not pregnant) must have a qualified immigration status. People with certain immigration statuses must wait five years after receiving the qualified immigration status before they are eligible for AC. Verification of

immigration status must be submitted within 90 days of the approval notice for AC. Qualified noncitizens include the following immigration statuses:

### **Qualified Noncitizen Statuses Without a Five-Year Waiting Period**

Lawfully present noncitizens with the following immigration statuses are eligible for AC **without** a five-year waiting period:

- Afghan or Iraqi Special Immigrants
- Amerasians
- American Indian noncitizens
- Asylees, including asylees who later adjust to lawful permanent resident status
- Conditional Entrants
- Cuban/Haitian Entrants
- Qualified noncitizens who are U.S. veterans or on active military duty and their spouses and children
- Refugees, including refugees who later adjust to lawful permanent resident status
- T-Visa
- Trafficking victims
- Withholding of Removal

### **Qualified Immigration Statuses With a Five-year Waiting Period**

Lawfully present noncitizens with the following qualified immigration statuses who entered the United States after Aug. 22, 1996, are eligible for AC **after** a five-year waiting period:

- Battered noncitizens
- Immigrants paroled for one year or more
- Lawful permanent residents (LPRs), except LPRs who adjusted from asylee or refugee status. LPRs who were formally asylees or refugees are eligible for AC without a five-year wait.

### **Exemption from the Five-Year Waiting Period for Military Service**

Noncitizens with an immigration status of battered noncitizen, immigrant granted parole for one year or more, or LPR may be eligible for AC regardless of their date of entry or length of time in the United States if they meet an exemption from the five-year waiting period due to military service.

The military service exemption is met if the person was an honorably discharged veteran or is on active duty in the U.S. armed forces. This exemption also applies to spouses and

unmarried dependent children of honorably discharged veterans or active duty personnel. It does not include National Guard service.

- **Verification of Immigration Status**

See immigration documentation types at <https://www.healthcare.gov/immigrants/documentation/> for information about immigration documentation. **5.15 Consumer Information**

Certified Assessor/LTCC staff must give the person receiving an assessment or LTCC Coordinated Service and support plan and/or their legal representative, the following materials and information:

- Written recommendations for community based services and consumer directed options
- Documentation that the most cost effective alternatives available were offered to the individual
- The need for and purpose of preadmission screening conducted by long term care options counselors if the person selects nursing facility placement
- Community assistance available, such as caregiver support services
- Freedom to accept or reject the recommendations of the team
- [Minnesota Health Care Programs DHS-3182 \(PDF\)](#)
- Notice of the right to appeal the determination of level of care including a statement to the effect that the decision affects payment for nursing facility services under Medical Assistance, and eligibility for the level of care waiver programs and the Alternative Care program <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-1941-ENG>
- Purpose of preadmission screening and community assessment ([Promoting and Supporting Independent Community Living DHS-2497 \(PDF\)](#))
- Right to appeal the lead agency's final decisions regarding public programs eligibility according to Minn. Stat. §256.045 (Long Term Services and Supports Notice of Action [DHS-2828 \(PDF\)](#))
- Right to confidentiality under the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13 ([Information access and privacy DHS-2667 \(PDF\)](#))
- [DHS-2727 Long Term Services and Supports Assessment Program Information and Signature Sheet](#)

### **5.16 LTCC Support Plan**

The county where the person is located at the time of assessment is responsible to develop the LTCC community support plan. The LTCC Team may use the [LTCC Community Support Plan DHS-](#)

[2925 \(PDF\)](#), [Community Support Plan DHS-4166 \(PDF\)](#) or the [MnChoices Community Support Plan with Coordinated Services and Supports DHS-6791B \(PDF\)](#). The LTCC community support plan is a written summary of the LTCC assessment and details a person's strengths, needs, preferences and community support options as assessed. If Alternative Care is selected, the assessor/case manager develops a person-centered service plan that identifies the amount, frequency and duration of services needed by the beneficiary and, where appropriate, caregiver supports. The plan includes a description of the safeguards in place to ensure health and safety, budget and cost information, and emergency backup plans and monitoring requirements. Approved services are prior authorized in the MMIS system. Reassessments are done at least annually or sooner if individual needs change.

## **5.2 Financial Eligibility**

The Alternative Care Program Eligibility Worksheets [DHS-2630-ENG](#) and [DHS-2630A-ENG](#) are used by LTCC certified assessors and/or case managers to determine financial eligibility for the Alternative Care program. Staff uses these worksheets to determine financial eligibility for the program based on asset assessment information communicated by a financial worker, and including asset transfer activity and the applicant's income and assets based on information from the client. Client fees are then assessed based on the calculation of Alternative Care adjusted gross income and assets and the monthly average cost of the approved Alternative Care service plan.

### **5.2.1 Determination of Financial Eligibility**

In determining Alternative Care financial eligibility the LTCC assessor/case manager adds the individual's income available to pay for 135 days of nursing facility care to the amount of assets available to fund nursing facility care. This total is compared to the projected nursing facility care cost for 135 days (+ MA Asset Limit) of \$33,546 (February 2017). If the applicant's income and assets available for nursing facility care are less than the projected nursing facility care cost for 135 days and the applicant's gross monthly income is greater than 120 percent FPG or gross assets are greater than \$3,000 the applicant is eligible for Alternative Care. If the applicant's income and assets available for nursing facility care are less than the projected nursing facility care cost for 135 days and the gross income is less than or equal to 120 percent FPG and assets are less than or equal to \$3,000 the applicant is ineligible for Alternative Care and should be referred to Medical Assistance. These ineligible applicants can be temporarily served under Alternative Care for up to 60 days during their first application to MA/EW if a completed signed MA/EW application has been received by the county for processing. If the applicant's available income and assets are greater than the projected nursing facility care cost for 135 days, the applicant is ineligible for Alternative Care and cannot be temporarily served.

## 5.22 Fee Schedule

Monthly fees are determined using adjusted income and gross assets and applying the percentage to the average monthly cost of Alternative Care services authorized for the beneficiary. Case managers can change fees on the service agreement for the following month if:

- There is a change in condition which results in a change in the cost of services;
- There is a change in the adjusted income or assets;
- A client enters a nursing facility with an admission of more than 30 days.
- A person has chosen to participate in CDCS – Consumer Directed Community Supports

## 5.23 Income and Assets

The treatment of income and assets will differ depending on the Alternative Care program applicant's marital status and the program status of the spouse.

### 5.231 Income and Asset calculation for married applicants with a community spouse

Form DHS-2630A is completed for applicants who are married with a community spouse.

**Income** The minimum spousal monthly income allocation is \$2,005 (July 1, 2016) and \$2,031 as of July 1, 2017. The allocation to the community spouse is the community spouse's monthly income subtracted from the minimum spousal monthly income allocation. The result is subtracted from the applicant's gross monthly income to establish an income subtotal. Recurring and predictable monthly expenses including health insurance premiums, drug costs and acute care costs that the applicant pays on a monthly basis are subtracted from the applicant's monthly income. A clothing and personal needs allowance is subtracted from the applicant's income. As of Jan. 1, 2017, this amount was \$97, the same amount that MA allows for a person residing in a nursing home. The result is the amount of income available to pay nursing home costs each month. This amount is multiplied by 4.5. The result is the amount of the individual's income that is available to pay nursing home costs for 135 days.

**Assets** Spousal impoverishment rules apply under the Alternative Care C program as they do for MA long-term care eligibility determinations. Alternative Care applicants who are married to a community spouse are referred for an MA Asset Assessment [DHS-3340B ENG](#) completed by the financial assistance division of the lead agency. The asset assessment determines the total marital assets and the amount of assets to be allocated to the community spouse to prevent spousal impoverishment. [As of June 1, 2016, the amount of a couple's assets that are protected for the community spouse, called the community spouse asset allowance \(CSAA\) is now the](#)

maximum amount under federal law for all community spouses, which is currently \$120,900-as of January 2016-7. The amount is adjusted on Jan. 1 of each year by the percentage increase in the consumer price index for all urban consumers(all items; United States city average) The community spouse's asset allowance is subtracted from the couple's total marital assets to determine the amount of gross assets available to the Alternative Care applicant as personal financial resources. The total assets owned by a couple from which the community spouse's asset allowance will be determined and are reviewed at the time a person requests long term care services on or after June 1, 2016 and anticipates receiving long term care services for 30 continuous days or more. At the time of request for AC services, the AC spouse and the community spouse must report their assets. The community spouse may keep up to the maximum asset allowance in effect on the date of the request.

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Incurred unpaid past medical bills owed by the individual that are payable which will not be payable by Medicare or medical insurance are subtracted from the total assets. The amount of \$3,000 is also subtracted if there are no burial accounts with a licensed mortuary for either spouse or \$1,500 for the applicant if the spouse has a burial account. The result is the amount of assets that are available to fund nursing home care.

### **5.232 Income and Asset calculation for all other applicants**

Form DHS-2630 is completed for applicants who are unmarried, or for married couples when both may choose Alternative Care or for a married person whose spouse is an Elderly Waiver recipient or is living in a nursing facility.

**Income** The applicant's monthly income is a gross income calculation of earned and unearned income received by the applicant including Social Security benefits, interest payments, pensions/retirement, annuity income, payment from rental, property and earnings, VA income, trust income and contract for deed payments. Recurring and predictable monthly expenses including health insurance premiums, drug costs and acute care costs that the applicant pays on a monthly basis are subtracted from the applicant's monthly income. A clothing and personal needs allowance is subtracted from the applicant's income. As of Jan. 1, 2017, this amount was \$97, the same amount that MA allows for a person residing in a nursing home. The result is the amount of income available to pay nursing home costs each month. This amount is multiplied by 4.5. The result is the amount of the individual's' income that is available to pay nursing home costs for 135 days.

**Assets** An applicant's total non-excluded assets include the value of all assets owned by the applicant including:

- Cash
- Checking accounts
- Savings Accounts
- CD's
- Annuities
- IRA/KEOGH and any other pensions
- Stocks and bonds
- Trust funds that are available
- Contract for deed
- Cash surrender value of Life Insurance
- Real property not used as applicant's primary residence
- Boats, campers and motorcycles

Individual assets that are not included in the total include:

- Homestead property including contiguous land
- Personal effects
- Household goods and furnishings
- The value of one vehicle

Incurred unpaid past medical bills owed by the individual that are payable and which will not be payable by Medicare or medical insurance are subtracted from the total assets. The amount of \$1,500 is also subtracted if there are no burial accounts with a licensed mortuary. The result is the amount of assets that are available to fund nursing home care.

## **5.24 Transfer of Assets**

The Alternative Care Program Eligibility Worksheet instructs the LTCC assessor/case manager on the process for determining the transfer of assets, improper or uncompensated asset transfers, exempt asset transfers, and the look back and penalty period. The asset transfer penalty is calculated in the same way as under MA with some exceptions. Under the Alternative Care program information provided by the client is not stored in the system nor does it go through the same verification procedures. The Alternative Care Program Eligibility worksheets are stored at the lead agency. The lead agency does not automatically request information on

the look back period or ask for 5 years of bank statements. The lead agency does ask the client if they made transfers and document these on the worksheet. If the client indicates that they have made transfers then the lead agency asks for documentation to determine if the transfer occurred in the look back period. The transfer penalty period is provided on the worksheet and notice of action provided to client.

## **5.25 Trusts**

Under the Alternative Care program the criteria used to evaluate whether assets held in a trust are counted or excluded and whether the trust is a current or potential source of income is the same as the criteria used to evaluate trusts for the purpose of determining MA eligibility.

## **5.26 Home Equity Limit**

The home equity limit analysis and the limits applied under the Alternative Care program are the same as the home equity analysis and long-term care home equity limits for clients requesting or receiving MA payment of long-term care services.

## **5.27 Liens and Estate Recovery**

The estate recovery process under the Alternative Care program is the same as the estate recovery process for MA, except that liens are not utilized under the Alternative Care program and the percentage retained by the county recovery unit is currently lower than amounts retained by the county recovery unit for MA. Claims against the estates of Alternative Care clients for services provided minus fees paid will be pursued by the county recovery unit and DHS. The county agency will file its claim after the death of a person who received Alternative Care services or upon the death of the survivor of the married couple, either or both of whom received assistance. The Alternative Care Program Eligibility worksheets include an overview of the estate recovery process and enrollees receive an informational worksheet [DHS-5186-ENG](https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-5186-ENG) - <https://edocs.dhs.state.mn.us/lfservlet/Public/DHS-5186-ENG> "Alternative Care Program Estate Recovery Information" at the time of application. Policy for recovery of Alternative Care overpayments is under development.

# **6. Alternative Care Program Participant Rights**

## **6.1 Notice to Beneficiary**

The lead agency is required to provide notification to the Alternative Care recipient anytime services are denied, terminated, reduced or suspended. Notification must be in writing and sent at least 10 days prior to the action being taken. Lead agencies must use the Long term Services and Supports [Notice of Action, DHS Form 2828 \(PDF\)](#) form to notify recipients of impending service changes.

The state must provide notice of Alternative Care program enrollment to the beneficiary. All Alternative Care applicants receive Notice of Privacy Practices [DHS-3979-ENG](#) advising clients of how their private information may be used or disclosed and how they can get this information.

## **6.2 Appeals**

The grievance and complaint system available to all home and community-based waiver program and Alternative Care program applicants and enrollees is described in the federally approved Elderly Waiver.

If an individual is dissatisfied with the lead agency's action or feels the agency has failed to act on their request for Alternative Care services they have the right to appeal by contacting their county human service agency or writing to DHS. Requests for appeals must be submitted within 30 days of receiving a notice of action or within 90 days if the person shows a good reason for delay beyond 30 days. An appeal must be filed within 10 days of receipt of the notice if an individual request continuation of services pending the outcome of an appeal.

A fair hearing can be requested if:

- A service is denied, terminated, reduced or suspended
- An agency claims that earlier benefits, payments or services were incorrectly provided
- The county/state agency fails to act with reasonable promptness

The person receiving services or their legal representative must complete a written request for hearing and send to the lead agency or directly to the DHS Appeals and Regulations Division. If a person has sent their written request to the lead agency, the lead agency must forward the request to the Appeals and Regulations Division.

If the person notifies the Appeals and Regulations Division directly, the appeals division will ask the lead agency whose action is being appealed to complete and submit an Appeal Summary for Long-Term Services and Supports [DHS-6807-ENG](#). This form may be filled out on the computer. This summary describes the action or decision being appealed in more detail. The state/lead agency uses this form to summarize facts for the decision being appealed and must

send a copy to all parties, including, for Alternative Care and Elderly Waiver, the Aging and Adult Services division, no later three days before the hearing.

The appeals division assigns the hearing to an appeals judge. An expedited fair hearing appeal may be requested due to an urgent matter or emergency when the issue requires an immediate resolution. The appeals referee shall schedule the fair hearing on the earliest available date. The Appeals and Regulation Division conducts a hearing in each case. There is no screening to determine if a hearing is necessary.

### **Notice of hearing**

The notice of hearing includes information regarding the fair hearing process to the person receiving services and/or their legal representative and all participating parties in the dispute. DHS sends notice of the hearing within 30 days of the receipt of the request for hearing. The notice of hearing includes the date, time and location of the hearing. Hearing dates are subject to change to permit flexibility.

A notice of hearing envisions the participation of parties - either in person or through written statements. The appeals judge must be notified if the party is not participating.

The Appeals and Regulations Division will notify program areas of the pending hearing, if requested to do so and the program area has clearly defined the parameters for notification.

### **Hearings**

A hearing is a semi-formal proceeding where rules of testimony and evidence are in place. Hearings are:

- Conducted at a location that permits ease of access
- Conducted by telephone or by videoconference at the discretion of the appeals referee
- Tape recorded - a transcript is only prepared if a person appeals to the district court

Hearing records may be kept open as long as necessary to allow the parties to submit relevant evidence.

### **Hearing order/decision (Post Hearing)**

Following the hearing, the appeals judge issues a recommended decision to the designee of the Commissioner, the chief appeals judge. The chief appeals judge can:

- Accept the recommended decision

- Revise the decision
- Reject the recommendation and issue his/her own decision

Federal law requires that decisions involving Medical Assistance benefit programs be issued within 90 days of the date the hearing is requested. Hearing decisions can be:

- Affirmed – lead agency/state action upheld
- Reversed – lead agency/state action not upheld
- Dismissed - determined at the hearing that the matter being appealed is not with the jurisdiction of the Appeals and Regulations Division

**Attachment B**  
**Proposed Evaluation for Reform 2020**  
**Section 1115 Demonstration Waiver**

This is a proposed evaluation plan for the Minnesota's demonstration waiver entitled Reform 2020: Pathways to Independence. It was approved in October 2013.

Minnesota's Medicaid program, known as Medical Assistance (MA), offers an array of home and community-based waiver services for low-income seniors and people with disabilities.

Minnesota has been reducing use of institutions through development of home and community-based long-term supports and services for over thirty years. Minnesota has rebalanced its system so that a large majority of the seniors (61% in 2010) and people with disabilities (94% in 2010) who are enrolled in MA and need long term care services are living in the community rather than in institutional settings.

Minnesota provides the following long-term services and supports through the state plan: home health agency services, private duty nursing services, rehabilitative services (several individualized community mental health services that support recovery) and personal care assistant (PCA) services.

The PCA program has played a critical role in supporting people in their homes and avoiding institutional care, and has been important in rebalancing the system. The service was designed in the late 1970's to support adults with physical disabilities to live independently in the community. Over time, the Legislature expanded PCA as a cost-effective option to support people of all ages with physical, cognitive and behavioral needs. PCA services are available to people based on functional need, without enrollment limits or waiting lists. PCA services help people who need assistance with activities of daily living (i.e., bathing, dressing, eating, transferring, toileting, mobility, grooming, positioning) or instrumental activities of daily living (e.g. cooking, cleaning, laundry, shopping). The PCA program has grown from 200 participants in 1986 to over 30,000 today. In 2009, the Legislature authorized changes to the PCA program to manage costs, which resulted in changes in authorized levels of services for many people, both increases and reductions, and loss of access to 170 people. At times, in an effort to get a specific service (such as special equipment or modifications to a person's home) or additional supports beyond traditional PCA services, persons using PCA services have accessed one of the HCBS waivers (e.g. Developmental Disabilities or Elderly Waiver).

Minnesota has five home and community-based services waivers: Developmental Disability (DD)<sup>1</sup>, Community Alternatives for Disabled Individuals (CADI)<sup>2</sup>, Community Alternative Care (CAC)<sup>3</sup>, Brain Injury (BI)<sup>4</sup> and Elderly Waiver (EW)<sup>5</sup>. Similar services to support individuals living in the community are offered under each waiver, but since each was developed over time

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<sup>1</sup> DD: 2011 unduplicated enrollment was 15,761.

<sup>2</sup> CADI: 2011 unduplicated enrollment was 18,927 (reflects high turnover rate)

<sup>3</sup> CAC: 2011 unduplicated enrollment was 390

<sup>4</sup> BI: 2011 unduplicated enrollment was 1,513

<sup>5</sup> EW: 2011 unduplicated enrollment was 29,291 (managed care and fee-for-service)

and under different constraints, opportunities, and different populations, HCBS waivers differ from one another in areas such as eligibility criteria and annual spending.

There are other Medicaid and state programs that support community living such as day treatment and habilitation, semi-independent living services, the Family Support Grant Program, mental health services, AIDS assistance programs, group residential housing, independent living services, vocational rehabilitation services, extended employment, special education and early intervention.

Minnesota's Reform 2020 demonstration enables the state to continue its history of on-going improvement to enhance its home and community-based service system in two ways.

- First, the demonstration allows the state to provide preventive services to seniors who are likely to become eligible for Medicaid and who need an institutional level of care.
- Second, the demonstration supports the state's efforts to reform the personal care benefit.

## 1. Background on the Reform 2020 Section 1115 Waiver

The Reform 2020 demonstration waiver is approved for the period October 18, 2013 through June 30, 2018. The demonstration is made up of two programs known as Alternative Care and Community First Services and Supports.

The Alternative Care or AC program was implemented under Reform 2020 beginning November 1, 2013. Formerly a state-funded program, Alternative Care provides home and community-based services to people ages 65 and older who need a nursing facility level of care, who have combined adjusted income and assets exceeding Medical Assistance (MA) standards for aged, blind and disabled categorical eligibility, but whose income and assets would be insufficient to pay for 135 days of nursing facility care. Acute care benefits are not covered under the program. Connecting seniors with community services earlier may divert them from nursing facilities and encourage more efficient use of services when full Medicaid eligibility is established. Minnesota has a home and community-based waiver for people over age 65 that need nursing facility care called the Elderly Waiver. Although Alternative Care covers fewer benefits, service definitions and provider standards for the Alternative Care program are the same as the service definitions and provider standards specified in Minnesota's federally approved Elderly Waiver. Services are provided by qualified enrolled Medicaid providers.

The Reform 2020 demonstration also supports Minnesota's efforts to redesign the state plan PCA benefit and expand self-directed options under a new service called Community First Services and Supports (CFSS). This service, designed to maintain and increase independence, will be modeled after Community First Choice. It will reduce pressure on the system as people use the flexibility within CFSS instead of accessing the more expanded service menu of one of the state's five home and community-based waivers to meet their needs. The new CFSS benefit will replace the existing PCA benefit. To ensure continuity of care and safety of enrollees, Minnesota must ensure that implementation of the consumer-directed option does not restrict eligibility for these services. Minnesota is currently negotiating with CMS to obtain authority for the CFSS benefit under state plan amendments utilizing sections 1915(i) and 1915(k) of the

Social Security Act. Once these state plan amendments are approved, Reform 2020 will provide authority to provide CFSS to two groups of people who would otherwise be ineligible to receive CFSS.

Minnesota is committed to implementing CFSS because all services should be designed in a way that is person-centered, and involves the person throughout planning and service delivery. The term self-direction in this context refers to a service model with increased flexibility and responsibility for directing and managing services and supports, including hiring and managing direct care staff to meet needs and achieve outcomes. Currently each of Minnesota's home and community-based waivers offers Consumer Directed Community Services and Supports (CDCS)<sup>6</sup>. This service option gives individuals receiving waiver services an option to develop a plan for the delivery of their waiver services within an individual budget, and purchase them through a fiscal support entity that manages payroll, taxes, insurance, and other employer-related tasks as assigned by the individual. CDCS allows individuals to substitute individualized services for what is otherwise available in the traditional menu of services in the waiver programs. Purchases fall into three categories: personal assistance, environmental modifications, and treatment and training.

In addition to CDCS, other existing self-directed options include PCA Choice option within the state plan PCA program, the Consumer Support Grant and the Family Support Grant. In PCA Choice the participant works with an agency, but can select, train and terminate the person delivering the service. Direct staff wages are typically higher under PCA Choice. The Consumer Support Grant is a state-funded program that provides individuals otherwise eligible for home care services to receive and control a budget for buying the supports they need to remain in the community. The family Support Grant program provides state-funded grants to families caring for a child with a disability.

## 2. Alternative Care

The Reform 2020 waiver allows Minnesota to receive federal financial participation to provide Alternative Care services to people over age 65 whose functional needs indicate eligibility for nursing facility care but have combined adjusted income and assets exceeding state plan Medicaid standards for aged, blind and disabled categorical eligibility.

Alternative Care is available to eligible individuals who meet all of the following *financial requirements*:

- Those with combined income and assets insufficient to pay for 135 days of nursing facility care, based on the statewide average nursing facility rate
- Those not within an uncompensated transfer penalty period
- Those with home equity within the home equity limit applicable under the state plan

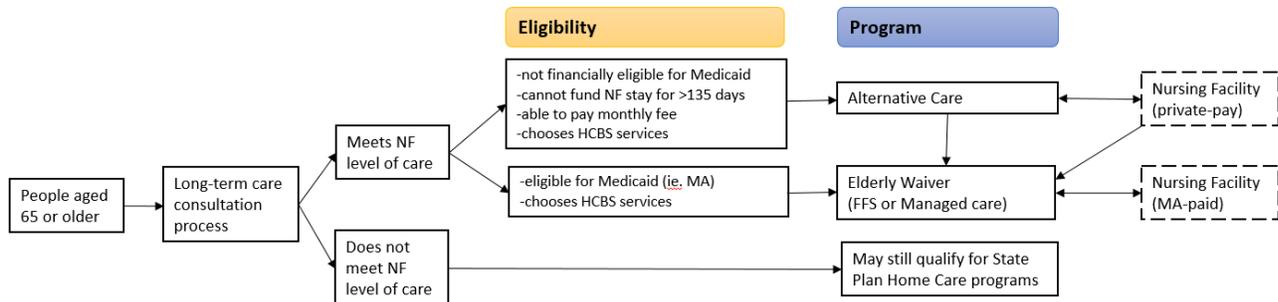
*Functional eligibility* for nursing home care and identification of needed services for Alternative Care is performed using the Long-term Care Consultation process, which is the same assessment

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<sup>6</sup> As of March 31, 2011 recipients using CDCS by waiver: BI – 53; CAC – 139; CADI – 1167; DD – 1689

tool and process that is used for the Elderly Waiver. Applicants for Alternative Care also discuss the option of qualifying for Medical Assistance under a medically needy basis (see Figure 1).

Figure 1. Minnesota Health Care Program Options for the Elderly



If an Alternative Care beneficiary is admitted to a nursing facility, his/her stay is either paid by Medicare (if eligible), other long-term care insurance, or out-of-pocket. If the person spends-down and becomes eligible for Medicaid, he/she can transition to the Elderly Waiver program where nursing facility use is a MA benefit. For details on how a person transitions from Alternative Care to Elderly Waiver program, refer to the “AC Operational Protocol”.

The Alternative Care program provides an array of home and community-based services based on assessed need and as authorized in the community support plan or care plan developed for each beneficiary. The monthly cost of the Alternative Care services must not exceed 75 percent of the monthly budget amount available for an individual with similar assessed needs participating in the Elderly Waiver program.

The benefits available under Alternative Care are the same as the benefits covered under the federally approved Elderly Waiver, *except*:

- Alternative Care **does not cover** transitional support services, assisted living services, adult foster care services, and residential care and benefits that meet primary and acute health care needs
- Alternative Care **additionally covers** nutrition services and discretionary benefits

The comprehensive list of Alternative Care benefits is below.

- Adult day service/adult day service bath;
- Family caregiver training and education and family caregiver coaching and counseling/assessment;
- Case management and conversion case management;
- Chore services;
- Companion services;
- Consumer-directed community supports;
- Home health services;

- Home-delivered meals;
- Homemaker services;
- Environmental accessibility adaptations;
- Nutrition services;
- Personal care;
- Respite care;
- Skilled nursing and private duty nursing;
- Specialized equipment and supplies including Personal Emergency Response System (PERS);
- Non-medical transportation;
- Tele-home care;
- Discretionary services

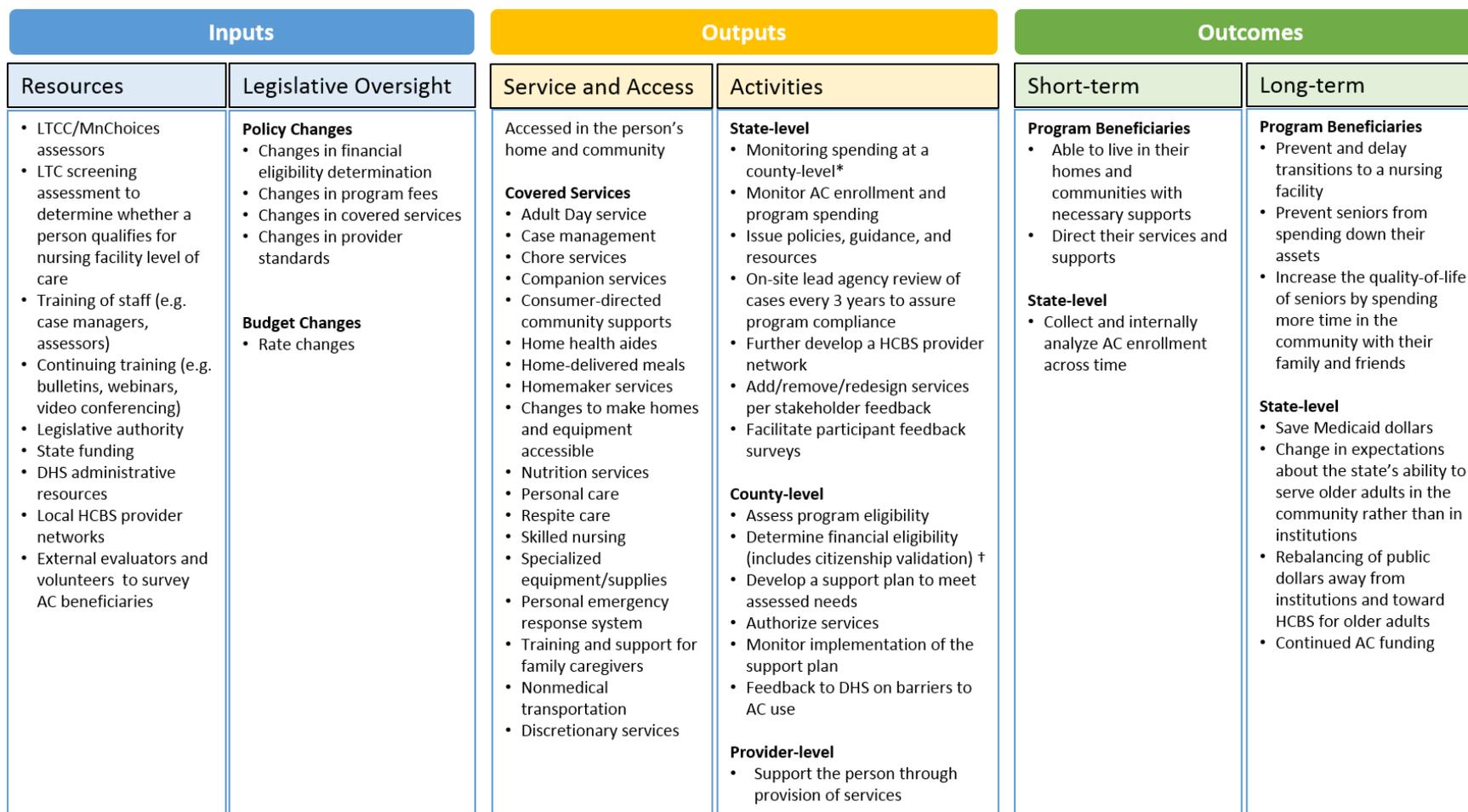
An overview of the Alternative Care program, services, and outcomes are provided in Figure 2.

## 2.1 Program Goals

The goals of the Alternative Care program are to:

- Provide access to coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
- Provide access to consumer-directed coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
- Provide high-quality and cost-effective home and community-based services that result in improved outcomes for participants measured by less nursing home use over time.

Figure 2: Alternative Care Program Logic Model



\*Minnesota DHS stopped monitoring county spending on AC program at the 2015 legislative session.

†After the federal match for AC program, DHS began validating citizenship.



### 3. Evaluation Strategy for Alternative Care

The Reform 2020 demonstration waiver is approved for the period October 18, 2013 through June 30, 2018. Since the federal waiver authorization has not resulted in any changes to the Alternative Care program structure, we propose the following hypotheses:

1. the waiver will not change the fundamentals of the program: size and characteristics of the population with AC;
2. the waiver will not change their conversion to Medicaid, particularly subsequent use of Elderly Waiver services; transition to and from nursing facilities; and health events
3. the waiver will not change outcomes as indicated by use of acute care services.

To test these hypotheses, we will evaluate the AC program over time (i.e., 2010-2018) in order to examine changes if any in program behavior, particularly any unintended negative consequences and the expected benefits to program enrollees (see Figure 2). We will also compare the AC to the Elderly Waiver (EW) population over the same time period (Section 3.1). This comparison allows us to describe the degree of transitions between programs, i.e., AC clients converting to Medicaid and using the EW, and to assess the potential impact of secular trends that may be affecting both programs, such as other policy shifts or changes in the elderly population or their use of services.

The goals and associated metrics identified in section 2.1 will be evaluated by DHS and University of Minnesota using MMIS claims and beneficiary assessment data linked to Medicare data. Although this will be an integrated effort, DHS will lead the descriptive component of the evaluation using readily available data sources, as part of its ongoing quality monitoring and management activities. The University will provide analyses of expanded data elements (including Medicare data) and employ more rigorous analysis methods.

#### 3.1 AC and Comparison Population

The populations included in the evaluation consist of Alternative Care (AC) program enrollees and Elderly Waiver enrollees. Elderly Waiver enrollees are very similar to Alternative Care program enrollees. Both groups: 1) are aged 65 and above, 2) must have an assessed need for an institutional level of care, and 3) are using home and community-based services to meet their needs and remain living in the community instead of in a nursing facility.

Some Elderly Waiver beneficiaries will use residential services (i.e., customized living, adult foster care, and residential care services). We will identify Elderly Waiver beneficiaries in non-residential settings by excluding beneficiaries with any claims for residential services. For this evaluation, we will focus on these comparison populations: 1) Elderly Waiver beneficiaries in total, and 2) Elderly Waiver beneficiaries without residential services use, who are most directly comparable to the AC beneficiaries. As a sub-analysis we will also draw comparisons with Elderly Waiver beneficiaries who have residential use to see how they might differ the primary comparison group.

Internal program monitoring and evaluation show that in the state fiscal year (July 2008-June 2009), there were approximately 4800 unique beneficiaries in the AC program and 25,500 unique beneficiaries in the Elderly Waiver program (of which 75% did not use any residential services). The number of AC enrollees has been declining slightly, while the number of Elderly Waiver enrollees has been increasing.

### 3.2 Goals and Objectives

The objective of the evaluation is to determine if access, quality of care and program sustainability for Alternative Care recipients has changed before and after the introduction of the AC waiver. We also will draw comparisons over time to Elderly Waiver recipients in non-residential settings at each time point and trace program growth over time (Section 3.1). We will evaluate trends in the population served under the AC waiver, by exploring the level of need, ability to access and use consumer-directed services, rates of nursing facility admission and experience of negative health outcomes.

### 3.3 Hypotheses

Research questions of interest include: 1) To what extent did access, quality of care, and program sustainability for Alternative Care recipients change before and after federal match? and 2) How do care and outcomes for Alternative Care beneficiaries compare to Elderly Waiver beneficiaries? We will evaluate changes over time (2010 to 2018) to the AC program in itself and in comparison to the Elderly Waiver program.

**3.31 The level of need, demographic characteristics, and service use patterns for Alternative Care beneficiaries will not change over time, neither alone nor in comparison to Elderly Waiver beneficiaries in non-residential settings.** This will be evaluated using the following measures:

- Casemix status (low-need vs. high-need)<sup>7</sup>
- ADL dependencies and health functions
- Acuity rate differences between AC and Elderly Waiver non-residential beneficiaries
- Use of home and community-based services
- Acute care services where available for AC beneficiaries and when there is comparability between AC and Elderly Waiver beneficiaries

**3.32 Alternative Care beneficiaries will experience equal or better access to consumer-directed service (CDS) options<sup>8</sup> over time, when examined alone and in comparison**

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<sup>7</sup> See section 3.42 for details on case-mix is determined and level of need is defined.

<sup>8</sup> Consumer directed services are available in the AC and Elderly Waiver programs. This measure will exclude discretionary services which are designed by the county (whereas the CDCS is a person's choice). Elderly Waiver beneficiaries in residential settings will not use CDCS.

**to Elderly Waiver beneficiaries in non-residential settings.** This will be evaluated using the following measures:

- Authorized consumer-directed community supports
- Difference in CDS use between AC and Elderly Waiver non-residential beneficiaries

**3.33 Alternative Care beneficiaries will experience equal or less nursing facility use over time, when examined alone and in comparison to Elderly Waiver beneficiaries in non-residential settings.** This will be evaluated using the following measures:

- Proportion of recipient days spent in nursing facilities
- Frequency of nursing facility admission, by length of stay
- Case-mix adjusted nursing facility admission
- Number of nursing facility days
- Return to AC or Elderly Waiver programs from nursing facility

**3.34 Alternative Care beneficiaries will remain in the community for as long or longer over time, when examined alone and in comparison to Elderly Waiver beneficiaries.** This will be evaluated using the following measures

- Remaining enrolled in AC
- Transition from AC to Elderly Waiver
- Transition to Essential Community Supports<sup>9</sup>
- Days alive in the community and not on Medicaid
- Use of Medicare services

## 3.4 Metrics and Data Available

### 3.41 Data Sources

#### MMIS

Medicaid Management Information Systems (MMIS) is the largest health care payment system in Minnesota, and one of the largest payment systems in the nation. Health care providers throughout the county – as well as DHS and county staff – use MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in Minnesota Health Care Programs, which provide health care services to low-income families and children, low-income elderly people and individuals who have physical and/or developmental disabilities, mental

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<sup>9</sup> The Essential Community Supports Program (ECS) program was established by the Minnesota Legislature and became effective January 1, 2015. Initially designed to provide support for individuals who might lose their HCBS program eligibility as a result of changes to the nursing facility level of care criteria that also became effective January 1, 2015, it was also adopted as an ongoing program for individuals aged 65 and older with emerging needs for HCBS but who do not yet meet level of care criteria and who are not MA eligible but meet the AC financial eligibility criteria. This program has a relatively small basket of services and monthly budget.

illness or who are chronically ill. MMIS contain the following variables that will be used for the current evaluation:

- Program begin and end date
- Claims for services (e.g. residential services, CDCS services)
- Death date
- Living arrangement
- In residential or non-residential setting

### **LTC Sreening Document**

This form is used to document pre-admission screening and long-term care consultation (LTC) activities. It is used to record public programs eligibility determination as well as to collect information about people screened, assessed, or receiving services under home and community-based services programs. These assessments contain the following variables that will be used for the current evaluation:

- Program type (i.e., indicates waived program, change to another waived program)
- Entry and exit from waived programs (including death) and exit reasons
- Continued use of waived program at reassessment
- Case-mix
- Health functions (e.g. activities of daily living (ADLs))
- Level of care
- Housing type (e.g. nursing facility, assisted living, foster care)
- Authorization of CDCS services

### **Minimum Data Set (MDS)**

This is a federally mandated assessment. Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). Case-mix related functions are conducted by the MDH on behalf of the Medicaid program under contract to the DHS (the Medicaid Agency). The MDH determines the resident's case mix classification based on the MDS data and also conducts regular audits of the MDS data submitted by NFs to ensure the data is accurate. These assessments contain the following variables that will be used for the current evaluation:

- Admission and discharge date
- Admission source (e.g., acute care or community) and discharge destination (e.g. acute care transfer, community, or mortality)
- Post-acute Medicare stay, either alone or in combination with a subsequent long stay.
- Health and functional status at admission and the latest assessment before discharge back to the community, if applicable.

### **Medicare Claims (fee-for-service)**

Medicare claims will provide utilization for non-Medicaid-covered services (particularly for AC recipients or for periods when a recipient is not covered by Medicaid), but otherwise will largely duplicate what we can learn from MMIS. We can also calculate HCC scores if we want to try to adjust for casemix.

- Dates of acute hospital, emergency department, and home health use

- Utilization outside of periods of Medicaid eligibility or for services not covered by Medicaid
- Associated diagnoses and procedure codes

### 3.42 Metrics

#### 3.421 Case-Mix

Case mix is a classification tool that is used in both AC and EW programs to establish monthly budget limits for HCBS services. A copy of the Case Mix Classification Worksheet describing the factors used to determine a case mix classification for all AC and EW recipients is at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3428B-ENG>. The classification is based on assessed need in:

- Eight activities of daily living (ADLs): bathing, dressing, grooming, walking, toileting, positioning, transferring, and eating
- The need for clinical monitoring in combination with a physician-ordered treatment, and
- The need for staff intervention due to behavioral or cognitive needs.

After assessment, the individual is assigned a case mix classification of A-L based on their combination of ADLs, clinical monitoring and behavioral/cognitive needs.

#### 3.422 Level of Need

For purposes of this evaluation, the case mix classifications have been grouped as follows:

- Low Need (A, L): This group includes individuals with 0-3 ADL dependencies
- Moderate Need (B, D, E): This group includes individuals with 4-6 ADL dependencies and/or behavioral/cognitive needs.
- High Need (G, H, I, J): This group includes individuals with dependencies in 7 or 8 ADLs (G), and those with specific other needs in combination with 7-8 ADL dependencies.
- High Need Clinical (C, F, K, V): This group includes individuals with varying number of dependencies but who have an assessed need for clinical monitoring at least once every 8 hours.
- Other/Missing

## 3.5 Design Approaches

We propose the following methods to address the hypotheses within this evaluation. The sections below provide information about each approach, including the comparison group(s), metrics, and statistical methods. To compare efficiently across years (2010 through 2018), we will also report our measures as rates (e.g. per 1000 beneficiaries).

### 3.51 Cross-Sectional Analysis

To test hypothesis 3.31 and 3.32, we will compare individuals in Alternative Care program to individuals in Elderly Waiver served in non-residential settings. For each fiscal year, we will identify AC and Elderly Waiver beneficiaries using LTC screening assessment data (also available in MMIS). We will further identify Elderly Waiver beneficiaries in non-residential settings by excluding beneficiaries with any claims for procedure codes denoting residential services (i.e., customized living, adult foster care, and residential care services). While living in the community, if an AC beneficiary uses CDCS, this information will be recorded in the MMIS claims data, as well as the total dollars paid for CDCS in a fiscal year. We will categorize acuity into two categories: low-need and high-need and calculate differences in casemix for each year between AC and Elderly Waiver beneficiaries by acuity type.

To test hypotheses 3.33 and 3.34, we will calculate the number of nursing facility admission per person and determine the number of days spent in a nursing facility (i.e., length of stay). The LTC screening document indicates when an AC beneficiary leaves the community to enter a nursing facility, and if and when the person can choose to re-enter a HCBS program. The MDS is an additional source of information on nursing facility use. We will compare nursing facility admission use for AC and Elderly Waiver non-residential beneficiaries.

To test hypothesis 3.34, we will define a cohort of AC users at the start of each fiscal year and follow the cohort until the end of the fiscal year and determine their outcomes. We will calculate the proportion of individuals that remain enrolled in AC, those that switched to Elderly Waiver, and the days alive in the community and not on Medicaid (i.e., not using residential services). We will account for death and loss of AC eligibility.

*Statistical Analysis:* For all measures, we will report the denominator, number and percent of beneficiaries, and utilization rates, as appropriate. We will test the difference in means, using t-tests for each fiscal year and compare the t-statistic across the years (e.g. a line graph). We will also compare the difference in means using ANOVA and post-hoc estimations. Covariates will include, but are not limited to, age, number of admissions to nursing facility in a given year, case-mix. We will stratify AC and EW users in each year according to categories of these covariates, and then draw comparisons and statistical tests within strata.

## 3.6 External Evaluation Strategy

### 3.61 Independent Evaluation

In addition to the designated activities to be conducted by DHS, DHS will contract with Center for Long-Term Care and Aging, University of Minnesota School of Public Health, Division of Health Policy and Management to conduct an evaluation of the impact of the continuation of the Alternative Care program under the waiver on access, quality and cost on the low-income senior population in the state. Greg Arling, PhD, Katherine Birck Professor, School of Nursing, Purdue University, will assist in the analysis.

### 3.62 Evaluation Objective and Comparison Population

This component of the evaluation will examine the same hypotheses as the internal evaluation but at a more granular beneficiary level and by using multivariable modeling and trend analysis (interrupted time series) to assess change over time and factors that may be accountinf for change. It will include analysis of service use and payments during the period before the demonstration and during the demonstration. Analysis will also be conducted on the relationship of Alternative Care to prior nursing facility use, Medicaid conversion and subsequent nursing facility use and Elderly Waiver use. Elderly Waiver and Alternative Care will be compared to determine whether different types of clients are being served and different needs are being met. The evaluation will also compare Alternative Care and Elderly Waiver client characteristics and service use. It will utilize meged data files from Medicaid and Medicare to examine the use of acute care services.

### 3.63 Data Availability

For this evaluation, the following data sources will be utilized: Medicaid Management Information Systems (MMIS), Medicaid files, Minimum Data Set (MDS v3), Medicare claims, Board on Aging Title III service use records, Client surveys, Waiver recipient case studies, Program staff interviews, and long-term care consultation (LTC) assessment data.

### 3.64 Analysis Plan

In addition to the research questions listed in the paragraph above and in section 3.3, descriptive statistics will be used to analyze characteristics of waiver recipients in the pre-waiver period (where data are available) and during the period that waivers are in place. We will also compare waiver recipients with other Medicaid services users (e.g., Elderly Waiver). Changes in service use and costs will be examined with a time series trend analysis, either multilevel models of change or differencing models. We also will use regression models to test whether amount of services at one point in time ( $T_0$ ) predict future outcomes for service use (HCBS, Title III), medical use, nursing home use, and functional status at a subsequent point in time ( $T_1$ ).

The planned analysis strategies will consist of multiple strategies involving descriptive statistics, cross-sectional comparisons at different time points, and longitudinal analysis of beneficiary-level care transitions, program transitions, and health outcomes. Comparisons will be made between AC and Elderly Waiver beneficiaries.

1. **Repeated cross-sectional beneficiary-level analysis.** Descriptive statistics will be prepared on the beneficiary population each year during baseline (2010-2018). Characteristics described will include demographics, health and functional status, transitions between care settings (provate home, residential care setting or nursing home) and programs (AC and Elderly Waiver), service use and Medicaid expenditures, acute care use (Medicare and Medicaid), and other variables. Multivariable logistic regression models will be applied in comparing AC and Elderly Waiver beneficiaries. Other

multivariable models using link functions and distributional assumptions appropriate to the outcome variable, e.g. gamma distribution or negative binomial, will be applied to count and cost data when drawing comparisons between groups.

2. **Interrupted time series analysis.** In order to assess changes in major variables over time in the AC and Elderly Waiver populations, we will conduct an interrupted time series analysis where:

Outcomes: AC and Elderly Waiver service use, Medicaid expenditures; transitions between care settings; movement in, out and between AC and Elderly Waiver programs; and acute care service use.

Time Periods: The time periods for the longitudinal analysis will be months for some outcomes, e.g. transitions between care settings and movement in and out of AC and Elderly Waiver programs, and calendar quarters or years for other outcomes, e.g., Medicaid expenditures

Covariates: demographics, health and functional status, length of time in the AC or Elderly Waiver program, and other variables found to be significant in analysis step 1.

Two approaches will be used for the analysis difference-in-difference equations and mixed-effect growth models. With both approaches the change in the outcomes for beneficiaries will be modeled as a function of time, AC waiver period (before or after), covariates (fixed or time-varying).

**Table 1. Major Variables and Data Sources for External Evaluation of Alternative Care**

Variable	Description	Data Source
AC use	Amount and cost of AC services	MMIS, Medicare claims
Health and functional status	ADLs, cognitive impairment, service need	LTC Assessment, MDS for NH users
<i>Financial characteristics</i>		LTC Assessment
Living arrangement	Home alone, home with family, organized setting	LTC Assessment
Medicaid payments	By type of service	MMIS
Disability level, function	ADLs, IADLs	LTC Assessment
<i>Prior LTC use</i>		MDS and MMIS
NH use	Days, dollars	MDS and MMIS
Title III services	List	Board on Aging
Acute services	Hospital, ER, SNF, DME, outpatient	Managed Care Plans, MMIS, Medicare
Health outcomes	Acute care use, death	Managed Care Plans, MMIS, Medicare

Note: ADLs, activities of daily living; DME, durable medical equipments; ER, emergency room; IADLs, instrumental activities of daily living; NH, nursing home; SNF, skilled nursing facility.

## UNDER DEVELOPMENT

### 4. Community First Services and Supports

Community First Services and Supports or CFSS is designed to replace the existing personal care assistance benefit with a consumer-driven and flexible benefit that will allow consumers to better direct their own care and access services as needed. This service, designed to maintain and increase independence, will be modeled after the Community First Choice option.

#### 4.1 Program Overview

The CFSS is intended to expand consumer choice in the types of services they receive and the way they are provided, while offering clients consultation and financial management support to assist them in service planning and budgeting. All clients will receive:

- Consultation services
- Worker training and development
- Ability to purchase goods and technologies
- Choice of caregivers – including relatives

Clients can choose from two basic models: 1) Agency Model - traditional agency staff and administration, and 2) Budget Model – with an emphasis on self-direction of care. (details in Section 4.42)

The CFSS replaces these current programs:

- *Personal Care Assistance (PCA)* -- Approximately 27,000 current PCA recipients will be transitioned to CFSS. The PCA service recipients will have an expanded choice of services and supports and greater consumer direction.
- *Community Service Grants (CSG)* – These grants will be eliminated and approximately 1,000 current CSG recipients will become eligible for CFSS, presumably choosing the budget model. The CFSS has a larger dollar limit than CSG but less flexibility. Also, spouses and parents of minors can be paid as support workers through CFSS.
- *Consumer Directed Consumer Supports (CDCS) waiver* – It is not clear how clients with this waiver will be affected. They may opt for CFSS; they would have less choice but better benefits.

#### 4.2 Program Rationale

While PCA services work well for many people, they are limited for others by only providing services that are done “for” people in situations when individuals could learn to do more for themselves. In those cases, PCA provides some support but less optimally than possible. Similarly, in situations where technology or a home modification would enable a person to do more for him or herself and possibly substitute for a level of human assistance, people are unable to do so. This is because environmental modification services are only available today through the waivers. Therefore, some people apply for home and community-based waiver services in

order to access technology, modifications or more flexible services, triggering an administrative process to enroll. Consequently, some people who need these services cannot access the waiver when they need it due to: 1) not meeting institutional level of care requirements, or 2) delays in accessing waiver services due to limits set to manage growth.

In some cases, PCA services alone do not adequately address individual needs because the service is not delivered by the provider with the appropriate skills, or the service does not address core needs. For example, while PCA services can provide redirection and assistance when a person has significant behavioral issues (e.g. physical aggression to self or others, destruction of property), the service provider does not deal with the underlying issues nor were they intended to substitute for appropriate services to address the cause of the behavior. To be most effective in these instances, the PCA services need to be provided in coordination with mental and behavioral health, and/or educational plans.

Currently, there is a need to improve service coordination for our program beneficiaries: 1) individuals who are eligible but are not connected with the appropriate service, and 2) people who are accessing many services across multiple systems. Both of these situations can result in poor outcomes such as unstable housing, high medical costs, frequent crises, provider time spent in planning, re-planning and crisis management, and institutionalization. Data analysis shows that approximately 10% of people currently using PCA services utilize a variety of other systems and services that, when not well coordinated, result in fragmented, duplicative and/or inappropriate services, including use of more expensive services (e.g. emergency department visit, hospitalizations) and lead to poorer outcomes. Similarly, people who have high costs for avoidable services are often those who encounter the system at many points or have multiple needs. CFSS would allow people to access more useful services tailored to their needs.

A limitation of the current system is that home and community-based services waivers are organized as alternatives to institutional care and program enrollment requires an assessed need for an institutional level of care. However, services—if provided before a person reaches a certain level of care threshold—could increase the person’s ability to be independent, stay in the community, and avoid or delay reliance on more intensive services.

Implementation of the new CFSS benefit is an important next step in Minnesota’s efforts to enhance Minnesota’s home and community-based service system to support inclusive community living. In order to meet rapidly growing demands, the system must be efficient and effective in supporting people’s independence, recovery and community participation. CFSS is a flexible service designed to meet more needs, more appropriately, for more people. This increased flexibility may reduce pressure on the system as people use CFSS instead of accessing the more expanded service menu of one of the State’s five existing HCBS waivers.

### **4.3 The CFSS Benefit**

Community First Services and Supports provides assistance with maintenance, enhancement or acquisition of skills to complete activities of daily living (ADLs), instrumental activities of daily living (IADLs), health-related tasks and back-up systems to assure continuity of services and

supports. The CFSS benefit is based on assessed functional needs for people who require support to live in the community.

The form that this assistance takes can vary widely and is driven by and tailored to the needs of the individual, based on a person-centered assessment and planning process. The participant receives a budget, based upon the assessed needs, and can use that budget to purchase CFSS.

#### **4.31 How much CFSS a person receives is determined by the person-centered assessment**

The amount of CFSS is determined by the person-centered assessment conducted by a certified assessor. This assessment is very similar to the one currently being utilized for the personal care benefit, except that it allows a higher base level of services for the lowest need individuals. Like now, the amount of CFSS authorized will be based on the participant's home care rating (also determined at the time of assessment).

The home care rating is determined by identifying the total number of ADLs that require hands-on assistance and/or constant supervision and cueing; the presence of complex health-related needs; and the presence of Level I behaviors (i.e., physical aggression towards self or others, destruction of property that requires the immediate response of another person). The number of units available to each person is assigned based on the number and severity of ADLs, complex health-related needs and Level I behaviors identified in the assessment.

#### **4.32 CFSS service delivery models**

Two different self-directed service delivery methods are available to people utilizing CFSS. These delivery methods are known as the *agency-provider model* and the *budget model*.

**Agency-provider model.** This is available to participants who choose to receive their services from support workers who are employed by an agency-provider that is enrolled as a provider with the state. Participants retain the ability to have a significant role in the selection and dismissal of the support workers who deliver the services and supports specified in their person-centered service delivery plan. A participant using goods and supports under the agency-provider model shall use a financial management services contractor for management of spending; recordkeeping; monitoring and billing. The participant will continue to have their support worker services delivered by an agency-provider. The participant and the consultation services provider shall develop a service delivery plan that specifies the services and funds to be authorized to the agency-provider, and the goods, supports and funds to be managed in by the participant with the financial management services contractor.

**Budget model.** Under this model, participants accept more responsibility and control over the services and supports described and budgeted within their person-centered service delivery plan. Participants may use their service budget to directly employ and pay qualified support workers, and obtain other supports and goods as defined in the service package. Participants will use a financial management services contractor for the billing and payment of services; for ensuring

accountability of CFSS funds; for management of spending; and to serve as an agent to maintain compliance with employer-related duties, including federal and state labor and tax regulations. Participants may utilize the consultation service for assistance in developing a person-centered service delivery plan and budget; and for learning how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss support workers.

Worker training and development services include a variety of services that assist participants under either model with developing support worker skills. These services may be provided or arranged by the employer of the support worker and consist of training, education, direct observation, evaluation, or consultation to direct support workers regarding job skills, tasks, and performance as required for the delivery of quality service to the participant.

#### **4.33 Services that may be accessed under the CFSS benefit**

Under the personal care assistance benefit, people receive assistance with ADLs, IADLs, and health-related tasks. CFSS participants have a much wider variety of services to choose from. CFSS participants may utilize any or all of the following services to meet needs and goals identified in the person-centered assessment:

- **Assistance with ADLs, IADLs, and health-related tasks** through hands-on assistance, supervision, and/or cueing.
- **Acquisition, maintenance, or enhancement of skills** necessary for the participant to accomplish ADLs, IADL's, and health-related tasks.
- **Assistance in accomplishing instrumental activities of daily living (IADLs)** related to living independently in the community and an assessed need: meal planning, preparation, and shopping for food; shopping for clothing or other essential items; cooking; laundry; housecleaning; assistance with medications; assistance with managing money; assist with individualized communication needs; arranging supports; assistance with participating in the community; and other appropriate IADL services.
- **Assistance in health-related procedures and tasks** that can be delegated or assigned by licensed health-care professionals under state law.
- **Observation and redirection of Level I behaviors**, defined as physical aggression towards self or others and/or destruction of property that requires the immediate response of another person.
- **Back-up systems** or mechanisms (such as the use of personal response systems or other mobile devices selected by the participant) to ensure continuity of the participant's services and supports. Specific risks and levels of back-up support needed are addressed during the participant's initial and annual person-centered assessments, in the development of the community support plan and the service delivery plan. Each participant will have an individualized back-up plan that identifies service options and support people, both formal and informal, that can be called on when needed.
- **Consultation services** provide assistance to support the participant in making informed choices regarding CFSS services in general and self-directed tasks in particular; eliminate barriers to services and streamlines access; assist the person in developing a quality person centered service delivery plan, and offer support with compliance and quality

outcomes. Consultation services provided to participants may include, but are not limited to: an orientation to CFSS, including assistance selecting a service model; assistance with the development, implementation, management and evaluation of the service delivery plan; assistance with recruiting, selecting, training, managing, directing, evaluating, supervising, and dismissing support workers; and facilitating the use of informal and community supports, goods or resources.

- **Worker training and development services** to enhance the support worker's skills as required by the participant's service delivery plan. Services provided to the direct support worker may include but are not limited to: training, education, direct observation, consultation, and performance evaluation.
- **Expenditures for environmental modifications, or goods**, including assistive technology. Such expenditures must relate to a need identified in a participant's CFSS community support plan; be priced at fair market value; increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for the human assistance for the participant's assessed needs; and fit within the annual limit of the participant's approved service allocation or budget.
- **Financial management services** to provide payroll services for participants who choose the budget model.

**CFSS does not cover:**

- Services that do not meet a need identified in the person-centered assessment;
- Services that are not for the direct benefit of the participant;
- Health services provided and billed by a provider who is not an enrolled CFSS provider;
- CFSS provided by a participant's representative or paid legal guardian;
- Services that are used solely as a child care or babysitting service;
- Services provided by the residential or program license holder in a residence licensed for more than four persons;
- Services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;
- Sterile procedures;
- Giving of injections into veins, muscles, or skin;
- Homemaker services that are not an integral part of the assessed CFSS service;
- Home maintenance or chore services;
- Services that are not in the participant's service delivery plan;
- Home care services (including hospice if elected by participant) covered by Medicare or any other insurance held by the participant;
- Services to other members of the participant's household:
- Services not specified as covered under Medical Assistance as CFSS;
- Application of restraints or implementation of deprivation procedures;
- Person-centered assessments;
- Services provided in lieu of staffing required by law in a residential or child care setting;
- Services not authorized by the Department or the Department's designee;
- Services that are duplicative of other paid services in the written service delivery plan

- Services available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act;
- Any fees incurred by the participant, such as Minnesota Health Care Program fees and co-pays, legal fees, or costs related to advocate agencies;
- Insurance;
- Special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;
- Assistive technology devices and assistive technology services other than those for back-up systems or mechanisms to ensure continuity of service and supports;
- Medical supplies and equipment;
- Environmental modifications, except as specified in the State Plan
- Expenses for travel, lodging, or meals related to training the participant, the participant's representative, or legal representative;
- Experimental treatments;
- Any service or good covered by other Medical Assistance state plan services;
- Membership dues or costs, except when the service is necessary and appropriate to treat a health condition or to improve or maintain the participant's health condition. The condition must be identified in the participant's community support plan and monitored by a physician enrolled in a Minnesota health care program;
- Vacation expenses other than the cost of direct services;
- Vehicle maintenance or modifications not related to the disability, health condition, or physical need; and
- Tickets and related costs to attend sporting or other recreational or entertainment events.

#### 4.4 Eligibility for CFSS under Reform 2020 Waiver

The Reform 2020 waiver allows Minnesota to receive federal financial participation to provide CFSS services to the following eligibility groups (Table 1):

- 1) **1915(i)-like CFSS recipients:** People who do not meet the Medicaid financial eligibility criteria to be eligible for the Section 1915(i) state plan benefit but are categorically eligible for Medical Assistance (i.e., have an assessed need for personal care assistance).

Demonstration waiver authority is necessary for this group because they do not meet the Medicaid financial eligibility criteria.

- 2) **1915(k)-like CFSS recipients:** People who are financially eligible for Medical Assistance if they utilize the eligibility rules of one of Minnesota's home and community-based waivers but have chosen CFSS services in lieu of home and community-based waiver services.

Minnesota has been granted authority to extend Medicaid eligibility to this group to encourage utilization of CFSS instead of home and community-based services where

appropriate. This group includes people who are: 1) Age 65 or over and eligible without a spend-down with income at or below 300% of SSI and spousal impoverishment rules; 2) Disabled, under age 65 and above age 20, and eligible without a spend-down with income at or below the relevant state plan standard with special institutional rules including an exemption from spousal deeming; or 3) Children under age 21 using eligible using special institutional rules including exemption from parental deeming.

**Table 1. CFSS groups and characteristics**

CFSS 1915 recipients (State Plan)		CFSS 1115 recipients (Waiver)	
1915-i group	1915-k group	1915 i-like group	1915 k-like group
Have incomes under 150% of the federal poverty level		Have income above 150% of the federal poverty level	Have income above a Medicaid state plan standard
			Meet all non-financial eligibility factors for eligibility for a home and community-based waiver
Enrolled in Medicaid	Enrolled in Medicaid	Are at or below the relevant state plan limit for categorical eligibility	Qualify for Medicaid using the rules of the special home and community-based waiver group under 42 CFR §435.217
<i>Do not have</i> an assessed need for an institutional level of care	<i>Have</i> an assessed need for an institutional level of care	Do not meet an institutional level of care for a NF, ICF-ID or hospital	Need an institutional level of care
		Meet the personal care assistance criteria*	Meet the personal care assistance criteria

\* A person meets the personal assistance criteria if he/she: 1) Has an assessed need for assistance with at least one activity of daily living, or 2) Demonstrates physical aggression toward oneself or others, or 3) Destruction of property that requires immediate intervention by another person

## 4.5 Program Goals

The goals of the CFSS program under the Reform 2020 Waiver are to:

- 4.51** Provide a comparable level of access to CFSS to the waiver populations as the other CFSS recipients in the state plan.
- 4.52** Achieve comparable health outcomes after utilization of CFSS for the waiver populations as is achieved for the comparable state plan eligibility groups using CFSS.
- 4.53** Achieve comparable consumer satisfaction and costs for consumers utilizing CFSS services under the waiver as compared to state plan CFSS participants.

## 5. Evaluation Strategy for Consumer First Services and Supports

The evaluation plan addresses both program processes and outcomes. It relies mainly on secondary data sources, such as Medicaid claims and administrative data gathered through the program. Primary data collection is proposed in areas not well covered by administrative systems, such as client quality of life or autonomy.

The goals and associated metrics identified in section 5.3 will be evaluated by DHS and University of Minnesota using MMIS claims and beneficiary assessment data. It is appropriate for DHS to conduct the descriptive component of the evaluation using readily available data sources, as part of its ongoing quality monitoring and management activities. External evaluation will include expanded data elements and more rigorous analysis methods.

The evaluation will focus on the transition period (first 24 months) from personal care and consumer support grants to CFSS, and the impacts on CFSS recipients and subgroups.

### 5.1 Goals and Objectives

Despite the need for multiple federal authorities to implement the reformed personal care benefit, access to CFSS services for waiver populations will be as good as access experienced by people receiving CFSS services who are eligible under the state plan (hereinafter “state plan eligibility groups.”) We will determine if experiences of the 1115 subgroups (“i-like” and “k-like) is comparable to the CFSS state plan eligibility groups, in terms of health outcomes and program satisfaction, and their use of the flexible CFSS budget.

### 5.2 Evaluation Populations for CFSS

The waiver evaluation populations will consist of the following subgroups: **CFSS 1915(i)-like group and CFSS 1915(k)-like group** (Table 1).

The comparison groups will be people receiving CFSS under 1915(i) or 1915(k) state plan option, respectively. People in 1915(i) group are enrolled in Medicaid with incomes under 150% of the federal poverty level and *do not have* an assessed need for an institutional level of care. People in

1915(k) group are enrolled in Medicaid and *have* an assessed need for an institutional level of care.<sup>10</sup>

### 5.3 Hypotheses

In this evaluation, we want to understand experiences of the CFSS waiver beneficiaries compared to CFSS state plan eligibility groups, relative to health outcomes and program satisfaction, and use of the flexible CFSS budget.

**5.31 CFSS waiver beneficiaries will experience comparable access to CFSS services, compared to CFSS beneficiaries under the state plan.** Access will be evaluated using the following measures:

- Number and percent of recipients using CFSS services
- Percent of CFSS authorized units paid over time

**5.32 CFSS waiver beneficiaries will experience similar health outcomes following use of CFSS services, compared to CFSS beneficiaries under the state plan.** Health outcomes will be evaluated using the following measures:

- Percent of recipients admitted to nursing facilities or other long-term care institutions
- Amount of nursing facility use
- Number of people that move from nursing facility to CFSS program
- Use of emergency departments and acute care use
- Level of independence with activities of daily living

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<sup>10</sup> This group will include a subgroup of people who are receiving HCBS waiver services in addition to CFSS and a subgroup of people who are not receiving HCBS waiver services in addition to CFSS. The experience of the subgroup of people who are not receiving HCBS waiver services in addition to CFSS are likely to be more similar to the CFSS 1915(k)-like waiver population.

**5.33 CFSS waiver beneficiaries will experience comparable satisfaction with CFSS services, compared to CFSS beneficiaries under the state plan.** Satisfaction will be evaluated using the following measures:

- Percent of CFSS recipients reporting that they are the primary decision makers regarding their service plans (or their child’s plan)
- Percent of CFSS participants reporting that support workers arrive when they are supposed to and perform the tasks requested
- Percent of CFSS participants reporting satisfaction with their service providers

**5.34 CFSS waiver beneficiaries will experience comparable average costs of CFSS services, as compared to CFSS beneficiaries under the state plan.** Costs will be evaluated using the following measures:

- Average cost per recipient of LTC services, by geographic and demographic group
- Percent of CFSS participants also using institutional services, by amount of use
- Percent of CFSS budgets spent on training, goods, equipment, modifications and support services during transition or over time

## 5.4 Data Sources

### MMIS

Medicaid Management Information Systems (MMIS) is the largest health care payment system in Minnesota, and one of the largest payment systems in the nation. Health care providers throughout the county – as well as DHS and county staff – use MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in Minnesota Health Care Programs. State Medicaid management information system contains extensive data related to Medicaid recipients’ eligibility and enrollment, as well as detailed claims data encompassing both traditional fee for service and managed care encounter records. It also records assessments of needs and service plans.

- Claims - cost and utilization for FFS population, diagnoses.
- Encounter data - utilization for managed care population, diagnoses; only partial cost data.
- Eligibility files - program enrollment, waiver status, demographics, reasons for eligibility, dual eligible status
- Assessment data - functional status, presence and extent of service needs
- Service agreements - specific authorized levels and types of service

### LTC Sreening Document

This form is used to document pre-admission screening and long-term care consultation (LTC) activities. It is used to record public programs eligibility determination as well as to collect information about people screened, assessed, or receiving services under home and community-based services programs. Variables include program type, entry and exit from waived programs (including death) and exit reasons, case-mix, level of care, etc.

## **MnCHOICES**

MnCHOICES is a single, comprehensive assessment and support planning Web-based application for long-term services and supports in Minnesota. MnChoices uses one assessment process for people of all ages, abilities and financial statuses, promotes choice and integrated community living, and provides a common data collection tool; it uses a person-centered planning approach to help people make decisions about long-term services and supports. It replaced the following assessment tools: Developmental Disability Screening, Long-Term Care Consultation, Personal Care Assistance Assessment.

- Consumer assessments
- Satisfaction surveys
- Other programmatic data

## **Minimum Data Set (MDS)**

This is a federally mandated assessment. Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). Case-mix related functions are conducted by the MDH on behalf of the Medicaid program under contract to the DHS (the Medicaid Agency). The MDH determines the resident's case mix classification based on the MDS data and also conducts regular audits of the MDS data submitted by NFs to ensure the data is accurate. Variables include admission and discharge date, type of entry, and Medicare stay.

## **5.5 Design Approaches**

The sections below provide information about the study design, the comparison group(s), metrics, and statistical methods.

### **5.51 Pre-Post Analysis**

We will measure CFSS service access use, nursing facility use, satisfaction with CFSS service and providers, and average cost of service, before and after the PCA-to-CFSS transition. Authorized CFSS units will be available in MMIS. Program satisfaction and provider evaluation data will be extracted from MnChoices/MnSP questions.

*Statistical Analysis:* For all measures, we will report the denominator, number and percent of beneficiaries, and utilization rates, as appropriate. We will test the difference in means before and after, using t-tests. We will also compare the difference in means using ANOVA and post-hoc estimations. Covariates includes, but are not limited to, age, number of admissions to nursing facility in a given year, case-mix.

## **5.6 External Evaluation**

In addition to the designated activities to be conducted by DHS, DHS will contract with Center for Long-Term Care and Aging, University of Minnesota School of Public Health, Division of

Health Policy and Management, to conduct an evaluation of the impact of the 1915 i-like and k-like waiver populations on access, quality and cost for eligible children, adults and low-income senior population in the state. Greg Arling, PhD, Katherine Birck Professor, School of Nursing, Purdue University, will assist in the analysis.

### 5.61 Evaluation Objective

This component of the evaluation will include analysis of pre-waiver and post-waiver 1915(i)-like and 1915(k)-like program service use and payments, and the relationship to utilization of flexible benefits, medical care, nursing facility use and HCBS Waiver use.

### 5.62 Analysis Plan

For this evaluation, the following data sources will be utilized: Medicaid Management Information Systems (MMIS), Medicaid files, Minimum Data Set (MDS v3), Medicare claims, MnChoices and MnSP data, and long-term care consultation (LTC) assessment data. The measures and comparison populations are listed in Table 2.

The planned analysis strategies will consist of multiple strategies involving descriptive statistics, cross-sectional comparisons at different time points, and longitudinal analysis of client level processes and outcomes. Comparisons will be made between the Budget and Agency Models and by client subgroups to determine differential use of services, costs, and program impacts.

1. **Baseline characteristics.** Descriptive statistics on the client population will be prepared during the 12-month period prior to CFSS implementation on client populations that are expected to transition into CFSS – PCA users, CS grant recipients, and CDCS recipients. Characteristics will include disability group, demographics, health and functional status, service use and expenditures.
2. **Repeated cross-sectional analysis.** To assess change in the program or its impact, descriptive statistics on characteristics of the CFSS population will be calculated for different time periods (quarterly or semi-annually). Characteristics will include disability group, demographics, health and functional status, service use and expenditures.
3. **Longitudinal client-level analysis.** In order to assess program processes and impact at the client level, clients will be tracked from baseline or program entry to program exit. Change will be analyzed in health and functional status, service use and expenditures, satisfaction with care, and independent living skills. The time points for the longitudinal analysis will vary from monthly (e.g. service use and costs) to semi-annual or annual (health and functioning or satisfaction with care).

**Table 2. Overview of Populations, Measures and Years**

Waiver Populations	Comparison Populations	Measures	Data Source
CFSS i-like & k-like groups	CFSS i and k groups	# and % of recipients using each CFSS service, compared by eligibility group	MMIS Claims

Waiver Populations	Comparison Populations	Measures	Data Source
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS authorized units paid over time by eligibility group	MMIS Claims; MMIS Service Agreement; Screening Documents
CFSS i-like & k-like groups	CFSS i and k groups, all groups over time	% of participants admitted to nursing homes during the year by amount and frequency of use	Screening documents; MDS
CFSS i-like & k-like groups	CFSS i and k groups, all groups over time	# of participants that moved from nursing homes onto the program	Screening documents; MDS
CFSS i-like & k-like groups	CFSS i and k groups, all groups over time	% of CFSS participants also using institutional services by amount of use	MMIS Claims
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS participants reporting they are the primary deciders of what is in their service plan (or their child's plan), compared by eligibility group	MnChoices/MnSP
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS participants reporting that whose paid to help them come when they are supposed to, compared by eligibility group	MnChoices/MnSP
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS participants reporting that whose paid to help them do the things you want them to	MnChoices/MnSP
CFSS i-like & k-like groups	CFSS i and k groups	% of CFSS participants reporting that they satisfied with their service provider	MnChoices/MnSP
CFSS i-like & k-like groups	CFSS i and k groups, all groups over time	Overall average cost per recipient of LTC services by eligibility group, lead agency, and demographic group, compared as well by eligibility group	MMIS Claims
CFSS i-like & k-like groups	CFSS i and k groups, all groups over time	% of CFSS budgets spent on training, goods, equipment, modifications and support services during transition or over time	MMIS Claims

## **6. Evaluation Implementation Strategy**

### **6.1 Coordination of the Alternative Care and CFSS Evaluations**

The goals and associated metrics identified in sections 3.3 and 5.3 will be evaluated by DHS using MMIS claims and assessment data. DHS conducts descriptive evaluations using readily available data sources, as part of its ongoing quality monitoring and management activities.

In addition, DHS will contract with Center for Long-Term Care and Aging, University of Minnesota School of Public Health, Division of Health Policy and Management, to conduct an evaluation of the impact of the continuation of the Alternative Care program under the waiver on access, quality and cost on the low-income senior population in the state. Greg Arling, PhD, Katherine Birk Professor, School of Nursing, Purdue University, will assist in the analysis. As discussed in section 4.42, this component of the evaluation will include analysis of service use and payments during the period before the demonstration and after the demonstration. Analysis will also be conducted on the relationship of Alternative Care to prior nursing facility use, Medicaid conversion and subsequent nursing facility use and Elderly Waiver use. Elderly Waiver and Alternative Care will be compared to determine whether different types of clients are being served and different needs are being met. The evaluation will also compare Alternative Care and Elderly Waiver client characteristics and service use. The CFSS external evaluation will include analysis of flexible benefits use before and after implementation of CFSS as well as the relationship between the utilization of flexible benefits, medical needs, nursing facility and HCBS waiver services use.

### **6.2 Integration of Alternative Care, CFSS and HCBS Waiver Quality Improvement Strategies**

Compliance, oversight and improvement activities for all Minnesota home and community-based waiver programs are conducted in a comprehensive manner across all HCBS waiver programs and Alternative Care. Many HCBS waiver recipients will also be CFSS recipients once the state plan amendments are approved, and quality monitoring for CFSS will be folded into the existing comprehensive quality plan.

The Department conducts site reviews of counties and tribes to monitor their compliance with HCBS waiver policies and procedures. At the conclusion of a review the Department issues a summary report that includes recommendations for program improvements (i.e., sharing best practice ideas) and corrective actions. Corrective actions are issued if the county or tribe being reviewed is found to be out of compliance with waiver policies and procedures. The county or tribe is required to submit a corrective action plan and evidence of the correction. The Department evaluates whether the correction and evidence are sufficient to demonstrate that the corrective action was implemented.

The Department also monitors HCBS waiver and case management activities through quality assurance plans and MMIS subsystems. Counties and tribes are required to submit a quality assurance plan to the Department every one to two years. The plan is a self-assessment of

compliance with waiver policies and procedures, some of which directly apply to case management activities. Our MMIS design supports HCBS waiver policies and procedures, including those related to case management. DHS uses data from MMIS to monitor case management activities. DHS reports on the quality assurance plans and MMIS subsystems in accordance with the §1915(c) waiver requirements.

In addition, the CFSS state plan amendments, still under negotiation with CMS, provide that individuals receiving CFSS are active participants in quality assessment and management through support planning and design of the service delivery plan to meet identified needs and mitigate risks. Counties, tribes and managed care organizations under contract with the Department to manage home and community-based services and supports (lead agencies) perform person-centered assessments and develop community support plans that reflect consumer preferences in services and support for self-direction and include risk management, back-up and emergency planning. Consultation service providers assist the participant with planning developing, and implementing the service delivery model by providing information about service options, choices in providers, and rights and responsibilities, including appeal rights. The FMS (financial management service), agency provider, consultation service provider and CFSS workers are mandated reporters for adult and child maltreatment. The Department establishes and manages the budget methodology for the CFSS authorization, ensures lead agencies perform their roles, ensures provider qualifications and other enrollment requirements are met, authorizes services, develops and implements quality measures and remediation strategies, and periodically analyzes aggregated measurement data for system improvement opportunities. The Department develops and delivers training to lead agencies and providers, manages provider enrollment, pays claims, and oversees county financial eligibility determination for Medical Assistance programs.

At least annually, DHS will monitor timeliness of CFSS beneficiary access to consultation services by reviewing data from consultation service providers, service authorization and claims data. Lead agency reviews will be expanded to include the review of the assessments and community support plans for people receiving CFSS.

Because of the comprehensive nature of the state's HCBS wavier quality improvement strategies, elements of this strategy are continuously applied to monitor and improve quality, access and timeliness of services for Reform 2020 demonstration enrollees. Therefore, while not formally incorporated in the evaluation, these activities further the goals of the demonstration. Where possible, DHS will seek opportunities to design and implement these activities in coordination with Reform 2020 waiver-related reporting and evaluation.

### **6.3 Conclusion, Best Practices, and Recommendations**

The final evaluation report will discuss the principal conclusions and lessons learned based upon the findings of the evaluation and current program and policy issues. A discussion of recommendations for potential action to be taken by DHS to improve health care services in terms of quality, access and timeliness will be provided.

**Attachment C**  
**Reform 2020 Section 1115 Demonstration Waiver**  
**Alternative Care Program: Interim Report**  
*May 18, 2017*

The Reform 2020 demonstration waiver is made up of two programs known as Alternative Care and Community First Services and Supports. In this report, we describe the current findings for the Alternative Care evaluation.

**Table of Contents**

- 1. Background on the Alternative Care program..... 2
  - 1.1 Overview ..... 2
  - 1.2 Program Eligibility ..... 2
  - 1.3 Benefits and Services ..... 3
- 2. Program Goals..... 3
- 3. Evaluation Strategy ..... 4
  - 3.1 Comparison Population ..... 4
  - 3.2 Hypotheses ..... 4
- 4. Preliminary Analysis ..... 6
  - 4.1 Methods ..... 6
    - 4.11 Data Sources ..... 6
    - 4.12 Samples ..... 7
    - 4.13 Statistical Analysis ..... 8
  - 4.2. Results..... 8
    - 4.21 Characteristics of AC and EW Community Participants in October 2012 & 2014 ..... 8
      - 4.211 Demographics ..... 8
      - 4.212 Case Mix and Functional Limitations ..... 10
    - 4.22 Service Use of AC and EW Community Recipients in CY 2012,2013,2014..... 13
    - 4.23 Outcomes for new AC enrollee cohorts before and after the waiver approval ..... 15
    - 4.23 Survival and outcomes for cohorts initially entering AC program in 2010-2012..... 17
- 5. Summary of Preliminary Findings and Hypotheses ..... 20
- 6. Further Evaluation ..... 22

# 1. Background on the Alternative Care program

## 1.1 Overview

The Reform 2020 waiver allows Minnesota to receive federal financial participation for the Alternative Care (AC) program, which was implemented under the waiver beginning November 1, 2013. Formerly a state-funded program, AC program provides home and community-based services (HCBS) to people ages 65 and older who meet nursing facility level of care criteria, who have combined adjusted income and assets exceeding Medicaid standards (i.e., Medical Assistance (MA)) standards for aged, blind and disabled categorical eligibility, but whose income and assets would be insufficient to pay for 135 days of nursing facility care. Acute, preventive and primary care benefits are not covered under the program.

Connecting seniors with community services earlier may divert them from nursing facilities and encourage more efficient use of services when full Medicaid eligibility is established. Minnesota has a home and community-based waiver for people aged 65 and older that meet nursing facility level of care criteria called the Elderly Waiver (EW). Although the AC program includes fewer HCBS services, the service definitions, provider standards, and provider rates for the AC program are the same as those specified in Minnesota's federally approved Elderly Waiver. Services are provided by qualified and enrolled Medicaid providers.

Currently each of Minnesota's HCBS waivers and the AC program include Consumer Directed Community Supports (CDCS) This service option gives individuals receiving waiver or AC services an option to develop a plan for the delivery of their services within an individual budget, and purchase them through a fiscal support entity that manages payroll, taxes, insurance, and other employer-related tasks as assigned by the individual. CDCS allows individuals to substitute individualized services for what is otherwise available in the traditional menu of services in the HCBS programs. CDCS purchases fall into four categories: personal assistance, environmental modifications, self-direction support activities, and treatment and training.

## 1.2 Program Eligibility

Alternative Care is available to eligible individuals who meet all of the following *financial requirements*:

- Those with combined income and assets insufficient to pay for 135 days of nursing facility care, based on the statewide average nursing facility rate
- Those not within an uncompensated transfer penalty period or other long term care ineligibility status
- Those with home equity within the home equity limit applicable under the state plan

*Functional eligibility* for nursing home care and identification of needed services for Alternative Care program is performed using the Long-term Care Consultation process, which uses the same nursing facility level of care criteria, assessment tool, and service planning process that is used for the Elderly Waiver.

### 1.3 Benefits and Services

The benefits available under Alternative Care are the same as the benefits covered under the federally approved Elderly Waiver, *except*:

- Alternative Care **does not cover** transitional support services, customized living services, adult foster care services, and residential care and benefits that meet primary, preventive, and acute health care needs
- Alternative Care **additionally covers** nutrition services and discretionary benefits

The comprehensive list of Alternative Care benefits includes:

- Adult day service/adult day service bath;
- Family caregiver training and education and family caregiver coaching and counseling/assessment;
- Case management and conversion case management;
- Chore services;
- Companion services;
- Consumer-directed community supports;
- Home health services;
- Home-delivered meals;
- Homemaker services;
- Environmental accessibility adaptations;
- Nutrition services;
- Personal care;
- Respite care;
- Skilled nursing and private duty nursing;
- Specialized equipment and supplies including Personal Emergency Response System (PERS);
- Non-medical transportation;
- Tele-home care;
- Discretionary services

## 2. Program Goals

The goals of the Alternative Care program are to:

- Provide access to coverage for home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
- Provide access to consumer-directed coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
- Provide high-quality and cost-effective home and community-based services that result in improved outcomes for participants measured by less nursing home use over time.

### 3. Evaluation Strategy

The Reform 2020 demonstration waiver is approved for the period October 18, 2013 through June 30, 2018. Since the federal waiver authorization has not resulted in any changes to the fundamental aspects of the State's original Alternative Care program, significant changes to the structure of the program and the size and characteristics of the AC population are not anticipated.

We will evaluate the AC program over time (i.e., 2010-2018) in order to examine changes (if any) in program behavior, particularly any unintended negative consequences and the expected benefits to program enrollees. We will also compare the AC to the Elderly Waiver population over the same time period. This comparison allows us to describe the degree of transitions between programs, i.e., AC beneficiaries converting to Medicaid and using the Elderly Waiver, and to assess the potential impact of secular trends that may be affecting both programs, such as other policy shifts or changes in the elderly population or their use of services.

#### 3.1 Comparison Population

The populations included in the evaluation consist of Alternative Care program enrollees and Elderly Waiver enrollees. Elderly Waiver enrollees are very similar to Alternative Care program enrollees. Both groups: 1) are aged 65 and above, 2) must have an assessed need for a nursing facility level of care, and 3) are using home and community-based services to meet their needs and remain living in the community instead of in a nursing facility.

Some Elderly Waiver beneficiaries will use residential services (i.e., customized living, adult foster care, and residential care services). We will identify Elderly Waiver beneficiaries in non-residential settings by excluding beneficiaries with any claims for residential services in the period under study. For this evaluation, we will focus on two comparison populations: 1) Elderly Waiver beneficiaries in total, and 2) Elderly Waiver beneficiaries without residential services use, who are most directly comparable to the AC beneficiaries. As a sub-analysis we will also draw comparisons with Elderly Waiver beneficiaries who have residential use to see how they might differ from the primary comparison group.

#### 3.2 Hypotheses

We will evaluate changes in the client populations and service use over time within the AC program itself and in AC compared to the EW program, using data from 2010-2013 (before the AC waiver was approved), and 2014-2018 (after approval).

**3.21 The level of need, demographic characteristics, and service use patterns for Alternative Care beneficiaries will not change over time, neither alone nor in comparison to Elderly Waiver beneficiaries in non-residential settings.** This will be evaluated using the following measures:

- Case mix status (low-need vs. high-need) for AC and EW
- ADL dependencies and professional conclusions
- Acuity rate differences between AC and Elderly Waiver non-residential beneficiaries

- Use of home and community based services
- Acute care services where available for AC recipients and when there is comparability between AC and EW.

**3.22 Alternative Care beneficiaries will experience equal or better access to consumer-directed service (CDCS) options over time, when examined alone and in comparison to Elderly Waiver beneficiaries in non-residential settings.** This will be evaluated using the following measures:

- Authorized consumer-directed community supports
- Difference in CDCS use between AC and Elderly Waiver non-residential beneficiaries

**3.23 Alternative Care beneficiaries will experience equal or less nursing facility use over time, when examined alone and in comparison to Elderly Waiver beneficiaries in non-residential settings.** This will be evaluated using the following measures:

- Proportion of recipient days spent in nursing facilities
- Frequency of nursing facility admission, by length of stay
- Case-mix adjusted nursing facility admission
- Number of nursing facility days
- Return to AC or Elderly Waiver programs from nursing facility

**3.24 Alternative Care beneficiaries will remain in the community for as long or longer over time, when examined alone and in comparison to Elderly Waiver beneficiaries.** This will be evaluated using the following measures

- Remaining enrolled in AC
- Transitions from AC to Elderly Waiver
- Days alive in the community and not on Medicaid
- Use of Medicare services
- Use of Essential Community Supports; see Section 6 for more information about the Essential Community Supports program for people age 65 and older that was implemented January 1, 2015.

## 4. Preliminary Analysis

The aim of the preliminary analysis is to gain a better understanding of similarities and differences between the AC program and EW waiver populations before the AC waiver became effective in November 2013 (pre-approval period) and after AC waiver approval (post-approval period). We conducted these analyses:

- Compared characteristics of the AC and EW community populations using October as a representative month, for the years CY 2010-2013 before the federal match was implemented and CY 2014 after the match was implemented. The analysis involved comparison of repeated cross-sectional sample drawn in October of each year.
- Compared 12-month outcomes for new entrants into AC and EW during the periods:
  - New entrants October 2011-September 2012 followed for 12 months each through September 2013, before the AC waiver was approved.
  - New entrants October 2013-September 2014 followed for 12 months each through September 2015, after the AC waiver was approved.
- Laid the groundwork for future longitudinal analysis by describing the 36-month survival and program outcomes for cohorts of new entrants into AC and EW during CY 2010-2012 before the AC waiver was took effect.

In the sections below we describe evaluation methods and present results from the preliminary analysis.

### 4.1 Methods

#### 4.1.1 Data Sources

**LTC Screening Document.** This form is used to document pre-admission screening and long-term care consultation (LTC) assessment and other administrative activities. It is used to record public programs eligibility determination as well as to collect information about people screened, assessed, or receiving services under home and community-based services programs.

**Medicaid Claims.** Medicaid Management Information Systems (MMIS) is the largest health care payment system in Minnesota, and one of the largest payment systems in the nation. Health care providers throughout the state, including HCBS providers and county and tribal staff providing case management, use MMIS to submit claims for MA and AC services. MN Department of Human Services (DHS) uses MMIS to validate and pay HCBS and health care claims, including managed care capitation payments, for over 525,000 Minnesotans enrolled in Minnesota Health Care Programs (MHCP). MHCP provide health care services to low-income families and children, low-income elderly people and individuals who have physical and/or developmental disabilities, mental illness or who are chronically ill.

**Medicare Claims (fee-for-service).** Medicare claims will provide utilization information for non-Medicaid-covered services (particularly for AC recipients or for periods when a recipient is not covered by Medicaid), but otherwise will largely duplicate what we can learn from MMIS.

**Minimum Data Set (MDS).** This is a federally mandated assessment used in nursing facilities. Nursing facilities conduct the MDS assessment on each resident and transmit that data to the

Minnesota Department of Health (MDH). Case-mix related functions are conducted by the MDH on behalf of the Medicaid program under contract to the DHS (the Medicaid Agency). The MDH determines the resident's case mix classification based on the MDS data and also conducts regular audits of the MDS data submitted by NFs to ensure the data is accurate.

#### 4.12 Samples

**Repeated cross-sectional analysis of recipient characteristics.** We selected recipients who were eligible for either Alternative Care (AC) or Elderly Waiver (EW) on October 1 or who became eligible during that month in each year from 2012 through 2014. We excluded EW recipients who were in residential services (i.e., adult foster care or customized living), since they are less comparable to the AC recipients both in terms of population composition and service use. Where available, we took descriptive variables from Medicaid administrative data. Some variables can only be sourced from the LTC Screening Document (SDOC), particularly those describing health and functional status of recipients. For those variables, we chose a reference assessment for each recipient -- the most recently completed as of October 1, 2014.

**Repeated cross-sectional analysis of service utilization.** We selected individuals who were eligible at any time during each of the calendar years 2012, 2013, or 2014. We then aggregated service use over the entirety of each calendar year in order to smooth out utilization of services that are not typically used monthly or whose level of use might vary widely month to month.

**12-month AC outcome cohorts.** We selected AC recipients who were newly enrolled into the AC program during the period before waiver approval (Pre-Period) and after waiver approval (Post-period):

PRE-Period: New enrollment Nov 2011-Oct 2012, followed for 12 months after enrollment (potentially through October 2013).

POST-Period: New enrollment Nov 2013-Oct 2014, followed for 12 months after enrollment (potentially through October 2015).

We excluded individuals with any prior history of AC or Medicaid eligibility in the 12 months prior to their enrollment. Each recipient was then followed for 12 months after their initial month of enrollment using data from nursing home MDS, death records, and Medicaid eligibility status.

**36-month AC and EW enrollment cohorts.** We selected these AC and EW cohorts from new AC and EW enrollees in calendar years 2010-2012 (January 1, 2010 to December 31, 2012). Each recipient was then followed for 36 months after their initial month of enrollment using data from nursing home MDS, death records, and Medicaid eligibility status. Because of a lag in the availability of Medicaid claims, it was not possible to follow a cohort of new AC enrollees for 36 months in the period after the waiver took effect. To conduct a 36-month follow-up for new enrollees in CY 2014, we would require Medicaid claims through December 2017. Our current claims file extends only through June 2016. The 36-month post-period follow up will be the subject of future analysis.

### 4.13 Statistical Analysis

Tests of statistical significance are based on a two-tailed Chi-square test, t-test for independent populations or t-test for paired populations, with an alpha of  $p < .001$ .

## 4.2. Results

### 4.21 Characteristics of AC and EW Community Participants in October 2012 & 2014

The first step in the analysis was to compare the demographic, case mix and functional characteristics of the AC program and EW community recipients at three time points: 1) October 2012 (the year before the federal waiver was approved), 2) October 2013 (the month of the waiver approval), and 3) October 2014 (the year after the waiver took effect). We chose a single month in order to obtain a snap-shot or cross-sectional view of the population.

Table 1 presents the demographics, health and function, and professional conclusions related to need for each population. We tested the statistical significance of differences between groups with a two-tailed Chi-square test. Since the samples were so large, we used a stringent alpha of  $p < .001$ . We report here on the statistical significance of differences in the characteristics of the AC and EW enrollees in 2012 and 2014. Since the AC waiver took effect in 2013, we tested for significant differences in the calendar year before it took effect and the calendar year after.

#### 4.211 Demographics

**Age.** AC enrollees were significantly older than EW recipients in 2012 (mean age of 82 years and 77 years, respectively). There was no significant change in the age composition of the AC and EW recipients between 2012 (pre-period) and 2014 (post-period).

**Gender:** The majority of recipients in both the AC and EW programs were female in 2012 (76% of AC and 74% of EW recipients). There was no significant change in the percentage of females in the AC or EW recipients between 2012 and 2014.

**Marital Status:** In 2012, only 14% of EW recipients were married; most were either widowed (37%) or divorced/separated (37%). It appears that AC recipients had similar patterns, although the percentages for AC are heavily influenced by 17% of cases where marital status was unknown. There appeared to be significant decline in the percentage of married AC recipients between 2012 and 2014; however, this finding must be qualified because of a large amount of missing data.

**Race/ethnicity:** 83% of AC program recipients in 2012 identified themselves as white, while small percentages identified as Hispanic (1%) or Native American (1%). In comparison, 61% of EW recipients identified as white, 16% identified as Black/African American, 17% as Asian. Only 2% EW identified as Hispanic and 2% as Native American. There was a substantial amount of missing data for AC recipients. The racial/ethnic composition of the AC and EW recipients did

not appear to change significantly between 2012 and 2014, although this finding must be qualified because of large amounts of missing data.<sup>1</sup>

**Geographic Location:** AC recipients are significantly more likely than EW recipients to reside outside the Twin Cities seven-county metro area, i.e., Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington counties (63% vs. 53% in 2012). They were somewhat more likely to reside in rural (non-SMSA) areas. The differences in geographic location could help explain differences in service use between AC and EW recipients because service availability tends to be clustered by location. The geographic location of AC and EW recipients did not change significantly from 2012 to 2014.

**Living Arrangement:** AC recipients were significantly more likely than EW recipients to live alone (65% vs. 52% in 2012). Living arrangements of AC and EW recipients did not change significantly between 2012 and 2014.

**Table 1. Demographic Characteristics of a Cross-section of AC and EW Community (Non-Residential) Recipients in October of 2012, 2013, and 2014**

	2012		2013		2014	
	AC	EWC	AC	EWC	AC	EWC
<b>Number</b>	2858	14623	2742	14846	2721	14961
<b>Age</b>						
Mean (years)	82	77	82	77	81	77
65-74	20%	<b>41%</b>	21%	41%	24%	<b>41%</b>
75-84	36%	39%	36%	40%	34%	40%
85-94	<b>39%</b>	18%	38%	17%	<b>37%</b>	17%
95+	5%	2%	5%	2%	4%	2%
<b>Gender</b>						
Female	76%	71%	75%	71%	74%	71%
Male	24%	29%	25%	29%	26%	29%
<b>Marital Status</b>						
Widowed	<u>45%</u>	37%	39%	35%	<u>36%</u>	33%
Divorced / Separated	22%	37%	22%	38%	24%	38%
Married	8%	14%	9%	15%	9%	16%
Never Married	8%	11%	8%	11%	9%	12%
Unknown	17%	0%	21%	1%	21%	1%
<b>Race/Ethnicity</b>						
Asian	0%	17%	0%	17%	0%	17%
Black/African American	3%	16%	3%	17%	4%	18%
Hispanic	1%	2%	1%	2%	1%	3%
Native American	1%	2%	1%	2%	1%	2%

<sup>1</sup> Information about race resides in the Recipient subsystem in MMIS, which is populated more completely by financial workers for individuals applying for or determined eligible for MA. Recipient subsystem information for AC participants comes primarily from the LTC Screening Document, since many AC participants do not have a financial worker. They are, by definition, financially ineligible for MA.

	2012		2013		2014	
	AC	EWC	AC	EWC	AC	EWC
White	83%	61%	82%	60%	80%	58%
Other	0%	0%	0%	0%	0%	0%
Multiple	0%	0%	0%	0%	0%	0%
<i>Unknown</i>	<i>11%</i>	<i>1%</i>	<i>13%</i>	<i>1%</i>	<i>14%</i>	<i>1%</i>
<b>Geography</b>						
7-County Metro Area	51%	<b>60%</b>	53%	62%	54%	<b>62%</b>
Greater Minnesota	49%	40%	47%	38%	46%	38%
<b>Geography by MSA</b>						
Twin Cities Central	53%	<b>63%</b>	55%	64%	57%	<b>65%</b>
Other Central	7%	7%	7%	7%	8%	7%
Outlying	6%	4%	6%	4%	6%	4%
Rural	30%	25%	29%	24%	27%	23%
Unknown	3%	1%	3%	1%	3%	1%
<b>Living Arrangement</b>						
Living alone	<b>65%</b>	52%	66%	52%	<b>66%</b>	52%

Note: Statistically significant differences ( $p < .001$ ) between AC and EW in individual years are **bolded**. Significant differences in characteristics between 2012 and 2014 for the AC or EW enrollees are Underlined.

#### 4.212 Case Mix and Functional Limitations

Table 2 provides summary information for the AC and EW populations using the most recent assessment information in MMIS related to their program participation in October of each year included in the analysis.

**Case mix:** Case mix is a classification tool that is used in both AC and EW programs to establish monthly budget limits for HCBS services. The classification is based on assessed need in:

- Eight activities of daily living (ADLs): bathing, dressing, grooming, walking, toileting, positioning, transferring, and eating
- The need for clinical monitoring in combination with a physician-ordered treatment, and
- The need for staff intervention due to behavioral or cognitive needs.

After assessment, the individual is assigned a case mix classification of A-L based on their combination of ADLs, clinical monitoring and behavioral/cognitive needs. For purposes of this evaluation, the case mix classifications have been grouped as follows:

- Low Need (A, L): This group includes individuals with 0-3 ADL dependencies
- Moderate Need (B, D, E): This group includes individuals with 4-6 ADL dependencies and/or behavioral/cognitive needs.
- High Need (G, H, I, J): This group includes individuals with dependencies in 7 or 8 ADLs (G), and those with specific other needs in combination with 7-8 ADL dependencies.

- High Need Clinical (C, F, K, V): This group includes individuals with varying number of dependencies but who have an assessed need for clinical monitoring at least once every 8 hours.
- Other/Missing

In 2012, AC recipients were significantly more likely to be in the moderate need category (36%) compared to the EW recipients (30%). On the other hand, EW recipients were significantly more likely to be low need (57% vs. 50%) as well as significantly more likely to be classified as high need (10% vs. 5%). Small percentages of recipients, 3% AC and 2% EW, were in the high need clinical category. The change in the number of missing values between years complicates significance testing. However, there appeared to be no significant change in case mix for either AC or EW recipients between 2012 and 2014.

**Critical Dependencies in Activities of Daily Living:** The functional assessment includes information about limitations and dependencies in eight activities of daily living. Toileting, positioning/bed mobility and transferring are considered “critical dependencies” because needed assistance cannot be easily scheduled. Among AC recipients, 14% had a dependency in positioning/bed mobility, 23% in transferring, and 64% in toileting. EW recipients had a significantly lower level of toileting dependence (53%) but they did not differ significantly in any of the other categories.

Prior to 2014, the toileting assessment item captured information about levels of incontinence, and was discovered to be less reliable in terms of coding the need for assistance in toileting rather than incontinence that was managed independently by the person. In 2014, a new toileting item was included to specifically address the need for supervision or physical assistance in toileting. When this clarifying item was added to the assessment, both the AC and EW recipients experienced a significant decline in toileting need as now measured by the need for assistance. Because of this change in assessment, the analysis below includes both assessed levels of incontinence and need for assistance in meeting toileting needs. The decline appearing between 2012 and 2014 is much more likely to be the result of this change in how need for assistance is assessed rather than any true change in AC or EW population status. There were no other significant changes in critical dependencies between 2012 and 2014 for AC or EW recipients.

**Other ADL Dependencies:** In 2012, AC recipients had significantly lower dependency in dressing. The AC and EW recipients had small changes between 2012 and 2014 in other dependencies; the pattern of change was not consistently increased or decreased dependency.

**Professional Conclusions:** Professional conclusions are indicated by the assessor upon completion of an assessment, and are intended to capture an assessor’s overall opinion about

the person’s need and/or presenting problems or conditions. These conclusions are not tied to other assessment item(s). Most differences in professional conclusions between AC and EW in 2012 were small and not statistically significant. However, AC recipients were significantly more likely to have a professional conclusion of behavioral symptoms (25% vs. 19%) or hearing impairment (19% vs. 11%) and less likely to have a professional conclusion of an IADL condition (98% vs. 92%). Between 2012 and 2014, the AC recipients experienced a significant increase in professional conclusions related to IADL conditions (74% to 78%), behavioral symptoms (25% to 31%), and risk of abuse/neglect (22% to 30%).

**Table 2. Case Mix and Functional Characteristics of a Cross-section of AC and EW Community Clients in October of 2012, 2013, and 2014**

Variable	Value	2012		2013		2014	
		AC	EWC	AC	EWC	AC	EWC
<b>Case Mix</b>							
	Low Need	50%	<b>57%</b>	51%	55%	48%	<b>54%</b>
	Moderate Need	<b>36%</b>	30%	38%	32%	<b>40%</b>	32%
	High Need ADL	5%	<b>10%</b>	7%	11%	6%	<b>12%</b>
	High Need Clinical	3%	2%	2%	2%	4%	1%
	Other/Missing	7%	1%	3%	1%	2%	1%
<b>Critical ADL Dependency</b>							
	Bed Mobility (2+)	14%	12%	12%	12%	10%	12%
	Transferring (2+)	23%	20%	22%	21%	21%	23%
	Toileting and Continence						
	Toileting (1+)	<b>64%</b>	<b>53%</b>	63%	53%	<b>53%</b>	<b>47%</b>
	Toileting Assist. Needed (Y/N)					19%	20%
	Both Toileting Items					18%	19%
	Neither Toileting Item					46%	51%
	Continence issue, No Need for Assistance					<b>33%</b>	26%
	No continence issue, Need for Assistance					1%	1%
	Does Not Have Both Items Valid Data					2%	2%
<b>Other ADL Dependencies</b>							
	Bathing (4+)	53%	52%	51%	53%	50%	54%
	Dressing (2+)	33%	<b>39%</b>	33%	42%	32%	<b>43%</b>
	Eating (2+)	25%	24%	23%	24%	23%	25%
	Grooming (2+)	24%	29%	23%	31%	23%	32%
	Walking (3+)	11%	4%	8%	4%	7%	3%
<b>Professional Conclusions</b>							
	ADL Condition	74%	73%	79%	74%	<b>78%</b>	73%
	IADL Condition	92%	98%	96%	98%	96%	97%

Complicated Condition	<u>14%</u>	14%	14%	14%	<u>20%</u>	16%
Impaired Cognition	24%	21%	26%	22%	<b>28%</b>	22%
Frequent Behavioral Symptoms	<b>25%</b>	19%	27%	20%	<b>31%</b>	22%
Self-Care Risk	57%	55%	60%	56%	58%	55%
Neglect/Abuse Risk	<u>22%</u>	18%	25%	18%	<b>30%</b>	21%
General Frailty	27%	25%	29%	25%	29%	24%
Frequent Institutional Stays	9%	7%	9%	7%	12%	7%
Significant Hearing Impairment	<b>21%</b>	14%	22%	13%	<b>19%</b>	11%
Need for Restorative / Rehabilitative Treatments	14%	11%	14%	11%	13%	10%
Unstable Health Condition	11%	10%	10%	10%	11%	9%
Needs Evening/Night Direct Care for Special Treatments	4%	2%	4%	2%	6%	2%
Complex Care Management	6%	9%	6%	8%	6%	5%
Uncorrected Visual Impairment	17%	14%	18%	14%	17%	14%

Note: Statistically significant differences ( $p < .001$ ) between AC and EW in individual years are **bolded**. Significant differences in characteristics between 2012 and 2014 for the AC or EW enrollees are Underlined.

#### 4.22 Service Use of AC and EW Community Recipients in CY 2012,2013,2014

The second step in the analysis was to compare the service use of the AC and EW community recipients at three time points: 1) CY 2012 (the year before the federal waiver was approved), 2) CY 2013 (the year of the waiver approval), and 3) CY 2014 (the year after the waiver took effect). We used claims paid in the CY in order to account for services that may have less than monthly delivery, or that may have episodes of high use throughout a person's service year.

Table 3 shows the number of unique recipients and total service use months that were used for the utilization rates in Table 4. The rates of utilization (Table 4) were calculated by dividing the services used by the user months (Table 3), for each service. We tested the statistical significance of differences between groups with a two-tailed Chi-square test. Since the samples were so large, we used a stringent alpha of  $p < .001$ . We report here on the statistical significance of differences in service use of the AC and EW enrollees in 2012 and 2014.

In 2012, AC recipients were significantly more likely to use home delivered meals (39% vs. 27%), home health aides (25% vs. 14%), personal emergency response systems (54% vs 38%), and specialized supplies and equipment (24% vs. 10%). The EW recipients were significantly more likely to use adult day services (18% vs. 5%), personal care assistance (30% vs. 12%), and non-medical transportation (27% vs. 9%). There was no significant change in service use between 2012 and 2014 for either AC or EW recipients.

**Table 3. Number of User Months and Unique Recipients with AC and EW by Calendar Year**

Year	Alternative Care		EW Community	
	User Months	Unique Recipients	User Months	Unique Recipients
2012	34,646	4,112	174,562	20,045
2013	33,051	3,971	176,920	19,389
2014	32,707	3,873	179,265	19,998

**Table 4. Service Use of AC and EW Community Program Recipients in CY 2012, 2013, and 2014**

Type of Service	Year	Alternative Care			Elderly Waiver (Community)		
		Unique Users	User Months	Utilization Rate	Unique Users	User Months	Utilization Rate
<b>Adult Day Services</b>	2012	222	1566	5%	3395	31538	<b>18%</b>
	2013	206	1461	4%	3552	32632	<b>18%</b>
	2014	196	1387	4%	3800	35167	<b>20%</b>
<b>CDCS Services</b>	2012	136	1126	3%	336	2908	2%
	2013	143	1253	4%	334	2961	2%
	2014	151	1361	4%	353	2976	2%
<b>Chore Services</b>	2012	284	1911	6%	702	4359	2%
	2013	303	2000	6%	714	4506	3%
	2014	280	1880	6%	675	4381	2%
<b>Companion Services</b>	2012	150	1120	3%	574	4121	2%
	2013	147	940	3%	556	4247	2%
	2014	117	775	2%	518	3936	2%
<b>Home Delivered Meals</b>	2012	1858	13612	<b>39%</b>	5911	47590	27%
	2013	1766	12984	<b>39%</b>	5869	47862	27%
	2014	1752	12896	<b>39%</b>	5658	45376	25%
<b>Home Health</b>	2012	1538	11027	32%	6807	51904	30%
	2013	1448	10223	31%	6712	51483	29%
	2014	1400	10093	31%	6622	50879	28%
<b>Home Health Aide</b>	2012	1212	8680	<b>25%</b>	3683	24380	14%
	2013	1081	7686	<b>23%</b>	3613	23726	13%
	2014	972	7094	<b>22%</b>	3429	22764	13%
<b>Homemaker Services</b>	2012	2537	20551	59%	10487	94208	54%
	2013	2429	19513	59%	10733	98063	55%
	2014	2336	19118	58%	10767	97279	54%
<b>Personal Emergency Response</b>	2012	2250	18709	<b>54%</b>	7437	65472	38%
	2013	2158	17525	<b>53%</b>	7644	68581	39%
	2014	2049	17118	<b>52%</b>	7665	68575	38%

Type of Service	Year	Alternative Care			Elderly Waiver (Community)		
		Unique Users	User Months	Utilization Rate	Unique Users	User Months	Utilization Rate
<b>Personal Care Assistance</b>							
	2012	536	4128	12%	5752	53043	<b>30%</b>
	2013	536	4212	13%	5983	56453	<b>32%</b>
	2014	556	4203	13%	6245	57778	<b>32%</b>
<b>Special Supply/Equipment</b>							
	2012	1721	8434	<b>24%</b>	4881	17657	10%
	2013	1656	7976	<b>24%</b>	4768	17198	10%
	2014	1549	7472	<b>23%</b>	4683	16433	9%
<b>Transportation</b>							
	2012	498	3064	9%	6051	46489	<b>27%</b>
	2013	516	3131	9%	6334	48455	<b>27%</b>
	2014	530	3305	10%	6765	51142	<b>29%</b>

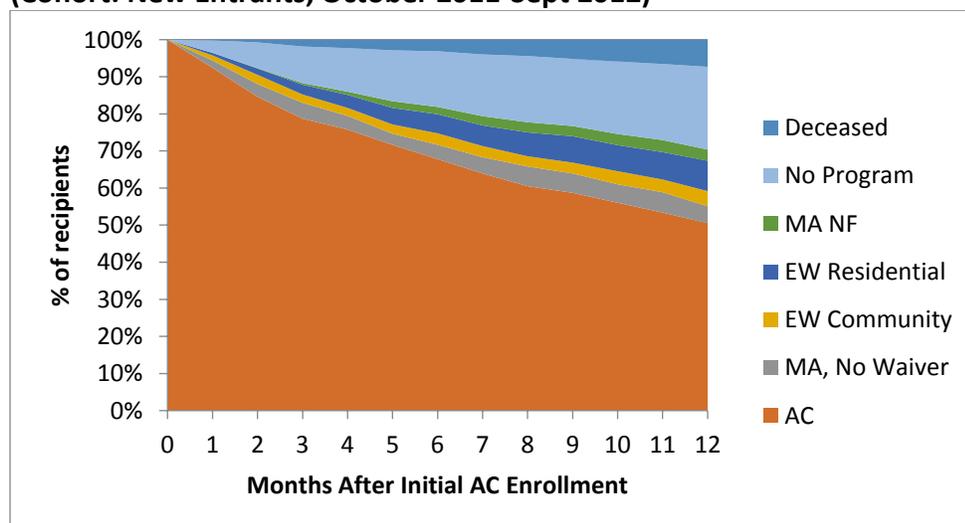
Note: Statistically significant differences ( $p < .001$ ) between AC and EW in individual years are **bolded**. There were no significant differences in service use between 2012 and 2014 for either AC or EW enrollees.

#### 4.23 Outcomes for new AC enrollee cohorts before and after the waiver approval

The next step in the analysis was to determine if survival and other outcomes (setting, waiver use, and Medicaid eligibility) changed for new AC enrollees in the periods before and after the waiver approval. In order to evaluate change over time in their survival and other outcomes, we tracked new AC enrollees for 12-months after enrollment. We compared the outcomes for enrollees during the pre-period (Nov 2011-Oct 2012) and post-period (Nov 2013-Oct 2014).

There were no significant changes in outcomes for AC recipients between the pre-period and post-period. Figures 1 and 2 show the outcomes graphically for these two time periods.

**Figure 1. Outcomes for AC Cohort by Post-Enrollment Program Status (Cohort: New Entrants, October 2011-Sept 2012)**



**Figure 2. Outcomes for AC Cohort by Post-Enrollment Program Status (Cohort: New Entrants, October 2013-Sept 2014)**

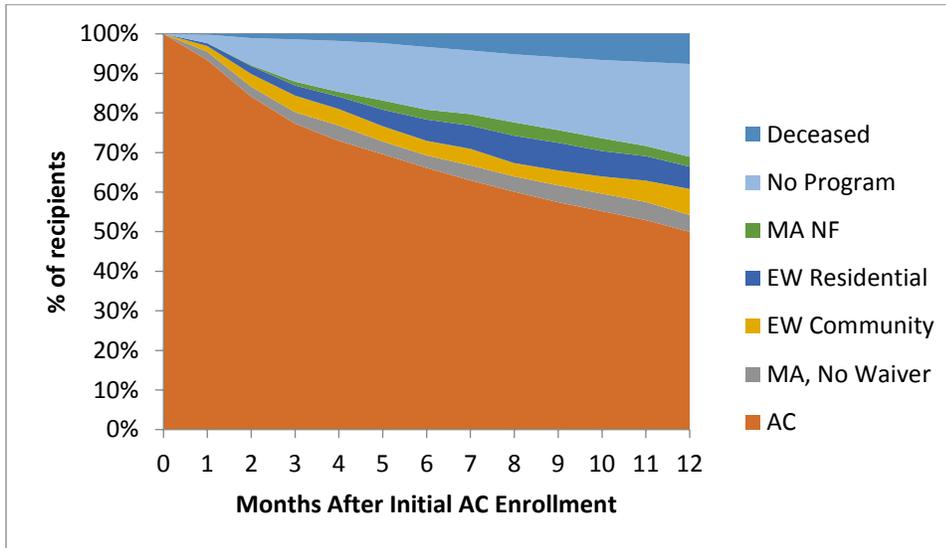


Table 5 summarizes the number and percentage of new AC enrollees by their status at 6 and 12 months after enrollment. During the pre-period, half of AC enrollees were still receiving AC and 23% were enrolled in no program at 12 months after enrollment. Small percentages were deceased (7%), on MA but without a waiver (5%), receiving an EW waiver in the community (4%) or in a residential setting (8%), or in a nursing facility (3%).

**Table 5. 12-Month Outcomes for a Cohort of New Entrants into AC During the Period Before Waiver Approval) Pre-Period and the Period After Approval (Post-Period)**

	Beginning at 0 Months		Status at 6 Months		Status at 12 Months	
	Pre	Post	Pre	Post	Pre	Post
AC	1053	933	714	617	532	466
MA, No Waiver	0	0	41	29	48	40
EW Community	0	0	32	35	43	61
EW Residential	0	0	54	50	86	53
MA NF	0	0	21	23	32	23
No Program	0	0	158	148	235	219
Deceased	0	0	33	31	77	71
AC	100%	100%	68%	66%	51%	50%
MA, No Waiver	0%	0%	4%	3%	5%	4%
EW Community	0%	0%	3%	4%	4%	7%
EW Residential	0%	0%	5%	5%	8%	6%
MA NF	0%	0%	2%	2%	3%	2%
No Program	0%	0%	15%	16%	22%	23%
Deceased	0%	0%	3%	3%	7%	8%

Note: There were no significant changes in any of the outcomes between the Pre and Post periods.

#### 4.23 Survival and outcomes for cohorts initially entering AC program in 2010-2012

As a preliminary step in examining long-term transitions of AC and EW recipients, we tracked new AC and EW community program enrollees in calendar years 2010-2011 who had no history of AC or EW use or of Medicaid eligibility in the 5 years prior to enrollment in AC. We tracked mortality, Medicaid eligibility and care setting.

Figures 3 and 4 show transition outcomes graphically (by number and percent of recipients, respectively). Table 6 presents the status of the enrollees at 12, 24, and 36 months after enrollment. After 36 months, only 23% of the AC cohort was still AC enrolled, 13% died, 2% entered a nursing home with MA, 5% were in EW community, 9% were in EW residential, 8% were on MA without a waiver and 32% had no program status.

The EW enrollees cohort had a different set of options available to them and, consequently, had different outcome patterns. At 36 months, 24% was still enrolled in EW community, 37% had died, 15% entered EW residential, 1% was in AC, 11% was still MA in the community without an EW waiver, 3% were MA in a nursing facility, and 9% were not on any program. Notable differences between AC and EW was the EW enrollees' much higher rate of mortality and the much lower percentage in the no program status. The mortality rate comparison is complicated because we have more limited information about AC enrollees for purposes of matching with death records. Some AC recipients in the no program status may be unmeasured deaths.

**Table 6. 36-Month Outcomes for AC and EW Community Cohorts during the Pre-Period (Cohort: New Enrollees in CY 2010-2012 followed for 36 months from enrollment)**

<b>Outcomes for Alternative Care Cohort</b>				
	<b>Month 0</b>	<b>Month 12</b>	<b>Month 24</b>	<b>Month 36</b>
Enrolled in AC	3268	1651	1055	740
MA, No Waiver	0	159	266	271
EW Community	0	167	140	175
EW Residential	0	264	347	287
MA NF	0	84	72	73
No Program	0	730	947	1037
Deceased	0	213	441	685
Enrolled in AC	100%	51%	32%	23%
MA, No Waiver	0%	5%	8%	8%
EW Community	0%	5%	4%	5%
EW Residential	0%	8%	11%	9%
MA NF	0%	3%	2%	2%
No Program	0%	22%	29%	32%
Deceased	0%	7%	13%	21%

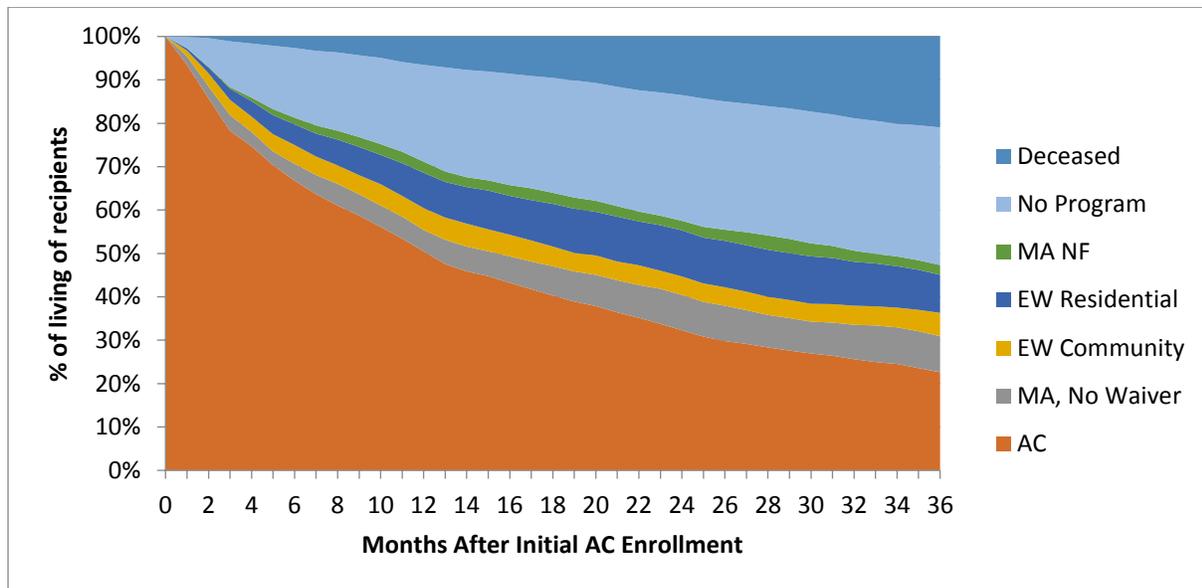
AC, Alternative Care; EW, Elderly Waiver; MA, Medical Assistance; NF, Nursing Facility.

**Outcomes for Elderly Waiver  
Community Cohort**

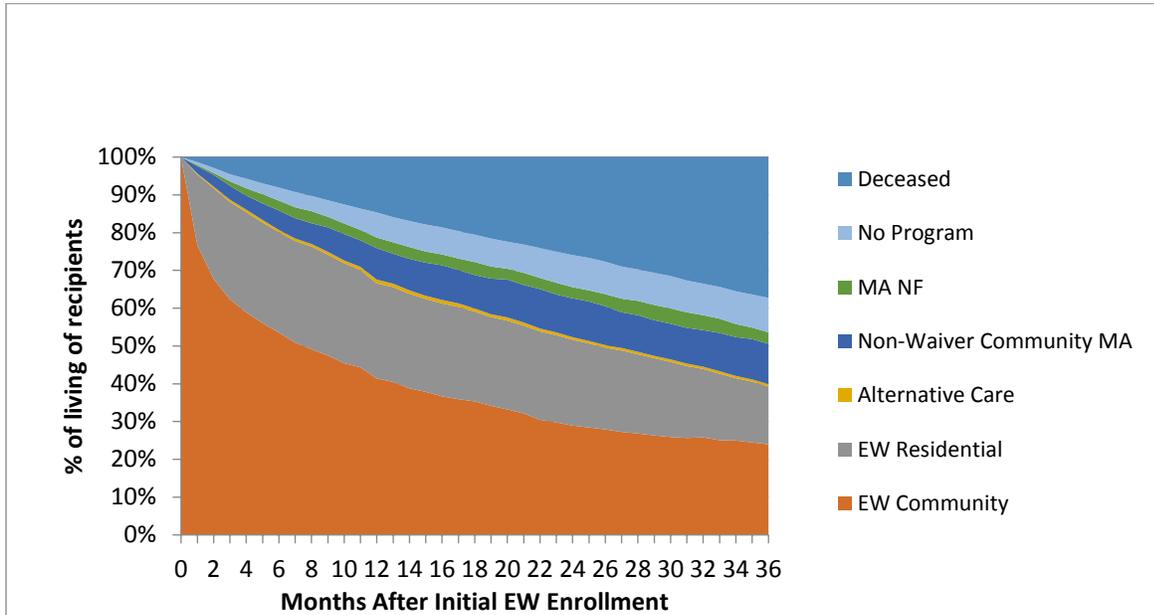
	Month 0	Month 12	Month 24	Month 36
EW Community	2597	1076	752	623
EW Residential	0	653	590	398
Alternative Care	0	26	18	16
Non-Waiver Community MA	0	216	266	277
MA NF	0	74	77	78
No Program	0	171	221	237
Deceased	0	381	673	968
EW Community	100%	41%	29%	24%
EW Residential	0%	25%	23%	15%
Alternative Care	0%	1%	1%	1%
Non-Waiver Community MA	0%	8%	10%	11%
MA NF	0%	3%	3%	3%
No Program	0%	7%	9%	9%
Deceased	0%	15%	26%	37%

EW, Elderly Waiver; MA, Medical Assistance; NF, Nursing Facility.

**Figure 3. Outcomes for AC Cohort by Post-Enrollment Program Status  
(Cohort: New Entrants, October 2010-September 2011)**



**Figure 4. Outcomes for Elderly Waiver Community Cohort Post-Enrollment Program Status (Cohort: New Entrants, October 2010-September 2011)**



## 5. Summary of Preliminary Findings and Hypotheses

Hypotheses	Preliminary Findings
<p><b>3.21 The level of need, demographic characteristics, and service use patterns for Alternative Care beneficiaries will not change over time, neither alone nor in comparison to Elderly Waiver beneficiaries in non-residential settings.</b> This will be evaluated using the following measures:</p>	
<ul style="list-style-type: none"> <li>Case mix status (low-need vs. high-need) for AC</li> </ul>	<p>AC recipient samples showed no significant change in case mix status between 2012 and 2014, either alone or in comparison to EW recipients.</p>
<ul style="list-style-type: none"> <li>ADL dependencies</li> </ul>	<p>AC recipient samples showed no significant change in critical or other ADL dependencies between 2012 and 2014, either alone or in comparison to EW recipients. There was a decrease in toileting dependency but that could be attributed to a change in assessment coding.</p>
<ul style="list-style-type: none"> <li>Professional conclusions</li> </ul>	<p>AC recipient samples showed no significant change in most professional conclusions between 2012 and 2014, either alone or in comparison to EW recipients. However, compared to 2012, AC recipients in 2014 were significantly more likely to have a professional conclusion of a complicated condition, behavioral problems, and abuse/neglect.</p>
<ul style="list-style-type: none"> <li>Demographics</li> </ul>	<p>AC recipient samples showed no significant change in demographic characteristics between 2012 and 2014, either alone or in comparison to EW recipients. Observed changes in marital status (reduced percentage married) could not be tested for significance because of a large amount of missing data on that item.</p>
<ul style="list-style-type: none"> <li>Use of home and community based services</li> </ul>	<p>AC recipient samples showed no significant change in service use between 2012 and 2014, either alone or in comparison to EW recipients.</p>
<ul style="list-style-type: none"> <li>Acute care services</li> </ul>	<p>Not evaluated</p>

Hypotheses	Preliminary Findings
<p><b>3.22 Alternative Care beneficiaries will experience equal or better access to consumer-directed service (CDCS) options over time, when examined alone and in comparison to Elderly Waiver beneficiaries in non-residential settings.</b> This will be evaluated using the following measures:</p>	
<ul style="list-style-type: none"> <li>Authorized consumer-directed community supports</li> </ul>	<p>There was no significant change in rates of CDCS services between 2012 and 2014 for either AC or EW recipients.</p>
<ul style="list-style-type: none"> <li>Difference in CDCS use between AC and Elderly Waiver non-residential beneficiaries</li> </ul>	<p>The rates of CDSC services were low among AC recipients (3%-4%) and EW recipients (2%).</p>
<p><b>3.23 Alternative Care beneficiaries will experience equal or less nursing facility use over time, when examined alone and in comparison to Elderly Waiver beneficiaries in non-residential settings.</b> This will be evaluated using the following measures:</p>	<p>There was no significant change in nursing facility services use between the new enrollee cohort prior to the waiver approval and a comparable cohort after waiver approval. Only 2%-3% of newly enrolled AC recipients were in a nursing facility at 12 months after enrollment.</p>
<ul style="list-style-type: none"> <li>Proportion of recipient days spent in nursing facilities</li> </ul>	<p>Not evaluated</p>
<ul style="list-style-type: none"> <li>Frequency of nursing facility admission, by length of stay</li> </ul>	<p>Not evaluated</p>
<ul style="list-style-type: none"> <li>Case-mix adjusted nursing facility admission</li> </ul>	<p>Not evaluated</p>
<ul style="list-style-type: none"> <li>Number of nursing facility days</li> </ul>	<p>Not evaluated</p>
<ul style="list-style-type: none"> <li>Return to AC or Elderly Waiver programs from nursing facility</li> </ul>	<p>Not evaluated</p>
<p><b>3.24 Alternative Care beneficiaries will remain in the community for as long or longer over time, when examined alone and in comparison to Elderly Waiver beneficiaries.</b> This will be evaluated using the following measures</p>	
<ul style="list-style-type: none"> <li>Remaining enrolled in AC</li> </ul>	<p>There was no significant change in continued AC enrollment between the new AC enrollee cohort prior to the waiver approval and a comparable cohort after waiver approval.</p>
<ul style="list-style-type: none"> <li>Transitions from AC to Elderly Waiver</li> </ul>	<p>There was no significant change in transitions to the EW between the new AC</p>

Hypotheses	Preliminary Findings
	enrollee cohort prior to the waiver approval and a comparable cohort after waiver approval.
<ul style="list-style-type: none"> <li>Days alive in the community and not on Medicaid</li> </ul>	There was no significant change in mortality between the new AC enrollee cohort prior to the waiver approval and a comparable cohort after waiver approval.
<ul style="list-style-type: none"> <li>Use of Medicare services</li> </ul>	Not evaluated
<ul style="list-style-type: none"> <li>Use of Essential Community Supports</li> </ul>	Not evaluated

## 6. Further Evaluation

In this preliminary analysis, we concentrated on building baseline data sets, refining measures, and conducting preliminary analysis. The lag in processing Medicaid claims and in receipt of Medicare data limited the timeframe for the analysis of changes after waiver approval. Nonetheless, we defined and conducted the preliminary analysis to test our hypotheses.

In the coming year (June 2017 – June 2018), the planned analysis will consist of multiple strategies involving descriptive statistics, cross-sectional comparisons at different time points, and longitudinal analysis of beneficiary-level care transitions, program transitions, and health outcomes. Comparisons will be made between AC and Elderly Waiver beneficiaries. We will continue with repeated cross-sectional analysis tracking AC and EW recipient demographics, case-mix and functional status and use of services waiver in the pre-waiver period (where data are available) and during the period after the waivers was in place. We will have more longitudinal data available to examine changes over time with a time series trend analysis, either multilevel models of change or differencing models.

1. **Repeated cross-sectional beneficiary-level analysis.** Descriptive statistics will be prepared on the beneficiary population each year during baseline (2010-2016). Characteristics described will include demographics, health and functional status, transitions between care settings (private home, residential care setting or nursing home) and programs (AC and Elderly Waiver), service use and Medicaid expenditures, acute care use (Medicare and Medicaid), and other variables.
2. **Interrupted time series analysis.** In order to assess changes in major variables over time in the AC and Elderly Waiver populations, we will conduct an interrupted time series analysis where:

Outcomes: AC and Elderly Waiver service use, Medicaid expenditures; transitions between care settings; movement in, out and between AC and Elderly Waiver programs; and acute care service use.

Time Periods: The time periods for the longitudinal analysis will be months for some outcomes, e.g. transitions between care settings and movement in and out of AC and Elderly Waiver programs, and calendar quarters or years for other outcomes, e.g., Medicaid expenditures

Covariates: demographics, health and functional status, length of time in the AC or Elderly Waiver program, and other variables found to be significant in analysis step 1.

Two approaches will be used for the analysis difference-in-difference equations and mixed-effect growth models. With both approaches the change in the outcomes for beneficiaries will be modeled as a function of time, AC waiver period (before or after), covariates (fixed or time-varying).

- 3. Essential Community Supports.** Future analysis of the AC cohort(s) will include entry into the Essential Community Supports Program (ECS). The ECS program was established by the Minnesota Legislature and became effective January 1, 2015. Initially designed to provide support for individuals who might lose their HCBS program eligibility as a result of changes to the nursing facility level of care criteria that also became effective January 1, 2015, it was also adopted as an ongoing program for individuals aged 65 and older with emerging needs for HCBS but who do not yet meet level of care criteria and who are not MA eligible but meet the AC financial eligibility criteria. This program has a relatively small basket of services and monthly budget.

Minnesota  
 MEDICAL ASSISTANCE PROGRAM  
 Recipient and Cost Projections  
 Basic Care by Type of Eligibility  
**February 2017 Forecast**

Fiscal Year -----	Monthly Average Eligibles -----	Monthly Average Payment Per Eligible -----	Total Annual Payments -----
<b>Families with Children</b>			
1991	256,014	112.74	346,361,325
1992	284,323	125.86	429,427,482
1993	310,526	129.45	482,389,596
1994	318,954	133.89	512,446,352
1995	318,819	155.07	593,254,906
1996	309,748	154.44	574,039,859
1997	295,216	162.95	577,252,646
1998	269,504	171.20	553,658,796
1999	250,538	191.45	575,596,558
2000	244,121	217.80	638,032,932
2001	250,196	224.21	673,159,000
2002	265,846	250.51	799,164,565
2003	301,473	260.57	942,667,113
2004	320,667	282.83	1,088,312,326
2005	336,398	272.35	1,099,400,594
2006	348,040	305.70	1,276,754,247
2007	356,464	334.10	1,429,124,611
2008	369,358	361.64	1,602,905,436
2009	395,274	373.92	1,773,624,736
2010	440,574	382.01	2,019,661,085
2011	463,151	384.00	2,134,186,227
2012	467,311	379.31	2,127,047,217
2013	471,949	341.35	1,933,195,089
2014	532,952	386.12	2,469,410,471
2015	668,752	339.82	2,727,026,016
2016	690,105	367.12	3,040,193,231
2017	703,343	330.32	2,787,931,382
2018	717,884	382.17	3,292,236,498
2019	722,358	385.22	3,339,161,637
2020	724,560	401.57	3,491,569,213
2021	735,557	415.88	3,670,823,651

0.03903754

Minnesota  
 MEDICAL ASSISTANCE PROGRAM  
 Recipient and Cost Projections  
 Basic Care by Type of Eligibility

**Adults with No Children**

Fiscal Year -----	Monthly Average Eligibles -----	Monthly Average Payments -----	Total Annual Payments -----
2011	27,841	319.86	106,865,468

2012	81,229	840.77	819,539,240		
2013	85,466	772.46	792,232,465		
2014	121,353	730.48	1,063,752,126		
2015	199,310	708.49	1,694,519,567		
2016	209,379	660.24	1,658,897,539		
2017	203,373	709.37	1,731,189,298		
2018	207,980	739.80	1,846,368,511		
2019	207,093	767.26	1,906,729,594		
2020	202,041	802.41	1,945,435,214		
2021	206,065	825.93	2,042,359,729		0.037532575

Fiscal Year	Monthly Average Eligibles	Monthly Average Payments	Total Annual Payments	Total Pmts. Excluding EW HMO	Monthly Average Payment Excluding EW HMO	
<b>Elderly</b>						
1991	41,163	208.92	103,195,807			
1992	44,853	239.77	129,053,421			
1993	48,252	233.85	135,407,525			
1994	48,655	221.75	129,470,525			
1995	49,473	281.37	167,042,561			
1996	49,667	323.15	192,597,915			
1997	48,847	336.02	196,962,920			
1998	47,890	362.30	208,205,153	207,746,186		
1999	47,445	419.57	238,878,981	237,706,209		
2000	47,748	455.79	261,156,531	259,153,619		
2001	48,345	489.13	283,765,447	280,743,351		
2002	50,583	563.28	341,911,325	336,758,634		
2003	51,492	622.27	384,500,096	379,785,426		
2004	52,224	725.44	454,626,046	445,611,006		
2005	52,725	727.93	460,561,790	449,745,308		
2006	54,216	815.22	530,378,428	468,462,829		
2007	54,831	863.93	568,444,815	434,370,169		
2008	55,237	971.15	643,721,598	468,012,069	706.07	
2009	55,562	1,097.27	731,599,545	504,681,233	756.93	
2010	56,015	1,193.05	801,945,193	536,661,224	798.39	
2011	56,474	1,259.77	853,732,496	579,831,831	855.60	
2012	56,948	1,275.27	871,497,671	597,163,420	873.84	
2013	57,339	1,186.33	816,277,557	566,420,266	823.20	
2014	59,028	1,405.17	995,336,255	677,768,134	956.84	
2015	60,093	1,328.11	957,729,642	653,778,571	906.61	
2016	61,305	1,500.02	1,103,513,112	747,087,991	1,015.53	
2017	63,848	1,421.14	1,088,844,078	763,995,950	997.16	
2018	65,971	1,745.95	1,382,185,969	957,034,274	1,208.91	
2019	67,686	1,755.06	1,425,516,455	991,796,556	1,221.08	
2020	69,665	1,853.51	1,549,498,006	1,077,989,157	1,289.49	
2021	71,675	1,951.02	1,678,072,241	1,165,121,372	1,354.64	0.05327
<b>Disabled or Blind</b>						
1991	41,246	235.77	116,693,183			
1992	43,900	268.82	141,618,009			
1993	53,528	266.58	171,235,472			
1994	60,578	221.23	160,819,940			
1995	65,149	272.98	213,414,322			
1996	67,130	523.23	421,495,080			
1997	67,428	509.45	412,211,274			
1998	66,689	543.09	434,617,013			
1999	68,099	580.19	474,121,480			
2000	71,494	625.67	536,782,101			
2001	75,345	660.79	597,443,812			

2002	81,429	713.70	697,394,299
2003	86,545	773.58	803,392,898
2004	90,759	782.63	852,367,162
2005	93,738	864.04	971,925,132
2006	96,150	814.36	939,606,470
2007	98,860	798.35	947,095,482
2008	102,406	814.17	1,000,514,624
2009	106,501	872.22	1,114,709,849
2010	112,062	892.91	1,200,732,554
2011	118,017	816.61	1,156,485,326
2012	121,901	852.25	1,246,683,704
2013	124,404	851.74	1,271,515,559
2014	124,923	1,003.96	1,505,002,871
2015	121,663	949.51	1,386,250,776
2016	118,617	1,037.86	1,477,298,636
2017	117,064	1,011.23	1,420,547,927
2018	117,480	1,174.31	1,655,495,307
2019	119,244	1,186.68	1,698,054,832
2020	121,971	1,246.62	1,824,607,680
2021	124,472	1,301.64	1,944,212,307

0.047318

**Department of Human Services**

**Health Care Administration**

**Request for Comments on the Reform 2020 Section 1115 Medicaid Waiver Renewal**

**Request**

DHS is announcing a 30-day comment period on the Reform 2020 Section 1115 Medicaid waiver renewal request. On October 18, 2013, the Centers for Medicare & Medicaid Services approved Minnesota's section 1115 demonstration project, entitled Reform 2020. The Reform 2020 waiver provides federal support for the Alternative Care program, which provides supports to help seniors at risk of nursing home placement to stay in their homes. The waiver also provides federal expenditure authority for children under the age of 21 who do not meet the institutional level of care as of January 1, 2015 and would therefore lose Medicaid eligibility without the demonstration. The Reform 2020 demonstration waiver will also provide access to expanded self-directed options under the Community First Services and Supports (CFSS) program for people who would not otherwise be eligible for these services. Implementation of this part of the demonstration is contingent upon federal approval of additional state plan and waiver authority. The current Reform 2020 waiver expires June 30, 2018. The proposed renewal request seeks to continue the current waiver for another three-year period, through June 30, 2021.

DHS invites public comment on the Reform 2020 waiver renewal request. Comments received will be posted on the DHS website. A copy of the waiver renewal request can be found at [Reform 2020 Waiver](#). To request a paper copy of the waiver request, please contact Betty Bonnell at (651) 431-2836.

Written comments may be submitted to the following email mailbox:

[Section1115WaiverComments@state.mn.us](mailto:Section1115WaiverComments@state.mn.us) or by mail to the address below. DHS would like to provide copies of comments received in a format that is accessible for people with disabilities. Therefore, we request that comments be submitted in Microsoft Word format or incorporated within the email text. If you would also like to provide a signed copy of the comment letter, you may submit a second copy in Adobe PDF format or mail it to the address below. Comments must be received by June 21, 2017.

Marie Zimmerman  
Medicaid Director  
Minnesota Department of Human Services  
P.O. Box 64983  
St. Paul, Minnesota 55164-0983

In addition to the opportunity to submit written comments during the 30-day public comment period, public hearings will be held to provide stakeholders and other interested persons the opportunity to comment on the waiver request. You may attend by phone or in person. If you would like to attend by phone, please send an email request to [Section1115WaiverComments@state.mn.us](mailto:Section1115WaiverComments@state.mn.us) to obtain the call-in information. If you would like to attend a hearing in person, the locations for the two public hearings are provided below. If you plan to testify by phone or in person, please send an email to [Section1115WaiverComments@state.mn.us](mailto:Section1115WaiverComments@state.mn.us) indicating that you will testify.

**Public Hearing #1**

Date: Wednesday, May 31, 2017  
Time: 3:00 p.m. to 4:00 p.m.  
Location: Department of Human Services, Elmer L. Andersen Human Services Building,  
540 Cedar St., St. Paul, MN 55101. Room 2370

**Public Hearing #2**

Date: Thursday, June 1, 2017  
Time: 1:00 p.m. to 2:00 p.m.  
Location: Department of Human Services, 444 Lafayette Rd., St. Paul, MN 55155. Room  
1238

Attachment F  
**Medicaid Tribal Consultation Process**

DHS will designate a staff person in the Medicaid Director's office to act as a liaison to the Tribes regarding consultation. Tribes will be provided contact information for that person.

- The liaison will be informed about all contemplated state plan amendments and waiver requests, renewals, or amendments.
- The liaison will send a written notification to Tribal Chairs, Tribal Health Directors, and Tribal Social Services Directors of all state plan amendments and waiver requests, renewals, or amendments.
- Tribal staff will keep the liaison updated regarding any change in the Tribal Chair, Tribal Health Director, or Tribal Social Services Director, or their contact information.
- The notice will include a brief description of the proposal, its likely impact on Indian people or Tribes, and a process and timelines for comment. At the request of a Tribe, the liaison will send more information about any proposal.
- Whenever possible, the notice will be sent at least 30 days prior to the anticipated submission date. When a 30-day notice is not possible, the longest practicable notice will be provided.
- The liaison will arrange for appropriate DHS policy staff to attend the next Quarterly Tribal Health Directors meeting to receive input from Tribes and to answer questions.
- When waiting for the next Tribal Health Directors meeting is inappropriate, or at the request of a Tribe, the liaison will arrange for consultation via a separate meeting, a conference call, or other mechanism.
- The liaison will acknowledge all comments received from Tribes. Acknowledgement will be in the same format as the comment, e.g. email or regular mail.
- Liaison will forward all comments received from Tribes to appropriate State policy staff for their response.
- Liaison will be responsible for insuring that all comments receive responses from the State.
- When a Tribe has requested changes to a proposed state plan amendment or waiver request, renewal, or amendment, the liaison will report whether the change is included in the submission, or why it was not included.
- Liaison will inform Tribes when the State's waiver or state plan changes are approved or denied by CMS, and will include CMS' rationale for denials.
- For each state plan or waiver change, the liaison will maintain a record of the notification process; the consultation process, including written correspondence from

Tribes and notes of meetings or other discussions with Tribes; and the outcome of the process.

**Attachment G**

**Minnesota Department of Human Service  
Federal Relations, Health Care Administration  
540 Cedar St.  
St. Paul, MN 55101**

May 22, 2017

Re: Request for Comments on Reform 2020 Waiver Renewal Request

Dear Tribal Health Director:

This letter is to inform you that the Minnesota Department of Human Services is announcing a 30-day comment period on the request to renew the Reform 2020 waiver.

On October 18, 2013, the Centers for Medicare & Medicaid Services approved Minnesota's section 1115 demonstration waiver, entitled Reform 2020. The Reform 2020 waiver provides federal support for the Alternative Care program, which provides supports to help seniors at risk of nursing home placement to stay in their homes. The waiver also provides federal expenditure authority for children under the age of 21 who do not meet the institutional level of care as of January 1, 2015 and would therefore lose Medicaid eligibility without the demonstration. The Reform 2020 demonstration waiver will also provide access to expanded self-directed options under the Community First Services and Supports (CFSS) program for people who would not otherwise be eligible for these services. Implementation of this part of the demonstration is contingent upon federal approval of additional state plan and waiver authority.

The current Reform 2020 waiver expires June 30, 2018. The proposed renewal request seeks to continue the current waiver for another three-year period, through June 30, 2021. A copy of the renewal request and information on the public comment process is available at [Reform 2020 Waiver](#).

Questions or comments regarding this notification or the waiver renewal application are welcome at any time within the next 30 days and should be submitted to Stacie Weeks, DHS Health Care Federal Relations. I can be reached by telephone at (651) 431-2151, in writing at PO Box 64983, St Paul, MN 55164-0967 or via email at [Stacie.Weeks@state.mn.us](mailto:Stacie.Weeks@state.mn.us). TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529.

Sincerely,

Stacie Weeks  
Federal Relations  
Minnesota Department of Human Services

## Attachment H

### Email received on Reform 2020

**Sent:** Friday, May 26, 2017 12:59 PM

**Subject:** Re medical funding both private & govt

Re 2020 reform waiver & other services & their abuses!! While the disabled vulnerable are in dire need of med help the crooks in guise of providers, crook criminal justice reps continue to prey on the disable veterans & vulnerable seniors & young people funding, it is a shame, while the superiors, lawmakers, law enforcement keep looking the other way what is in it for them perhaps getting campaign funding or a bribe to hush up but for sure these small time politicians are definitely using & abusing their power using hackers to change data to custom feed their needs, they're putting an illegal or even bringing in people or using crooks from other countries giving or using our families's identity! Go to Hospitals while u are there use ur info to use ur blood like they took 6 viles of my disable son probably to support their illegal people a legal status in court they're waltzing in & out of our country using refugees status coming in from Germany, using those international flights perhaps work for that country's Airlines! Security is definitely lacking or is so busy you dummies the crooks are right under our noses hacking our communicative devices!!don't tell me you to have used these hackers some way so naturally u couldn't do anything as your name will come up! Well u r not looking at the big picture they're plundering our government & private financial institutions they're stealing our ids using our account # this is no laughing matter they're using your insurance, Auto health & the crooks befriends the adjusters, having or getting doctors, & very sick patient's data on a normal person to support all they do is change the names to custom feed their needs & bill our state or insurance company using data from other countries.Stop trying to go after insignificant stuff, focus on our Country First there is an indian saying " light a candle in your home first than at the place of worship" our country is our home' protect it & our citizen. A mother of a disable Autistic nonverbal son with a seizure disorder!

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