Medical Assistance Reform Report

Office of the State Medicaid Director

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Minnesota Department of **Human Services**

Legislative Report

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Executive Summary

This report has been prepared to address the requirements of the Minnesota Legislature as delineated in Section 53, Subdivision 3 of statute 256b.021. The Minnesota Legislature, in order to reform components of the medical assistance (MA) program, directed the Commissioner of the Department of Human (DHS) services "to develop a proposal to the United States Department of Health and Human Services which shall include any necessary waivers, state plan amendments, requests for new funding or realignment of existing funds, and any other federal authority that may be necessary for the projects."

This document is intended to satisfy the reporting requirement of this law while illustrating how redesign efforts may coordinate with current and ongoing department initiatives. It also provides detailed programmatic background and conceptual framework which includes specific options and next steps for development of new service delivery designs.

The legislation designated twelve separate initiatives be examined in this report. To best achieve this request, each initiative has its own short report with sections to address background, service delivery, vision, next steps and supporting detail. The report was a collaborative effort across DHS and is designed to identify initiatives that support a wide range of medical assistance recipients from those with the lowest to those with the most needs all while delivering the right level of services, at the right time.

Initiatives are listed in the same order as in the legislative language. A few pieces of the report require more than one section to sufficiently explain service delivery and coordination across complex systems. The report addresses how Minnesota might reform components of the medical assistance program for seniors, people with disabilities or other complex needs and medical assistance enrollees in general to:

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

The Department of Human Services' goal is to provide reform recommendations that will effectively meet people's needs, better align services and while ensuring long-term sustainability.

Purpose of the Report

This report has been prepared to address the requirements of the Minnesota Legislature as delineated in Section 256B.021, Subdivision 3 of Minnesota Statutes.

Section 256B.021 9 (see Appendix A) required that the Commissioner of the Department of Human Services, in order to reform the medical assistant (MA) program, to "develop a proposal to the United States Department of Health and Human Services which shall include any necessary waivers, state plan amendments, requests for new funding or realignment of existing funds, and any other federal authority that may be necessary for the projects. Section 53 also requires "the commissioner shall ensure all projects are budget neutral or result in savings to the state budget, considering cost changes across all divisions and other state agencies that are affected." This document meets the Commissioner's obligation to report the progress of this waiver and the Department's recommendations by January 15, 2012.

The Minnesota Legislature intended to reform components of the medical assistance program to achieve better outcomes, "such as community integration and independence; improved health; reduced reliance on institutional care; maintained or obtained employment and housing; and long-term sustainability of needed services through better alignment of available services that most effectively meet people's needs, including other state agencies' services."

In order to accomplish this goal, the legislature designated twelve initiatives to be examined. These initiatives are:

a. Health Care Delivery Demonstration
b. Promote Personal Responsibility and Encourage and Reward Health Outcomes
c. Encourage Utilization of High Quality, Cost-effective Care
d. Adults Without Children Eligibility Proposal
e. Empower and Encourage Housing, Work and Independence
f. Redesign Home and Community Based Services
g. Coordinate and streamline services for Individuals with Complex Needs
h. Implement Nursing Facility Level of Care Criteria
i. Improve Integration of Medicare and Medicaid
j. Redesign Intensive Residential Treatment Services
k. Waive the Institution for Mental Disease (IMD) Exclusion for Anoka Metro Regional Treatment Center (AMRTC)
l. Seek Exception to the IMD Exclusion for Individuals under Age 21

WORK PROCESS

DHS effort to develop this reform proposal began in August 2011. To ensure agency- wide representation, DHS created workgroups across the major administrations. Subgroups were formed around different policy themes. Workgroups formed include the duals planning grant team for (i), a chemical and mental health team for (j,k,l),several long-term care reform workgroups (e,f,g and h) and separate housing and employment workgroups for (e).

Each workgroup was directed to engage necessary stakeholders and the public, holding several meetings for their respective initiatives. These meetings typically included an overview of the Medical Assistance Reform initiative overall followed by subject specific information. A discussion then took place to solicit stakeholder feedback for inclusion in the department's recommendations. A list of stakeholder groups and meetings is available in Appendix B.

In addition to the workgroups above, an assistant commissioner level senior leadership group met on a bi-weekly basis to monitor progress and provide recommendations and guidance for workgroups.

Workgroups and stakeholder groups will continue to meet through February 15, 2012, and some will continue to work throughout 2012. Once projects have been finalized by workgroups and their stakeholders, DHS will provide the Legislature with an addendum to this report which will highlight additional detail and significant project changes which differ from this report. After the addendum, additional updates will be provided to the Legislature and general public as needed.

TIMELINE

A draft Section 1115 waiver and necessary state plan amendments will be completed by March 15th and released for a public comment and tribal consultation period. After the public comment period has closed, the Section 1115 Waiver will be submitted in mid to late April 2012.

DHS will negotiate the terms and conditions of the waiver and any state plan amendments over the course of the next eight months with the intent to complete negotiations by December 2012. DHS will then present to the legislature the authority we receive and the department will bring forward budget and policy changes necessary to implement these projects.

BUDGET NEUTRALITY REQUIREMENTS

The legislature required these proposals in the aggregate, to be cost neutral to the state budget. Prior to the submission of the Section 1115 waiver, budget and forecasting staff, in

consultation with Minnesota Management and Budget (MMB) will undertake a fiscal analysis to ensure that the overall proposal meets the cost neutral requirement.

Therefore, any individual proposal outlined in this report may change or be removed if it does not meet the budget neutrality requirement.

CONCLUSION

It is a priority of the Department of Human Services to effectively meet people's needs, improve health outcomes, increase independence and community integration, and ensure long-term sustainability of services while delivering the right services at the right time. DHS looks forward to working with stakeholders and the legislature to help guarantee Minnesota's citizens have a high value and high quality Medical Assistance program.

Section One - Health Care Delivery Demonstration Projects

M.S. 256B.021, Subd. 4, paragraph (a)

BACKGROUND

Minnesota has long been a national leader in developing innovative and effective Medicaid payment and care delivery models such as health care homes and integrated Medicare and Medicaid managed care programs. These reforms have been premised on the idea that incentives in the health care payment system need to be adjusted and aligned to promote better outcomes and lower costs. Recently, these projects have sought to support robust primary care, improve care coordination and test payment models that increase provider accountability for the quality and total cost of care provided to Medicaid enrollees.

VISION

A 2010 state law authorized DHS to develop a Medicaid demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations, that would provide services to certain patient populations based on a total cost of care and risk/gain-sharing arrangements. In 2010, a law also passed that enabled Hennepin and Ramsey counties to establish pilot programs to provide health delivery networks to adults without children with income at or below 75 percent of the FPG.

Since the beginning of 2011, DHS has aggressively worked to implement both of these projects. In October 2011, DHS issued a request for proposals for a Health Care Delivery System (HCDS) demonstration to which nine applicants responded. DHS also entered into formal negotiations with Hennepin County in November 2011 to create a pilot program for adults without children.

NEXT STEPS

DHS expects to implement the first phase of the HCDS demonstration projects by April 2012. Contract negotiations are underway with all nine applicants. As of January 1, 2012, DHS and Hennepin County entered into a contract to establish *Hennepin Health*, an integrated health delivery network that will serve adults without children.

DHS has submitted the necessary requests for the federal authority needed for these projects.

Section Two – Promote Personal Responsibility and Encourage and Reward Health Outcomes

M.S. 256B.021, Subd. 4, paragraph (b)

BACKGROUND

Health care cost is recognized as a growing component of the U.S. Gross Domestic Product and a commensurate leading cost driver of state budgets. There is growing consensus these costs are unsustainable. Interventions that address behavioral and social circumstances that influence participation in preventive health services have proven to have a positive impact on health outcomes and may decrease growth in health expenditures. One way to encourage difficult changes in life habits such as overeating or smoking, research has shown, is to offer economic incentives to those who reach health goals.

VISION

Recognizing the important role of preventive health services in controlling rising health care costs, DHS intends to seek Medicaid funding to provide individual and group incentives to encourage healthy behavior and prevent the onset of chronic disease by rewarding improved health outcomes. Focus areas may include diabetes prevention and management, tobacco cessation, reducing weight and lowering cholesterol, and lowering blood pressure. To support this vision, DHS applied for and received a $10 million five-year grant from CMS to test the effects of incentives on the participation and success in diabetes prevention activities for people enrolled Minnesota's Medicaid program. This project, known as *We Can Prevent Diabetes MN*, will provide the opportunity for more than 3,200 Medical Assistance enrollees between the ages of 18 and 75 in the metro area who have a diagnosis of pre-diabetes or significant risk of developing diabetes to participate in a diabetes prevention program. The program will include 16 weekly and eight monthly sessions that are free to all participants.

NEXT STEPS

We Can Prevent Diabetes MN is scheduled to launch in the metro area in April, 2012. DHS will continue to seek ways to expand the program statewide, either through additional funding from CMS or other innovative financing mechanisms. DHS will also explore expanding incentive programs to address other areas such as tobacco use and high blood pressure.

Section Three – Encourage Utilization of High Quality, Cost-effective Care

M.S. 256B.021, Subd. 4, paragraph (c)

BACKGROUND

In 2008 Minnesota enacted a major bipartisan health reform law to improve health care access and quality and to contain the rising costs of health care. A cornerstone of the law is the Provider Peer Grouping (PPG) initiative at the Minnesota Department of Health (MDH), the purpose of which is to develop a comprehensive system that provides information about health care value – both cost and quality. PPG will compare physician clinics and hospitals based on a combined measure of risk-adjusted cost and quality to offer a clearer picture of each provider's value.

Providers will be able to use the results to improve their quality and reduce costs and consumers can use it to make more informed health care choices. Also, the law requires employers and health plans to use it in developing products that encourage consumers to use high-quality, low-cost providers.

The first set of provider results will be made public at the end of 2012.

VISION

As one of the largest health care purchasers in the state, DHS intends to maximize the benefit PPG by creating incentives to encourage the utilization of high quality, low cost, high-value providers through MA enrollee cost-sharing and other yet-to-be determined incentives. As an example, enrollees who seek care from a high value provider could have their copayments reduced or eliminated. Some people on MA are exempt from copayments, so other incentives will have to be identified in order for them to take advantage of this initiative. Also, DHS will need to consider if or how the program should be implemented in parts of the state where access to high value providers is limited.

NEXT STEPS

DHS will work, in consultation MDH, to develop this project and implement it on Jan. 1, 2013, contingent upon federal approval. In constructing the program, DHS will attempt to identify non-cost-sharing incentives that would effectively influence an enrollee's choice of providers.

Section Four – Adults Without Children Eligibility

M.S. 256B.021, Subd. 4, paragraph (d)

BACKGROUND

Prior to June 2010, adults without children with incomes at or below 75 percent of FPG in Minnesota were eligible for health insurance through the state-funded programs, General Assistance Medical Care (GAMC) and MinnesotaCare. For a single adult, the GAMC program had an asset limit of $1,000, and MinnesotaCare imposed an asset limit of $10,000. From June 2010 through February 2011, the GAMC program covered only prescription drugs, and a more limited benefit set was delivered through coordinated care delivery systems.

The passage of the Affordable Care Act (ACA) allowed states to provide Medicaid coverage to adults without children with incomes up to 138 percent FPG. This provision, however, prohibited states from imposing an asset test as a condition of eligibility. The 2010 Legislature authorized the expansion of Medical Assistance (MA) for adults without children with incomes up to 75% FPG upon executive order by the governor. Governor Dayton issued the executive order, and this expansion was implemented effective March 1, 2011. The 2011 Legislature then required DHS to seek waiver authority to impose an asset test of $10,000 on adults without children enrolled in MA.

Adults without children with income between 75 percent and 250 percent of FPG are eligible for MinnesotaCare coverage. Since the beginning of the program, these enrollees have not been eligible for federal funding. Effective August 2011, through the renewal of the Prepaid Medical Assistance Program Plus (PMAP+) waiver by CMS, the state became eligible for Medicaid matching funds for expenditures on behalf of adults without children enrolled in MinnesotaCare. As a condition of federal financial participation, CMS required the state to eliminate the then-existing 180-day durational residency requirement. The 2011 Legislature authorized initial implementation of federally funded MinnesotaCare for this group under these conditions, but required DHS to seek a waiver amendment in order to impose a residency requirement.

NEXT STEPS

DHS will seek a waiver to the ACA that allows the state to impose an asset test for adults without children enrolled in MA with incomes at or below 75 percent of FPG. DHS will also submit an amendment to the PMAP+ waiver to reinstate the 180-day residency requirement for adults without children in MinnesotaCare. Both requests will be made in the spring of 2012.

Section Five – Work: Empower and Encourage Independence

M.S. 256B.021, Subd. 4, paragraph (e)

BACKGROUND

Helping individuals maintain employment has been shown to delay or prevent the need to qualify for disability services, which can result in lower state and federal expenditures. Mental health recovery models cite employment as a factor that contributes to recovery by contributing to people's independence, self-esteem and feelings of self-worth, as well as by providing the kinds of social connections that result from working. Paid employment also contributes to economic stability and potentially interacts with people's ability to access and maintain housing. Investment in employment supports has the potential to contribute in a positive way to MA reform.

The goal of this section of the law is to help delay or prevent permanent disability, and reduce the need for long-term care services and supports for individuals who have a potentially disabling condition but are not yet certified as disabled. Increased employment can increase productivity, tax payments, and discretionary income of those working while reducing dependency on public programs. Employment supports may also help individuals maintain or obtain employment or return to work.

Minnesota has benefited from several projects aimed at decreasing barriers to employment and improving employment outcomes of people with disabilities. These include:

Pathways to Employment, which provided policy and program support to the Medical Assistance for Employed People with Disabilities (MA-EPD) program, developed policies that focused on employment within community integration and consumer-directed initiatives, and worked within DHS and with partner agencies to generate ongoing support of employment of people with disabilities.

The Demonstration to Maintain Independence and Employment (DMIE), which was a research project completed in 2010 that studied the effects of providing a comprehensive set of health, behavioral health care services and employment-related supports to employed persons with serious mental illness. Compared to the control group, DMIE participants were less likely to pursue a disability determination, experienced improvements in functioning and greater job stability, earned higher wages, and were less likely to delay or skip needed care due to cost.

Individual Placement Support (IPS), a Johnson and Johnson/Dartmouth demonstration grant, tested supported employment, or IPS/supported employment in six pilot sites. Principles of the IPS model have been integrated into ongoing efforts within DHS, including motivational interviewing training for mental health and addictions treatment staff and Evidence Based Practice Fidelity scale reviews for mental health agencies.

DHS currently provides employment support services through the home and community-based waiver programs, mental health services, and TANF/DWP programs.

Considerations
This element intersects directly with all other DHS initiatives and reform elements as individuals served in every program may need to be connected with employment supports.

We will leverage existing relationships with the departments of Employment and Economic Development (DEED) and Education (MDE) and engage representatives from both agencies for collaboration.

Employment supports should be included as a component of holistic care models and we will engage stakeholders from the medical provider community to research collaboration opportunities.

Options

Services will be designed to benefit a wide range of people identified as having a potentially disabling condition. We are designing supports that will serve populations according to their needs, and plan a phased approach with several subgroups. Preliminary discussions have identified several groups as having characteristics consistent with those of participants in past projects who had the best outcomes with similar supports. These include:

- MinnesotaCare and MA recipients who have multiple chronic conditions
- MinnesotaCare and MA recipients who have a severe mental illness, including parents with disabilities with children on MFIP
- Certain unemployed and low wage workers, Family Stabilization Services recipients, families with parents with serious, chronic and often multiple health problems and their children.
- Health care homes recipients (dependent upon direction the state takes with initiative)

Services are also being designed to function as part of potential wrap-around options in future health insurance exchanges. Employment and navigation support services will help prevent exchange eligible individuals from experiencing income fluctuations above and below the MA income standard of 138% of FPG. People whose income is close to the standard are at risk of losing program eligibility and are at risk of gaps in coverage.

Services
For people with potentially disabling conditions, there is a continuum of ability levels and readiness to enter the workforce. For this reason, job match and support strategies must be individualized for each worker. For those individuals who are already working, there is a continuum of work effort ranging from periodic to steady employment, from part-time to full-time hours, from entry-level to professional positions, and from starting one's own business to managing an enterprise that employs others. Potential employment, benefits planning and navigation services may include:

Wellness assessment and goal setting: a navigation service which empowers people to learn about benefits available to them and better understand how to use them. This may be telephonic or face to face.

Benefits analysis and benefits counseling: education about how employment works together with public benefits to reduce people's fear of losing benefits due to an income increase. These services are currently available through the Disability Benefits 101 website and Disability Linkage Line.

Career counseling: job training, career planning, job placement services, worker supports, and workplace accommodation assessments.

NEXT STEPS

- Fiscal analysis will be necessary to make decisions regarding potential implementation
- Meet with MDE and DEED to further analyze how these services and supports may interact with their services and supports
- Continue stakeholder engagement

Section Six – Housing: Empower and Encourage Independence

M.S. 256B.021, Subd. 4, paragraph (e)

BACKGROUND

National research shows that stable housing can improve stability of employment, save health care dollars and contribute to personal and family stability[1]. Housing plays a vital role in the lives of all Minnesotans. The documented impact of housing instability is significant because people who don't have stable housing or are homeless cycle through costly institutional, treatment, and crisis services.

Many people who are or could become eligible for Medical Assistance have complex health challenges exacerbated by homelessness. These individuals cycle through crisis care, and other services with three results: (a) their health deteriorates, (b) the cost of delivering health care increases, and (c) the public and private sectors struggle in a very disjointed environment to provide the housing, health care, and services these people really need.

Housing is also an issue for many Minnesotans who do not qualify for MA or other government services, but the lack of housing can result in the need to enroll in these programs. People who receive services lasting several weeks or months in a hospital or nursing home may lose access to their housing due to the extended stay in a facility and may be forced to rely on government services in the long run. In addition, access to affordable safe housing is an issue for many people who receive home and community-based services, and is addressed elsewhere in this report.

Minnesota has been a national leader in documenting the demographics of homelessness and unstable housing through resources such as the Wilder Research Statewide Homeless Survey, the Homeless Management Information System, the Supportive Housing and Managed Care Pilot, and other data collected by separate state programs serving individuals moving through institutional settings such as hospitals, residential facilities, shelters, and corrections.

VISION

Stable housing is essential for efficient and cost-effective medical services. The goal of this reform is to support all people with a disability or complex health needs with the services necessary to assure safe, affordable and permanent housing. These services will be informed by evidence-based practices and, in particular, will support Permanent Supportive Housing and Critical Time Intervention evidence-based practices that have demonstrated significant beneficial health and service-cost outcomes. The reform will also seek more resources for

[1] *The Minnesota Supportive Housing and Managed Care Pilot: Quantitative Outcome Study Final Report*, prepared by The National Center on Family Homelessness, 8/14/06; and *Permanent Supportive Housing: The Evidence*. HHS Pub. No. SMA-10-4509, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2010. http://store.samhsa.gov/shin/content//SMA10-4510/SMA10-4510-07-TheEvidence-PSH.pdf.

housing support services and the Adult Rehabilitative Mental Health Services (ARMHS) rates through seeking a Medicaid match on service funds in the Group Residential Housing program. They are discussed in more detail below. Reform is needed to maximize housing choice, independence and community integration.

Target Group: Medicaid eligible individuals who have a disability, or complex needs, that create significant barriers in accessing, establishing, or retaining housing. Complex needs in this context include homelessness, and one or more of the following conditions: repeated use of institutional settings, aging or health conditions with significant functional impairments, behavioral health, and other co-occurring conditions that impair the individual's ability to live independently.

NEXT STEPS
Service Recommendations

1) Review existing service options within the home and community based service waivers and the state plan, and define services to be available in the future and their funding source to assure consistency in access to needed services for people with different diagnoses or access points. We will explore the greater provision of services that support housing access and housing stability through targeted case management and ARMHS or general case management.

2) Identify gaps in services and funding. The necessary level of service intensity is not always available. Services are not always available where a person wants to live by housing type and geography and the necessary level of service intensity is not always available. Existing housing stability services, in particular, may not continue long enough to assure stability. The following are examples of the types of services that need to be considered:

   Outreach and In-reach: To locate, contact, and engage people who do not have stable housing in order to decrease use of institutional settings by facilitating access to housing, healthcare and economic resources, and other supports. Outreach is to individuals who are living in locations not meant for human habitation or who are unstably housed. In-reach is to individuals who are in settings, such as shelters, corrections, hospitals, and treatment centers, and who do not have access to housing.

   Tenancy Support: Services that are designed to identify individual housing needs and preferences; assess barriers and develop a person-centered plan to resolve barriers to accessing, establishing, and retaining housing. Tenancy supports may include life skills training and support to: secure and maintain affordable housing, understand the rights and responsibilities of tenancy, stabilize income, support employment, foster community integration, prevent and resolve crises, develop natural support systems, and provide connection to a range of flexible, voluntary, and person-directed services.

3) Standardize quality and provider requirements as much as possible. Consider continuity or coordination of requirements and availability of options such as peer-to-peer supports to maximize individual choice.
4) Implement Housing Access Services (HAS) in all home and community based service waivers, and make it available as a demonstration service for all qualified participants in the Money Follows the Persons Rebalancing Demonstration (MFP);and, evaluate the effectiveness of HAS in serving the various populations.

Complementary strategies DHS Will Pursue:

Increase Support for Permanent Supportive Housing (PSH) – PSH is an evidence-based practice that has demonstrated positive health, housing, economic, employment, and social outcomes, which reduce reliance on costly institutional resources such as hospitals, treatment and correctional facilities and shelters. People who do not have stable housing suffer from a broad range of documented negative health impacts. Homelessness or being at risk of homelessness in the near future is the definition of housing instability. The documented economic impact of housing instability is significant because people cycle through costly institutional, treatment, and crisis services in an effort to meet their needs. This evidence-based practice refers to housing that is:
Permanent – tenancy based upon community rental or home ownership standards;
Supportive – person-directed flexible support services that focus on obtaining and retaining housing; and
Housing – a home that is affordable, private, safe, and integrated into the community.

PSH is based upon seven core principles:

1. Choice of housing
2. Separation of housing and services
3. Housing that is decent, safe, and affordable
4. Housing integration into the community
5. Rights of tenancy
6. Access to housing is not dependent on a demonstration of housing readiness
7. Flexible, voluntary services

Pilot Critical Time Intervention in the PATH – Critical Time Intervention (CTI) is an empirically supported, emerging evidence-based practice, supported by the federal Substance Abuse and Mental Health Service Administration (SAMHSA). The case management model is designed to prevent homelessness for people with mental illness following discharge from institutions by focusing CTI services during a time-limited transition period to help the individual establish themselves in stable housing, recovery oriented services, and natural supports. CTI functions by providing emotional and practical support during critical transitions and through strengthening linkages to needed services and natural supports.

The Project for Assistance in Transition from Homelessness (PATH) is a federal McKinney–Vento Homeless Assistance Act program administered by SAMHSA. Funded by federal and matching state dollars, PATH provides services for people with serious mental illness, including co-occurring substance use disorders, who are homeless or at risk of homelessness. PATH services provide community outreach, and a set of defined service activities, to engage with people and link them to housing and mainstream resources and services. In 2010, eleven Minnesota PATH providers (ten counties) contacted 3,607 individuals; 1,940 were able to enroll in PATH services and reduce their homelessness, received and were linked to mental health and other services. The need for PATH services has consistently exceeded program capacity. The Wilder Research Statewide Homeless Survey has shown that the percentage and number of individuals who are homeless with mental illness has consistently increased since the survey started identifying individuals with mental illness in 1991. The pilot will provide CTI evidence-based practice service to the PATH program participants.

Group Residential Housing Services – Group Residential Housing (GRH) is a state-funded program that provides income supports for aged, blind or disabled adults living in licensed or registered housing. In addition, GRH can provide a service payment to providers called Rate 2 if there are no other sources of funding such as Medicaid state plan or waiver services available to the individual. GRH services typically include, but are not limited to, oversight and up to 24-hour supervision, medication reminders, assistance with transportation, arranging for meetings and appointments, and arranging for medical and other services.

MA reform efforts, including the early expansion of Medicaid eligibility to persons at or below 75 percent of poverty, may create an opportunity to extend Medicaid benefits to those individuals who have disabilities with the advantage of possible savings for the state and more comprehensive services for the individual. Health care reform efforts will provide an opportunity to review the services and payments in GRH and determine if they may be covered by Medicaid in the future under either state plan amendments or waiver reform.

ARMHS Rate – Established in 2001, ARMHS provides community-based, mental health rehabilitative services to people with serious mental illness using evidence-based best practices to foster recovery and self-sufficiency. ARMHS works with individuals diagnosed with serious mental illness to reduce the severity of symptoms, as well as the impact of related functional limitations and barriers. Unlike the Day Treatment program which ARMHS replaced, the majority of the services are delivered to individuals in their community and home settings. By focusing on instructing, assisting, and supporting a person to improve functioning despite mental illness, the person realizes higher levels of self-sufficiency within their community and in important personal relationships.

Transitioning to community living, household management, and connecting people to community resources are some of the key ARMHS rehabilitative interventions which assist people to obtain and maintain stable housing. Housing needs are particularly high among people served by ARMHS, with 8.2 percent of people being homeless upon admission. With its emphasis on community-based, person-centered treatment, ARMHS decreases costly acute

care hospitalization as well as other intensive residential treatment services. This effective and efficient level of service reduces homelessness, incarceration, unemployment and family fragmentation.

Despite the success of the ARMHS model, it has been a challenge to maintain provider participation due to low reimbursement rates which do not account for administrative and other non-reimbursable costs that are unique to ARMHS. In order to better support and expand the program, this reform will seek to increase the rate paid to ARMHS providers by a level and method that will be determined by DHS.

Section Seven – Long-term Care Reform: Introduction

M.S. 256B.021, Subd. 4, paragraphs (f) to(h)

BACKGROUND

Minnesota has made considerable progress over the last two decades towards rebalancing the state's long-term care delivery system for older adults and people with disabilities away from largely institution-based, toward more home- and community-based services (HCBS) and supports. Examples of state policy and program changes to support this progress include:

- "Rebalancing" from institutional to community-based services as a result of a class action and court order (Welsh v Noot, 1980) requiring the development of community services in support of the downsizing of state institutions, and also in response to the growing recognition that people with disabilities have the right to live independently, make their own choices, and enjoy full integration into society;
- A state moratorium on new construction of nursing facilities followed by additional state incentives for nursing facilities to downsize;
- A state moratorium on the development of intermediate care facilities for people with developmental disabilities (ICFs/DD) and incentives to close or downsize;
- The 1989 enactment of a plan for the closure of regional treatment centers serving people with developmental disabilities;
- 1995 legislation allowing the development of regional adult mental health initiatives, which resulted in more and better community services for people who have mental illnesses, shorter and less frequent hospital stays, and the closure of some regional treatment centers;
- The 2001 legislative/executive Long-Term Care Task Force enacted the Community Service/Service Development Grant Program to increase the capacity of the HCBS system to support older adults in their homes and communities. At the same time, incentives were enacted for the closure of nursing facility beds;
- The 2001 legislation expanded the Linkage Line Network and MinnesotaHelp ™ information, developed initially for older people, to assist people of all ages and incomes in finding the services they or their family might need to sustain a person with disabilities or an older person in the community; and
- The 2001 Options and 2005 Options Too initiatives to reduce the use of nursing facilities for younger people, and increasing relocation assistance for people to move from facilities using HCBS.

Minnesota is a national leader in directing a higher ratio of public funds to support persons with disabilities or older adults in more cost effective home and community-based settings rather than institutional settings. In addition, the state is currently implementing several initiatives to

emphasize person-centered planning across the system and improve the quality, consistency and long-term sustainability of services including:

- Assisting people (especially older people who have their own resources) who are in nursing facilities but do not need nursing facility level of care and wish to return to their homes in the community (Return to the Community);
- Establishing a moratorium on new corporate foster care licenses and encouraging the development of less expensive service options for persons with disabilities;
- Consolidating multiple tools used for the assessment of needs and the development of support plans into a new comprehensive assessment and support plan (MnCHOICES) that is designed to better support informed decisions and access to the right service at the right time;
- Establishing quality outcome standards for disability waiver services, integrate standards for residential support services to update and streamline regulatory requirements, and reduce administrative burdens on providers (Quality Outcome Standards);
- Implementing statewide standards for enrollment of long-term care providers to reduce duplication and promote uniform provider standards and capacity across the state;
- Developing consistent statewide methodologies for setting rates to reimburse providers of HCBS waivers for people with disabilities; the rates will address service needs of the individual recipients;
- Developing a tool that produces consistent payment rates for customized living and adult foster care;
- Changing personal care assistance to strengthen and clarify eligibility criteria and improve program integrity;
- Modifying HCBS level-of-care requirements for people seeking admission to nursing facilities and to the Elderly Waiver, Alternative Care, CADI and Brain Injury waivers, in order to better target services based on an individuals' needs and improve long-term sustainability of the system; and
- Expanding long-term care consultation so that people who seek to enter a registered housing with services establishment would understand all of their long-term care options.

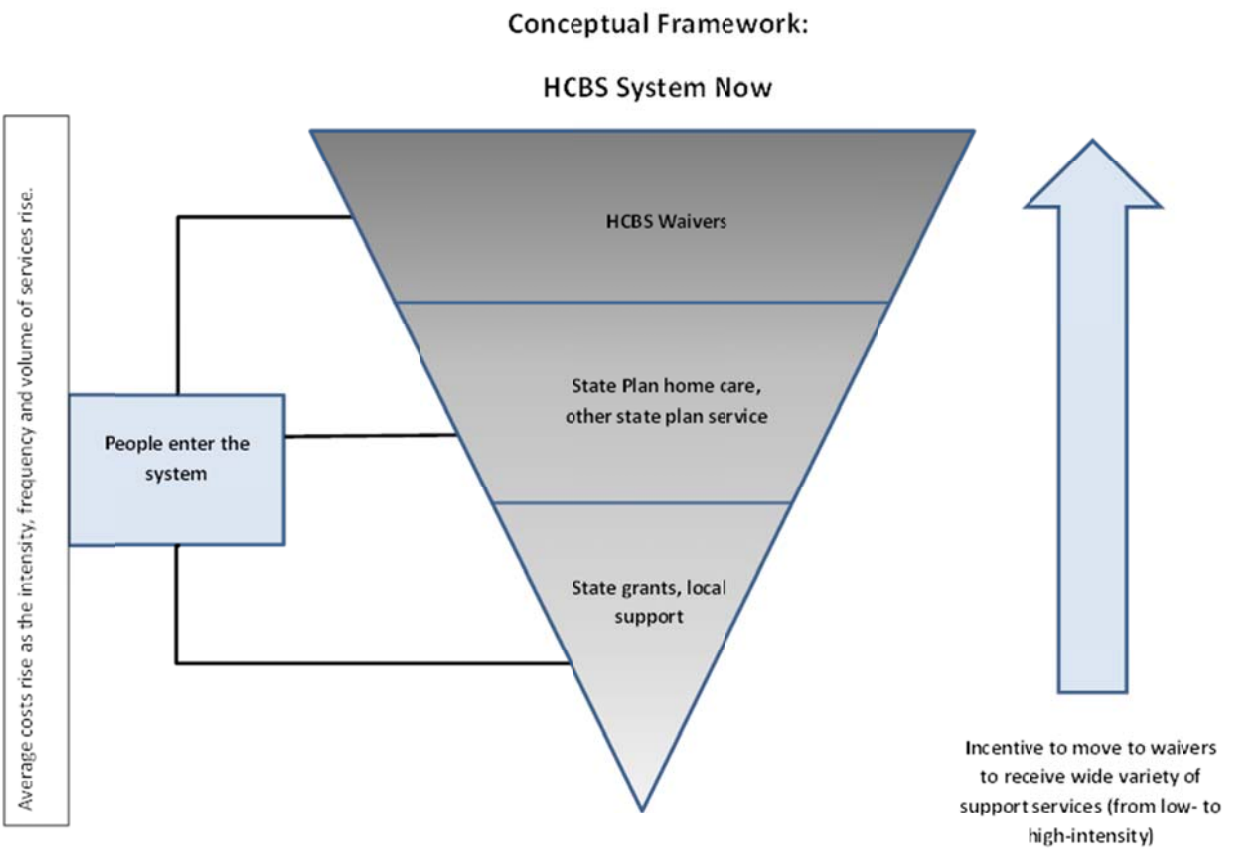
Even with these important efforts, there are competing pressures of increasing demand for services and budget constraints that are driving the need for additional reform. Pressures include:

- Changes in technology and medicine that have resulted in increased longevity for persons with a wide range of chronic conditions;
- Changing demographics as baby boomers age;
- An increase in the population over age 85, and the increasing frailty of that segment of the population;

- The need for increased community supports for individuals with severe or severe and persistent mental illness to reduce the use of hospital-based services and other services outside the DHS health care and long-term care system;
- Increasing numbers of persons with disabilities;
- Changing expectations about services that will allow people of all ages to remain in community settings;
- Availability of certain services only through HCBS, creating the potential for people to access a broader HCBS benefit set when only specific services may be required; and
- The desire on the part of service users and their families to make necessary services available based on individual need, rather than age or specific disability.

As Minnesota has experienced expansion in HCBS over the last ten years, the need for budget constraints has resulted in limits on growth. These constraints have resulted in uncertainty as to the ongoing availability of services for individuals who are accessing HCBS. Practically, this uncertainty may have resulted in an unintentional bias toward providing more extensive benefits than may be required and may also result in people being unwilling to reduce their service utilization as their needs change. Funding limits have resulted in waiting lists and uncertainty as to whether funding will be available in the future should needs change.

For the past 25 years, legislative policy reforms have established HCBS as the preferred means of supporting the long-term care needs of older adults and people with disabilities. Minnesota is increasingly serving people with the most complex needs through its HCBS programs by providing crisis interventions, end of life care and flexibly adapting through life transitions. MA reform offers an opportunity to modify the system to ensure the availability of needed services over the long term.



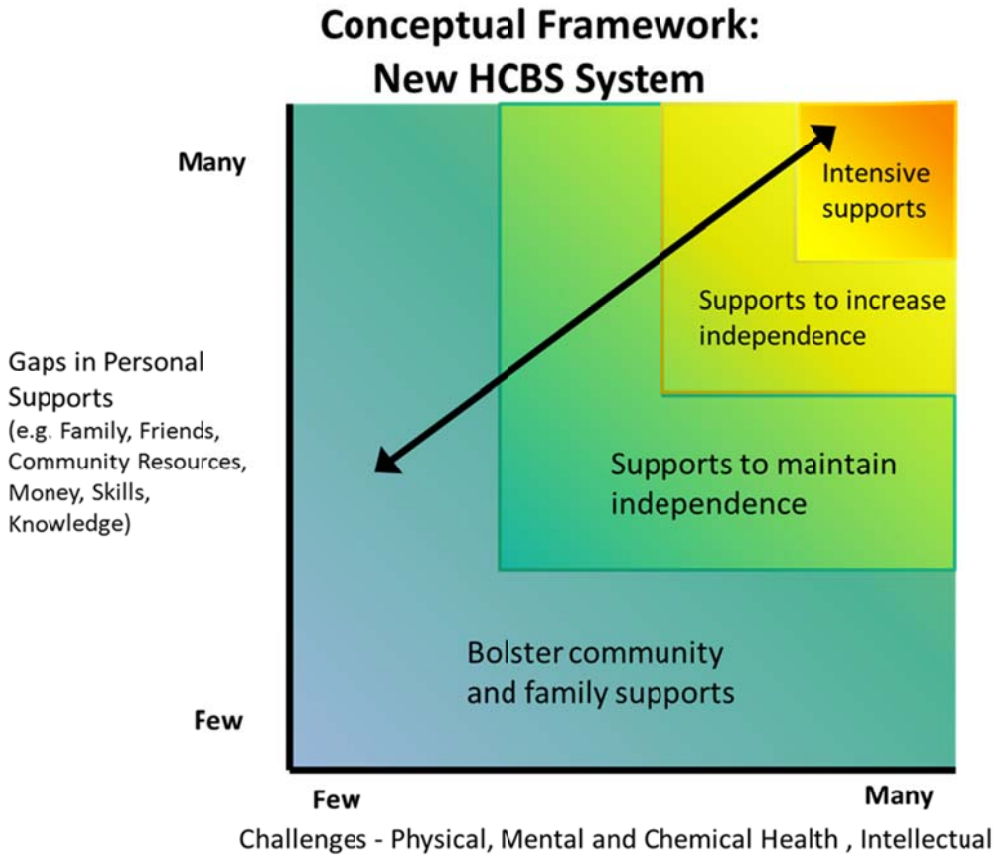
Current System Dynamic: There is pressure to move into waivered services in order to receive services that aren't available otherwise. Once on a waiver a person has access to a waiver-specific menu of services. There are people with low needs and high needs on the same waiver program.

VISION

The MA reform effort provides a critical opportunity to realign the HCBS system to:

- Maintain and increase independence by making certain basic low-cost community services available to more individuals;
- Bolster the systems that provide information and assistance, and navigational help for individuals and their families; and planning for transitions throughout their lifetime;
- Increase the utilization of self-directed services across the continuum of home- and community-based supports;
- Increase innovative integration of HCBS with chemical and mental health services, and coordination with health care;
- Assure coordination of services, especially during transitions;
- Maximize purchasing strategies and incentives to strengthen provider capacity to meet complex needs;
- Assure that people can access services with flexibility as their needs change;

- Focus more intensive service to individuals whose needs cannot be otherwise met due to the complexity of their needs or gaps in the individual's personal support system;
- Supplement, but not supplant, family and community support;
- Increase the skills and tools of service providers to work with complex individuals; and
- Explore the use of evolving technologies that support people living independently.



Desired System Dynamic: People get the right service at the right time. System is flexible and fluid, so that people get a higher level of service when needed, but stay at or return to lower levels when those are sufficient.

MA reform related to the HCBS system of MA waivers and state plan services as well as state and locally funded services is needed at this time for several reasons. From both a short-term and a long-term budget perspective, Minnesota must address the future sustainability of the MA long term care system. Primarily a function of the aging of the population and increased longevity, demands on the public payment system will challenge its ability to support the greater number of people. In addition, recent changes in federal law, and the willingness of the federal government to consider new arrangements with states provide opportunities that need analysis and call for decisions by state policy makers about pursuing these new opportunities.

Minnesota has multiple HCBS waivers that were developed at different times, for different populations to respond to different pressures. They have been built over time with incremental change upon incremental change. This has made the system hard to navigate and calls for simplification on behalf of providers, lead agencies, and recipients alike. Additional changes over the years to the financing and delivery of HCBS, including the statewide expansion of capitated payments to managed care providers to provide the Elderly Waiver benefit set, have shifted the roles of providers, lead agencies and other partners. This is a dimension that must be taken into account when considering reforms to the system. The driving force of providing the right service at the right time remains an overall goal in the redesign of HCBS.

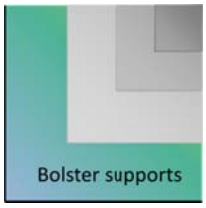
It is important to recognize that home and community-based services exist within a larger social context that impacts the responsiveness and outcomes of the system. For example, HCBS are closely linked with other long-term care services and to acute and primary health care services. No discussion of HCBS reform can take place without consideration of these other services, and the payment structures in place for them. The ability to support people in their homes is dependent upon multiple issues of community capacity, such as the availability of service providers, accessible and affordable housing, and transportation. When there are gaps in the continuum of available services, or community resources, people sometimes have little option than to go into an institutional setting. And, while institutional care settings include housing, the ability of the individual to cover the cost of their housing is essential to the success of any long-term care support system that is not based in institutional care. Some of these contextual issues are addressed elsewhere sections of the report; others are being considered through DHS initiatives, such as the Continuing Care Administration's gaps analysis which looks at the community capacity issue.

The following pages outline a vision for services that could be made available within each of the service clusters in the conceptual model. The vision is organized around five themes with some variation that together can support a person in a more holistic and integrated way: Navigation and Self/Family Advocacy, Prevention and Self-Management, In-Home Supports, Employment Supports, and Housing Access, Supports and Preservation. Employment and housing are two themes that are addressed in other sections in addition to the redesign of HCBS.

Additionally, there are overarching strategies that cut across all of the themes and are foundational to the conceptual model. They include options to: self-direct and manage services; receive appropriate assistance navigating and managing the system to receive needed services and supports; and, have an assurance of quality and outcomes in services. Further refinement of the concepts outlined in this report will reflect these strategies across the continuum of services that support people in their communities.

Section Eight – Redesign Home and Community Based Services

M.S. 256B.021, Subd. 4, paragraph (f)



Bolster Community and Family Supports

The goal of this reform element is to increase the availability of low-cost services and supports that prevent or delay the need for more costly and intensive long-term services and supports for people with disabilities and older adults. These services will benefit a broad population with a low level of need for services, allowing them to access services as needed. Provision of these supports may enable a person to avoid enrollment in MA, or avoid more intrusive services. Proposed services include:

- **Navigation and Self/Family Advocacy** services provided to families with children, adults, older adults and family caregivers to increase their capacity to access community resources, make informed decisions, advocate for their needs and preferences, and plan for their future. These services will create the capacity to identify and refer to appropriate resources, offer just-in-time assistance, and potentially provide more in-depth planning to understand options for the short term as well as long-term decisions over the course of a lifetime.
- **Prevention and Self-Management** services provided on an occasional (situation-based or periodic), time-limited basis in the community to people with a limited complexity of condition(s). These services would provide screening and identification, information, education and skills training for individuals in order to prevent disease and crises, as well as to better manage their physical, mental and chemical health.
- **In-Home Support** services provided to individuals and their families to help identify changes needed to allow the individual to remain at home, including a home safety assessment, a financial resources assessment, andhelp accessing available public transportation options. Training, education and other supports are provided to caregivers to increase their capacity to support family members in the community.
- **Employment Supports** includes help to navigate the employment and benefits systems and undertake planning for the future. These supports could be provided online, over the phone or in-person.
- **Housing Access, Supports and Preservation** includes financial planning to preserve assets and help people determine where and what they can afford. It also includes a connection

made in the community to find resources such as seasonal and periodic chore services, home repairs and adaptations.

Supports to Maintain Independence

The goal of this reform element is to simplify and broaden access to a defined set of services for people with less intense need for support to maintain their community living. The intent is to develop services or a benefit set that can meet the long-term care needs of individuals in their homes. This new service model must provide an element of coordination of health and other needs, and ensure 24/7 awareness of the individual's situation and response to emerging needs. Proposed services include:

- **Navigation and Self/Family Advocacy** support assists the individual to design a support plan that meets their needs and preferences. Frequent, as-needed contact between the individual and support coordinator or navigator using phone, video or face-to-face contact to identify emerging concerns and address problems promptly. Life planning assistance is provided to the individual and their family that addresses future needs, anticipates potential crisis points, financing options, and transition planning.
- **Prevention and Self-Management** supports include health mentors for individuals at high risk of developing preventable diseases, and remote monitoring and treatment for chronic health conditions or other situations where appropriate. It also includes integration with health care homes and other primary care.
- **In-Home Support** may include supervision and assistance with personal care, household chores, outdoor chores, medication review and transportation. Options for service delivery include personal assistance, home modifications and assistive devices, remote monitoring technology that provides real time notification of adverse events to responders, short-term respite care, caregiver counseling, occupational and physical therapist home visits, and a medication management plan.
- **Employment Supports** includes benefits planning, workplace visits, worker supports and coaching, and assessment of workplace accommodations.
- **Housing Access, Supports and Preservation** includes supports to help an individual find and obtain housing, deal with landlord/tenant issues, and other ongoing issues that could impact their ability to maintain housing.

Supports to Increase Independence

The goal of this reform element is to provide additional supports to increase independence or assist individuals who are moving out of intensive community supports or institutional settings to establish or re-establish their life in the community. For those individuals who have accessed a more intense level of service, supports are in place to enable them to return to or establish their home, stabilize their health and gain skills to increase their independence in the community. For young adults who are preparing to move out on their own, it includes helping them gain skills to make this transition successfully.

- **Navigation and Self/Family Advocacy** includes a professional assessment of an individual's condition and situation and offers direction. Life planning assistance includes developing a long-term plan with independent living and community engagement goals.
- **Prevention and Self-Management** includes crisis prevention and early intervention. Crisis planning is available for a broad range of individuals to create a mitigation plan based on an assessment of potential risks to their community living, such as a relapse of a mental or chemical health condition or acute care crisis.
- **In-Home Support** includes teaching and training services provided to individuals in their home or in the community to increase crisis prevention, independence, productivity and inclusion in the community. This service is intended to develop, maintain, enhance and/or restore an individual's skills in a particular area. Education and training is available to the family caregivers to increase their ability to safely provide care/support and maintain their own health and well-being.
- **Employment Supports** includes benefits planning, resume or skill building, career counseling, employer co-worker education and financial assistance.
- **Housing Access, Supports and Preservation** includes payments to keep housing in place while an individual is in a temporary institutional placement, as well as assistance finding and maintaining the housing.

Intensive Services and Supports

This element describes the services available to individuals who require more intensive interventions and support, including those individuals with complex needs. These services may be long-term or could be short-term services needed to provide stability to an individual. Proposed services include:

- **Navigation and Self/Family Advocacy** involves specialists to develop an intensive support plan, determine necessary resources and assist with implementing the plan.
- **Prevention and Self-Management** includes crisis planning, intervention and engagement, and a mobile multidisciplinary team approach for an individual with complex needs, which are available by phone and potentially face-to-face at any time.
- **In-Home Support** includes intensive support for living in one's own home, including the use of technology or necessary staffing to assure the individual's health and safety, intensive caregiver counseling and skills training/education (e.g. capable of providing care to people with dementia) and assisted transportation.
- **Employment Supports** include day services and ongoing employment support (i.e., not intended to be time-limited), including evidence-based practices.
- **Housing Access, Supports and Preservation** includes payments to keep housing in place while an individual is in a temporary institutional placement, as well as assistance finding and maintaining housing.

The system recognizes that people needing more intensive services and supports may need to receive their care through residential settings or through customized living services, also known as assisted living. These service settings are a vital and important part of the service continuum. Proposed services include:

Residential settings in which the service provider has ongoing responsibility for the individual receiving services, including training, treatment and supportive services. There currently is a moratorium on the development of new corporate foster care capacity. Additional steps may be necessary to assess community capacity and need, and match this resource to those most in need of intensive supports.

Customized living service in which a bundled package of services is delivered by the provider of the individual's choice in a registered housing-with-services establishment. This service package would be limited to those who need more intensive supports.

Section Nine – Individuals with Complex Needs

M.S. 256B.021, Subd. 4, paragraph (g)

BACKGROUND

There are people with complex needs who have not been effectively served in the community. Characteristics include complex medical or behavioral needs, or co-occurring conditions such as a developmental disability and a mental illness or dementia and a chronic disease like diabetes, that require disciplined approaches to coordinate and access appropriate services that are essential for successful community living. Some costs are high and represent good value, while in other situations, costs may be high without strong outcomes. There is high use of hospital emergency rooms, crisis services or institutional stays. There may be involvement with the criminal justice system, and/or civil commitment due to the inability to provide appropriate community services. There are promising crisis services, assessment and planning approaches, transitional assistance, and strategies to coordinate services, as well as recommendations from previous summits on crisis services, working groups and task forces, including the redesign of state-operated services to inform this work.

VISION

The goal of this reform element is to better support individuals with complex needs. The identified strategies and services may be incorporated into the redesign of home and community-based services discussed in the previous section. Proposed strategies and services include:

- **Navigation and Self/Family Advocacy** includes providing specialized, intensive care coordination to people with complex needs and their caregiver, and facilitation of transitions between nursing facility, hospital and home. People leaving more intensive services for the community are supported in planning for and through their transition and are actively followed after transition to ensure their success.
- **Prevention and Self-Management** includes establishing protocols for targeting earlier identification and provision of crisis prevention planning and assessment to those with avoidable emergency room use, use of crisis services and/or involvement with the criminal justice system.
- **In-Home Support** includes developing and incenting specialized community provider capacity, consideration of time-limited intensive services to respond to specific needs, demonstration of models of provider coordination of services, including health care, for specialized populations, development of specialized health care homes, exploration of new service definitions to serve people with complex needs, and exploration of alternative management of waiver resources to respond to high cost, intermittent needs.

- **Employment Supports** includes discovery processes, comprehensive vocational assessments, work training, individualized planning and job placement.
- **Housing Access, Supports and Preservation** includes payments to keep housing in place while an individual is in a temporary institutional placement, as well as assistance finding and maintaining housing.

Section Ten – Nursing Facility Level of Care Criteria

M.S. 256B.021, Subd. 4, paragraph (h)

BACKGROUND

In 2009, the Legislature modified the nursing facility level-of-care (NF LOC) criteria for public payment of long-term care. NF LOC status affects eligibility for MA payment of nursing facility services and HCBS waivers that provide alternatives to nursing facility services. This includes the Brain Injury-Nursing Facility (BI-NF), Community Alternative for Disabled Individuals (CADI) and Elderly Waiver (EW) waiver programs. This change in the NF LOC criteria was needed to ensure that the highest cost services are targeted to individuals with the highest needs, and that the long-term sustainability of the service system is maintained. However, Minnesota has been prevented from implementing the revised criteria due to federal maintenance of effort requirements.[2] (See www.dhs.state.mn.us/healthcare/waivers for a description of the current and proposed NF LOC criteria.)

In 2011, the Legislature directed DHS to seek permission from CMS to implement the new NF LOC criteria effective July 1, 2012, 18 months earlier than currently permitted under federal law. If permission is not granted, DHS is directed to implement a 1.67 percent rate reduction for long-term care providers, excluding nursing facilities, from July 1, 2012, to Dec. 31, 2013.

VISION

The goal of this reform is to increase program stability by ensuring that higher intensity, higher cost services are used when necessary, and by relying on high impact, lower cost services for people with lower needs and fewer dependencies.

NEXT STEPS

Long-Term Care Realignment Section 1115 Waiver Proposal

DHS is in the process of submitting a waiver request to CMS. On Nov. 28, 2011, DHS announced in the State Register[3] a 30-day comment period on the Long-Term Care Realignment Section 1115 Medicaid Waiver[4]. This waiver seeks federal authority for the following activities:

[2] Maintenance of effort requirements were included first in the American Recovery and Reinvestment Act, and then in the Affordable Care Act. This included the requirement that states maintain Medicaid standards, methodologies and procedures that are no more restrictive than those in effect on the dates of enactment of the Affordable Care Act.

[3] The State Register Notice can be found at *http://www.comm.media.state.mn.us/bookstore/stateregister/36_19.pdf*, starting on page 616.

[4] A copy of the waiver request can be found on the DHS website at *www.dhs.state.mn.us/healthcare/waivers*.

1) Minnesota proposes to modify its **nursing facility level-of-care criteria** (NF LOC) to require that a person demonstrate one or more of the following:

- a high need for assistance in four or more activities of daily living (ADL); or
- a high need for assistance in one ADL that requires 24-hour staff availability; or
- a need for daily clinical monitoring; or
- significant difficulty with cognition or behavior; or
- the person lives alone and risk factors are present.

This replaces a standard that allowed a determination of nursing facility level of care if an individual needs ongoing periodic assistance with any one ADL. As noted above, state law directing DHS to adopt this modified NF LOC standard was first passed in 2009 (see Minnesota Statutes, section 144.0724, subdivision 11). The new criteria greatly simplify the level-of-care decision and more precisely define the needs that must be present to meet the nursing facility level-of-care criteria.

2) Minnesota seeks authority for federal matching funds for the **Alternative Care (AC)** program. AC is a state-funded program that provides home and community-based services to people 65 and older who meet the nursing facility level of care, who have income or assets above the MA standards, but whose income and assets are insufficient to pay for 135 days of nursing facility care. Connecting these high needs seniors with modest income and assets to community services earlier will divert them from nursing facilities and encourage more efficient use of services when full Medicaid eligibility is established.

3) Minnesota seeks authority for federal matching funds for the **Essential Community Supports (ECS)** program. ECS is a new program that will provide services for people age 65 and older who, because they do not meet the revised nursing facility level-of-care criteria are no longer eligible for MA, but have an assessed need for one or more of the services provided under the program.[5] Like the AC program, ECS enrollees must have income and assets that are insufficient to pay for 135 days of nursing facility care. The goal of this reform is to support this group of seniors with a low cost, high-impact set of home and community-based services to promote living at home longer. Providing accurate information about level-of-care needs and supportive services now will encourage more efficient use of services when full Medicaid eligibility is established.

[5] The services provided in the ECS program are: 1) personal emergency response system, 2) homemaker services, 3) chore services, 4) caregiver education and support, and 5) service coordination. Nutrition services, including home-delivered meals and congregate dining, will be available to ECS participants through Older Americans Act (OAA) Title III funding.

In the event that Minnesota is successful in obtaining federal matching funds for the AC and ECS program, DHS will use at least a portion of the state savings that result, to expand the benefits available under the ECS program.

Further changes to level-of-care (LOC) criteria

As outlined in this report, DHS is considering a number of additional reforms that will serve to redesign the home and community-based system. A major goal of this effort will be to *further* target the highest cost, most intensive services and/or benefit sets to individuals with the highest needs. Defining the level-of-care (LOC) criteria that is needed in order to access a particular service or benefit set will be an important strategy within this redesign effort. The exact nature of these additional LOC changes is unknown at this time, but will become clear as analyses are completed and the reform options are chosen.

Section Eleven – Long-term Care Reform: Conclusions

STAKEHOLDERS

Stakeholder groups, like the HCBS Partner Panel (also known as the Expert Panel) and the Aging and Disabilities workgroups (see Appendix for members) have been meeting regularly over the past few years. In 2010, the HCBS Partner Panel echoed its support for this vision through the development of principles for the long-term service and support system and agreed that related programs for people with disabilities and older people should be sustainable, person-focused, accessible, predictable and equitable. In addition, panel members felt it was important to invest in prevention rather than reactive interventions to maximize people's natural support networks and support people's economic self-control and self-reliance.

The redesign of HCBS (in the previous section) articulates reforms that are necessary to fully achieve the state's vision for its long-term services and support system. Although the HCBS Partner Panel has met for several years, the timeline to develop the reform design details resulting from the 2011 legislative session was aggressive. DHS staff met with the Panel and its workgroups to develop the overall reform design, determine interactions with current reform efforts, work through scenario-building exercises and develop the specific additional reform components. The Department intends to continue working with the panel as in-depth data and financial analyses become available to further define the specific reforms needed to achieve our vision.

TIMELINES AND NEXT STEPS

Beginning in late 2011 and extending through 2012, more in depth data and fiscal analysis will inform specific components of reform, including the most appropriate and cost-neutral vehicles to obtain federal authority to implement the desired changes. This analysis will help identify any components that potentially could be implemented by July 1, 2012, as well as an overall redesign in the 2013 legislative proposal for implementation by July 1, 2013. It will assist in determining the staging of reform and the transition from current to future state while we continue to learn about the complexity and needs of those we serve. Potential vehicles (defined in the Appendix) include:

- Community First Choice Option (1915(k) option)
- HCBS Waivers (1915(c) authority)
- 1115 Demonstration Waiver
- MA State Plan
- Home- and Community-Based Services Access Option (1915(i) option)

To assist with the necessary data analysis, the Department of Human Services has contracted with Thomson Reuters, a well-respected contractor who previously was under contract to develop Minnesota's Long-Term Care Profile, and is experienced with long-term care.

As the fiscal and impact analyses are completed, decisions will be necessary regarding expansion of certain services. A balance may be necessary on expanded availability of certain services with options for limiting service access in an effort to maintain budget neutrality.

Discussions are also underway with other state departments (e.g. Education, Health, Employment and Economic Development, Corrections, etc.), to understand areas where better coordination and reform strategies could lead to efficiencies while maintaining budget neutrality when considering all state and local spending.

Minnesota has a system of home- and community-based services to be proud of, yet the future demand for services, changing expectations and budget constraints require reform for a sustainable future with quality outcomes. These reforms will enable and require those who may need services to be more engaged, families to be involved, business practices to adapt, and a workforce to be properly trained and available to sustain the vision. It will in significant ways challenge counties, health plans, tribes, providers, administrators and policy makers in evaluating our roles and assumptions as we look at a future that will require different approaches than what has been successful in the past.

Decisions on how to move forward toward this vision for the future of HCBS will be informed through in-depth data analysis and modeling of options in the upcoming months. Collectively, even as we each hold a different role in the system, we have experienced the impact of a series of rate reductions, limits on waiver growth and other changes to manage the mounting pressures and recognize that a more cohesive plan for reform is necessary. Reform will likely be in phases in order to allow thoughtful decisions, reasonable transitions for implementation and monitoring of their impact. Reform that maintains budget neutrality implies that there will be a redistribution of dollars to some extent unless there is an infusion of additional resources to the system. Our goal is to search for efficiencies to maximize use of current dollars and manage transitions when necessary changes may affect current services. Towards this goal, we will continue to work together with stakeholders and legislators as decisions are made that will reform home- and community-based services.

Section Twelve – Improve Integration of Medicare and Medicaid

M.S. 256B.021, Subd. 4, paragraph (i)

BACKGROUND

In Minnesota, people who are eligible for both Medicare and Medicaid (dual eligibles) represent 22 percent of the MA population, but account for 40 percent of program spending. Their disproportionate share of the costs can be attributed in part to the high prevalence of chronic health conditions among this population. Nationally, 66 percent of dual eligibles have three or more chronic conditions, and 61 percent have a cognitive or mental impairment.[6] An additional, and significant contributing factor to their incommensurate costs, is they often find themselves in a highly fragmented system in which neither Medicare nor Medicaid is responsible for coordinating care and benefits. Because of this dynamic, dual eligibles encounter difficulty getting the care they need in the most appropriate setting, and often receive duplicative or unnecessary tests and treatments.

To improve coordination, and to align the financing and the incentives of the two programs, Minnesota has been a pioneer in establishing integrated programs for dual eligibles. In 1997, the state implemented the first state Medicare demonstration for dually eligible beneficiaries, the Minnesota Senior Health Options (MSHO) program. Currently, Minnesota serves over 70 percent of dually eligible seniors and 10 percent of dually eligible people with disabilities through contracts with Medicare Advantage Special Needs Plans (SNPS) under MSHO and Special Needs BasicCare (SNBC) programs.

VISION

DHS is committed to the further integration of the Medicare and Medicaid. In April 2011, Minnesota was one of 15 states to receive a grant from CMS to plan and design a new delivery and payment system model that integrates health care for dual eligibles. In July 2011, the Legislature mandated that DHS seek authority to enter into a demonstration project with CMS to further the financial integration of the two programs, including the opportunity for Medicaid to share potential savings with Medicare. CMS concurrently issued an opportunity for states to undertake shared savings models (capitated or managed fee-for-service) that would integrate the primary, acute, behavioral health and long-term services and supports for dual eligibles.

Minnesota responded by submitting a letter of intent to CMS to pursue a re-design of the MSHO program for seniors under the capitated model. For dually eligible people with disabilities under age 65, DHS intends to discuss with CMS how to improve coordination of capitated services under SNBC with fee-for-service long-term care services through virtual total cost of care arrangements.

[6] Medicare Payment Advisory Committee Report to the Congress, Aligning Incentives in Medicare, Chapter 5: Coordinating the Care of Dual-Eligible Beneficiaries" (Washington: MedPAC: June 2010), available online at http://www.medpac.gov/documents/Jun10_EntireReport.pdf.

NEXT STEPS

In early 2012, DHS will enter into negotiations with CMS regarding a proposal to create a fully capitated financing model for the MSHO program. An application for the model will be submitted by April, 15, and if successful the new financing model will be implemented by Jan. 1, 2013.

While the Department's focus will be on the re-design of MSHO, DHS will continue to explore with CMS ways in which Medicaid and Medicare can be better integrated for people under 65 with disabilities, without pursuing a fully capitated model.

Section Thirteen – Redesign Intensive Residential Treatment Services

M.S. 256B.021, Subd. 4, paragraph (j)

BACKGROUND

The Intensive Residential Treatment Services (IRTS) program provides services in residential settings to adults who have serious mental illness. Individuals served by IRTS have person-centered treatment plans that may include group and individual counseling, medication monitoring, integrated dual diagnosis treatment, assistance with community resources, and illness management and recovery. In addition to their mental illness diagnosis, many individuals served by IRTS have co-occurring complex needs, including chronic physical health needs, that may require additional residential care even after their mental health condition has stabilized. Therefore, some individuals who are discharged from IRTS facilities, despite having their mental health condition stabilized, may have other serious health needs that have gone unaddressed during their time at the facility. These health issues can lead to subsequent, costly and unnecessary hospitalizations or the need for other residential care.

VISION

To address the complex physical and behavioral health needs of individuals receiving IRTS services, the Legislature directed DHS to develop a proposal for the improved integration of medical and behavioral health services at IRTS facilities and to pursue the development of specialized rates to support this effort.

NEXT STEPS

This project will be developed within the context of a comprehensive health care reform planning process to enhance the state's continuum of care, including State Operated Services (SOS) programs, that is being undertaken by the Chemical and Mental Health Administration in 2012. This effort will examine how DHS can best structure IRTS programs to better serve those who have co-occurring and complex physical and behavioral health needs. While it is not anticipated this review will be completed in time for the project to be included in the MA reform waiver submission, upon its conclusion, the Commissioner will seek any necessary federal approval or legislative changes necessary for its implementation.

Section Fourteen– Waive the Institution for Mental Disease (IMD) Exclusion for Anoka Metro Regional Treatment Center (AMRTC)

M.S. 256B.021, Subd. 4, paragraph (g)

BACKGROUND

Minnesota has been an advocate for and a national model of deinstitutionalization for decades, starting with individuals with developmental disabilities, then elderly individuals and those with physical disabilities, and most recently, people with a mental illness. Anoka Metro Regional Treatment Center (AMRTC), Minnesota's remaining non-forensic "institution," has continued to downsize as a more robust array of community services and community-based providers has arisen. AMRTC's capacity has shrunk from 250 beds a decade ago to 110 specialized acute care hospital beds today.

Despite the development of more community-based services, AMRTC is comprised of six very specialized units of care that have been developed to meet a critical community need not met in any other way: Med/Psych (20-bed unit) serving people with a mentally illness who also have complex, chronic medical conditions; Complex Co-Occurring (a 22-bed and a 20-bed unit) serving people with multiple disabilities in addition to their mental illness such as addictions, traumatic brain injury, intellectual disabilities and medical conditions; Mental Illness and Intellectual Disabilities (12 beds) serving people with those two diagnoses (an increasing number also have aggressive behavioral issues); and Intensive Behavioral (a 20-bed unit and a 16-bed unit) serving those people with a mental illness, often with addiction as a secondary diagnosis and a history of aggression and violence in less acute community settings.

Although AMRTC has been downsizing and no longer functions as a long-term residential institution for people with a serious mental illness, it continues to serve a population whose needs have not been met through the current service array in the community. In most cases, the people served at Anoka have been or would be Medicaid-eligible for services if those services were available in the community. The average length of stay at AMRTC is approximately 90 days, and continuity of care and active participation in the person's discharge planning would greatly assist in the transition back to community living. However, when a patient enters Anoka, MA eligibility is suspended, creating risk for their ongoing transition services as well as their community services and housing once they are discharged. For example, if a person was receiving services from an Assertive Community Treatment (ACT) team, these services are no longer available and his ACT team can no longer follow his progress in a meaningful way because MA services at AMRTC are non-billable. This inability to intervene results in a significant disruption of a person's continuity of care and prevents the ACT team from actively participating in discharge planning.

VISION

Obtain a waiver of the federal law prohibiting Medicaid coverage for persons "residing in institutions for mental diseases" (the IMD exclusion) for people receiving services at AMRTC to allow for continuity of care during a person's transition from the community to an inpatient setting and back to the community. Develop a "limited time frame" pilot (3-5 years) to permit

the development of health care homes, accountable care organizations, and further refinement of health care reform which should lessen the demand for AMRTC-type services. The 3-5 year "pilot" window would also permit the state and CMS to study the development and success of "Money Follows the Person" initiatives.

All units within AMRTC would be sized to 16 beds in preparation for movement into community settings as they become available and to better reflect the non-IMD structure. As the community gaps in service become more prevalent, revenue generated by AMRTC could be utilized to support innovative "community-based" strategies to keep individuals out of higher cost emergency rooms, hospital beds, AMRTC, etc.
Reoffending and incarcerations would certainly be lessened if innovative community services that are otherwise available to people with MA were available and billable to MA while these same people are at AMRTC (aggressive ACT/IRTS; ID Crisis Services; Housing w/ Intensive Services, etc.). These services could also be funded to some extent by revenue generated with the non-IMD AMRTC.

As health care reform is implemented in Minnesota, innovative community programs and strategies, health care homes and ACOs, the AMRTC "specialized unit" and community re-integration model, will result in less reliance on AMRTC as the state's "safety net."

NEXT STEPS
DHS will include a provision for a waiver to the IMD exclusion in the submission of the Section 1115 demonstration waiver in the Spring of 2012.

Section Fifteen –The Exception to the IMD Exclusion for Individuals Under Age 21)

M.S. 256B.021, Subd. 4, paragraph (l)

BACKGROUND

Title XIX of the Social Security Act prohibits federal financial participation for the cost of care for Medicaid beneficiaries in facilities that fall under the federal definition of an "institution for mental diseases" (IMD). IMDs are defined as a stand-alone hospital, nursing facility or other institution of more than 16 beds primarily providing diagnosis, treatment or care for persons with mental diseases.

For individuals ages 21 to 64, the IMD exclusion pertains to all aspects of care and treatment. For children, federal payments are limited in a different way. Children may have coverage for treatment they receive in an IMD, but only for the inpatient psychiatric hospital services provided. In what the federal government refers to as "the exception to the IMD exclusion for individuals under age 21," Medicaid pays for the mental health services, but denies coverage for care (room and board, and other basic care for children's needs) as well as for all other health care services, regardless of medical need. This circumstance creates major obstacles to both necessary care, in that a child diagnosed with diabetes or leukemia could not be treated for those conditions until discharged from a psychiatric hospital; and to the kind of integrated care which is rapidly becoming industry standard, in that children receiving psychiatric treatment in an IMD also are not allowed reimbursement for dental care, immunizations, or care for routine childhood illnesses such as ear infections.

VISION

Implications for Minnesota's Children's Mental Health Continuum of Care – While the IMD exclusion explicitly applies to psychiatric hospitals, it also applies to children's psychiatric residential treatment facilities, or PRTFs. This type of non-hospital setting is designed for the treatment of children who continue to need a secure, supervised environment, but not at a hospital level of intensity or medical staffing. Minnesota has not been able to develop this new level of care, despite having at least some capable and willing providers, largely because of the children's exception to the IMD exclusion.

Moreover, in recent years, the need for this "intermediate level of care" has been repeatedly identified by stakeholder groups. Following considerable debate over the state's need for additional child and adolescent inpatient psychiatric beds in the 2008 legislature, a 2009 "Unmet Needs" study submitted to the legislature determined that many children and adolescents could be served in less intensive and more economical settings, if barriers to developing these could be removed. Further, the most similar level of care currently available, in residential facilities licensed for mental health service provision under the Umbrella Rule, works well for some children, but is insufficient for children with complex medical needs or who

are highly aggressive, documented in the 2011 Mental Health Transformation report submitted to the legislature. The funding model for the current residential treatment option in Minnesota requires foster care placement by counties, a burden for both families and counties, and county financial coverage of some treatment costs (the non-federal share for children on FFS Medical Assistance) and all room and care costs, a portion of which may be reimbursed through Title IV-E. Ironically, these current children's residential facilities might also be vulnerable to federal IMD designation, since federal guidelines defining the IMD are ambiguous; were Medicaid reviewers to make this determination, children and adolescents currently served through this mechanism could lose access to both critical and routine health care.

National Efforts – Many entities have attempted to circumvent or overturn the IMD exclusion, including its application to children's residential treatment. The National Council for Children's Behavioral Health has been particularly active in providing information to states and lobbying the federal government to rescind the children's exception; their arguments include the following:

- The IMD exclusion exception violates the EPSDT mandate;
- Medicaid law needs to evolve to cover best practices; and
- Unclear and subjective guidance for identifying IMDs leaves states perpetually exposed to CMS reinterpretation, audits and recoupment of federal matching funds.

NEXT STEPS

While the need to fill gaps in the children's mental health continuum of care has been repeatedly documented, there is no collective desire from parents, advocates, counties and other stakeholders to do so in the current ambiguous and insufficient Medicaid environment. A necessary first step both to protect current residential facilities licensed under the Umbrella Rule and to enable analysis of the feasibility of PRTF development is to seek a federal waiver of the exception to the IMD exclusion for individuals under age 21.

Minnesota Statutes, Chapter 3.197 requires that the cost of preparing a report to legislature be reported at its beginning. Approximately $20,000 in staff salaries, printing and distribution was spent to prepare this report.

Appendix A: Minnesota Statutes 256B.021

256B.021 MEDICAL ASSISTANCE REFORM WAIVER.

Subdivision 1.**Intent.** It is the intent of the legislature to reform components of the medical assistance program for seniors and people with disabilities or other complex needs, and medical assistance enrollees in general, in order to achieve better outcomes, such as community integration and independence; improved health; reduced reliance on institutional care; maintained or obtained employment and housing; and long-term sustainability of needed services through better alignment of available services that most effectively meet people's needs, including other state agencies' services.

Subd. 2.**Proposal.** The commissioner shall develop a proposal to the United States Department of Health and Human Services, which shall include any necessary waivers, state plan amendments, requests for new funding or realignment of existing funds, and any other federal authority that may be necessary for the projects specified in subdivision 4. The commissioner shall ensure all projects are budget neutral or result in savings to the state budget, considering cost changes across all divisions and other agencies that are affected.

Subd. 3.**Legislative proposals; rules.** The commissioner shall report to the members of the legislative committees having jurisdiction over human services issues by January 15, 2012, regarding the progress of this waiver, and make recommendations regarding any legislative changes necessary to accomplish the projects in subdivision 4.

Subd. 4.**Projects.** The commissioner shall request permission and funding to further the following initiatives.

(a) Health care delivery demonstration projects. This project involves testing alternative payment and service delivery models in accordance with Minnesota Statutes, sections 256B.0755 and 256B.0756. These demonstrations will allow the Minnesota Department of Human Services to engage in alternative payment arrangements with provider organizations that provide services to a specified patient population for an agreed upon total cost of care or risk/gain sharing payment arrangement, but are not limited to these models of care delivery or payment. Quality of care and patient experience will be measured and incorporated into payment models alongside the cost of care. Demonstration sites should include Minnesota health care programs fee-for-services recipients and managed care enrollees and support a robust primary care model and improved care coordination for recipients.

(b) Promote personal responsibility and encourage and reward healthy outcomes. This project provides Medicaid funding to provide individual and group incentives to encourage healthy behavior, prevent the onset of chronic disease, and reward healthy

outcomes. Focus areas may include diabetes prevention and management, tobacco cessation, reducing weight, lowering cholesterol, and lowering blood pressure.

(c) Encourage utilization of high quality, cost-effective care. This project creates incentives through Medicaid and MinnesotaCare enrollee cost-sharing and other means to encourage the utilization of high-quality, low-cost, high-value providers, as determined by the state's provider peer grouping initiative under Minnesota Statutes, section 62U.04.

(d) Adults without children. This proposal includes requesting federal authority to impose a limit on assets for adults without children in medical assistance, as defined in Minnesota Statutes, section 256B.055, subdivision 15, who have a household income equal to or less than 75 percent of the federal poverty limit, consistent with Minnesota Statutes, section 256L.17, subdivision 2, and to impose a 180-day durational residency requirement in MinnesotaCare, consistent with Minnesota Statutes, section 256B.056, subdivision 3c, for adults without children, regardless of income.

(e) Empower and encourage work, housing, and independence. This project provides services and supports for individuals who have an identified health or disabling condition but are not yet certified as disabled, in order to delay or prevent permanent disability, reduce the need for intensive health care and long-term care services and supports, and to help maintain or obtain employment or assist in return to work. Benefits may include:

(1) coordination with health care homes or health care coordinators;

(2) assessment for wellness, housing needs, employment, planning, and goal setting;

(3) training services;

(4) job placement services;

(5) career counseling;

(6) benefit counseling;

(7) worker supports and coaching;

(8) assessment of workplace accommodations;

(9) transitional housing services; and

(10) assistance in maintaining housing.

(f) Redesign home and community-based services. This project realigns existing funding, services, and supports for people with disabilities and older Minnesotans to ensure community integration and a more sustainable service system. This may involve changes that promote a range of services to flexibly respond to the following needs:

(1) provide people less expensive alternatives to medical assistance services;

(2) offer more flexible and updated community support services under the Medicaid state plan;

(3) provide an individual budget and increased opportunity for self-direction;

(4) strengthen family and caregiver support services;

(5) allow persons to pool resources or save funds beyond a fiscal year to cover unexpected needs or foster development of needed services;

(6) use of home and community-based waiver programs for people whose needs cannot be met with the expanded Medicaid state plan community support service options;

(7) target access to residential care for those with higher needs;

(8) develop capacity within the community for crisis intervention and prevention;

(9) redesign case management;

(10) offer life planning services for families to plan for the future of their child with a disability;

(11) enhance self-advocacy and life planning for people with disabilities;

(12) improve information and assistance to inform long-term care decisions; and

(13) increase quality assurance, performance measurement, and outcome-based reimbursement.

This project may include different levels of long-term supports that allow seniors to remain in their homes and communities, and expand care transitions from acute care to community care to prevent hospitalizations and nursing home placement. The levels of support for seniors may range from basic community services for those with lower needs, access to residential services if a person has higher needs, and targets access to nursing home care to those with rehabilitation or high medical needs. This may involve the establishment of medical need thresholds to accommodate the level of support needed; provision of a long-term care consultation to persons seeking residential services, regardless of payer source; adjustment of incentives to providers and care coordination organizations to achieve desired outcomes; and a required coordination with medical assistance basic care benefit and Medicare/Medigap benefit. This proposal will improve access to housing and improve capacity to maintain individuals in their existing home; adjust screening and assessment tools, as needed; improve transition and relocation efforts; seek federal financial participation for alternative care and essential community supports; and provide Medigap coverage for people having lower needs.

(g) Coordinate and streamline services for people with complex needs, including those with multiple diagnoses of physical, mental, and developmental conditions. This

project will coordinate and streamline medical assistance benefits for people with complex needs and multiple diagnoses. It would include changes that:

(1) develop community-based service provider capacity to serve the needs of this group;

(2) build assessment and care coordination expertise specific to people with multiple diagnoses;

(3) adopt service delivery models that allow coordinated access to a range of services for people with complex needs;

(4) reduce administrative complexity;

(5) measure the improvements in the state's ability to respond to the needs of this population; and

(6) increase the cost-effectiveness for the state budget.

(h) Implement nursing home level of care criteria. This project involves obtaining any necessary federal approval in order to implement the changes to the level of care criteria in Minnesota Statutes, section 144.0724, subdivision 11, and implement further changes necessary to achieve reform of the home and community-based service system.

(i) Improve integration of Medicare and Medicaid. This project involves reducing fragmentation in the health care delivery system to improve care for people eligible for both Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term care. The proposal may include:

(1) requesting an exception to the new Medicare methodology for payment adjustment for fully integrated special needs plans for dual eligible individuals;

(2) testing risk adjustment models that may be more favorable to capturing the needs of frail dually eligible individuals;

(3) requesting an exemption from the Medicare bidding process for fully integrated special needs plans for the dually eligible;

(4) modifying the Medicare bid process to recognize additional costs of health home services; and

(5) requesting permission for risk-sharing and gain-sharing.

(j) Intensive residential treatment services. This project would involve providing intensive residential treatment services for individuals who have serious mental illness and who have other complex needs. This proposal would allow such individuals to remain in these settings after mental health symptoms have stabilized, in order to maintain their mental health and avoid more costly or unnecessary hospital or other residential care due to their other complex conditions. The commissioner may pursue a specialized rate for projects created under this section.

(k) Seek federal Medicaid matching funds for Anoka Metro Regional Treatment Center (AMRTC). This project involves seeking Medicaid reimbursement for medical services provided to patients to AMRTC, including requesting a waiver of United States Code, title 42, section 1396d, which prohibits Medicaid reimbursement for expenditures for services provided by hospitals with more than 16 beds that are primarily focused on the treatment of mental illness. This waiver would allow AMRTC to serve as a statewide resource to provide diagnostics and treatment for people with the most complex conditions.

(l) Waivers to allow Medicaid eligibility for children under age 21 receiving care in residential facilities. This proposal would seek Medicaid reimbursement for any Medicaid-covered service for children who are placed in residential settings that are determined to be "institutions for mental diseases," under United States Code, title 42, section 1396d.

Subd. 5.**Federal funds.** The commissioner is authorized to accept and expend federal funds that support the purposes of this section.

History: *1Sp2011 c 9 art 7 s 53*

Appendix B: Background Information

- Health Care Home and payment reform (http://www.heath.state.mn.us/healthreform/index.html)
- Duals Demonstration (http://www.dhs.state.mn.us/dhs16_163573)
- Status of Long-Term Care Report to the Legislature, 2010
- State Plan on Aging, FFY 2011(http://www.mnaging.org/about/statePlan.htm)
- Nursing Facility Level of Care – current and proposed NF LOC criteria (http://www.dhs.state.mn.us/healthcare/waivers)
- DHS's Continuing Care Administration's Strategic Plan (to be posted)
- Money Follows the Person – http://www.dhs.state.mn.us/dhs16_162194
- Provider Enrollment and Provider Standards Initiative – http://www.dhs.state.mn.us/dhs16_144650
- Residential Support Services and Quality Outcomes Standard Initiative – http://www.dhs.state.mn.us/dhs16_152344
- Rate Setting Methodologies Initiative – http://www.dhs.state.mn.us/dhs16_144651 (including Assisted Living rate tool) – http://www.dhs.state.mn.us/dhs16_143983
- Minnesota CHOICES - http://www.dhs.state.mn.us/id_054837
- Minnesota Long-Term Care Profile – http://www.dhs.state.mn.us/dhs16_141142
- Consumer Directed Task Force Recommendations - http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_143672.pdf
- Case Management reports:
  March 2011 - https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6353-ENG
  March 2007 - http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5062-ENG
- Quality Assurance Reports:
  February 2011 - https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6332-ENG
  March 2009 - https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6332-ENG
- AARP's *Raising Expectations – A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers;* Susan C. Reinhard, Enid Kassner, Ari Houser, and Robert Mollica; Sept. 2011 – www.longtermscorecard.org
- Definitions:
  1915(k) - http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Community-First-Choice-1915-k.html

1915(c) - http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-c.html

1115 - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstration.html

1915(i) - http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services-1915-i.html

MA State Plan - http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html

Appendix C: Stakeholders

Long Term Care: HCBS Expert Panel
Mary Jo George, AARP
Mary Kay Kennedy, Advocating change Together (ACT)
Mary Youle, Aging Services of Minnesota
Mary Birchard, Alzheimer's Association
Patricia Coldwell, Association of Minnesota Counties/CBP
Barb Turner, Association of Residential Resources of Minnesota
Pete Klinhammer, Brain Injury Association of Minnesota
Patti Cullen, Care Providers of Minnesota
John Tschida, Courage Center
Jodi Greenstein, Courage Center
Colleen Wieck, governor's Council on Developmental Disabilities
Laura Kadwell, Heading Home Minnesota
Dr. Amy Hewitt, Institute on Community Integration
Michele Fedderly, Minnesota Network of Hospice and Pallative Care
Kay Dickison, Local Public Health Association (LPHA)
Deb Holtz, LTC Ombudsman
Jodi Harpstead, Lutheran Social Services
Jerry Pederson, MACSSA – Anoka County
Julie Faulhaber, Medica – representing MN council of Health Plans
Laura Philbrook, Minnesota Adult Day Services Association
Robert Kane, Minnesota Area Geriatric Education Center
Cahterine Sampson, Minnesota Association of Area Agencies on Aging
Victoria Dalle Molle, Minnesota Association of Centers for Independent Living
Debora Saxhaung, Minnesota Association for Children's Mental Health
Rond Brand, Minnesota Association of Mental Health Centers
Joseph Grant, Minnesota Board on Aging
Minnesota Commission Serving Deaf and Hard of Hearing
Steve Larson, Minnesota Consortium of Citizens with Disabilities
Christopher Bell, Minnesota Consortium of Citizens with Disabilities
Mary Regan, Minnesota council of Child-Caring Agencies
Anne Henry, Minnesota Disability Law Center
Lynn Noren, Minnesota Habilitation Coalition
Tim Sullivan, Minnesota HIV Services Planning Council
Jennifer Sorensen, Minnesota Home Care Association
Dr. Edward Ratner, Minnesota Leadership Council on Aging
Jim Abeler, Minnesota Legislature, Chair House Health & Human Services
Steve Gottwalt, Minnesota Legislature, Chair House Health & Human Services
David Hann, Minnesota Legislature, Chair House Health & Human Services
Joan Willshire, Minnesota State Council on Disability
Bob Niemiec, MNAPSE-The Network for Employment
John Wayne Barker, MN DACA

Sue Abderholden, NAMI Minnesota
Roberta Opheim, Ombudsman for MR/MI
James Jordan, State Advisory Council on Mental Health
Jen Stevens, White Earth Home Health Agency

Aging Services
Janice Jones, MDH
Kari Thurlow, Aging Services of MN
Monica Douglas, Lutheran Social Services
Gail Jerve, Prairie Five CAC
David Zaffrann, SEIU Healthcare
Kirsten Anderson-Stembridge, Lutheran Social Services

Disability Services
Katherive Kreager-Pieper, LPHA
Vicki Gerrits, MHC
Jennifer McNertney, MN Hospital Association
Kari Thurlow, Aging Services of MN
David Zaffrann, SEIU Healthcare
Ron Brand, Minnesota Association of Mental Health Centers
Sue Abderholden, NAMI Minnesota
Anni Simons, MN Consortium for Citizens with Disabilities
Kay Hendrickson, Office of Ombudsman for Mental Health and Development Disabilities

M**edicaid and Supportive Housing Work Group (Interagency Taskforce Workgroup on Medicaid)**
Jane Lawrenz, DHS
Vicki Farden, MN Housing
Laura Kadwell, Heading Home Minnesota
Rich Hooks Wayman, Hearth Connection
Kelby Grovender, Hearth Connection
George Stone, Corporation for Supportive Housing (Minnesota)
Leah Rhea, Corporation for Supportive Housing (Minnesota)
Rebecca Shultz, Corporation for Supportive Housing (Minnesota)
Peggy Bailey, Corporation for Supportive Housing (National Office)
Mike Manhard, Metro-wide Engagement on Shelter and Housing
Barbara McCormick, Project for Pride in Living
Julie Shannon, Project for Pride in Living
Tracy Berglund, Catholic Charities
Dawn Petroskas, Catholic Charities
Grace Tangjerd Schmitt, Guild, Inc.

Mary Morris, Cabrini Partnership
Katherine Pollack, Cabrini Partnership
Carol Priest, Red Lake Homeless Shelter
David Browne, Common Bond Communities
Kelly Matter, Common Bond Communities
Pam Sabey, Lydia House
Wendy Wiegmann, Simpson Housing
Eric Grumdahl, Dakota County
Michael Crawford, Dakota County
Markus Klimenko, Hennepin County
Kristi Olzeske, Hennepin County
Kristina Hayes, Anoka County
Kate Erickson, MN Department of Corrections
Gary Travis, DHS
Alison Niemi, DHS
Janel Bush, DHS
Dianne Wilson, DHS
Ben Dossman, Affirmative Options
Lee Lewis, Clare Housing
Mary Hartmann, New Foundations

SBNC Expansion Dual Demo Workgroup
Nancy Noetzelman, Hennepin County HSPHD
Shelly, Brandl, Fraser Child & Family Center
Mary, Regan, MN Council of Child Caring Agency
Bob Wagner, Ramsey County Human Services
Amy Wark, Wilder Foundation
Susan Wingert, Pediatric Home Service
Becki (Rebecca Long, Pediatric Home Service
Tom Henderson, SCHA/Brown County
Julie Faulhaber, Medica Health Plan
Carolyn Allshouse, Family Voices of MN
Pamela Zolik, Hennepin County
Anne Henry MN Disability Law Center
Sarah Anderson, Key Medical Supply, Inc.
Joan Willshire MN State Council Disability
Steve Larson, ARC MN
Jennifer Stevens, White Earth Reservation
Steve Piekarski, PICS
Eve Lee, ARC Greater Twin Cities
Kara Hall-Tempel, MN Department of Education

Jodi Greenstein, TBI Advisory Community & Courage
Tim Sullivan MN HIV Service Planning Council
Christian Knights, Public Affairs Associate
Kristy Wilfahrt, Medica
Teresa Chicoine, Medica
Colleen Larson, Vinland National Center
Sue McGuigan,
Cary Zahrbock, Medica Behavioral Health
Clifford Gibson, Hennepin County
Trish Stark, MN Psychological Association
Susan McGeehan, Medica
Lois Foehringer, Axis Healthcare
Randall Bachman, Axis Healthcare
Kathy Thurston, Axis Healthcare
Ronna Linroth, Gillette Children's Specialty Health Care
Carol Laumer, Rice Home Medical
Jackie Anderson, Key Medical Supply
Annette Pearson, Vinland National Center
Vicki Gerrits, Lifeworks
Lisa Jenkins, Hennepin County Managed Care
Mary Gabel, Hennepin County
Patricia Coldwell, AMC
Jernell Walker, Hennepin County
Cea Grass South County Health Alliance
Jeri Peters, UCare
Anna Tockman, UCare
David Doth, REM
Joel Ulland, UCare
Jennifer McNertney, Minnesota Hospital Association
Jeff Lewis, Ramsey County
Jody Kougl-Lindstrom, Ramsey County
Melissa Anne Hensley, Augsburg College
Mitchel Paulson, SE MN Center for Independent Living
Lynda Anderson, University of Minnesota
Linda Halbur, SW Center for Independent Living
Sherrie Kenny, Autism Society of MN -AuSM
Bonnie Markham, TBI Advisory Committee
Mary Broddock, Gillette Children's Speciality Health Care
Cecile Kudela, St. Thomas
Jennifer Perry, Axis Healthcare
Susan Sommers, Metropolitan Health Plan
Veronica Schulz, Metropolitan Health Plan
Hank Schoonover, Metropolitan Health Plan
Stephanie Brown, Chisago County HHS

Patricia Mack, NAMI Minnesota
Heidi Nordin, NAMI Minnesota
Sunni Monson, NAMI Minnesota
Abby Marier, NAMI Minnesota
Becky Bills, Medica
Michael Landgren, MN Department of Human Services
Janis Perry, Dungarvin MN
Telesea Everett Dakota County
Pam Brumfield, Carlton County
Larrine Pierce, DHS Adult Mental Health Division
Natalie Graf, Dungarvin
Gene Martinez, ARC of MN
Annette Pearson, Vinland Center
Sue Abderholden, NAMI
AJW, Wilder Foundation
Colleen Wick, State of MN
D. Thorn, Lifeworks
Leah Drillias, Take Action Minnesota
Jill Parkinson, MS Society
Jeff Nachbar, Brain Injury Association of MN
John Tschida, Courage Center
Lee George, Brain Injury Association of MN
Norm Munk, Partnership Resource
Ron Brandt, Minnesota Association of Mental Health Centers
Melissa Huberty, Ramsey County
Sandi Shadley, Recover Health

Employment Stakeholder Group
Inez Wildwood, GWDC
Joel Luedtke, Phillips Foundation
Jane Leonard, Bush Foundation
Gary Cunningham, Northwest Area Foundation
Alyssa Klein, DEED
Stacy Myhre, DHS
Cindy Swan Henderlite
Bob Niemiec, MNTAT
Joan Willshire, MSCOD
Kim Peck, DEED/VR
Kathy Sweeney, DEED
Kim Feller, MN Resource, INC
Robyn Widley/Al Hauge, Dept of Education
Al Hauge Dept of Education
Don Lavin/Jon Alexander, Rise
Lucas Kunach, Fraser

Steffany Truax, Hennepin County
Andreas Zuber, Ramsey County
Pete Klinkhammer, Brain Injury Association of MN
Steve Larson -Consortium of Citizens with Disabilities
John Tschida, Courage Center
Colleen Wieck, Gov's Council on DD
Amy Hewitt, ICI
Jerry Pederson, MACSSA
CIL rep

Mental Health Experts
Ron Brand, MN Assoc. of Mental Health Centers
Sue Abderholden, NAMI
Bruce Hodek, Deaf and Hard of Hearing
John Wayne Barker, MNDACA
Lynn Noren - MN Habilitation Council/ Rise

Family Stabilization Services
Boyd Brown, Goodwill EasterSeals
Melinda donaway, Open Cities Health Center
Bill Fuller, American Indian Family Center
Ella Gross, Institute for Minority Development
Sharon Henry Blythe, Family Supportive Housing
Marcie Jefferys, Children's Defense Fund
Elizabeth Kuoppala, MN Coalition for the Homeless
Kevin Martineau, American Family Center
Cora Murph, Open Cities Health Center
Alicia Smith, American Family Center
Bao Vang, Hmong American Partnership
Katherine Wagoner, Affirmative Options Coalition
Jessica Webster, Legal Services Advocacy Project
Stella Whitney West, NorthPoint Health and Wellness Center
ThaoMee Xiong, MN Coalition for Battered Women