Reform 2020: Pathways to Independence

Section 1115 Waiver No. 11-W-00286/5

Demonstration Year IV
July 1, 2016 through June 30, 2017
Annual Report

Submitted to:

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services

Submitted by:

Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55164-0983

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1. Introduction

On October 18, 2013, the Centers for Medicare & Medicaid Services approved Minnesota's section 1115 demonstration project, entitled Reform 2020. The five year demonstration provides federal waiver authority to implement key components of Minnesota's broader reform initiatives to promote independence, increase community integration and reduce reliance on institutional care for Minnesota's older adults and people with disabilities. The Reform 2020 waiver provides federal support for the Alternative Care program and provides access to expanded self-directed options under the CFSS program for people who would not be eligible for these services under the 1915(i) and 1915(k) state plan option. The demonstration is effective through June 30, 2018.

1.1 Alternative Care Program

The Alterative Care program provides a home and community services benefit to people age 65 and older who need nursing facility level of care and have income or assets above the Medical Assistance (MA) standards. The Alternative Care program was established as an alternative to provide community services to seniors with modest income and assets who are not yet eligible for MA. This allows people to get the care they need without moving to a nursing home. The Reform 2020 demonstration waiver provides federal matching funds for the Alternative Care program.

1.2 Community First Services and Supports (CFSS)

Minnesota is redesigning its state plan personal care assistance services to expand self-directed options under a new service called Community First Services and Supports (CFSS). This service, designed to maintain and increase independence, will be modeled after the Community First Choice Option. It will reduce pressure on the system as people use the flexibility within CFSS instead of accessing the expanded service menu of one of the state's five HCBS waivers to meet gaps in their needs.

The new CFSS service, with its focus on consumer direction, is designed to comply with the regulations regarding section 1915(k) of the Social Security Act. Minnesota is currently seeking federal approval of the 1915(i) and 1915(k) state plan amendments required to implement this PCA reform initiative. To avoid a reduction in services for people currently using PCA services, CFSS will be available both to people who meet an institutional level of care [via 1915(k)] and people who do not [via 1915(i)]. These two components of CFSS are designed to work together seamlessly to provide appropriate services to people who have a functional need. Services authorized under 1915(i) will be identical to those authorized under 1915(k). The enhanced FMAP rate will apply to the 1915(k) services and the regular FMAP rate will apply to the 1915(i) services. Appropriateness of CFSS services will be based on the CFSS functional eligibility criteria.

Federal authority under the Reform 2020 section 1115 demonstration waiver allows Minnesota to extend the CFSS benefit to people who would not be eligible to receive such services under

the state plan. Under the Reform 2020 demonstration waiver, a 1915(i)-like benefit will be available for people with incomes above 150% of the federal poverty level (FPG) who do not meet an institutional level of care and who receive the reformed PCA benefit (CFSS). The regular FMAP rate will apply to these services. A 1915(k)-like benefit will be available for people who meet an institutional level of care, receive the reformed PCA benefit (CFSS), are not receiving HCBS waiver services and are financially eligible if using financial eligibility rules for HCBS waivers. The regular FMAP rate will apply to these services. CFSS will be implemented for all populations once Minnesota's 1915(i) and 1915(k) state plan amendments are approved by CMS. Reporting on the 1915(i)-like and 1915(k)-like component of the Reform 2020 demonstration will begin once approval of the state plan amendments has been secured and implementation has begun.

1.3 Children under 21 with Activities of Daily Living (ADL) Needs

The Reform 2020 waiver provides federal expenditure authority for children under age 21 who are eligible under the state plan and who meet the March 23, 2010 institutional level of care criteria, but do not meet the institutional level of care criteria established in state law effective January 1, 2015, and would therefore lose Medicaid eligibility or home and community based services eligibility. Please refer to Section 7.1 of this report for more detail.

1.4 Goals of Demonstration

The Reform 2020 demonstration is designed to assist the state in its goals to:

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

2. Enrollment Information

Demonstration Populations (as Hard coded in the CMS 64)	Enrollees at close of DY IV (June 30, 2017)	Current Enrollees (as of data pull on July 5, 2017)	Disenrolled in DY IV (July 1, 2016 to June 30, 2017)
Population 1: Alternative Care	2,643	2,631	38
Population 2: 1915(i)-like			
Population 3: 1915(k)-like			
Population 4: ADL Children			

3. Alternative Care Program Wait List Reporting

There is no waiting list maintained for the Alternative Care program and there are no plans to implement such a list.

4. Outreach and Innovative Activities

4.1 Minnesota Department of Human Services Public Web Site

Information on the Alternative Care program is available to the public on the Department of Human Services (DHS) website. The Alternative Care web page provides descriptive information about program eligibility, covered services, and the program application process. The web page also refers users to the Senior LinkAge Line® (described in the following section) where they can speak to a human services professional about the Alternative Care program and other programs and services for seniors.

4.2 Senior Linkage Line®

The Senior Linkage Line® is a free telephone information service available to assist older adults and their families find community services. With a single call, people can find particular services near them or get help evaluating their situation to determine what kind of service might be helpful. Information and Assistance Specialists direct callers to the organizations in their area that provide the services in which they are interested. Specialists can conduct three-way calls and offer follow-up as needed. Specialists are trained health and human service professionals. They offer objective, neutral information about senior service and housing options.

4.3 Statewide Training

DHS staff provides on-going consultation and training on Alternative Care program policy to all lead agencies. For the Alternative Care program, the lead agency can be a county social service department, local public health agency or a Tribal entity. Training sessions on the Alternative Care program are offered twice a year via statewide video conferencing. These training sessions cover the policies and procedures for the Alternative Care program. The training targets staff with up to 12 months of program experience. Staff with more experience is encouraged to attend if they have not previously attended or need a refresher in the program basics. The learning objectives for the training include understanding the Alternative Care program eligibility requirements and service definitions, and case manager roles and responsibilities in administering the Alternative Care program.

DHS also publishes and maintains provider and MMIS manuals and provides technical assistance through a variety of means including written resource material, electronic and call-in help centers and weekly training opportunities via statewide video conferencing on topics related to aging. Ongoing training related to MMIS tools and processes, long term care consultation and level of care determinations, case management, vulnerable adult and maltreatment reporting and prevention is also provided. DHS staff regularly attends regional meetings convened by lead agencies.

5. Updates on Post-Award Public Forums

In accordance with paragraph 32 of the Reform 2020 special terms and conditions, the State held a public forum on December 16, 2016 to provide the public with an opportunity to comment on the progress of the Reform 2020 demonstration. An overview of the December 16, 2016 public forum including comments and issues raised by the public is provided at Attachment A. DHS plans to hold the next public forum in December 2017.

6. Operational Developments and Issues

6.1 1915(i) and 1915(k) State Plan Amendments

Two types of federal authorities are necessary for the state to implement CFSS – both state plan and waiver authorities. Implementation of the 1915(i)-like and 1915(k)-like components of the Reform 2020 waiver is contingent upon approval of the corresponding 1915(i) and 1915(k) state plan amendments. Due to systems modernization efforts, projected implementation of the CFSS benefit has been delayed.

6.2 CFSS 1915(b)(4) Waiver

On June 20, 2014, DHS submitted a 1915(b)(4) selective contracting waiver request to limit the number of financial management services contractors and consultation service providers.

Under CFSS, people may directly employ and pay qualified support workers and/or purchase goods or environmental modifications that relate to an assessed need identified in their service delivery plan. Spending must be limited to the authorized amount. A financial management services contractor (FMS) will be the employer-agent assisting participant-employers to comply with state and federal employment laws and requirements and for billing and making payments on behalf of participant-employers. In addition, participants will utilize a consultation services provider to learn about CFSS, select a service delivery model, and develop a person-centered service delivery plan and budget and to obtain information and support about employing, training, supervising and dismissing support workers.

Under this waiver, DHS would contract with FMS and consultation services providers via competitive procurement. Competitive procurement is appropriate for FMS and consultation services providers to ensure the most qualified providers are utilized and to allow DHS to concentrate provider training and monitoring efforts on a few highly qualified providers. FMS and consultation services providers will have a new and critical role in ensuring that participants learn how to use this self-directed option and experience expected outcomes, funds are spent appropriately and participant's identified needs are met. This waiver authority will help to ensure a smooth transition to this more flexible benefit, and to implement quality services, by limiting the pool of FMS and consultation services providers to a small number of highly qualified entities. In addition, selective contracting is particularly appropriate because other states offering participant-directed benefits have had success in purchasing financial

management services at a lower price when the number of contractors is limited so that the contractors have a sufficient volume of participants. The effective date of the 1915(b)(4) waiver will coincide with the approval of the state plan amendments referenced in Section 6.1 of this report.

6.3 Alternative Care Program Operational Protocol

On August 8, 2014, DHS submitted the Operational Protocol for the Alternative Care program that is to be appended to the Reform 2020 special terms and conditions. The protocol was updated to incorporate changes in response to CMS' questions and comments and resubmitted on January 26, 2015. An updated protocol was submitted in October 2015 to include changes made to the Alternative Care program after the State's 2015 legislative session. Additional changes have been made to the Alternative Care program after the State's 2016 legislative session. An updated protocol reflecting these changes was provided as Attachment A in the Reform 2020 Annual Report for demonstration year III.

7. Policy Developments and Issues

7.1 Delay in Changes to the NF LOC Standard and Children with ADL Needs

In 2009, the Minnesota Legislature passed legislation that changes the nursing facility level of care criteria for public payment of long-term care services. These revised criteria were implemented on January 1, 2015. The change affects people who would receive publicly-funded nursing facility services or publicly-funded long-term care services in the community through programs such as Elderly Waiver (EW), Alternative Care (AC), and Community Alternatives for Disabled Individuals (CADI). Governor Dayton requested a delay to provide additional time to make sure the appropriate supports are available to Minnesotans affected by this change.

The Reform 2020 waiver provides federal expenditure authority for children under the age of 21 who are eligible under the state plan and who met the March 23, 2010 nursing facility level of care criteria, but who do not meet the revised nursing facility level of care criteria and would therefore lose Medicaid eligibility or home and community-based services eligibility. Quarterly enrollment and member-month reporting for children meeting these criteria began January 1, 2015.

7.2 HCBS Settings Final Rule

The State has reviewed the final rule for the Medicaid home and community-based services settings, issued by CMS in January 2014. The final regulation addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for home and community-based services. In particular, the state has assessed requirements established in the rule for the qualities of settings that are eligible for Medicaid reimbursement for home and community-based services provided under sections 1915(c), 1915(i) and 1915(k) and the potential implications for Minnesota's personal care assistance services redesign initiative and

the state's efforts to expand self-directed options under CFSS. On January 7, 2015 DHS submitted Minnesota's plan to transition to compliance with the CMS regulation governing home and community –based settings. The transition plan applies to all five of Minnesota's home and community-based waiver programs under authority of §1915(c) of the Social Security Act. On June 2, 2017, the state received initial approval of systemic assessment and remediation strategies to be implemented under the Statewide Transition Plan. The State is currently working with CMS to secure final approval of its Statewide Transition Plan.

8. Financial and Budget Neutrality Development Issues

Demonstration expenditures are reported quarterly using Form CMS-64, 64.9 and 64.10.

9. Member Month Reporting

Eligibility Group	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Total for DY IV Ending June 30, 2017
Population 1: Alternative Care	2,588	2,612	2,630	2,641	2,657	2,650	2,659	2,659	2,666	2,693	2,684	2,690	31,829
Population 2: 1915(i)-like													
Population 3: 1915(k)-like													

Population 4: ADL Children During the period of July 1, 2016 through June 30, 2017, there were six children identified as meeting the criteria outlined in the special terms and conditions paragraph 18 for the ADL Children eligibility group. All services received by these children were provided on a fee-for-service basis. Service expenditures for these children are reported each quarter on a separate Form CMS-64.9 Waiver.

10. Consumer Issues

10.1 Alternative Care Program Beneficiary Grievances and Appeals

A description of the State's grievance system and the dispute resolution process is outlined in the 1915(c) HCBS Waiver application and the 372 report for the Elderly Waiver. These processes apply to the Alternative Care Program. Grievances and appeals filed by Alternative Care program recipients are reviewed by DHS on a quarterly basis. Alternative Care program staff assist in resolving individual issues and identify significant trends or patterns in grievances and appeals filed. Following is a summary of Alternative Care program grievance and appeal activity during the period July 1 2016 through June 30, 2017.

Alternative Care Program Beneficiary Grievance and Appeal Activity
July 1, 2016 through September 30, 2016

	Affirmed	Reversed	Dismissed	Withdrawn
AC Appeals	0	0	0	0

Alternative Care Program Beneficiary Grievance and Appeal Activity
October 1, 2016 through December 31, 2016

	Affirmed	Reversed	Dismissed	Withdrawn
AC Appeals	1	0	1	1

Alternative Care Program Beneficiary Grievance and Appeal Activity
January 1, 2017 through March 31, 2017

	Affirmed	Reversed	Dismissed	Withdrawn
AC Appeals	0	0	0	0

Alternative Care Program Beneficiary Grievance and Appeal Activity
April 1, 2017 through June 30, 2017

	Affirmed	Reversed	Dismissed	Withdrawn
AC Appeals	1	0	1	1

10.2 Alternative Care Program Adverse Incidents Consistent with 1915(c) EW Waiver Requirements

A detailed description of participant safeguards applicable to Alternative Care enrollees, including the infrastructure for vulnerable adult reporting, the management process for critical event or incident reporting, participant training and education, and methods for remediating individual problems is outlined in the 1915(c) HCBS Waiver application and the 372 report for the Elderly Waiver.

Incidents of suspected abuse, neglect, or exploitation are reported to the common entry point (CEP) established by DHS. The CEP forwards all reports to the respective investigative agency. In addition, CEP staff also screen all reports for immediate risk and make all necessary referrals. Immediate referral is made by the CEP to county social services when there is an identified emergency safety need. Reports containing information regarding an alleged crime are forwarded immediately by the CEP to law enforcement. Reports of suspicious death are forwarded immediately to law enforcement, the medical examiner and the ombudsman for mental health and developmental disabilities.

For reports not containing an indication of immediate risk, the CEP notifies the lead agency responsible for investigation within two working days. The lead investigative agency provides information, upon request of the reporter, within five working days as to the disposition of the report. Each lead investigative agency evaluates reports based on prioritization guidelines. DHS has made use of a standardized tool required for county lead investigative agencies to promote safety through consistent, accurate and reliable report intake and assessment of safety needs.

Investigation guidelines for all lead investigative agencies are established in statute and include interviews with alleged victims and perpetrators, evaluation of the environment surrounding the allegation, access to and review of pertinent documentation and consultation with professionals.

Supported in part by funding under a CMS Systems Change Grant, DHS developed, implemented and manages a centralized reporting data collection system housed within the Social Services Information System (SSIS). This system stores adult maltreatment reports for the CEP. SSIS also supports county functions related to vulnerable adult report intake, investigation, adult protective services and maintenance of county investigative results. Once maltreatment investigations are completed the county investigative findings are documented within SSIS.

The SSIS system has the capacity to provide statewide maltreatment summary information, supplies comprehensive and timely maltreatment information to DHS, allows the department to review maltreatment incidents statewide and analyze by program participation, provider and agency responsible for follow-up. Data from SSIS is drawn on a quarterly and annual basis. This allows DHS to review data and analyze for patterns and trends including program specific patterns and trends that may be addressed through DHS and partners in maltreatment response and prevention, or policy. Maltreatment data gathered from SSIS is also used by DHS to evaluate quality in preventative and protective services provided to vulnerable adults, assess trends in maltreatment, target training issues and identify opportunities for program improvement.

Please refer to Attachment B for reports on allegations and investigation determinations of maltreatment where the county was the lead investigative agency and the alleged victim was receiving services under the Alternative Care program.

Reports are provided for the following Reform 2020 waiver reporting periods:

Reform 2020 1st Quarter Report, Demonstration Year IV, July 1, 2016 to September 30, 2016
Reform 2020 2nd Quarter Report, Demonstration Year IV, October 1, 2016 to December 31, 2016
Reform 2020 3rd Quarter Report, Demonstration Year IV, January 1, 2017 to March 31, 2017
Reform 2020 4th Quarter Report, Demonstration Year IV, April 1, 2017 to June 30, 2017

The reporting of suspected maltreatment for all vulnerable adults in Minnesota recently changed from a county based reporting system to a centralized reporting system operated under DHS. The centralized reporting system includes more robust data for use in analysis for prevention and remediation. Modifications to the existing data warehouse are required to accommodate the increased data being reported. These modifications are underway and are expected to be completed soon. Reports which include allegations and investigation determinations of

maltreatment where DHS or the Minnesota Department of Health was the lead investigative agency and where the alleged victim was receiving services under the Alternative Care program will be provided once this data becomes available.

11. Quality Assurance and Monitoring Activity

11.1 Alternative Care Program and HCBS Quality Strategy under the 1915(c) EW Waiver

As described in the 1915(c) EW waiver, the DHS Quality Essentials Team (QET) within the Continuing Care Administration will meet twice a year to review and analyze collected performance measure and remediation data. The QET is a team made up of program and policy staff from the Alternative Care and HCBS waiver programs. The QET is responsible for integrating performance measurement and remediation association with monitoring data and recommending system improvement strategies, when such strategies are indicated for a specific program, and when DHS can benefit from strategies that impact individuals served under the Alternative Care and HCBS programs.

Problems or concerns requiring intervention beyond existing remediation processes (i.e. system improvement) are directed to the Policy Review Team (working with QET) for more advanced analysis and improved policy and procedure development, testing, and implementation.
The QET has identified and implemented a quality monitoring and improvement process for determining the level of remediation and any systems improvements required as indicated by performance monitoring.

11.2 Update on Comprehensive Quality Strategy

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

12. Demonstration Evaluation

DHS has contracted with researchers at the University of Minnesota and Purdue University for development of an evaluation design and analysis plan that covers all elements outlined in paragraph 60 of the Reform 2020 waiver special terms and conditions. A draft evaluation design was submitted to CMS on February 14, 2014. In response to CMS feedback, DHS modified the draft evaluation design so that it aligns with the desired format for section 1115 demonstrations. A revised evaluation design was submitted on December 9, 2014. On April 6, 2015 CMS

provided additional feedback and requested an updated evaluation. DHS has revised the evaluation design in response to CMS feedback. The revised plan was submitted to CMS on March 9, 2016. On May 17, 2017 DHS received additional comments from CMS. The evaluation plan was revised and submitted on June 22, 2017.

13. State Contact

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Reform 2020 and HCBS Partners Panel Notes

December 16, 2016

Welcome and Introductions

Lori Lippert, *Disability Services Division*

Update on Reform 2020

Kari Benson, *Director, Aging and Adult Services Division*

Alex Bartolic, *Director, Disability Services Division*

See handout: "Reform_2020_Public_Forum_12.16.16".

Reform 2020 Evaluation

Kari Benson, *Director, Aging and Adult Services Division*

See handout: "Reform_2020_Public_Forum_12.16.16".

Reform 2020 Public Comment

Questions and comments:

- Comment: It is still a challenge for service participants to access and understand the system. For lead agencies, we have dual payment systems and it is a lot of work to figure out how to support our service participants and providers. What would help would be if the state can have one menu of services and clearer information for lead agencies and service participants.
    - Response: It can be a complicated system for lead agencies and service participants. Even if we make services easier for program participants, that won't necessarily mean it will be easier for lead agencies. Community First Services and Supports (CFSS) is a good example of a service that is created to be easy for service participants to access. To do that, CFSS is administratively complex to set up.
- Q: There's been approval for 30 additional crisis beds. Can you talk more about that?
    - A: We needed to identify providers who are willing and have the capacity to provide this service. We went through a solicitation process to know who those people are in order to award licenses to them.

Access Analyses: Gaps Analysis Study and HCBS Access Project

Mary Olsen Baker, *Manager, Aging and Adult Services Division*

Sara Galantowicz, *Abt Associates*

See handouts:

- "Access-Analyses-PPT_HCBS-PP-12-16-16-acc"
- "2015-2016-Gaps-Analysis_Wilder-Workplan-Priorities-Summary_DRAFT-2016-8-31"
- "Gaps-Analysis-Study-overview_FINAL_11-2016"
- Click here to find the "Access Study Comparison Chart" from the October 2015 Partners Panel meeting.

Questions and comments:

- Q: How does DHS measure need?
    - A: The Gaps Analysis looks at the capacity of the system to provide services. The National Core Indicators survey looks at quality of life and quality of services.

- Q: Do you have access to data from health plans and managed care?
    - A: We have encounter claims information but do not have care plan data for those in managed care so we can't do the analysis to compare what services were approved to what was actually delivered.

Mental Health Task Force recommendations

Claire Wilson, *Assistant Commissioner, Community Supports Administration*

See handout: "Gov_Task_Force_on_MH-Final_Report_Exec_Summary_12.16.16"

Questions and comments:

- Q: Was there any recommendation about how to fund the recommendations? Or, perhaps a list of priorities?
    - A: The Task Force did not prioritize the list of recommendation, however they did say that the in-patient bed recommendations were short-term recommendations which indicates they saw this as something which should be addressed immediately.
- Q: How do we measure these areas to make sure we are making progress?
    - A: The report suggests how to measure change and impact but doesn't get into setting goals. For example, the report doesn't lay out timelines for accomplishing this work. It will take the whole stakeholder community to engage in these recommendations and to hold ourselves accountable.
- For more information, see the Mental Health Task Force web page: https://mn.gov/dhs/mental-health-tf/

HCBS Rule Transition Plan

Leah Zoladkiewicz, *Disability Services Division*

Rachel Shands, *Manager, Aging and Adult Services Division*

See handout: "HCBS_Rule_Transition_Plan_Milestones_12.16.16"

Questions and comments:

- Q: If I'm currently a provider of residential services in group settings, is there a template or review process available to help me determine if I meet the HCBS Rule criteria?
    - A: DHS will develop this for the attestation process. There will be a tool which will help providers determine how they will meet the requirements.
- Q: What happens if a person wants to remain at a setting that is presumed not to be HCBS?
    - A: If, after going through the DHS process, a setting is presumed not to meet the home and community-based (HCB) criteria, it will need to go through a "heightened scrutiny review" by CMS. If CMS determines it is *not* HCB, the person cannot get HCBS services at that setting. DHS and the lead agency will work with the person to transition to new services and/or a new setting.
- Comment: Across the country people are struggling with what MN is struggling with because CMS' guidance is unclear.
- Q: Why are two services held to a higher standard than the other services?
    - A: CMS has told DHS that the two services CMS will ask DHS about are DTH and Residential Services. These standards are helping MN look at all services to see how they can be enhanced to promote choice and independence. In residential, we need to do a better job at defining standards. We are hoping to meet these standards and not create disruption for service participants.
- Q: Are 100% of services still getting desk audits?
    - A: No, we will do a statistically significant number of desk audits.

- Q: The Alzheimer's Association is concerned about how this impacts services that serve people with dementia. For example, the requirement to be able to freely come and go from a facility.
    - A: CMS just released a FAQ on this concern. In the FAQ, CMS emphasized person-centered planning and that services need to meet the needs of individuals. They also said that "controlled egress" (locked unit) is allowed if it is addressed as a modification of the HCBS rule requirements, meaning that a person has a specific assessed need for the controlled egress, and it is justified and documented in the person-centered plan. See the handout "CMS FAQ Settings Final Rule".
- For more information: HCBS Transition Plan website and email address: hcbs.settings@state.mn.us

November 2016 Forecast

Bob Meyer, *Director, Fiscal Analysis and Performance Management*
See handouts:

- "November_2016_Forecast_CS_and_CC_Programs_12.16.16"
- "November_2016_Forecast _Presentation_12.16.16"

Questions and comments:

- Q: How much of the funds are state funds and how much is federal?
    - A: It depends on what slides you are looking at because some programs receives varying amounts of federal funding. In the presentation, page 7 shows 100% state funds and page 5 shows all funding including federal funds.
- Q: How do you get the annual growth?
    - A: The 9% annual increase is from the SFY to SFY specified.
- Email the contacts listed in the presentation if you have questions.

Discussion

Panel Members

Closing

Lori Lippert, *Disability Services Division*
See handout.

2017 Meeting Schedule

Location: Hi-Way Federal Credit Union Admin Office 840
Westminster Street
St. Paul MN 55103
Times: 9:00 a.m. – 12:00 p.m.

Attachment A

Dates:

Date	Location
February 17, 2017	Hi-Way Federal Credit Union Administrative Office
April 21, 2017	Hi-Way Federal Credit Union Administrative Office
June 16, 2017	Hi-Way Federal Credit Union Administrative Office
August 18, 2017	Hi-Way Federal Credit Union Administrative Office
October 20, 2017	Hi-Way Federal Credit Union Administrative Office
December 15, 2017	Hi-Way Federal Credit Union Administrative Office

Attachment A

Organization	Panel Member	Attendanc
AARP	Mary Jo George	x
Advocating Change Together (ACT)	Mary Kay Kennedy	
Alzheimer's Association	Beth McMullen	x
Arc Minnesota	Steve Larson	
Association of Minnesota Counties/CBP	Rochelle Westlund	
Association of Residential Resources of Minnesota	Barb Turner	
Brain Injury Alliance	David King	x
Care Providers of Minnesota	Patti Cullen	x
TBI Advisory Committee	Christina Kollman	x
Governor's Council on Developmental Disabilities	Lynne Megan	x
Corporation for Supportive Housing	George Stone	
HIV Housing Coalition	Chuck Peterson	
Institute on Community Integration	Amy Hewitt (Dr.)	x
Minnesota Network of Hospice and Palliative Care	Susan Marschalk	
LeadingAgeMN	Bobbie Guidry	
Local Public Health Association (LPHA)	Kay Dickison	x
LTC Ombudsman	Paula Wieczorek	x
Lutheran Social Services	Jeri Schoonover	x
MACSSA - Ramsey County	Beth Pierce	x
MN Council of Health Plans	Susan McGeenhan	x
Mid-Minnesota Legal Aid, Senior Law Project	Anne Henry	x
Minnesota Adult Day Services Association	Gail Skoglund	
Minnesota Area Geriatric Education Center	Robert Kane	
Minnesota Association of Area Agencies on Aging	Lori Vrolson	x
Minnesota Association of Centers for Independent Living	Don Brunette	
Minnesota Association for Children's Mental Health	Debora Saxhaug	
Minnesota Association of Community Mental Health Programs	Steve Thomas	
Minnesota Board on Aging	Meghan Coleman	
Minnesota Consortium of Citizens with Disabilities	Randall Bachman	x
Minnesota Council of Child-Caring Agencies	Mary Regan	
Minnesota Disability Law Center	Anne Henry	
Minnesota Organization for Habilitation and Rehabilitation	Tim Dickie	
Minnesota Home Care Association	Kathy Messerli	
Minnesota Hospital Association	Kristin Loncorich	
Minnesota Leadership Council on Aging	Rajean Moone	
Minnesota Legislature, Chair House Health and Human Services Finance	Matt Dean	
Minnesota Legislature, Chair House Health and Human Services Policy Committee	Tara Mack	
Minnesota Legislature, Chair House Aging and Long Term Care Policy Committee	Joe Schomacker	
Minnesota Legislature, Chair Senate Health, Human Services Finance Committee	Tony Lourey	

Minnesota Legislature, Chair Senate Health, Human Services Policy Committee	Kathy Sheran	
Minnesota State Council on Disability	Joan Willshire	
MNAPSE-The Network for Employment	Bob Niemiec	
Minnesota Organization for Habilitation and Rehabilitaton	John Wayne Barker	x
NAMI Minnesota	Sue Abderholden	
Ombudsman for MH/DD	Roberta Opheim	
State Advisory Council on Mental Health	Michael Trangle	
White Earth Home Health Agency	Rachel LaFrinier	
DHS Disability Services Division	Alex Bartolic	x
DHS Aging and Adult Services Division	Kari Benson	x
DHS Mental Health Division		
DHS Alcohol and Drug Abuse Division	Brian Zirbes	

Attachment B-1

Analysis of Adult Maltreatment Reported for AC Participants
(07/01/2016 - 09/30/2016)

Allegations reported while the alleged victim was Eligible for Alternative Care Services and where:
Reports were received by the Common Entry Point between 07/01/2016 and 09/30/2016
Determinations limited to those made between 07/01/2016 and 12/10/2016

CEP- Reported Adult Maltreatment Involving AC Participants
(07/01/2016 - 09/30/2016)

	Allegations Reported to CEP where Alleged Victim is an enrollee*		Allegations Investigated by the County		County Investigations with Final Disposition as of 12/10/2016	% Substantiated Maltreatment (of Allegations Investigated with Final Disposition)	
	#	% Total Allegations	# Allegations Investigated by the County	% of Total Allegations Investigated by the County	# County Investigations with Final Disposition	# Substantiated	% Substantiated of Total Investigated with Final Disposition
Emotional Abuse	20	11.49%	7	15.56%	7	1	2.78%
Mental Abuse	0	0.00%	0	0.00%	0	0	0.00%
Physical Abuse	4	2.30%	2	4.44%	2	0	0.00%
Sexual Abuse	0	0.00%	0	0.00%	0	0	0.00%
Financial Exploitation (Fid. Rel.)	10	5.75%	3	6.67%	3	0	0.00%
Financial Exploitation (Non-Fid. Rel.)	31	17.82%	12	26.67%	11	0	0.00%
Involuntary Servitude	0	0.00%	0	0.00%	0	0	0.00%
Caregiver Neglect	42	24.14%	10	22.22%	9	0	0.00%
Self-Neglect	67	38.51%	11	24.44%	4	1	2.78%
Total	174	100.00%	45	100.00%	36	2	5.56%

Source: DHS Data Warehouse 12/20/2016 (this should be at least 3 mos 10d following end of waiver reporting period.)

Dispostion of County Investigations of Maltreatment Allegations Involving AC Adult Participants
CEP Reported Allegations : 07/01/2016 and 09/30/2016

	Allegation Dispostion				
	Substantiated Maltreatment	False Allegation*	Inconclusive	No Determination - Investig Not Possible^	Total
Emotional Abuse	1	4	2		7
Mental Abuse					0
Physical Abuse		2			2
Sexual Abuse					0
Fin. Exploitation (Fid Rel)		2	1		3
Fin. Exploitation (Non-Fid Rel)		10		1	11
Involuntary Servitude					0
Caregiver Neglect		6	1	2	9
Self -Neglect	1	2		1	4
Total	**2**	**26**	**4**	**4**	**36**

* Includes No Determination: No Maltreatment
^ Includes No determination - Not a Vulnerable Adult

Source: DHS Data Warehouse 12/20/2016 (this should be at least 3 mos 10d following end of waiver reporting period.)

Attachment B-2

Analysis of Adult Maltreatment Reported for AC Participants

(10/01/2016 - 12/31/2016)

Allegations reported while the alleged victim was Eligible for Alternative Care Services and where:
Reports were received by the Common Entry Point between 10/01/2016 and 12/31/2016
Determinations limited to those made between 10/01/2016 and 04/10/2017

CEP- Reported Adult Maltreatment Involving AC Participants
(10/01/2016 - 12/31/2016)

	Allegations Reported to CEP where Alleged Victim is an enrollee*		Allegations Investigated by the County		County Investigations with Final Disposition as of 4/10/2017	% Substantiated Maltreatment (of Allegations Investigated with Final Disposition)	
	#	% Total Allegations	# Allegations Investigated by the County	% of Total Allegations Investigated by the County	# County Investigations with Final Disposition	# Substantiated	% Substantiated of Total Investigated with Final Disposition
Emotional Abuse	10	6.67%	3	6.67%	2	0	0.00%
Mental Abuse	0	0.00%	0	0.00%	0	0	0.00%
Physical Abuse	8	5.33%	4	8.89%	0	0	0.00%
Sexual Abuse	0	0.00%	0	0.00%	0	0	0.00%
Financial Exploitation (Fid. Rel.)	12	8.00%	7	15.56%	4	1	5.00%
Financial Exploitation (Non-Fid. Rel.)	24	16.00%	8	17.78%	3	0	0.00%
Involuntary Servitude	0	0.00%	0	0.00%	0	0	0.00%
Caregiver Neglect	31	20.67%	15	33.33%	6	1	5.00%
Self-Neglect	65	43.33%	8	17.78%	5	0	0.00%
Total	150	100.00%	45	100.00%	20	2	10.00%

Source: DHS Data Warehouse 03/20/2017 (this should be at least 3 mos 10d following end of waiver reporting period.)

Dispostion of County Investigations of Maltreatment Allegations Involving AC Adult Participants
CEP Reported Allegations : 10/01/2016 and 12/31/2016

	Allegation Dispostion				
	Substantiated Maltreatment	False Allegation*	Inconclusive	No Determination - Investig Not Possible^	Total
Emotional Abuse			1	1	2
Mental Abuse					0
Physical Abuse					0
Sexual Abuse					0
Fin. Exploitation (Fid Rel)	1	3			4
Fin. Exploitation (Non-Fid Rel)			1	2	3
Involuntary Servitude					0
Caregiver Neglect	1	3	1	1	6
Self -Neglect		3	2		5
Total	**2**	**9**	**5**	**4**	**20**

* Includes No Determination: No Maltreatment
^ Includes No determination - Not a Vulnerable Adult

Source: DHS Data Warehouse 03/20/2017 (this should be at least 3 mos 10d following end of waiver reporting period.)

Analysis of Adult Maltreatment Reported for AC Participants
(01/01/2017 - 03/31/2017)

Allegations reported while the alleged victim was Eligible for Alternative Care Services and where:
Reports were received by the Common Entry Point between 01/01/2017 and 03/31/2017
Determinations limited to those made between 01/01/2017 and 07/10/2017

CEP- Reported Adult Maltreatment Involving AC Participants
(01/01/2017 - 03/31/2017)

	Allegations Reported to CEP where Alleged Victim is an enrollee*		Allegations Investigated by the County		County Investigations with Final Disposition as of *7/10/2017*	% Substantiated Maltreatment (of Allegations Investigated with Final Disposition)	
	#	% Total Allegations	# Allegations Investigated by the County	% of Total Allegations Investigated by the County	# County Investigations with Final Disposition	# Substantiated	% Substantiated of Total Investigated with Final Disposition
Emotional Abuse	36	15.25%	21	23.86%	19	5	6.02%
Mental Abuse	0	0.00%	0	0.00%	0	0	0.00%
Physical Abuse	11	4.66%	10	11.36%	10	0	0.00%
Sexual Abuse	1	0.42%	1	1.14%	1	0	0.00%
Financial Exploitation (Fid. Rel.)	18	7.63%	8	9.09%	7	0	0.00%
Financial Exploitation (Non-Fid. Rel.)	48	20.34%	12	13.64%	12	4	4.82%
Involuntary Servitude	0	0.00%	0	0.00%	0	0	0.00%
Caregiver Neglect	53	22.46%	21	23.86%	19	0	0.00%
Self-Neglect	69	29.24%	15	17.05%	15	2	2.41%
Total	236	100.00%	88	100.00%	83	11	13.25%

Source: DHS Data Warehouse 10/09/2017 (this should be at least 3 mos 10d following end of waiver reporting period.)

Dispostion of County Investigations of Maltreatment Allegations Involving AC Adult Participants
CEP Reported Allegations : 01/01/2017 and 03/31/2017

	Allegation Dispostion				
	Substantiated Maltreatment	**False Allegation***	**Inconclusive**	**No Determination - Investig Not Possible^**	**Total**
Emotional Abuse	5	2	10	2	19
Mental Abuse					0
Physical Abuse		2	6	2	10
Sexual Abuse				1	1
Fin. Exploitation (Fid Rel)		5	2		7
Fin. Exploitation (Non-Fid Rel)	4	3	4	1	12
Involuntary Servitude					0
Caregiver Neglect		8	10	1	19
Self -Neglect	2	8	4	1	15
Total	**11**	**28**	**36**	**8**	**83**

* Includes No Determination: No Maltreatment
^ Includes No determination - Not a Vulnerable Adult

Source: DHS Data Warehouse 10/09/2017 (this should be at least 3 mos 10d following end of waiver reporting period.)

Analysis of Adult Maltreatment Reported for AC Participants
(04/01/2017 - 06/30/2017)

Allegations reported while the alleged victim was Eligible for Alternative Care Services and where:
Reports were received by the Common Entry Point between 04/01/2017 and 06/30/2017
Determinations limited to those made between 04/01/2017 and 10/09/2017

CEP- Reported Adult Maltreatment Involving AC Participants
(04/01/2017 - 06/30/2017)

	Allegations Reported to CEP where Alleged Victim is an enrollee*		Allegations Investigated by the County		County Investigations with Final Disposition as of *10/9/2017*	% Substantiated Maltreatment (of Allegations Investigated with Final Disposition)	
	#	% Total Allegations	# Allegations Investigated by the County	% of Total Allegations Investigated by the County	# County Investigations with Final Disposition	# Substantiated	% Substantiated of Total Investigated with Final Disposition
Emotional Abuse	16	8.25%	12	17.65%	10	2	3.77%
Mental Abuse	0	0.00%	0	0.00%	0	0	0.00%
Physical Abuse	10	5.15%	4	5.88%	2	0	0.00%
Sexual Abuse	0	0.00%	0	0.00%	0	0	0.00%
Financial Exploitation (Fid. Rel.)	11	5.67%	3	4.41%	3	1	1.89%
Financial Exploitation (Non-Fid. Rel.)	36	18.56%	13	19.12%	11	2	3.77%
Involuntary Servitude	0	0.00%	0	0.00%	0	0	0.00%
Caregiver Neglect	51	26.29%	17	25.00%	14	1	1.89%
Self-Neglect	70	36.08%	19	27.94%	13	2	3.77%
Total	194	100.00%	68	100.00%	53	8	15.09%

Source: DHS Data Warehouse 10/09/2017 (this should be at least 3 mos 10d following end of waiver reporting period.)

Dispostion of County Investigations of Maltreatment Allegations Involving AC Adult Participants
CEP Reported Allegations : 04/01/2017 and 06/30/2017

	Allegation Dispostion				
	Substantiated Maltreatment	False Allegation*	Inconclusive	No Determination - Investig Not Possible^	Total
Emotional Abuse	2	3	5		10
Mental Abuse					0
Physical Abuse			2		2
Sexual Abuse					0
Fin. Exploitation (Fid Rel)	1	2			3
Fin. Exploitation (Non-Fid Rel)	2	8	1		11
Involuntary Servitude					0
Caregiver Neglect	1	6	6	1	14
Self -Neglect	2	8	3		13
Total	**8**	**27**	**17**	**1**	**53**

* Includes No Determination: No Maltreatment
^ Includes No determination - Not a Vulnerable Adult

Source: DHS Data Warehouse 10/09/2017 (this should be at least 3 mos 10d following end of waiver reporting period.)