

MN2030 - Access

Current Status

The Senior LinkAge Line® is the Minnesota Board on Aging's free statewide service that provides options counseling. The Senior LinkAge Line® service is provided by six Area Agencies on Aging that cover all 87 counties of Minnesota. The Senior LinkAge Line® staff are trained social workers, nurses and gerontology/human services professionals that have expertise in:

- Prescription Drug Expense assistance for Minnesotans of all ages
- Health Insurance Counseling and benefits such as Medicare and Medical Assistance
- Forms assistance, including help applying for Medical Assistance and enrolling into Medicare plans
- Long-term Care Insurance, including the Long-term Care Partnership
- Caregiver planning and support
- Care Transitions including Pre-Admission Screening, successful discharges back to the community from a nursing home or hospital
- Options to age in place or to make a move, when necessary

The Senior LinkAge Line has seen immense growth over the past roughly two decades (1,156 percent increase).

	Total Contacts	Total Number of Consumers Assisted
• 1997 number of contacts:	21,675	21,675
• 2016 number of contacts	272,435	123,868

The service has also gone through significant change with full automation of processes and the addition of significant amounts of in person assistance. This strategic effort was made a priority by the Minnesota Board on Aging (MBA) starting in 2000 and has continued through the current board membership. In addition, the Senior LinkAge Line® has grown substantially in terms of staff and funding, reporting and compliance. Taking on Pre-Admission Screening and the support of high risk individuals through their care transitions – now the number one referral to Senior LinkAge Line® - requires an increased attention to security, detail and risk management.

Senior LinkAge Line® - unlike many government services – is made available to all older Minnesotans who need it. In addition to this foundational service, though, the board has added capacity to target particular populations who are at high risk and are experiencing particular challenges that threaten their ability to live well at home with a focus on the critical pathways to long term services and supports. But the capacity is limited. Meeting with people in their homes and through face to face contact requires more intensive staffing levels and higher

credentialing among the staff and this all has an increasing cost. The current funding for this work can support the delivery of care transition assistance to an estimated 10,000 older adults through phone and in person assistance annually. The Return to Community initiative has been a key part of this and, with the expansion, provides the MBA and AAAs with increased capacity to target high risk populations. Through the implementation, the Return to Community expansion will allow us to partner even more closely with home care and health care providers (including hospitals) to increase coordination, service and follow-up with these individuals to help them live well at home.

Trends and Recommendations for Strategic Priorities

Summarized below are the major trends affecting the Senior LinkAge Line over the next several years. These trends were the most frequently identified by stakeholders to date through the MN2030: Looking Forward process and by MBA staff with expertise in this area.

1. Ending of Minnesota Cost Plans: December 31, 2018

As it stands right now, the Cost plans, which are considered “Other Medicare Plans”, are scheduled to end on December 31, 2018. This means 386,922 current Medicare beneficiaries that are enrolled in a Medicare Cost Plan in Minnesota will have to choose a new plan.

Cost plans are considered almost a "hybrid" plan. The key difference between Medicare Cost plans and other types of Medicare plans is that enrollees are not restricted to the plan’s network of providers. They can go outside the network to receive Medicare-covered services.

The cost plans are reimbursed by Medicare according to the cost of services provided by the health plan instead of receiving a fixed monthly dollar amount to provide all services (as is done with the Medicare Advantage plans).

Overall, Minnesota has the nation’s largest concentration of people with Medicare Cost plans. An estimated 386,000 of the state’s 836,000 Medicare beneficiaries have Medicare Cost plans, The Centers for Medicare & Medicaid Services (CMS) has indicated that cost plan enrollees will most likely be transitioned to Medicare Advantage plans offered by the cost plan companies, if they choose to offer them. This will create many problems for our beneficiaries because they will no longer have “Original Medicare” to revert back to for out of network services. If they go out of network and it is not an emergency, they will be liable for the cost unless they have the Point of Service option (in a Health Maintenance Organization (HMO), this option lets you use doctors and hospitals outside the plan for an additional cost).

Recommendations for Strategic Priorities

- Educating Medicare beneficiaries using a new Health Care Choices tool

Each year, renewal requests for health plans are submitted to CMS for approval. MBA staff receive the list of plan renewals and then builds this into the Health Care Choices Publication for the coming year. This publication is used extensively by professionals, the MBA volunteers and some beneficiaries. The challenge is the short timeframe between when staff receive the information and when the Health Care Choices publication needs to be printed. As a result, the

MBA will be developing an online PDF automation strategy which will allow call center staff and volunteers to use the document but print off specific pages for callers/beneficiaries. This will significantly reduce printing costs and also make the document more accessible to the public.

- Managing the workload

Over the past several years, the Senior LinkAge Line® has moved to paid on call staff to support the higher open enrollment volume. MBA works closely with the AAAs to create a staffing model that supports this approach. In the event that the cost plans end, statewide call routing may be explored and/or a major increase in benefits enrollment sites may be considered along with scheduling callers to receive on site assistance. In addition, the MBA staff unit that oversees the Senior LinkAge Line® will fill in staffing gaps in order for all affected individuals to receive the assistance that they need to make good decisions. Should Congress decide to finally end the cost plans, it will certainly be an all hands on deck scenario.

- Confirmation from ACL and CMS about counseling option for beneficiaries

The MBA (in its role as the designated Minnesota State Health Insurance Assistance Program) needs confirmation from CMS to verify that Medicare Cost plan enrollees will have the option to enroll in a Medicare Supplement (Medigap) or a Medicare SELECT plan option without health screening if they decide they do not want to enroll in a Medicare Advantage plan. Staff will work directly with regional office CMS office staff and the national offices of the Administration for Community Living (ACL) to determine the full list of options.

2. Pre Admission Screening: Challenges in Effectively Serving People with Mental Health Conditions

Federal and state laws require that ALL individuals entering a Medical Assistance (MA)-certified nursing facility (NF), a certified boarding care facility, or a hospital “swing” bed receive a Pre-Admission Screening (PAS) OBRA Level I, regardless of the anticipated length of stay or the payer source for facility services.

PAS is completed to:

- Avoid unnecessary facility admissions by identifying people whose needs might be met in the community and connecting them to home and community-based services;
- Screen people for mental illness or developmental disabilities based on the requirements in the Omnibus Budget Reconciliation Act (OBRA) of 1987, also referred to as OBRA Level I screening. This screening is completed to identify and refer individuals to other professionals for evaluation of the need for specialized mental health or developmental disability services as required under federal law. These activities are referred to as OBRA Level II activities;

- Determine and document the need for NF services for purposes of MA payment for NF services;
- Identify individuals who can benefit from assistance after NF admission to transition back to the community.

The Minnesota Board on Aging, in partnership with the Area Agencies on Aging, has developed an efficient process for receiving Pre-Admission Screening OBRA Level I referrals from health care professionals and processing them within one business day.

OBRA Level II referrals are made to the lead agencies or their contractor and then processed in order to determine if nursing facility placement is appropriate or if the resident needs special services in order to remain successfully in the nursing home with the appropriate level of care. Referrals for OBRA Level II occur when someone currently has, or has a history of, a mental illness or intellectual or developmental disabilities. OBRA Level II screenings review the appropriateness of nursing home placement, as well as determine if the consumer could benefit from additional services that are not offered within the nursing home, called specialized supports and services. These may include counseling, therapy animals or day treatment and habilitation services.

The Senior LinkAge Line® has seen delays in the process once the referral is made for an OBRA Level II. There are communication gaps between lead agencies related to who is responsible for completing the assessment and then further between the lead agency and the nursing home. This can involve lack of correct documentation, and sometimes, an inaccurate conclusion that a person would not benefit from specialized services.

Specific challenges include:

- Lead agencies may not conduct OBRA Level II when appropriate.
- The OBRA Level II process is not automated or tracked within a tool available to lead agencies, Senior LinkAge Line®, MBA or other state agency staff.
- Communication back to the NF with the results of the OBRA Level II assessment can be inconsistent.

Even though dementia is not considered a mental illness diagnosis for purposes of an OBRA Level II referral, there are indicators that with the increasing numbers of people with dementia that the federal government may rethink their approach on this. Also, when one mental illness diagnosis is present there are oftentimes two and that can include dementia as a secondary diagnosis. In an ongoing effort to improve our identification and support of people with Alzheimer's disease and related dementia it will be important to identify ways to make improvements in the PAS process.

In addition, like much of population, people with developmental disabilities are living longer and possibly aging into Older Americans Act services and other home and community-based service programs designated for older adults. It is important to identify these individuals in order to make sure that they continue to receive the support that they need to successfully age in place.

Recommendations for Strategic Priorities:

- Automation of OBRA Level II screening and referral process

Referrals to lead agencies for OBRA Level II will be automated to reflect that 1) the referral was received by the lead agency; 2) the OBRA Level II screening was completed by the lead agency; and 3) if it was not, the reason it was not conducted. This type of system will allow for data analysis to ensure accurate referrals to lead agencies and that consumers receive timely screenings and appropriate specialized services.

In addition, completed OBRA Level II screenings for mental illness should be automated or tracked electronically allowing Senior LinkAge Line® specialists, lead agencies, MBA and DHS staff, as appropriate, to verify that an OBRA II screening was done for mental illness and the results of that screening. Discussions with the Adult Mental Health division at DHS have already begun and plans are underway to create some automation, although specifics are not known at this time. Currently, OBRA Level II screenings for developmental disabilities are available electronically for viewing by appropriate staff.

- Increase state oversight and support of, including training, entities responsible for implementing the process.

The MBA will assist each Area Agency on Aging with creation of a communications plan outlining meetings with health care providers who complete or receive pre-admission screenings, including providing training on the process. These meetings will also be places on the Extranet Calendar used by Senior LinkAge Line® staff allowing the MBA to review and monitor progress of the plans.

Statewide letters, updates to the mnaging.org and seniorlinkageline.com websites and recorded trainings will be provided by the MBA and appropriate DHS staff outlining the process for Pre-Admission screening, each party's responsibilities in the process and timelines. An updated bulletin with the most recent Pre-Admission Screening OBRA Level I information is currently being reviewed by the DHS bulletin liaison and will be issued shortly.

- Improve data collection and/or analysis related to individuals with dementia admitting to a nursing facility

Additional analysis will be conducted based on submitted Pre-Admission Screenings to identify the number of individuals identified as having dementia, as well as a co-occurring mental illness. Based on this analysis, data collected upon submission of the Pre-Admission screening

may be revised or follow-up protocols updated to ensure those with dementia, regardless of co-occurring conditions, have the supports they need in the nursing facility after admission. This analysis will be shared with a broader planning group developed by the MBA.

- Review Senior LinkAge Line® protocols targeting individuals with mental illness or developmental disabilities who are living longer

As individuals with MI and DD are living longer, it is important that individuals with mental illness and developmental disabilities understand their options regarding housing settings and services available; both in the nursing facility and in the community. This is especially true for those who are not on a public program and therefore do not have a care coordinator or case manager. Analysis will occur to determine if these individuals should receive additional follow-up or be targeted through the Return to Community initiative based on their needs, co-occurring diagnoses and support systems in the community.

3. Changing Workforce Needs as a Result of Increasing Complexity of SLL work

The Senior LinkAge Line is reaching a point where it must rethink how it uses volunteers due to the increasing complexity of Medicare assistance. Historically, volunteers have provided:

- Assistance with enrolling in a Medicare plan through the use of the Medicare plan finder tool
- Screening beneficiaries for programs that can help pay for Medicare related costs
- Conducting Senior Surf Days to help beneficiaries learn how to use a computer to find Medicare related information
- At the metro call center only, a Medicare Volunteer “Hunt Group” was established so calls could be routed
- Help with data entry and administrative tasks

The rate of volunteering with SLL has remained relatively stable, with a slight decrease (6 percent) seen in recent years. SLL currently has 192 volunteers (in kind paid not included) that provided 11,560 hours of assistance for grant period that ended on 3/31/2017. This averages to 60.21 hours of assistance provided by each volunteer in one year. Medicare, long term care insurance and related claims and billing issues are becoming so complex that it is becoming harder to find volunteers that are able to, or perhaps even willing to, provide the type of assistance needed.

Specific challenges include:

- Increased demand for services is expected with the aging of the population.
- There is increased complexity of the issues to be addressed.

Traditionally full retirement age coincided with Medicare eligibility, however; Social Security full retirement is currently age 66 and will eventually rise to age 67, Medicare eligibility remains at age 65. The number of Medicare eligible beneficiaries who continue to work has never been

higher, and is projected to grow exponentially as Social Security delays full retirement age even more. Employers provide little to no guidance to employees about the choices that must be made that can lead to a lifetime of premium penalties if the wrong decision is made.

An increasing number of choices and increased use of cost saving measures by both Medicare and the HMOs has increased the complexity and skill level required to assist Medicare beneficiaries with understanding their options to enroll.

In 2018, the Medicare Cost plans will end which will leave more than 386,000 Minnesota Medicare beneficiaries with the need to change plans. Options counseling provided by the Senior LinkAge Line will be more complex than ever before due to the unfamiliar plan decisions that Minnesota Medicare beneficiaries will have to make.

- There has been an increase in appeals, a trend that is expected to continue.

The number of Medicare appeals increased 267% from FY 2010 to 2015. As more boomers age into Medicare the need for appeals assistance will most certainly grow just as rapidly. Appeals are complex, lengthy legal processes that require a highly skilled person to pursue.

As the complexity of Medicare grows, so does the increasing risk to the program related to incorrect Medicare counseling and assistance services. Health Insurance Counseling remains highly dependent on volunteerism. The risk associated with providing incorrect information or assistance requires extensive training, monitoring and guidance. The rate of volunteerism within Minnesota has dropped about 6% and although the rate among highly educated is quite high so is the demand for their services. In addition, the Department of Labor has recently stepped up enforcement of the rules around stipends and are requiring most organizations to label a volunteer a part time employee.

Recommendations for Strategic Priorities:

While the majority of time, errors are occurring due to lack of knowledge about the Medicare program there are also risks related to the need to:

- Ensure appropriate review of the work of the volunteer as well as mentoring so that the volunteer does not feel that they are going it alone in a complicated environment and building a tracking tool to support the volunteer coordinators in their roles

The Senior LinkAge Line® does not have sufficient tracking and monitoring of the volunteers. Even though volunteers are treated for all intents as the same as a staff by CMS and ACL. This causes challenges with regard to the need for locked bags, encrypted laptop data and ensuring appropriate access to the tools. The MBA will continue to develop an online extranet volunteer tracking tool that can be used to track the work, allow for complaint handling and effective management of the volunteers.

- Maintain clear guidance in a volunteer standards and policies around insurance, transportation, liability and stipends/mileage reimbursement

The MBA has a set of volunteer management standards on the extranet for the Senior LinkAge Line®. This was a requirement of the SMP (Senior Medicare Patrol) and SHIP (State Health Insurance Assistance Program) grants in 2014. MBA staff will maintain this manual and add local Minnesota specific requirements and additional policy guidance to the staff.

- Conduct regular (annually) background checks in alignment with standard security practice to ensure that volunteers are not targeting vulnerable elderly.

Currently background checks are done upon the volunteer starting. Best practices in the industry is starting to be one background check per year. This will result in increased costs but is likely to be a basic security requirement for all organizations going forward.

- Maintain and support the volunteer coordinator position at the Area Agencies on Aging. This will require additional funding and support as the position becomes more complex.

The volunteer coordinator position was funded with the one stop shop funds from Governor Dayton. It is essential to maintain this level of funding to support the coordinators so that they can recruit the best type of volunteer to fit without the work of SMP and SHIP but also so that they can mentor and oversee the existing volunteers and ensure adequate updates and training are provided as changes happen in the world of health insurance and benefits for the elderly.

4. Senior LinkAge Line® will continue to enhance service delivery to cultural and ethnic communities and older adults living in rural areas.

The demographics of Minnesota have been changing for some time. With the increasing numbers of refugees and the growing diversity of the older adult population. In addition, rural communities are facing even more challenges as the aging population grows in greater numbers in rural Minnesota.

Senior LinkAge Line® has been actively pursuing strategies to engage diverse populations and increase hiring of people of color and Native Americans:

- Area agencies are monitoring for their diversity hiring strategies and a metric is monitored on the annual dashboard for consumers assistance programs
- Staff have worked hard to engage beneficiaries on reservations or of a Native American background. There are now monthly health insurance counseling sites at tribal locations
- AAA are also attended quarterly meetings that are a part of networks that serve culturally specific community events (Somali, Korean, Hmong etc)
- The Senior LinkAge Line® has an outreach presence annually to Farm Fest in collaboration with the Department of Human Services
- Numbers of minorities served are reported annually to the Board on Aging on the SLL dashboard

- Youtube video have been produced in multiple languages including a What is Senior LinkAge Line? Video. But they have not had broad dissemination.

Challenges:

- MBA staff have noted that SLL staff are often not following the protocol about collecting ethnicity and race data and are instead making assumptions about callers.
- It can be challenging to engage cultural and ethnic communities if the MBA and AAA staff do not represent the face of these cultures. This can come with an expected distrust of staff that requires ongoing reengagement and careful trust building.
- Transportation is an issue for rural communities to get to see a volunteer as it can be a full day trip to get to see a volunteer and they may not have the means to get out and get help.
- The race and ethnicity categories for data collection as issued by the federal government are limiting in terms of meeting person-centered needs since some of these issues are a construct.

Recommendations for Strategic Priorities:

- Utilization of existing tools to do more in person assistance via telemonitoring

The community living specialists have indicated that they feel that there is an opportunity to do more camera based telemonitoring of consumers. The MBA staff will develop a policy for issuing of equipment and criteria to determine those that the fit for this approach. An initial pilot would be done.

- Site visits will include a review of hiring practices

Currently, the Client Services Center is located is one of the most rural towns in Minnesota – Slayton. MNRAA in particular has done an effective job of located staff in home based offices in order to engage more rural workers. These types of promising will be share at site visits and more flexible work arrangements will be reviewed as the SLL is a good service for considered of these practices due to the high level of security of the technology. AAAs are provided with an annual dashboard that includes two metrics measuring minority status of staff hired. The site visit protocol will be modified to include a discussion about outreach strategies and areas where more minority can occur.

- Social media including the MBA's Facebook page, Twitter and the web page and Minnesotahelp.info will be used more effectively to post materials in a variety of formats and languages

The Youtube videos from ECHO will be more broadly disseminated to the Board's social media pages but also through hospitals and clinics including conducting an outreach effort to the Federally Qualified Health Care Clinics as there is opportunity to more broadly promote the work of SLL.

- An existing statutorily mandated annual neighborhood level outreach plan will be incorporated into the area plan access section

In the mid to late 2000's the SLL call centers were mandated to provide outreach plans that place "an emphasis on the metropolitan area and improving outreach and services to seniors and caregivers by establishing annual plans by neighborhood, city and county (See Minn. Stat. 256.975 Subd. 9). This requirement will be added to the annual area plan process and negotiations so that it can be reviewed by the diversity committee and all MBA staff to ensure that a broader review of approaches represents all talents and expertise. In addition, new call monitoring will validate staff are collecting the ethnicity field to ensure adherence to the protocol.