Reform 2020: Pathways to Independence

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

Demonstration Year III
July 1, 2015 through June 30, 2016
Annual Report

Submitted to:

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

Submitted by:

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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 III (June 30, 2016)	Current Enrollees (as of data pull on July 6, 2016)	Disenrolled in DY III (July 1, 2015 to June 30, 2016)
Population 1: Alternative Care	2,545	2,520	24
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 18, 2015 to provide the public with an opportunity to comment on the progress of the Reform 2020 demonstration. An overview of the December 18, 2015 public forum was provided in a previous quarterly report. DHS plans to hold the next public forum on December 16, 2016.

6. Operational Developments and Issues

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

Operational and systems changes required to implement the 1915(i)-like and 1915(k)-like options under Reform 2020 are underway. Implementation of this component of the Reform 2020 waiver is contingent upon approval of the corresponding 1915(i) and 1915(k) state plan amendments submitted to CMS on December 19, 2013.

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 is provided at Attachment A.

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 will begin 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.

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 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Total for DY III Ending June 30, 2016
Population 1: Alternative Care	2,725	2,714	2,703	2,693	2,680	2,683	2,671	2,661	2,667	2,647	2,623	2,594	32,061
Population 2: 1915(i)-like													
Population 3: 1915(k)-like													

Population 4: ADL Children During the period of July 1, 2015 through June 30, 2016, there were no children identified as meeting the criteria outlined in the special terms and conditions paragraph 18 for the ADL Children eligibility group.

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 2015 through June 30, 2016.

Alternative Care Program Beneficiary Grievance and Appeal Activity
July 1, 2015 through September 30, 2015

	Affirmed	Reversed	Dismissed	Withdrawn
AC Appeals	0	0	0	0

Alternative Care Program Beneficiary Grievance and Appeal Activity
October 1, 2015 through December 31, 2015

	Affirmed	Reversed	Dismissed	Withdrawn
AC Appeals	0	0	0	0

Alternative Care Program Beneficiary Grievance and Appeal Activity
January 1, 2016 through March 31, 2016

	Affirmed	Reversed	Dismissed	Withdrawn
AC Appeals	1	0	0	2

Alternative Care Program Beneficiary Grievance and Appeal Activity
April 1, 2016 through June 30, 2016

	Affirmed	Reversed	Dismissed	Withdrawn
AC Appeals	0	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 2nd Quarter Report, Demonstration Year III, October 1, 2015 to December 31, 2015
Reform 2020 3rd Quarter Report, Demonstration Year III, January 1, 2016 to March 31, 2016
Reform 2020 4th Quarter Report, Demonstration Year III, April 1, 2016 to June 30, 2016
Reform 2020 Annual Report, Demonstration Year III, July 1, 2015 to June 30, 2016

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

DHS submitted Minnesota's comprehensive quality strategy to CMS on February 12, 2015. The quality improvement process required for Minnesota's five HCBS waiver programs serves as the foundation for the Reform 2020 demonstration comprehensive quality strategy. Minnesota's proposed 1915(i) and 1915(k) state plan amendments in support of CFSS also derive from the existing quality improvement strategies in the waiver programs.

12. Demonstration Evaluation

DHS has contracted with researchers at the University of Minnesota and Indiana State 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.

13. State Contact

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Attachment A

Alternative Care Program
Operational Protocol

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1. Delivery System

1.1 Alternative Care Delivery System

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

1.2 Alternative Care Program Allocation to Lead Agencies

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

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

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

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

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

2. Benefits

2.1 Benefits under the Alternative Care Program

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

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

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

2.2 Service Definitions and Provider Standards

Service definitions and provider standards for the Alternative Care program are the same as the service definitions and provider standards specified in Minnesota's federally approved Elderly Waiver, CMS control number 0025.91.R4.07, to the extent the services are the same. Please see MHCP Provider Manual Elderly Waiver and AC for more information on Elderly Waiver and AC service definitions and provider standards. Definitions and provider standards for the additional services provided by the Alternative Care program (but included in the Elderly

Waiver) are described below. Approved services are prior authorized in the MMIS system based on a long-term care needs assessment. Services are provided by qualified enrolled Medicaid providers.

2.21 Nutrition Services Definition

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

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

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

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

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

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

2.22 Nutrition Services Provider Standards and Qualifications

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

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

2.23 Discretionary Services Option

Discretionary services allow lead agencies to utilize a portion of Alternative Care program funds to address special or unmet needs of a client or family caregiver that are not otherwise defined in the Alternative Care program service menu. These services may be used to improve access, choice and/or cost effectiveness of the Alternative Care program in order to address chronic care needs of the client and that do not duplicate other services or funding streams. Discretionary services, as with other Alternative Care services, are necessary to delay or prevent nursing facility admission and are identified in the individual community support plan. Lead agencies who wish to use the discretionary services option must complete the application process described in DHS-5815-ENG.

2.3 Relative Hardship Waiver

Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a lead agency may contract with a client's relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional. Relative hardship is established by the lead agency when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost wages, obtain a leave of absence resulting in lost wages, incur substantial client-related expenses, provide services to address authorized, unstaffed direct care time, or meet special needs of the client unmet in the formal service plan.

3. Cost Sharing

3.1 Alternative Care Program Cost-Sharing

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

3.2 Determining Fees

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

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

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

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

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

3.3 Billing and Non-payment of Fees

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

4. Eligibility

4.1 Alternative Care Eligibility

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

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

beneficiary's assessed needs, the Alternative Care program could pay for other assessed unmet needs.

4.2 Alternative Care Eligibility Process

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

4.3 Roles

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

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

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

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

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

- Conducts a LTCC assessment to determine Nursing Facility level of care
- Conducts a community assessment of the person's needs
- Assures informed choice and consent
- Assists with the application process
- Develops a community support plan based on assessed needs

- Develops a community support plan that reasonably ensures the person's health and safety
- Makes necessary referrals
- Arranges and coordinates service delivery

5. Alternative Care Enrollment

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

5.1 The Long-term Care Consultation (LTCC)

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

The intention of the LTCC program is the following:

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

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

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

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

- Consumer information and education about local long-term care services options.
- Face-to-face assessment and support planning to determine program eligibility for people considering home and community-based programs (AC and CAC, CADI, DD, EW, and BI waivers).
- Transition assistance to relocate people currently in nursing facilities to community settings.
- Initial and annual LTCC assessments to determine and re-determine program eligibility are always the responsibility of the LTCC staff in the lead agencies. As these are administrative functions, lead agencies cannot delegate them to contracted case managers.

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

5.11 Access

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

5.12 Assessment

The assessment process identifies:

- Level of care

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

LTCC assessment includes the following activities:

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

5.13 LTC Assessments

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

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

5.14 Citizenship and Immigration Status

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

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

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

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

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

If an AC applicant who indicates he or she is a U.S. Citizen or National is not enrolled in one of the programs listed above or is unable to provide verification of receipt of Medicare, SSI or RSDI

benefits, the following paper documentation of U.S. citizenship will be requested. Verification of citizenship must be submitted within 90 days of approval for the AC program:

Stand-Alone Documentation of Citizenship

Note: Do not request original documents; copies are acceptable.

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

  Documents that meet these requirements include, but are not limited to:
    - A Tribal enrollment card;
    - A Certificate of Degree of Indian Blood;
    - A Tribal census document;
    - Documents on Tribal letterhead, issued under the signature of the appropriate Tribal official, that meet the requirements above.

Documentation of Citizenship that Requires Identity Documentation

If an individual does is unable to provide one of the documents listed above, he or she may submit one of the following documents accompanied by an identity document:

- U.S. birth certificate.
- Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.
- Report of Birth Abroad of a U.S. Citizen.
- Certification of birth.
- U.S. Citizen ID card.
- Northern Marianas ID Card, issued to a collectively naturalized citizen, who was born in the CNMI before November 4, 1986.

- Final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a Statement from a State-approved adoption agency that shows the child's name and U.S. place of birth.
- Evidence of U.S. Civil Service employment before June 1, 1976.
- U.S. Military Record showing a U.S. place of birth.
- Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000 (8 U.S.C. 1431).
- Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth. Life, health, or other insurance record that indicates a U.S. place of birth.
- Official religious record recorded in the U.S. showing that the birth occurred in the U.S.
- School records, including preschool, Head Start and daycare, showing the child's name and U.S. place of birth.
- Federal or State census record showing U.S. citizenship or a U.S. place of birth.
- Affidavit. If the applicant does not have one of the documents listed above he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

Identity Documentation

Identity may be documented as follows:

A. The following documents may be used to document identity, provided that such document has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color, or address:
   - Driver's license or ID card containing a photograph, issued by a state or territory of the U.S.;
   - School ID card with a photograph;
   - Voter's registration card;
   - U.S. military card or draft record;
   - U.S. military dependent's ID card;
   - ID card issued by federal, state, or local government;
   - Native American tribal documents;
   - U.S. Coast Guard Merchant Mariner Card;

B. The following documents may be used to document identity for children under age 19:
   - Clinic records
   - Doctor records

- Hospital records
- School records, including preschool or day care records.

C. Two documents containing consistent information that supports an applicant's identity. Such documents include, but are not limited to:
   - Employer ID card;
   - High school and college diploma (including high school equivalency diplomas);
   - Marriage certificate;
   - Divorce decree;
   - Property deed or title.

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

Because AC will follow the immigration requirements for Medical Assistance and all AC enrollees are age 65+, enrollees in the AC program must be qualified noncitizens in order to be eligible. Verification of immigration status must be submitted within 90 days of approval for AC. Qualified noncitizens include the following immigration statuses:

Qualified Noncitizen Statuses

- Lawful Permanent Resident (LPR/"Green Card" holder) who entered the U.S. before August 22, 1996 (with permission by U.S. Citizenship and Immigration Services) or who has resided in the U.S. for five years or more

- Battered Immigrant who entered the U.S. before August 22, 1996 (with permission by U.S. Citizenship and Immigration Services) or who has resided in the U.S. for five years or more
- Paroled for at least one year who entered the U.S. before August 22, 1996 (with permission by U.S. Citizenship and Immigration Services) or who has resided in the U.S. for five years or more
- Asylee
- Refugee
- Conditional Entrant
- Withholding of Deportation/Removal
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Cuban/Haitian entrants
- Amerasians
- Victims of Trafficking
- Iraqi or Afghan Special Immigrant Status

- Immigrant who is a veteran of the U.S. military, or immigrants who are active duty military, their spouses, children, and un-remarried surviving spouses

Verification of Immigration Status

The following chart shows the appropriate supporting documentation by immigration status:

Qualified Immigration Status	Supporting Documents
Amerasian	• Arrival/Departure Record (I-94) • Arrival/Departure Record (I-94) in unexpired foreign passport • Permanent Resident Card, "Green Card" (I-551) • Temporary Permanent Resident (I-551) stamp on passport • Reentry Permit (I-327) • Other*
American Indian Born in Canada or Member of a Federally Recognized Indian Tribe	• Permanent Resident Card, "Green Card" (I-551) • Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada • Other*
Asylee	• Arrival/Departure Record (I-94) • Arrival/Departure Record (I-94) stamp in unexpired foreign passport • Refugee Travel Document (I-571) • Employment Authorization Document (I-766) • Unexpired foreign passport • Other*
Battered spouse, child, or parent**	• Permanent Resident Card, "Green Card" (I-551) • Employment Authorization Document (I-766) • Notice of Action (I-797) indicating Prima Facie Determination under Violence Against Women Act • Other*
Conditional Entrant	• Arrival/Departure Record (I-94) • Arrival/Departure Record (I-94) stamp in unexpired foreign passport • Employment Authorization Document (I-766) • Other*
Cuban/Haitian Entrant	• Arrival/Departure Record (I-94) • Arrival/Departure Record (I-94) stamp in unexpired foreign passport • Permanent Resident Card, "Green Card" (I-551) • Temporary Permanent Resident (I-551) stamp on passport • Reentry Permit (I-327)

Qualified Immigration Status	Supporting Documents
	• Other*
Iraqi/Afghani Special Immigrant	• Arrival/Departure Record (I-94) • Arrival/Departure Record (I-94) stamp in unexpired foreign passport • Permanent Resident Card, "Green Card" (I-551) • Temporary Permanent Resident (I-551) stamp on passport • Machine Readable Immigrant Visa with Temporary I-551 Language • Unexpired Foreign Passport • Other*
Lawful Permanent Resident (LPR)**	• Permanent Resident Card (I-551) • Temporary Permanent Resident (I-551) stamp on passport • Reentry Permit (I-327) • Arrival/Departure Record (I-94) • Arrival/Departure Record (I-94) stamp in unexpired foreign passport • Employment Authorization Document (I-766) • Other*
Paroled into the U.S. for at least one year**	• Arrival/Departure Record (I-94) • Arrival/Departure Record (I-94) stamp in unexpired foreign passport • Employment Authorization Document (I-766) • Other*
Refugee	• Arrival/Departure Record (I-94) • Arrival/Departure Record (I-94) stamp in unexpired foreign passport • Refugee Travel Document (I-571) • Employment Authorization Document (I-766) • Other*
Victim of Severe Trafficking	• Arrival/Departure Record (I-94) • Arrival/Departure Record (I-94) stamp in unexpired foreign passport • Other*
Withholding of Removal or Withholding of Deportation	• Arrival/Departure Record (I-94) • Arrival/Departure Record (I-94) stamp in unexpired foreign passport • Refugee Travel Document (I-571) • Employment Authorization Document (I-766) • Other*

*Other acceptable supporting documents include court orders, USCIS notice of action (I-797), or other official document from immigration authorities. At minimum, these documents must include identifying information, an alien number or I-94 number and the individual's immigration status.

** Individuals with LPR, battered, or paroled for at least 1 year status must have entered the U.S. before 8/22/96; or have resided in the U.S. for five year or more in a qualified status; or meet the military service exemption in order to qualify for AC or MA. The military exemption allows immigrants with LPR, battered, or paroled for at least 1 year statuses to qualify for MA regardless of their date of entry or length of time in the U.S. Immigrants meet this exemption if they are honorably discharged veterans of the U.S. armed forces or are on active duty in the U.S. armed forces. The exemption also applies to the spouse and unmarried children of the veteran or active duty personnel.

5.15 Consumer Information

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

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

5.16 LTCC Support Plan

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

5.2 Financial Eligibility

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

5.21 Determination of Financial Eligibility

In determining Alternative Care financial eligibility the LTCC assessor/case manager adds the individual's income available to pay for 135 days of nursing facility care to the amount of assets available to fund nursing facility care. This total is compared to the projected nursing facility care cost for 135 days (+ MA Asset Limit) of $31,190~~$28,020~~ (July 1, 2016)~~(January 1, 2015)~~. If the applicant's income and assets available for nursing facility care are less than the projected nursing facility care cost for 135 days and the applicant's gross monthly income is greater than 120 percent FPG or gross assets are greater than $3,000 the applicant is eligible for Alternative Care. If the applicant's income and assets available for nursing facility care are less than the projected nursing facility care cost for 135 days and the gross income is less than or equal to 120 percent FPG and assets are less than or equal to $3,000 the applicant is ineligible for

Alternative Care and should be referred to Medical Assistance. These ineligible applicants can be temporarily served under Alternative Care for up to 60 days during their first application to MA/EW if a completed signed MA/EW application has been received by the county for processing. If the applicant's available income and assets are greater than the projected nursing facility care cost for 135 days, the applicant is ineligible for Alternative Care and cannot be temporarily served.

5.22 Fee Schedule

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

- There is a change in condition which results in a change in the cost of services;
- There is a change in the adjusted income or assets;
- A client enters a nursing facility with an admission of more than 30 days.

5.23 Income and Assets

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

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

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

Income The minimum spousal monthly income allocation is $2,005~~$1,992~~ (July 1, 2016)~~(July 1,2015)~~. The allocation to the community spouse is the community spouse's monthly income subtracted from the minimum spousal monthly income allocation. The result is subtracted from the applicant's gross monthly income to establish an income subtotal. Recurring and predictable monthly expenses including health insurance premiums, drug costs and acute care costs that the applicant pays on a monthly basis are subtracted from the applicant's monthly income. A clothing and personal needs allowance is subtracted from the applicant's income. As of January 1, 2016~~2015~~ this amount was $97, the same amount that MA allows for a person residing in a nursing home. The result is the amount of income available to pay nursing home costs each month. This amount is multiplied by 4.5. The result is the amount of the individual's income that is available to pay nursing home costs for 135 days.

Assets Spousal impoverishment rules apply under the Alternative Care C program as they do for MA long-term care eligibility determinations. Alternative Care applicants who are married to a community spouse are referred for an MA Asset Assessment DHS-3340B ENG ~~DHS-3340A-ENG~~ completed by the financial assistance division of the lead agency. The asset assessment determines the total marital assets and the amount of assets to be allocated to the community spouse to prevent spousal impoverishment. As of June 1, 2016, the amount of a couple's assets that are protected for the community spouse, called the community spouse asset allowance (CSAA) is now the maximum amount under federal law for all community spouses which is currently $119,220 during 2016. The amount is adjusted on January 1 of each year by the percentage increase in the consumer price index for all urban consumers(all items; United States city average) ~~The minimum asset allowance is $33,851 and the maximum is$119,220.~~ The community spouse's asset allowance is subtracted from the couple's total marital assets to determine the amount of gross assets available to the Alternative Care applicant as personal financial resources. The total assets owned by a couple from which the community spouse's asset allowance will be determined and are reviewed at the time a person requests long term care services on or after June 1, 2016 and anticipates receiving long term care services for 30 continuous days or more. At the time of request for AC services, the AC spouse and the community spouse must report their assets. The community spouse may keep up to the maximum asset allowance in effect on the date of the request.~~on a specific date. The date is the earliest of the 1st day of the 1st continuous 30 day period of:~~

- ~~Admission to a medical hospital~~
- ~~Admission to a nursing facility~~
- ~~Determination that an individual meets NF level of care criteria, needs a long-term care service to meet an assessed need, and is expected to continue to need these services for at least 30 days.~~

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

5.232 Income and Asset calculation for all other applicants

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

Income The applicant's monthly income is a gross income calculation of earned and unearned income received by the applicant including Social Security benefits, interest payments, pensions/retirement, annuity income, payment from rental, property and earnings, VA income, trust income and contract for deed payments. Recurring and predictable monthly expenses including health insurance premiums, drug costs and acute care costs that the applicant pays on a monthly basis are subtracted from the applicant's monthly income. A clothing and personal needs allowance is subtracted from the applicant's income. As of January 1, 2016~~2015~~ this amount was $97, the same amount that MA allows for a person residing in a nursing home. The result is the amount of income available to pay nursing home costs each month. This amount is multiplied by 4.5. The result is the amount of the individual's' income that is available to pay nursing home costs for 135 days.

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

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

Individual assets that are not included in the total include:

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

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

5.24 Transfer of Assets

The Alternative Care Program Eligibility Worksheet instructs the LTCC assessor/case manager on the process for determining the transfer of assets, improper or uncompensated asset transfers, exempt asset transfers, and the look back and penalty period. The asset transfer penalty is calculated in the same way as under MA with some exceptions. Under the Alternative Care program information provided by the client is not stored in the system nor does it go through the same verification procedures. The Alternative Care Program Eligibility worksheets are stored at the lead agency. The lead agency does not automatically request information on the look back period or ask for 5 years of bank statements. The lead agency does ask the client if they made transfers and document these on the worksheet. If the client indicates that they have made transfers then the lead agency asks for documentation to determine if the transfer occurred in the look back period. The transfer penalty period is provided on the worksheet and notice of action provided to client.

5.25 Trusts

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

5.26 Home Equity Limit

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

5.27 Liens and Estate Recovery

The estate recovery process under the Alternative Care program is the same as the estate recovery process for MA, except that liens are not utilized under the Alternative Care program and the percentage retained by the county recovery unit is currently lower than amounts retained by the county recovery unit for MA. Claims against the estates of Alternative Care clients for services provided minus fees paid will be pursued by the county recovery unit and DHS. The county agency will file its claim after the death of a person who received Alternative Care services or upon the death of the survivor of the married couple, either or both of whom

received assistance. The Alternative Care Program Eligibility worksheets include an overview of the estate recovery process and enrollees receive an informational worksheet DHS-5186-ENG - "Alternative Care Program Estate Recovery Information" at the time of application. Policy for recovery of Alternative Care overpayments is under development.

6. Alternative Care Program Participant Rights

6.1 Notice to Beneficiary

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

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

6.2 Appeals

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

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

A fair hearing can be requested if:

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

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

a person has sent their written request to the lead agency, the lead agency must forward the request to the Appeals and Regulations Division.

If the person notifies the Appeals and Regulations Division directly, the appeals division will ask the lead agency whose action is being appealed to complete and submit an Appeal Summary for Long-Term Services and Supports DHS-6807-ENG. This form may be filled out on the computer. This summary describes the action or decision being appealed in more detail. The state/lead agency uses this form to summarize facts for the decision being appealed and must send a copy to all parties, including, for Alternative Care and Elderly Waiver, the Aging and Adult Services division, no later three days before the hearing.

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

Notice of hearing

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

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

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

Hearings

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

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

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

Hearing order/decision (Post Hearing)

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

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

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

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

Attachment B-1

Analysis of Adult Maltreatment Reported for AC Participants

(10/01/2015 - 12/31/2015)

Allegations reported while the alleged victim was Eligible for Alternative Care Services and where:
Reports were received by the Common Entry Point between 10/01/2015 and 12/31/2015
Determinations limited to those made between 10/01/2015 and 04/10/2016

CEP- Reported Adult Maltreatment Involving AC Participants

(10/01/2015 - 12/31/2015)

	Allegations Reported to CEP where Alleged Victim is an enrollee*		Allegations Investigated by the County		County Investigations with Final Disposition as of 4/10/2016	% 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	16	10.67%	8	14.29%	7	1	1.96%
Mental Abuse	0	0.00%	0	0.00%	0	0	0.00%
Physical Abuse	9	6.00%	3	5.36%	2	0	0.00%
Sexual Abuse	1	0.67%	2	3.57%	2	0	0.00%
Financial Exploitation (Fid. Rel.)	8	5.33%	5	8.93%	4	0	0.00%
Financial Exploitation (Non-Fid. Rel.)	27	18.00%	13	23.21%	12	0	0.00%
Involuntary Servitude	0	0.00%	0	0.00%	0	0	0.00%
Caregiver Neglect	38	25.33%	17	30.36%	16	0	0.00%
Self-Neglect	51	34.00%	8	14.29%	8	1	1.96%
Total	150	100.00%	56	100.00%	51	2	3.92%

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 : 10/01/2015 and 12/31/2015

	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		2			2
Fin. Exploitation (Fid Rel)		2	1	1	4
Fin. Exploitation (Non-Fid Rel)			9	3	12
Involuntary Servitude					0
Caregiver Neglect		9	6	1	16
Self -Neglect	1	3	4		8
Total	**2**	**22**	**22**	**5**	**51**

* 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
(01/01/2016 - 03/31/2016)

Allegations reported while the alleged victim was Eligible for Alternative Care Services and where:
Reports were received by the Common Entry Point between 01/01/2016 and 03/31/2016
Determinations limited to those made between 01/01/2016 and 07/10/2016

CEP- Reported Adult Maltreatment Involving AC Participants
(01/01/2016 - 03/31/2016)

	Allegations Reported to CEP where Alleged Victim is an enrollee*		Allegations Investigated by the County		County Investigations with Final Disposition as of *7/10/2016*	% 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	15	10.07%	5	5.15%	4	0	0.00%
Mental Abuse	0	0.00%	0	0.00%	0	0	0.00%
Physical Abuse	8	5.37%	9	9.28%	8	6	6.82%
Sexual Abuse	0	0.00%	0	0.00%	0	0	0.00%
Financial Exploitation (Fid. Rel.)	10	6.71%	9	9.28%	5	0	0.00%
Financial Exploitation (Non-Fid. Rel.)	40	26.85%	35	36.08%	34	0	0.00%
Involuntary Servitude	0	0.00%	0	0.00%	0	0	0.00%
Caregiver Neglect	31	20.81%	27	27.84%	26	5	5.68%
Self-Neglect	45	30.20%	12	12.37%	11	2	2.27%
Total	149	100.00%	97	100.00%	88	13	14.77%

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 : 01/01/2016 and 03/31/2016

	Allegation Dispostion				
	Substantiated Maltreatment	False Allegation*	Inconclusive	No Determination - Investig Not Possible^	Total
Emotional Abuse		3		1	4
Mental Abuse					0
Physical Abuse	6	2			8
Sexual Abuse					0
Fin. Exploitation (Fid Rel)		5			5
Fin. Exploitation (Non-Fid Rel)		17	15	2	34
Involuntary Servitude					0
Caregiver Neglect	5	16	4	1	26
Self -Neglect	2	6	3		11
Total	**13**	**49**	**22**	**4**	**88**

* 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-3

Analysis of Adult Maltreatment Reported for AC Participants
(04/01/2016 - 06/30/2016)

Allegations reported while the alleged victim was Eligible for Alternative Care Services and where:
Reports were received by the Common Entry Point between 04/01/2016 and 06/30/2016
Determinations limited to those made between 04/01/2016 and 09/10/2016

CEP- Reported Adult Maltreatment Involving AC Participants
(04/01/2016 - 06/30/2016)

	Allegations Reported to CEP where Alleged Victim is an enrollee*		Allegations Investigated by the County		County Investigations with Final Disposition as of 9/10/2016	% 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	17	11.56%	8	14.04%	4	0	0.00%
Mental Abuse	0	0.00%	0	0.00%	0	0	0.00%
Physical Abuse	8	5.44%	4	7.02%	2	0	0.00%
Sexual Abuse	1	0.68%	0	0.00%	0	0	0.00%
Financial Exploitation (Fid. Rel.)	7	4.76%	5	8.77%	5	0	0.00%
Financial Exploitation (Non-Fid. Rel.)	31	21.09%	12	21.05%	10	0	0.00%
Involuntary Servitude	0	0.00%	0	0.00%	0	0	0.00%
Caregiver Neglect	29	19.73%	13	22.81%	9	0	0.00%
Self-Neglect	54	36.73%	15	26.32%	15	5	11.11%
Total	147	100.00%	57	100.00%	45	5	11.11%

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 : 04/01/2016 and 06/30/2016

	Allegation Dispostion				
	Substantiated Maltreatment	False Allegation*	Inconclusive	No Determination - Investig Not Possible^	Total
Emotional Abuse		1	2	1	4
Mental Abuse					0
Physical Abuse		1	1		2
Sexual Abuse					0
Fin. Exploitation (Fid Rel)			1	4	5
Fin. Exploitation (Non-Fid Rel)		6	1	3	10
Involuntary Servitude					0
Caregiver Neglect		3	6		9
Self -Neglect	5	7	2	1	15
Total	**5**	**18**	**13**	**9**	**45**

* 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-4

Analysis of Adult Maltreatment Reported for AC Participants
(07/01/2015 - 06/30/2016)

Allegations reported while the alleged victim was Eligible for Alternative Care Services and where:
Reports were received by the Common Entry Point between 07/01/2015 and 06/30/2016
Determinations limited to those made between 07/01/2015 and 09/10/2016

CEP- Reported Adult Maltreatment Involving AC Participants
(07/01/2015 - 06/30/2016)

	Allegations Reported to CEP where Alleged Victim is an enrollee*		Allegations Investigated by the County		County Investigations with Final Disposition as of 9/10/2016	% 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	72	11.46%	30	10.71%	25	1	0.39%
Mental Abuse	0	0.00%	0	0.00%	0	0	0.00%
Physical Abuse	33	5.25%	20	7.14%	17	6	2.36%
Sexual Abuse	3	0.48%	3	1.07%	3	0	0.00%
Financial Exploitation (Fid. Rel.)	36	5.73%	24	8.57%	22	4	1.57%
Financial Exploitation (Non-Fid. Rel.)	135	21.50%	74	26.43%	69	6	2.36%
Involuntary Servitude	0	0.00%	0	0.00%	0	0	0.00%
Caregiver Neglect	146	23.25%	80	28.57%	73	6	2.36%
Self-Neglect	203	32.32%	49	17.50%	45	9	3.54%
Total	628	100.00%	280	100.00%	254	32	12.60%

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 : 07/01/2015 and 06/30/2016

	Allegation Dispostion				
	Substantiated Maltreatment	False Allegation*	Inconclusive	No Determination - Investig Not Possible^	Total
Emotional Abuse	1	13	8	3	25
Mental Abuse					0
Physical Abuse	6	5	6		17
Sexual Abuse		3			3
Fin. Exploitation (Fid Rel)	4	10	3	5	22
Fin. Exploitation (Non-Fid Rel)	6	24	31	8	69
Involuntary Servitude					0
Caregiver Neglect	6	31	33	3	73
Self -Neglect	9	21	14	1	45
Total	**32**	**107**	**95**	**20**	**254**

* 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.)