DEPARTMENT OF HUMAN SERVICES

Reform 2020: Pathways to Independence

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

Extension Request

MM/DD/2024

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Section I – Background and Historical Narrative

Background

On October 18, 2013, the Centers for Medicare & Medicaid Services (CMS) initially approved Minnesota's Reform 2020: Pathways to Independence (Reform) waiver, project number 11-W-00286/5, under section 1115(a)(2) of the Social Security Act (Act). The initial waiver was authorized through June 30, 2018. On March 21, 2018 the State submitted a request to extend the waiver. The waiver operated under a temporary extension through January 31, 2020. CMS subsequently approved the waiver extension on January 31, 2020 for the period February 1, 2020 through January 31, 2025. The waiver is managed by the Minnesota Department of Human Services (DHS).

This extension request is for the period of February 1, 2025 through January 31, 2030. The submission was postponed due to an unexpected delay in completion of the required Interim Evaluation Report.

The Reform waiver provides federal authority to support independence, increase community integration and reduce reliance on institutional care for older adults with limited assets who are at risk of nursing home placement. The Reform waiver specifically provides Medicaid funding for the Alternative Care (AC) program, which provides community-based services to older adults who have limited assets, but are not yet financially eligible for Minnesota's Medicaid program, Medical Assistance (MA).

The waiver's previous extension (approved on January 31, 2020) also included coverage for a targeted group of children (under age 21) who would have lost coverage of personal care attendant services due to a change in Medicaid state plan eligibility. The children were assessed to have needs related to activities of daily living, but were no longer eligible for Medicaid state plan personal care attendant services. These children were eligible to continue to receive services under the Reform waiver based on their eligibility status for personal care attendant services on January 1, 2015. The waiver authority for these children continued through October 31, 2020 and has sunset.

Goals and Objectives

DHS seeks to further the objectives of Title XIX of the Act to improve health outcomes of older adults with low income in Minnesota by increasing their access to community-based services and supporting service delivery through the AC program. The goals and objectives are carried forward from those originally outlined in the

waiver extension dated June 30, 2017. The goals for Reform parallel Minnesota's Elderly Waiver (CMS control number MN.0025.91) which is authorized under section 1915(c) of the Social Security Act and provides home and community-based service options to people age 65 and older who are enrolled in MA and require the level of care provided in a nursing facility.

The Reform waiver operates statewide and is designed to further these goals:

- Achieve better health outcomes
- Increase and support independence
- Increase community integration
- Reduce reliance on institutional care
- Simplify the administration of and access to the AC program
- Provide a more fiscally sustainable program for AC participants

Alternative Care Program

Medicaid funding for Minnesota's AC program was authorized under the Reform waiver beginning November 1, 2013. AC provides home and community-based services to participants age 65 and older who:

- Meet the nursing facility level of care;
- Are not yet eligible for MA coverage because their income and assets exceed the MA eligibility limits; and
- Have excess income and/or assets that are insufficient to pay for 135 days of nursing facility care.

The AC program provides older adults with community-based services in an effort to divert them from nursing facility admission. It also supports more efficient use of services should the AC participant become MA eligible in the future. Minnesota seniors who are eligible for AC are not eligible for other Medicaid services, including state plan or Elderly Waiver services.

Services covered by AC are a subset of those covered under the Elderly Waiver, in addition to three services that are not covered under the Elderly Waiver: conversion case management, nutrition services and discretionary services. These three services are defined in Section V – Covered Services and Information for Participants, along with a complete list of services.

The waiver extension does not change the service delivery system, eligibility, benefit coverage (with the exception of adding transitional services) or cost sharing requirements. The waiver extension applies to current and new beneficiaries.

Changes

Name Modification

The state proposes to change the name of the waiver to remove the year 2020 in the waiver name at the time the extension becomes effective, from *Reform 2020: Pathways to Independence* to *Reform: Pathways to Independence*. When the waiver was first approved in 2013, the focus on 2020 was appropriate. However, having a specific year in the title is confusing for some people. The waiver continues to test service designs to improve the Medicaid program.

Community First Services and Supports (CFSS)

The state proposes to change the implementation date for CFSS from June 1, 2024 to October 1, 2024. CMS approved CFSS under section 1915(i) and 1915(k) authorities on February 27, 2024 as a state plan service. DHS submitted a Reform waiver amendment on April 8, 2022 for the CFSS service and submitted an updated amendment on November 29, 2023. CMS confirmed on February 28, 2024 that no additional authority was required for CFSS to be covered under the Reform waiver for AC participants.

Transitional Services

The state proposes to change the benefits by adding transitional services. The 2024 Minnesota State Legislature authorized the addition of transitional services as a covered service for AC participants. The law permits the service to be available upon federal approval. The service description, provider qualifications, and rates parallel those in Minnesota's Elderly Waiver.

Section II – Eligibility, Assessment, Support Planning and Service Authorization

Eligibility

People interested in AC services contact their local county or contracted tribal human service agency[1] for an assessment. Applicants are required to provide all information necessary, including Social Security Number (SSN), to determine eligibility for the AC program and potential eligibility for MA. The county or tribal human service agency determines program eligibility initially and must redetermine financial and service eligibility annually. Individuals who appear categorically eligible for MA are referred for a financial eligibility determination and may receive services through the AC program for up to 60-days while their eligibility is being determined. County or tribal human service agency financial workers determine Medicaid eligibility. DHS is authorized to maintain a waiting list any time it is not enrolling applicants into the AC program; however, the state has not had a waiting list for the AC program.

Assessment, Support Planning and Service Authorization

Each applicant receives a comprehensive assessment completed by a certified assessor, using the MnCHOICES application. MnCHOICES is a comprehensive application that eliminates the need for multiple assessments, and integrates assessment and support planning functions. MnCHOICES is used to determine program eligibility for several long-term care programs, supports consumer choice, and assists with service planning.

Assessments and reassessments are conducted by certified assessors using the MnCHOICES application. Certified assessors must meet DHS requirements. Reassessments must be completed at least annually or earlier if there is a change in the participant's condition that warrants an earlier reassessment. The certified assessor also evaluates financial eligibility for AC.

Following the assessment, the case manager discusses service options with the person, assists in the development of the support plan, and completes the corresponding service authorization. Case managers

[1] Five tribal human service agencies contract with DHS to administer the AC program: Bois Forte Band of Chippewa, Red Lake Nation, White Earth Nation, Mille Lacs Band of Ojibwe, and Leech Lake Band of Ojibwe.

oversee implementation of the support plan, monitor overall service delivery and cost-effectiveness of services, and coordinate reassessment of the participant's level of care.

Section III – Benefit Set and Cost Sharing Requirements

Benefit Set

The AC program benefit set includes a targeted set of home and community-based services that are authorized based on a participant's assessed needs as identified in their individualized support plan. Refer to Section V – Covered Services and Information for Participants, for a complete list of services.

Cost Sharing

A cost sharing fee is required for some AC participants to help pay for the cost of services provided under the program. The cost sharing schedule is in state law, see Minnesota Statutes, section 256B.0913, subd. 12. Currently, AC participants pay cost-sharing fees of up to 30 percent (30%) of the average monthly cost of their services.

Determining Fees

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

- Monthly spousal income allowance to the community spouse (calculated using the spousal impoverishment rules applicable under the Elderly Waiver);
- Recurring and predictable medical expenses; and
- Federally indexed clothing and personal needs allowance.

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

- Recurring and predictable medical expenses; and
- Federally indexed clothing and personal needs allowance.

Table 1: Cost Sharing Fees

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

Billing and Non-payment of Fees

Costs sharing fees are billed the month after services are delivered. If fees are not paid within 60-days, the county or tribal human service agency works with the participant to arrange a payment plan. The county or tribal human service agency can extend the participant'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 ten (10) days prior to termination stating the participant will be disenrolled from the program. The participant may appeal the disenrollment under the fair hearing process. An appeal must be filed within ten (10) days of receipt of the notice if a participant requests continuation of services pending the outcome of an appeal. Following disenrollment due to nonpayment of a monthly fee, eligibility may not be reinstated for 30-days.

Section IV – Delivery System and Payment Rates for Services

Delivery System

AC services are provided fee-for-service and are administered by county and contracted tribal human service agencies.

Table 2: Delivery System Chart

Eligibility Group	Delivery System	Authority
Alternative Care	Fee-for-service	Section 1115 waiver number 11-W-00286/5

Payment Rates

The fee-for-service provider payment rates for AC services are the same as the approved rates for the corresponding services in Minnesota's Elderly Waiver or state plan. Rates are updated if they are changed and are published on DHS' website. See Long-Term Services and Supports Service Rate Limits (DHS-3945) for rate information. County and tribal human service agency case managers authorize AC services through individual service agreements in Minnesota's Medicaid Management Information System (MMIS) and claims are paid through MMIS.

Section V – Covered Services and Information for Participants

Covered Services

The AC benefit set includes a targeted set of home and community-based services and are authorized based on a participant's assessed needs and included in their person-centered support plan. The monthly cost of AC services must not exceed 75 percent (75%) of the monthly budget amount available for an individual with similar assessed needs participating in the state's Elderly Waiver program.

The services available under AC are the same as those covered under the Elderly Waiver except for the following differences.

1. Nutrition services, discretionary services, and conversion case management are covered under AC.
2. Adult foster care and customized living services are not covered under AC.

AC services that may be authorized in the participant's individualized support plan include the following.

- Adult companion services
- Adult day services, including family adult day services
- Adult day services bath
- Case management, case management aide, and conversion case management

- Chore services
- Community First Services and Supports (CFSS)
- Consumer-directed community supports, including:
    - Community integration and support
    - Environmental modifications and provisions
    - Environmental modifications – home modifications
    - Environmental modifications – vehicle modifications
    - Financial management services
    - Individual-directed goods and services
    - Personal assistance
    - Self-direction support activities
    - Support planning
    - Treatment and training
- Discretionary services
- Environmental accessibility adaptations – home modifications
- Environmental accessibility adaptations – vehicle modifications
- Family caregiver services, including caregiver counseling and caregiver training
- Home delivered meals
- Home health services, including home health aide, home care nursing, skilled nursing, and tele-home care
- Homemaker
- Individual Community Living Supports
- Nutrition services
- Personal care assistance (PCA)
- Respite
- Specialized equipment and supplies, including Personal Emergency Response Systems
- Transitional services
- Transportation (non-medical)

The services described as extended under the Elderly Waiver may be authorized for AC participants without the participant using the state plan service. Services that are approved for participants are prior authorized in MMIS

and are based on the comprehensive assessment. To be covered, services must be provided by qualified enrolled providers or as otherwise permitted under the Elderly Waiver.

Service definitions and provider standards for the services available under the AC program that are a subset of service covered under Minnesota's Elderly Waiver, are the same as the definitions and provider standards for the parallel services in the Elderly Waiver. Refer to the AC section of the Community-Based Services Manual for service definitions and provider standards. The definitions and provider standards for the additional services covered under the AC program (but not included in the Elderly Waiver) are provided below.

Community First Services and Supports (CFSS)

Minnesota is redesigning its Medicaid state plan personal care assistance (PCA) benefit to expand self-directed options for beneficiaries under a new service called Community First Services and Supports (CFSS). Currently PCA services are covered under AC. CFSS provides the same coverage as what is available under Minnesota's state plan PCA service, but CFSS additionally provides increased consumer control, and permits funding for certain goods and services. CFSS also permits spouses to be paid caregivers.

As AC participants complete annual reassessments, their PCA services will be transitioned to CFSS. The support planning process is used to determine whether a participant's spouse may provide the service. The determination considers the care and services needed by the participant, the availability and ability of the spouse, and whether the participant's needs would be met.

Conversion Case Management

The service definition, limitations, and provider qualifications are the same for conversion case management as for case management services under the Elderly Waiver, except that conversion case management is available to people who:

- Reside in a qualified setting (i.e. certified boarding care home, hospital, intermediate care facility, or nursing home);
- Will relocate to the community; and
- Will receive services through the AC program.

Access to this service is limited to 180 consecutive days per admission to a qualified setting. People may receive another 180-days of service if they are readmitted to a qualified setting.

Activities include, but are not limited to:

- Developing and implementing a relocation plan.
- Coordinating referrals and helping people access services.
- Coordinating and monitoring the overall implementation of a relocation plan.
- Coordinating with the discharge planner and others.

Nutrition Services

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

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

- Shopping
- Selecting foods
- Preparing meals
- Planning healthy menus
- Preparing therapeutic diets
- Cooking for one or two
- Providing tips for eating well on a limited budget.

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

- Managing therapeutic diets (e.g., diabetic, low sodium, low cholesterol, renal, or gluten free).
- Providing weight management strategies for chronically underweight or overweight conditions.
- Addressing severe weight loss or gain.
- Addressing difficulties chewing or swallowing.
- Other nutritional care issues.

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

Nutrition Services are provided by enrolled providers that meet one of 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 services incidental to their practice, such as a diabetic educator or registered nurse.

Discretionary Services

Discretionary services allow county and tribal human service agencies to use AC program funds to address special or unmet needs of an AC participant or their family caregiver if the service is not otherwise defined in the AC program service menu and if the service is prior authorized by DHS. These services may be used to improve access, choice, and/or cost effectiveness of the AC program by addressing the chronic care needs of the participant. Discretionary services must not duplicate other services or other funding that covers the service. Discretionary services must be necessary to delay or prevent nursing facility admission and must be identified in the participant's support plan. County and tribal human service agencies that wish to use the discretionary services option must complete the Alternative Care Program Application for Discretionary Services and submit it to DHS. DHS staff review and approve requests and coverage amounts based on the above criteria.

Information for Participants

At the time of the person's assessment, the certified assessor must give the applicant and, if applicable, 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 applicant.
- Need for and purpose of preadmission screening conducted by long term care options counselors if the applicant selects nursing facility placement.
- Resources for community assistance, such as caregiver support services.
- Freedom to accept or reject the recommendations of the team.

- Minnesota Health Care Programs brochure (DHS-3182).
- Notice of the right to appeal a level of care determination, including a statement that the decision affects payment for nursing facility services under Medical Assistance, and eligibility for waiver and AC programs (Your Appeal Rights, DHS-1941).
- Right to appeal the county or tribal human service agency's final decision regarding public program and service eligibility according to Minnesota Statutes, section 256.045 using Long Term Services and Supports Notice of Action (DHS-2828A or DHS-2828B).
- Right to confidentiality under the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13 using Information access and privacy (DHS-2667).
- Long Term Services and Supports Assessment and Program Information and Signature Sheet (DHS-2727).

If the person is eligible for AC, the case manager works with the person (and as applicable their legal representative) in developing a person-centered support plan.

AC program information, including information about service options and providers is also available on DHS' website. The operational processes for AC follow those that apply to the Elderly Waiver to the extent possible. There are some exceptions. For example, AC has different financial eligibility criteria. The operational processes for AC are available to the public in the Minnesota Health Care Programs Provider manual, the Community-Based Services Manual, and state law.

Section VI – Quality Assurance and Monitoring

Quality Improvement Strategy

DHS must have a quality improvement strategy to assess the quality of home and community-based services as required in items 35 and 37 of the waiver's special terms and conditions (STCs)[2]. CMS conducted an accelerated review of the state's Evidence Report, submitted on February 8, 2024. CMS provided its response report on March 29, 2024. The response report requested the state provide additional information in four areas: 1) Level of Care; 2) Qualified Providers; 3) Service Plans; and 4) Health and Welfare. DHS provided the requested information on May 23, 2024. CMS identified July 15, 2024 as the proposed date to provide the final report of

[2] Reform 2020 Special Terms and Conditions dated January 31, 2020.

the state's Quality Improvement Strategy. The report is not included because it was not received prior to finalizing the extension request for submission. Because the Reform waiver covers services on a fee-for-service basis and includes home and community-based services, this is the only quality report required.

Monitoring

DHS staff across the Adult and Disability Services Administration meet as needed when issues are identified, and a sub-group within the Aging and Adult Services Division meets monthly to discuss identified issues. The sub-group is responsible for integrating performance measurement and remediation associated with monitoring data and recommending system improvement strategies. The scope of the strategies are determined by the issues and related data.

Problems or concerns requiring intervention beyond existing remediation processes, such as systems improvements, are directed to the Aging and Adult Services Division policy area for more advanced analysis and improved policy and procedure development, testing, and implementation. The sub-group 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.

Section VII – Evaluation Activities

Summative Evaluation Report

The draft Summative Evaluation Report for the demonstration period of October 2013 through October 2019 was submitted to CMS on August 12, 2021. CMS' comments on the draft report were received on January 11, 2022. DHS revised the report in response to CMS' feedback and resubmitted the report on March 4, 2022. The report is pending with CMS. CMS provided feedback on May 16, 2024 concerning including the temporary extension period of November 2019 through January 2020. The state has addressed that waiver period in the Interim Evaluation Report.

Interim Evaluation Report

DHS contracted with the University of Minnesota for development of an evaluation design and analysis plan that covers all elements outlined in STC 72[3].

There was an unexpected delay in completion of the Interim Evaluation Report that was due to be submitted with the Reform waiver extension request in January 2024. DHS reported the issue in the state's demonstration year 11 quarter two (2) report submitted February 27, 2024, covering the period of October 1, 2023 to December 31, 2023. The Interim Evaluation Report was completed in May 2024. DHS consulted CMS about the timing of the extension request relative to the expected evaluation completion. The Interim Evaluation Report is available on the DHS Federal Health Care Waivers webpage and will be provided as part of this waiver extension request as Attachment A [PLACEHOLDER].

Table 3: Interim Evaluation Summary

Goals	Hypotheses	Data Source	Analytic Approach
Understand the characteristics of AC participants to provide access to HCBS services	Hypothesis 1: The demographic characteristics and service needs of AC participants will not change	• MMIS • LTC assessment • LTC Screening Document	• Multiple cross-section comparisons for successive years • Descriptive statistics • Chi-square test/Fishers exact test • Regression models with service need as an outcome, controlling for demographics
Ensuring consistent access to specific HCBS services and/or services of a similar intensity	Hypothesis 2: AC participants will not experience a change in types of HCBS services or decrease in intensity of services	MMIS	• Multiple cross-section comparisons for successive years • Descriptive statistics • Chi-square test/Fishers exact test • Regression models with service use as an outcome, controlling for demographics and service needs • T-tests
Ensuring or increasing access	Hypothesis 3: AC participants will experience equal or	MMIS	• Multiple cross-section comparisons for successive years • Descriptive statistics

[3] Reform 2020 Special Terms and Conditions dated January 31, 2020.

Goals	Hypotheses	Data Source	Analytic Approach
to self-directed services	better access to consumer-directed service options		• T-tests • Regression models with CDCS use as an outcome controlling for demographics and service need
Reducing reliance on institutional care and increasing community integration	Hypothesis 4: AC participants will not experience increase in nursing facility use	• MDS[4] • MMIS	• Multiple cross-section comparisons for successive years • Descriptive statistics • Chi-square/Fishers exact test, t-tests • Regression models with NH use as an outcome controlling for demographics and service needs • Time-to-event models (e.g., Cox proportional hazard)
Provide high-quality and cost-effective HCBS service access	Hypothesis 5: AC participants will not experience an increase in acute events, as indicated by an increase in acute hospitalizations or emergency department visits	• MMIS • Medicare data	• Multiple cross-section comparisons for successive years • Descriptive statistics • Chi-square/Fishers exact test, t-tests • Cross-sectional regression and growth models controlling for demographics and service needs • Time-to-event models (e.g., Cox proportional hazard)
Ensuring cost-effective administration of the AC program	Hypothesis 6: The rate of Medicaid conversion for AC participants through transitions between AC and EW and other waiver programs or nursing home use will not increase	• MMIS • Medicare data	• Multiple cross-section comparisons for successive years • Descriptive statistics • Cross-sectional regression models • Time-to-event models (e.g., Cox proportional hazard)

[4] Minimum Data Set (MDS). This is a federally mandated assessment used in nursing facilities (NF). Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). The MDH conducts regular audits of the MDS data submitted by NFs to ensure the data is accurate.

Reform Evaluation Design

The evaluation design for the Reform waiver extension period of February 1, 2025 through January 31, 2030 will be provided no later than 180 calendar days after approval of the demonstration. The state expects to continue an independent evaluation using a contracted entity to evaluate the following research hypotheses.

Hypothesis 1: The level of need, demographic characteristics, and service use patterns for AC participants will not change over time, neither alone nor in comparison to Elderly Waiver participants in non-residential settings.

Hypothesis 2: AC participants will not experience a change in the types of home and community-based services or a decrease in the intensity of services.

Hypothesis 3: AC participants will experience equal or better access to consumer-directed service options over time, when examined alone and compared to Elderly Waiver participants in non-residential settings.

Hypothesis 4: AC participants will experience equal or less nursing facility use and mortality during the demonstration period.

Hypothesis 5: AC participants will not experience an increase in acute events, as indicated by an increase in acute hospitalizations or emergency department visits.

Hypothesis 6: The rate of Medicaid conversion for AC participants through transitions between AC and Elderly Waiver and other waiver programs or nursing home use will not increase.

Section VIII – Demonstration Financing and Budget Neutrality

Budget Neutrality

The hypothetical budget neutrality model is used for the Reform waiver. The updated with and without waiver cost projections are provided in the budget neutrality spreadsheet available on the DHS Federal Health Care Waivers webpage, and will be provided as part of this waiver extension request as Attachment B [PLACEHOLDER]. The significant per member per month cost increases were primarily driven by rate increases required under state law. These necessitated a base adjustment to the waiver's cost projections. The rate

increases for AC services varied by service, averaging 34.5% overall, and were effective January 1, 2024. The state applied a 5.8% trend based on state fiscal year 2021 through state fiscal year 2023 claims. This time period is more accurate than a five-year waiver lookback period because it does not include the claims history that was most impacted by the COVID-19 public health emergency.

The annualized enrollment growth over the previous five-year period was 0.4%; the low growth of this period was likely due at least partly to COVID impacts. The projected enrollment increase is five percent (5%) for each waiver demonstration year (DY) 13 through 17, using enrollment data in state fiscal year 2023 as a base. The increased growth is expected due to high growth rates in the elderly population in Minnesota, particularly in the over age 85 cohort.

For purposes of this financial analysis, waiver demonstration years (DY) are from July 1 to June 30. The first DY under the waiver extension period would be DY 13 for the period of July 1, 2024 through June 30, 2025.

Table 4: Estimates of member months and costs during the demonstration

	DY 13	DY 14	DY 15	DY 16	DY 17
Member Months	34,656	36,389	38,208	40,119	42,125
PMPM Costs	$2,002.05	$2,118.77	$2,242.29	$2,373.02	$2,511.37
Total Expenditures	$69,383,015	$77,099,464	$85,673,917	$95,202,322	$105,790,372

Section IX – Waivers and Expenditure Authorities

Expenditure Authorities

This waiver covers expenditures for AC services provided to eligible individuals. Under the authority of section 1115(a)(2) of the Act, expenditures made by DHS for the items identified below, which are not otherwise included as expenditures under section 1903, will be regarded as expenditures under the state's Title XIX plan for the period of this waiver extension. The state is not proposing to add any new expenditure authorities with this extension.

Table 5 defines the waiver population and provides the qualifying criteria, funding stream, and expenditure and eligibility group for reporting to CMS.

Table 5. Waiver Population and Approved Expenditure Authorities

Demonstration Expansion Group	Federal Poverty Level (FPL) and/or other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting
Alternative Care	• Age 65 and older; • Income and/or assets exceeding state plan standards for the aged, blind and disabled for any groups covered in the state plan (100 percent [100%] FPL for the aged, blind and disabled); • Combined adjusted income, assets do not exceed projected nursing facility cost for 135 days of care; • No asset penalty period for uncompensated transfers as defined in Minnesota Statutes, section 256B.0595; and • Home equity is within the limit defined under Minnesota Statutes, Section 256B.056.	Title XIX	AltCare

Section X – Public Notice and Comment Process

Public Notice

A notice requesting public comment on the proposed Reform waiver extension request was published in the Minnesota State Register on June 3, 2024. The notice provided information about the 30-day comment period from June 3, 2024 to July 3, 2024 on the draft waiver extension request and a link to the DHS website with more information. An electronic version of the draft waiver extension request and a summary of the extension request was posted on the DHS website on May 31, 2024. The webpage is updated on a regular basis and includes information about the public notice process, opportunities for public input and provides a link to the waiver application. A copy of the Minnesota State Register Notice is provided as Attachment C [PLACEHOLDER].

Public Hearings

A notice providing information about two public hearings concerning the proposed Reform waiver extension request was published in the Minnesota State Register on June 3, 2024. The notice provided information about two public meetings seeking state-wide participation. One hearing will be held June 25, 2024 in-person at the Minnesota Department of Human Services building located at 540 Cedar Street, St. Paul, Minnesota. The other hearing will be held June 26, 2024 via teleconference. Both provide external parties the opportunity to comment on the waiver request. A copy of the Minnesota State Register Notice is provided as Attachment C [PLACEHOLDER].

Use of electronic mailing list or similar mechanism to notify the public

In addition to posting information on its website, DHS used GovDelivery[5] to notify the public of the proposed Reform waiver extension. On May 31, 2024, an email was sent via GovDelivery to provide information about DHS' intent to request an extension for the Reform waiver and opportunities to provide comments. The email also included that more information is available on the DHS Federal Health Care Waivers webpage. A copy of the GovDelivery is provided as Attachment D [PLACEHOLDER].

Tribal Consultation

There are eleven Tribal Nations in Minnesota, seven Ojibwe reservations and four Dakota (Sioux) communities. The seven Ojibwe reservations are: Grand Portage Band of Lake Superior Chippewa, located in the northeast corner of the state; Bois Forte Band of Chippewa, located in far northern Minnesota; Red Lake Nation, located in northern Minnesota west of Bois Forte; White Earth Nation, located in northwestern Minnesota; Leech Lake Band of Ojibwe, located in the north central portion of the state; Fond du Lac Band of Lake Superior Chippewa, located in northeastern Minnesota west of Duluth; and Mille Lacs Band of Ojibwe, located south of Brainerd in the central part of the state. The four Dakota communities are: Shakopee Mdewakanton Sioux Community, located south of the Twin Cities near Prior Lake; Prairie Island Indian Community, located near Red Wing; Lower Sioux Indian Community, located near Redwood Falls; and Oyate (Upper Sioux Community), whose lands are near the city of Granite Falls.

[5] GovDelivery is a subscription-based email system used by Minnesota state government to share information with the public. It is also sent to specific provider and stakeholder groups as applicable.

While these eleven Tribal Nations frequently collaborate on issues of mutual benefit, each operates independently as a separate and sovereign entity government – a state within a state or nation within a nation. Recognizing American Indian tribes as sovereign nations with distinct and independent governing structures is critical to the work of DHS. DHS recognizes each American Indian tribe as a sovereign nation with distinct and independent governing structures. It is vital for DHS to have strong collaborative relationships with tribal governments. To support this for health and human services programs, DHS has a designated staff liaison in the Medicaid Director's office who is responsible to inform and, as applicable, coordinate Medicaid issues with the eleven Tribal Nations. Furthermore, Minnesota Executive Order 19-24 affirms the Government-to-Government Relationship between the State of Minnesota and Minnesota Tribal Nations.

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

Notice of the planned waiver extension was provided during the Tribal and Urban Indian Health Directors meeting on [PLACEHOLDER FOR DATE]. Please refer to Attachment E [PLACEHOLDER] for a copy of the Tribal and Urban Indian Health Directors Meeting Agenda.

On May 31, 2024, a letter was sent to all Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, the Indian Health Service Area Office Director and the Director of the Minneapolis Indian Health Board clinic informing them of DHS' intent to submit a request to extend the Reform waiver and inviting feedback. The letter also informed Tribes of the public input process and provided a link to the DHS webpage that includes the Reform extension information. Please refer to Attachment F [PLACEHOLDER] for a copy of the letter.

Comments received by DHS during the 30-day public notice period

DHS received [PLACEHOLDER FOR NUMBER] comments regarding the proposed Reform waiver extension during the comment period from June 3, 2024 to July 3, 2024. A copy of the comments and DHS' responses are provided as Attachment G [PLACEHOLDER].

Stakeholder Support

DHS received [PLACEHOLDER FOR NUMBER] letters of support for continuing the Reform waiver. Copies of the letters are provided as Attachment H [PLACEHOLDER].

Post Award Public Forums

In accordance with STC 42[6], DHS holds public forums to provide the public with an opportunity to comment on the progress of the Reform waiver. Public forums were held on October 22, 2020; April 29, 2022; July 27, 2023; March 6, 2024. Due to issues related to the COVID-19 public health emergency, the dates of the forums were adjusted and one was not held in 2021. Due to the length of the delay in scheduling the forum in 2021 and the purpose of the forum for feedback on a current waiver period, CMS agreed that there was not a reason to hold the 2021 forum that was otherwise required during the waiver period.

Notices of the forums were published on DHS' webpage informing the public of the date, time and location of the forums and instructions on how to join the forums. There were no members of the public in attendance at the 2020, 2022, 2023, or 2024 forums.

Section XI – Demonstration Administration

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[6] Reform 2020 Special Terms and Conditions dated January 31, 2020.

Attachment A

(reserved for Interim Evaluation Report)

See Federal health care waivers with public hearings and comments / Minnesota Department of Human Services (mn.gov).

Attachment B

(Reserved for budget neutrality spreadsheet)

See Federal health care waivers with public hearings and comments / Minnesota Department of Human Services (mn.gov).

Attachment C

(Reserved for State Register Notice)

Attachment D

(Reserved for GovDelivery notice)

Attachment E

(Reserved for Tribal and Urban Indian Health Directors Meeting Agenda)

Attachment F

(Reserved for Tribal Letter)

Attachment G

(Reserved for Public Comments)

Attachment H

(Reserved for Stakeholder Support)