

**Housing With Services
Assisted Living
Medical Assistance Study**

Legislative Report

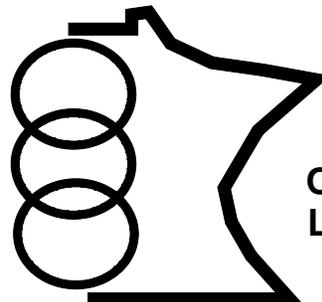
Office of Ombudsman for
Long-Term Care

Minnesota Board on Aging

March 2013

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I. Legislation

Laws of Minnesota, 2012, Chapter 247, Article 4, Section 48 directs the Office of Ombudsman for Long-Term Care to:

- A. Research the existence of differential treatment based on source of payment in assisted living settings;
- B. Convene stakeholders to provide technical assistance and expertise in studying and addressing these issues, including but not limited to consumers, health care and housing providers, advocates representing seniors and younger persons with disabilities or mental health challenges, county representatives, and representatives of the Departments of Health and Human Services; and
- C. Submit a report of findings to the legislature no later than January 31, 2013 with recommendations for the development of policies and procedures to prevent and remedy instances of discrimination based on participation in or potential eligibility for medical assistance.

II. Introduction

Office of Ombudsman for Long-Term Care

The mission of the Office of Ombudsman for Long-Term Care (referred to as the Office), a program of the Minnesota Board on Aging, is to enhance the quality of life and the quality of services for long-term care consumers through advocacy, education and empowerment. The Office promotes person-directed living which respects individual values and preferences and preserves individual rights. Under state and federal mandates, the Office works with stakeholders to address systemic issues and identify solutions that ensure consumers experience high quality long-term care and quality of life.

The Office assists consumers who live in Housing With Services establishments and receive health-related home care services, including assisted living services.

Overview of Housing With Services and Assisted Living Services

There are approximately 970 Housing with Services (HWS) establishments offering services classified as assisted living in Minnesota with a total of 51,175 units. HWS establishments include various housing types such as apartment buildings, corporate adult foster care and board and lodging facilities. The Legislature requested this study in response to a wide range of stakeholder comments, including comments from HWS residents regarding their treatment.

Most HWS establishments are rental buildings and therefore governed by the Minnesota landlord tenant law (Minnesota Statutes Chapter 504B.) The HWS registration law (Minnesota Statutes Chapter 144D) was enacted in 1995. This law requires these various housing types that offer a certain amount of health-related and/or supportive services for persons age 55 and older to register with the Minnesota Department of Health as a “HWS establishment.” Chapter 144D requires certain disclosures to residents and prospective residents, and requires establishments to comply with all other applicable laws depending on its building type, for example board and/or lodging licensure.

The entity that holds the HWS registration may be either the HWS owner or a management or home care agency contracted by the owner.

HWS establishments that offer “assisted living services” are subject to additional regulation under Minnesota Statutes Chapter 144G, which requires a minimum standard set of health-related services to be made available and requires further consumer disclosures.

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Nearly all the health-related services, including assisted living services, offered in HWS establishments are governed by the Minnesota home care licensure law (Minnesota Statutes Chapter 144A and Minnesota Rules Chapter 4668) and the Minnesota Nurse Practice law and rules.

These health-related services are offered through an arrangement of a licensed home care provider. This “arranged home care provider” is either the entity which holds the HWS registration or a home care provider contracted to deliver these services.

III. Identification of Issues

The Office solicited input from a comprehensive set of stakeholders regarding the specific issues of concern that may impact the treatment of potential or current HWS residents based on their source of payment. These issues were identified through:

- Presentations to and discussion by the HWS/Assisted Living (HWS/AL) Work Group,
- On-line surveys of HWS managers and Lead Agency case managers/care coordinators, and
- Consumer interviews.

The HWS/AL Work Group met eight times between July and October 2012. Office staff facilitated the meetings. A total of 243 HWS managers responded to the HWS Provider Survey. A total of 186 Lead Agency Case Managers/Care Coordinators responded to the Lead Agency Survey. A total of 50 HWS residents were interviewed by Regional Ombudsmen for Long-Term Care staff. More detailed information regarding the HWS/AL Work Group, surveys and interviews is available in the Appendices.

For purposes of this report, the input from these three groups is organized into five themes. The themes, and the recommendations that follow, are not ordered in terms of priority or level of consensus but are shared as a range of issues that were identified through the stakeholder input process.

1. Consumer Information
2. Consumer Safeguards
3. Consumer Fees
4. Medical Assistance (MA)
5. Housing

In response to the specific legislative charge, very little evidence was found about “instances of discrimination based on participation in or potential eligibility for medical assistance.” Differential treatment seems to occur more as a result of funding and policy.

Theme #1: Consumer Information

Housing with Services regulations and payment options are very complex and involve a variety of policy areas. It is challenging for professionals working in the field full-time to

understand all of the implications and ramifications. Consumers currently receive a variety of written materials related to their rights, obligations and the regulations governing housing with services. Some information is provided verbally, in addition to or instead of, in writing.

It is important for consumers to understand the following points.

- The Medical Assistance (MA) long-term care application and Long-Term Care Consultation (LTCC) are two distinct and separate processes, managed by the MN Department of Human Services (DHS) and counties.
- It is the consumer's responsibility to pay for home care services until the effective date of MA long-term care eligibility and the date of the LTCC authorization for customized living services. Payment cannot begin before both the MA approval and LTCC authorization of services, whichever date is later. DHS and counties are responsible for informing consumers of this responsibility.
- A consumer may be responsible for a rent or room and board obligation. The HWS provider is responsible for informing consumers of this. The county is responsible for informing consumers who are eligible for Group Residential Housing (GRH).
- The implications of spending down to MA eligibility and what a "spend down" means before moving into HWS or before signing a HWS lease. DHS and counties are responsible for informing consumers of these implications.
- The availability of public funds to pay for housing or services and whether the HWS provider accepts public payment for services or housing and food, prior to moving into HWS. This is important information because when a HWS does not accept public funding this might necessitate a transition to another setting when consumers need public programs. This is the responsibility of the HWS provider.
- The cost of all services in HWS, including fees for additional services that are not covered by MA. It is the responsibility of the HWS provider to inform consumers of these costs.

The information that is available in written form about public programs including Elderly Waiver, Group Residential Housing (GRH) and housing options is confusing for consumers due to the complexity of regulations and public programs and funding. For example, there is a common misperception that HWS and nursing homes are regulated and funded similarly.

HWS marketing materials are sometimes misunderstood by consumers. The information regarding home care charges, the home care services plan and the rent/lease agreement are often difficult to understand.

The Long-Term Care Options Counseling now required for prospective HWS residents can be helpful in informing consumers about their housing and service options and MA eligibility. Some consumers decline this service.

Some counties have developed useful consumer tools about the MA and LTCC processes. Work group members from Hennepin and Ramsey Counties presented consumer tools available through these links:

[http://www.co.hennepin.mn.us/files/HennepinUS/HSPHD/Aging%20and%20Disability%20Services/Community%20Informational%20Sessions%20\(CIS\)/InfoSessionBooklet_September_to_December2012.pdf](http://www.co.hennepin.mn.us/files/HennepinUS/HSPHD/Aging%20and%20Disability%20Services/Community%20Informational%20Sessions%20(CIS)/InfoSessionBooklet_September_to_December2012.pdf) (Hennepin County provides additional written information on MA eligibility to clients.)

<http://www.co.ramsey.mn.us/hs/aped/Elderly.htm>

Theme #2: Consumer Safeguards

As noted previously, the underlying consumer safeguard for tenants in HWS establishments is the Minnesota Landlord Tenant Act. Also, federal and state fair housing laws provide additional safeguards from discrimination on the basis of a protected class, including disability and participation in public assistance. The Minnesota Office of the Attorney General has also utilized its authority under the Minnesota consumer protection status to address issues in this setting.

The Housing with Services statute, MS 144D, was enacted in 1995. Services in HWS are governed by the Minnesota Department of Health (MDH) home care regulations. HWS establishments must comply with all applicable building, fire, rental facility (if applicable,) board and lodging, and corporate foster care licensure regulations, among others.

Given this complexity of regulations, consumers and providers share the challenge of understanding and complying with them.

There are also issues related to the use of behavioral interventions or psychotropic medications in HWS settings that are not adequately addressed in our current regulatory framework.

Theme #3: Consumer Fees

The Minnesota Landlord Tenant Law explicitly defines screening fees, pre-lease fees and security deposits; however rental rates and other fees relating to housing services are not regulated by law. HWS residents may be asked to pay one or more fees, not covered by public funds, in addition to their rent deposit and monthly rental payments. These various fees may limit the ability of consumers, especially those with low incomes, to access HWS.

The use and characterization of some fees, such as screening fees and pre-lease fees, is inconsistent across HWS providers.

Theme #4: Medical Assistance

Medical Assistance (MA) pays for medical and other health-related services, such as assisted living home care services utilized by residents of HWS establishments. It is federal policy that Medicaid (MA in Minnesota) does not cover room and food for home care waivers. Federal policy limits the amount of money that MA consumers can retain each month which limits their ability and choices when paying for housing, food and other non-medical expenses, thus creating a barrier for them to access various HWS settings.

The Legislature reduced the Elderly Waiver (EW) customized living rates by 12.58% over the past four years. Providers in the workgroup stated that the reduced rates are not adequate. Currently, there is no public data on provider costs to deliver services, making a fiscal analysis of adequacy of rates not feasible.

Some HWS providers limit the number of residents they will accept who are MA-eligible or may limit room and/or service options. Providers state this occurs because those residents do not have the private resources to pay normal charges for the services they may need, which many providers state has an adverse impact on their ability to cover the cost of operations. This number may change over time and there is no guarantee that a “public pay” slot will be available when someone spends down to public pay after using their private resources to pay for rent and services.

It was reported that some providers require that residents pay privately for a certain period of time (for example, two years) before public funds can cover the costs.

Others stated that the EW Customized Living Rate Setting Tool is not used consistently among counties and managed care organizations.

In order to be eligible for EW payment for customized living, the consumer must complete a LTCC assessment and be determined to be in need of long-term care services and be approved for MA payment of long-term care (LTC) services. Stakeholders reported that the MA application and LTCC eligibility process is complex and challenging to navigate for consumers. Consumers are sometimes unaware that they need to complete both applications. Also, applications may be delayed if consumers fail to provide required information and may ultimately be denied if they do not meet the requirements for MA payment of LTC services.

DHS provided mandatory statewide training for all financial workers who work with MA-Long Term Care Systems in 2010 and the first half of 2011. The MA-LTC Disability Waiver Only Course was rolled out in February of 2012 and statewide training was conducted through June 2012. DHS also includes training on the process as part of its regular basic training on EW for case managers and care coordinators.

Theme #5: Housing

There is a lack of affordable and accessible housing for persons with moderate and low incomes.

Fair Housing Act and Minnesota's landlord tenant law offer protections for tenants. Many consumers are not aware of their rights as a tenant or may not exercise these rights because they are unfamiliar with the laws. For example, most are not aware that a landlord must take a tenant to court to obtain an eviction order and that tenants cannot be evicted or otherwise be discriminated against due to a disability.

MN Landlord Tenant Act requires landlords to notify residential tenants that the handbook titled Landlords and Tenants: Rights and Responsibilities, published by the Minnesota Office of the Attorney General, is available to them.

Group Residential Housing is a Minnesota income supplement program which provides up to \$867 per month for eligible individuals living in qualified settings for housing and meals. Approximately 80 percent of GRH consumers are between the ages of 18 and 64. A fairly low percent of GRH consumers are older adults. Effective July 1, 2013 the GRH rate increases to \$877 per month.

Across stakeholder groups there is confusion regarding what GRH will pay for. For example, it is unclear if GRH can be used to pay a security deposit.

Some HWS providers do not accept GRH for rental payment or may limit the number of units available for GRH payment in part because of the low rates.

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GRH does not facilitate a return to home for residents who go to the hospital for an acute episode and may spend time in a nursing home to recuperate. GRH does not pay for absences of more than 18 days.

IV. Report Recommendations

The recommendations below are submitted by the Office of Ombudsman for Long-Term Care, based on the input received from stakeholders through this study. The recommendations are not ranked in priority.

1. The Office of Ombudsman for Long-Term Care should continue the HWS/AL Work Group to review Minnesota's housing with services paradigm. In addition to current constituencies, the Work Group should be expanded to include representatives of:
 - Major housing groups
 - Tribal representation
 - Various cultural communities
 - Lead agency MA financial eligibility workers
2. DHS and MDH should review the range of services and building arrangements that are included under the umbrella of HWS and realign regulatory structures as appropriate to provide strong consumer protection. One area to be explored is locked/secured memory care units.
3. DHS and MN Housing Finance Agency should implement a study to explore appropriate funding sources for rent support for MA consumers to promote community living as a viable option.
4. The Office of Ombudsman for Long-Term Care should coordinate with stakeholders to review both landlord tenant law, MS 504B and the HWS law, MS 144D, and determine if clarification is needed regarding housing fees.
5. The MN Board on Aging (MBA), MN Department of Human Services (DHS) and the MN Department of Health (MDH) should develop clear written materials for consumers; require lead agency case managers/care coordinators, Senior LinkAge Line® staff and HWS providers to share the written information with all potential and existing HWS residents and should develop and provide training for these professionals to ensure that the information is shared with consumers at critical junctures and in a way that respects and upholds consumer choice.

The information must include consumer-friendly explanations of:

- Medical Assistance (MA) application process and Long-Term Care Consultation (LTCC) process;
- GRH application process and coverage of expenses;
- Consumer responsibility to pay for home care services until the effective date of MA long term care eligibility;

- Consumer responsibility for rent or room and board obligation;
 - Spending down to MA eligibility and what a “spend down” means before moving into HWS or before signing a HWS lease.
 - The availability of public funds to pay for housing or services and whether the HWS provider accepts public payment for services or housing and food, prior to moving into HWS.
6. DHS should fully implement MS 256.975, Subdivision 7 to “incorporate information about the availability of housing options, as well as registered housing with services and consumer rights within the MinnesotaHelp.info network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall provide information that will facilitate price comparisons, including delineation of charges for rent and for services available.

The commissioners of health and human services shall align the data elements required by section [144G.06](#), the Uniform Consumer Information Guide, and this section to provide consumers standardized information and ease of comparison of long-term care options.” The MBA, DHS and MDH should fully implement these statutes to make available standard information to consumers regarding HWS settings in order to make meaningful comparisons.

7. DHS should continue to provide training to lead agency case managers/care coordinators on the EW and MA long-term care application process. DHS should continue to look for ways to automate more of the application processes and related communication as part of larger system changes. DHS should offer training for HWS providers on the EW and MA long-term care application process and also on the obligation of all waiver service providers to obtain an authorization before expecting payment for services.
8. DHS should continue to evaluate the component rates within the Customized Living Rate Setting Tool and the disability waiver rate methodology to determine the impact of MA long-term care rate reductions on consumer access to long-term care services.
9. DHS should implement the proposed Home and Community-Based Services Critical Access Study to delve more deeply into the factors that impact consumer access to service, if funded by the Legislature.
10. DHS should examine the number of Community Alternatives for Disabled Individuals (CADI) waiver slots and method of allocation for persons under age 65.

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11. DHS should review the GRH non-payment after 18 absent day policy and explore policy changes that could provide an alternative payment structure with limited or no budget impact.
12. DHS should review the policy regarding whether or not security deposits could be an eligible expense under GRH.

V. Conclusion

Minnesota has developed a wide range of housing with services arrangements over the past 20 years. While affording consumers many choices, it also adds complexity for consumers when choosing housing and services and understanding their rights, the costs and regulations.

Although much information is available for consumers and many consumers experience success and satisfaction in their HWS living, some experience challenges once they begin their journey as HWS tenants, home care/HCBS consumers, MA applicants or GRH recipients.

The Office of Ombudsman for Long-Term Care should engage stakeholders across the state to discuss and address their important concerns to enhance and ensure quality long-term care in Minnesota.

A special thanks to the consumers, providers, lead agencies and advocates who took the time to work on this issue and develop recommendations, and to the Ombudsman Office and Aging and Adult Services staff who devoted many hours to this project.

VI. Appendix

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APPENDIX 1

Definitions

Assisted Living (AL) – Minnesota defines this as a type of home care service offered only in registered Housing With Services establishments through a Class A or Class F Minnesota home care license. There is no reference to “assisted living residences” in Minnesota statute. Also see: Housing With Services definition.

Brain Injury Waiver (BI) – A Medical Assistance home care waiver that funds home and community-based services for adults and children who have an acquired or traumatic brain injury.

Care Coordinator – The professional from a managed care organization/health plan charged with completing independent assessments and assisting Medical Assistance clients in selecting from among services and service providers that meet their needs.

Case Manager – The professional from a county human services or public health nursing service or tribe charged with completing independent assessments and assisting Medical Assistance clients in selecting from among services and service providers that meet their needs.

Community Alternatives for Disabled Individuals (CADI) Waiver – A Medical Assistance home care waiver that funds home and community-based services for adults and children who would otherwise require the level of care provided in a nursing facility.

Customized Living and 24 Hour Customized Living – A bundled set of services with a monthly rate as established through the Customized Living Tool available to Elderly Waiver consumers living in Housing With Services establishments.

Customized Living Tool – The tool that establishes the service need and payment rate for EW consumers utilizing customized living or 24 hour customized living services.

Elderly Waiver (EW) – A Medical Assistance home care waiver that funds home and community-based services for people age 65 and older and require a level of medical care provided in a nursing facility, but choose to live in the community.

Group Residential Housing (GRH) – A state-funded income supplement program that pays for room and board costs for low-income adults who live in a licensed or registered setting with which a county human service agency has negotiated a monthly rate.

Home Care – Supportive and health-related services to enable persons to live at home. Most in-home health-related services in Minnesota must be delivered through a Medicare certified home health agency or a Minnesota licensed home care provider, except for Personal Care Assistant (PCA) services. **Arranged home care provider** is the licensee that offers health-related services to tenants in a HWS establishment.

Home and Community-Based Waivers (HCBS) – Also see Medical Assistance Home Care Waiver definition. The federal Medicaid program allows states the flexibility to develop and implement creative options for MA members to live at home or in community settings (hence the term “home and community-based services”) other than hospitals, nursing facilities or intermediate care facilities for persons with developmental disabilities, Minnesota offers five HCBS waivers.

Housing With Services (HWS) – A housing establishment (registered by the Minnesota Department of Health) which offers supportive and health-related services primarily to tenants age 55 and older. Arranged health-related services must be delivered by a state home care license.

Lead Agency – A county human service agency, tribal organization or managed care organization that manages home and community-based services funded by a Medical Assistance home care waiver.

Long-Term Care Consultation (LTCC) – LTCC services include a variety of services designed to help consumers make decisions about long-term care needs. LTCC services are provided by county agency staff, tribes and health plans (managed care organizations) and require the expertise of both social workers and public health nurses.

Long-Term Care Options Counseling – also called transitional LTCC or consultation for Housing With Services requires most prospective HWS tenants to receive this consultation prior to executing a lease or contract with the HWS establishment. The consultation purpose is to support persons in making informed choices among home care and community services options to help them remain at home and delay or prevent a move into HWS.

Managed Care Organization (MCO) – A health care provider or a group or organization of medical service providers who offers managed care health plans. It is a health organization that contracts with insurers or self-insured employers and finances and delivers health care using a specific provider network and specific services and products. The Minnesota Department of Human Services contracts with several health plans or MCOs to deliver its Medical Assistance health care services.

Medical Assistance (MA) – The federal program is called Medicaid and Minnesota calls its Medicaid program “Medical Assistance.” MA is a health care program for low-income persons of all ages. Funded with state and federal money, the program is managed by the Minnesota Department of Human Services and eligibility is administered by county offices. Most enrollees receive their health care through a health plan or MCO.

Medical Assistance Home Care Waiver – MA home care waivers include Brain Injury Waiver; Community Alternative Care Waiver; Community Alternatives for Disabled Individuals Waiver; Developmental Disabilities Waiver and Elderly Waiver. See also Home and Community-Based Services definition.

Medicare – A federally funded health care program for persons age 65 and older and certain disabled adults.

Minnesota Department of Health – The state agency that certifies, licenses and registers certain health care program providers such as home care, housing with services establishments, hospitals and nursing homes.

Minnesota Department of Human Services – The state agency that administers three programs discussed in this Report: Group Residential Housing; Medical Assistance (including MA home care waivers) and Minnesota Senior Health Options.

Minnesota Senior Health Options (MSHO) – An optional health care program for Minnesota consumers age 65 and older who participate in both Medicare (Parts A & B) and Medical Assistance. MSHO combines these programs and support systems into one health care package. It is administered by the Minnesota Department of Human Services and nine managed care organizations. Each enrollee has a care coordinator who helps arrange health care and related support services.

Spenddown/ Medical Assistance Spenddown – Similar to an insurance deductible, if a consumer's allowed income is over the MA eligibility limit, the consumer may still qualify for health care coverage by paying toward medical bills before MA will start to pay. A monthly spenddown is the most common type of spenddown.

Uniform Consumer Information Guide (UCIG) – A document required to be completed by each registered Housing With Services establishment and given to each prospective tenant and current tenant to allow comparison of housing, services and costs.

1915 c Home & Community-Based Waivers – The federal name of the program that allows states to provide long-term care services in home and community-based settings under the Medicaid Program.

APPENDIX 2

HWS/Assisted Living Medical Assistance Study

Stakeholders Work Group

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APPENDIX 3

Consumer Interviews Summary

Consumer Profile

50 Consumers interviewed statewide who live in Housing With Services (HWS)

- All participate in Medical Assistance (MA): 39 in the Elderly Waiver (EW); 10 in the Community Alternatives for Disabled Individuals (CADI) Waiver and 1 in regular Medical Assistance home care
- All but 1 received home care services in the past 6 months

Type of HWS Establishment and Living Arrangement

All consumers interviewed live in HWS establishments that offer state licensed home care services; for MA funding purposes these services are called Customized Living or 24 Hour Customized Living under the waivers or home health aide services under regular MA.

40 live in HWS establishments that are apartment buildings (studio or 1 or more bedrooms)

- 24 live in a 1-bedroom
- 12 live in a studio
- 4 live in a 2-bedroom
- Of these: 34 live alone and
- 6 share the apartment: 3 with a related person; 2 live in a 2-bedroom with 1 unrelated roommate and 1 lives in a 1-bedroom with 1 unrelated roommate – one uses the living room as the bedroom

10 live in HWS establishments that are board and lodging type settings (private or shared bedrooms and private or shared bathrooms; all tenants share remaining living space). Private means alone or not shared. Related roommate is defined as one's spouse, partner or other relative or friend, someone the tenant chose to live with. Unrelated roommate is defined as one with whom the tenant agreed to room with or was asked to room with.

- 5 live in a private bedroom with a private bathroom
- 1 lives in a private bedroom and shares a bathroom with other tenants
- 3 individually share a bedroom and bathroom with 1 unrelated roommate
- 1 shares a bedroom with 1 unrelated roommate; bathroom shared with all tenants

Rent

- 28 Participate in public rental programs (25 in Group Residential Housing)
- 15 Pay from their own resources
- 6 Didn't know the rent payment source
- 1 Has other assistance (no details)

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Question: *If you were paying from your own resources for rent when you first moved in and later could not afford to pay rent, did you:*

1 received help from family/friend/other and remained in same unit
1 received help from family/friend/other and moved to another unit
13 applied for GRH, of which 11 remained living in the current unit without an additional charge and 2 moved to a smaller unit

Spenddown/Waiver Obligation Question: *Do you have a Medical Assistance waiver obligation:*

28 said Yes

15 said No

5 said Do not know

Questions Relating to Treatment based on participation in or eligibility for Medical Assistance and Additional Comments

Question: *If you became eligible for Medical Assistance after first paying privately (from your own resources) was there a change in health-related services or supportive services such as laundry or housekeeping when MA began covering the services?*

- 2 said Yes
- 26 said No
- 4 said Don't Know

If yes, were you given an explanation for any changes?

1 said Yes

0 said No

1 said Don't recall

Question: *“Do you think persons who participate in public programs are treated differently than those who don't participate in public programs here?”*

- 12 said Yes
- 33 said No
- 3 said Don't know

Question: *“Can you give specific examples of experiences in which choices were not available to or different for consumers with limited income (for example, with meals or opportunities for socialization such as activities or social events?”*

Examples of some responses from among these 3 questions:

“Don't believe people here are labeled – or that people know who is on public assistance.”

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“You are entitled to everything you had before once you are on government help.”

“Very good services can’t think of better help than here.”

“No, everyone is treated well.”

“No, everyone is treated the same.”

“No; I know some folks on my floor pay privately, but we have the same meal plan and activities. However, I was not given a one bedroom unit as a potential option. They showed me only the studio and the 2 bedroom plus roommate option.”

“No; doesn’t feel treated poorly but feels can’t go elsewhere due to MA/CADI waiver status; feels that being on public program limits choice of providers who will take [me.]”

“Yes, in meal and activity choices.”

“Those who are private pay eat at their choice of dining rooms...we ‘EW people’ have to eat in the main hall and (there are) many “pay activities” that we cannot take part in as we have nothing extra after rent is paid.”

“I am having to share a 2-bedroom apartment with someone I don’t know and didn’t choose ...because of being in a public program...and am limited in activities outside of facility that I would like to participate in if I had money.”

Additional Comments offered at the end:

“I like living here in my community.” “Good staff. Trust case manager to know things and help (me.)”

“...enjoys [her] apartment... [if not for EW] she would have had to remain in the care center.”

“Only comment is good; really fine staff on floor, office and kitchen; can talk to office [staff] anytime you want; they’d get a triple A rating.”

“This is a wonderful place to live and they take care of your physical, spiritual and emotional needs, and have a good continuum of care...”

“Us waiver residents with low incomes are forced to live in...studios that are only 200 square feet with only a shower curtain on the bathroom door and insufficient closet space...”

“I have no way to cook anything in my [studio] room; we have no kitchenette and are not allowed to have a microwave, coffeemaker, hot plate only allowed...a small fridge.”

“It’s very difficult to live with \$92/month in discretionary income. I cannot afford the fresh fruits and vegetables I like to eat... it has been difficult having roommates. I have had two here so far...It can be very difficult to share a room with strangers. I am not given a choice in roommates, which is also difficult.”

APPENDIX 4

HWS Manager Survey Summary

On-Line Survey

- 694 HWS establishments invited to participate
243 HWS Managers responded

Questions about the organizational structure of the establishment

These questions asked about the ownership, type of housing units offered and how many establishments are managed.

Question: As a Manager, I oversee:

69.3% (160)	One solo HWS establishment
16.0% (37)	Two or more HWS establishments at separate locations
14.7% (34)	Two or more HWS establishments on one campus
0.0%	Other

Question: The ownership of the HWS establishment(s) I manage is:

49.8% (115)	For profit
45.5% (105)	Not for profit
3.9% (9)	Government
0.0%	Tribal Organization

Question: Which best describes your HWS setting? Complete all that apply.

212 said they manage an apartment building

Tenant capacity of total apartments (studios and/or 1 or more bedrooms):

45.9% (106)	Less than 40
32.0% (74)	41-100
15.2% (35)	Over 100

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Tenant capacity of board and lodging type setting (tenant has a private or shared bedroom with a private or shared bathroom, and the rest of the setting is shared among tenants.) Of those that manage these settings:

- 72.7% (168) Are single-person bedrooms
- 63.2% (146) Are shared bedrooms: 55.4% (128) shared by 2 tenants
- 39.8% (92) shared by 3 tenants

Total tenant capacity of board and lodging type settings:

- 23.8% (55) Up to 25
- 17.7% (41) 25-50
- 13.9% (32) 50-75
- 10.8% (25) Over 75

Questions about the rental options within the HWS establishment

These questions used the term “unit” to apply to a studio apartment; an apartment with 1 or more bedrooms; and a bedroom in a board and lodging type setting.

Available rental payment options:

Group Residential Housing

75.0% (171) Respondents said this option is available

Of these:

53 said 100% of the units are available

7 said 75% of the units are available

7 said 50% of the units are available

27 said 25% of the units are available

75 said under 25% of the units are available

2 said they didn't know

22.1% (51) Respondents said this option is not available

Section 8 housing voucher

- 8.7% (20) Respondents said this option is available
- 86.6% (200) Respondents said this option is not available

Setting is entirely publically subsidized (all tenants receive a rent subsidy)

- 7.4% (17) Respondents said yes
- 87.9% (203) Respondents said no

Setting has a mix of market-rate and subsidized units

- 23.4% (54) Respondents said yes
- 72.7% (168) Respondents said no

Question: If GRH is not an option for payment, which of the following is the reason? Check one option.

- 13.9% (32) Not financially viable
- 6.5% (15) Other
- 4.3% (10) Have not considered this option
- 2.6% (6) Don't know
- 0.9% (2) Contracting process too complex

“Other” responses include:

“Contract is in process.”

“County will not give us another contract.”

“Looking at offering a few waiver units in near future.”

“Owners decision.”

“Reimbursement will not cover our expenses.”

Questions about tenancy options for tenants with limited resources

For these questions, a roommate is someone the tenant agreed to room with in order to live in the HWS establishment. A roommate is not a spouse, partner or other relative or friend.

Question: When a tenant can no longer afford to pay rent for her/his current unit, what happens? Check all that apply.

- 46.3% (107) The tenant can continue to live (here) because all units are publically subsidized.
- 8.2% (19) The tenant may continue to live (here) because we have an endowment fund to help supplement rent for a limited number of tenants for as long as the tenant wants to live here.
- 3.9% (9) The tenant may continue to live (here) because we have an endowment fund to help supplement rent for a limited number of tenants for a limited number of months.

Question: Can the tenant continue living in this building under any of the following circumstances? Check all that apply.

- 78.4% (181) With family help to pay for rent
- 47.2% (109) If an affordable unit is available
- 20.8% (48) If s/he accepts a roommate who shares the cost of rent

Questions: Can the tenant continue living in this building if there is an available GRH unit?

- 73.6% (170) Yes
- 10.0% (23) No

If GRH is a possibility, what options are available to the tenants?

- 54.5% (126) Remain in the same unit (no roommate)
- 35.5% (82) Move to another single unit (no roommate)
- 18.2% (42) Move to another unit and accepts a roommate
- 14.3% (33) Remain in same unit and accepts a roommate

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If there are other HWS buildings on your campus: The tenant may be able to move into another HWS building on campus to:

- 14.3% (33) An available and affordable unit (no roommate)
- 13.4% (31) An available GRH single unit (no roommate)
- 6.5% (15) An available GHR shared unit (with a roommate)
- 5.6% (13) An available HUD unit
- 4.8% (11) An available and affordable unit (with a roommate)

The tenant may need to move out of the building because:

- 24.2% (56) Even though GRH is accepted here, there may be no available unit with the building that meets the \$867 GRH rate
- 18.2% (42) There may be no affordable unit available
- 16.9% (39) This building offers no public or other funding source for rent and there is no family support available
- 14.7% (34) Other

“Other” responses include:

“If case mix less than E.”

“Have limited number of [GRH] apartments.”

“No longer accept new cases of EW or GRH.”

“The patient does not pay their GHR rate or refused to make payments.”

“We don’t ask people to move out, they are put on a wait list to move to a qualified GHR apt. or studio.”

“We do not make any resident move out because of finances, we would ask that they move to a smaller unit when one comes available to make it more cost effective for the facility.”

Information required to be given to HWS tenants about public programs.

HWS establishments are required, within a written HWS contract, to give

a statement regarding the availability of public funds for payment for residence or services...”

Question: What method does your establishment use to convey this information?

Check one option.

- | | |
|------------|--|
| 42.9% (99) | Both in the HWS contract/lease/residency agreement and in supporting documents such as a tenant handbook |
| 39.0% (90) | Within the individual tenant HWS contract which may be contained within the lease or residency agreement |
| 12.1% (28) | Within a supporting document or attachment to the HWS contract |
| 2.6% (6) | Other |

“Other” responses include:

“Also available within our (Uniform) Consumer Information Guide.”

“Part of each person’s chart.”

“Don’t know.”

Availability of licensed home care services and the MA home care waivers.

A HWS establishment that offers health-related home care services must obtain a state home care license or contract for this service with a licensed provider (this is referred to as the “arranged home care provider.”) MA waiver services must be delivered through a Class A or Class F home care license.

87.0% (201) Respondents operate with a Class F license

10.0% (23) Respondents operate with a Class A license

Of the 23 HWS establishments that operate with a Class A license, 6.9% (16) also are Medicare certified.

Question: Does the HWS establishment’s arranged home care provider contract for the following MA home care waiver programs? Check all that apply.

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83.1% (192)	Elderly Waiver (EW)
52.8% (122)	Community Alternatives for Disabled Individuals (CADI)
16.9% (39)	Brain Injury (BI) Waiver
13.9% (32)	None of the above

Question: Of all your home care clients in your establishment, about what percent are:

90.5% (209)	EW
58.0% (134)	CADI
39.0% (90)	BI Waiver

Question: If a HCBS/MA home care waiver payment is accepted for only certain number of consumers, check the reason that most closely applies.

30.3% (70)	Not financially viable/rates too low
8.7% (20)	Don't know
3.5% (8)	Other
1.3% (3)	Contracting process too complex
0.9% (2)	Have not considered these public funding options

“Other” responses include:

“The HCBS waiver rate is not the issue for us, but financial case managers use the GRH rate (for rent) even if someone is not GRH qualified (but is an MA consumer.)”

“The higher quality care you provide with positive health outcomes....brings significant reimbursement cuts!”

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Question: If none of these public programs are available in this setting, please select one option (or indicate in text box) why.

- 6.5% (15) Not financially viable/rates too low
- 6.5% (15) Don't know
- 5.2% (12) Other
- 1.3% (3) Have not considered these public funding options
- 0.9% (2) Contracting process too complex

"Other" responses include:

"Private pay operation."

"....county not accepting new contracts."

"No tenants in need of these programs at this time."

"We have a few EW residents but no longer are accepting."

Question relating to differential treatment.

In your experience as a HWS Manager, do you see any barriers for consumers who participate in MA or are spending down to MA eligibility?

- 47.2% (109) No
- 44.2% (102) Yes

If yes, please explain these barriers. Comments include:

"Application process takes too long, sometimes 3 or more months. Also hard on the facility when a person currently living there is....unsure if they will qualify."

"Complicated process with applying for assistance....confusing for family and paper work is excessive."

"Consumer does not have enough money left over....to afford simple necessary things

to maintain a normal lifestyle.”

“Consumers and families need more education on MA.”

“Consumers complain about persona needs money allowed [\$92/month] and private pay residents try to avoid MA... they will go without needed services in order to conserve money. They are coming to our place later and more frail, because they were trying to make it at home for as long as possible, to save money. Consumers take pride in taking care of themselves and providing for themselves during their lives, so if they have spent down all their money in spite of their best efforts, getting any kind of financial assistance affects [their] pride.”

“Due to the large losses incurred in serving EW/GRH consumers, providers are forced to...make up for it by maintaining a certain number of private paying consumers. It would be impossible for us to keep our doors open if we were to only serve EW/GRH consumers because the reimbursement has become so poor.”

“Due to the low reimbursement, we limit our memory care and care suite programs to only two residents on waivers in each of these programs.”

“ Family is unable to subsidize services beyond what MA pays for.”

“Daunting paperwork process; inconsistencies in social workers staying on the case; differing answers to questions for family members....availability of county staff...missing phone calls because of county workers not working after 4:30.”

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“If a person does not need an extensive amount of services...we cannot afford to let them live here.”

“Uncertainty. Changes to EW that are out of the providers control make it impossible to give concrete answers to families about future availability. This is unsettling to consumers and difficult for providers to navigate.”

“...when a person is applying for MA and in a long-term care facility, they cannot move to (HWS) until MA is approved because EW will not back pay like long-term care does. This does not make sense since long-term care is much more expensive thanEW/CL.”

“Many providers are no longer accepting EW which limits choice for consumers; ...many profit providers take limited waiver clients which limits seniors ability to stay in a setting when their funds have been depleted.”

“Reluctance of insurance companies to surrender the cash value of policies.”

“Scare availability of memory care assisted living options...due to reimbursement factors.”

“Seeking to transfer between counties...a specific resident left one county for another and there was no good way to get them connected with the new county.”

“The biggest barrier pertains to the requirement, determined by the provider, for an individual to pay privately for a specific length of time. Providers need to educate individuals that they may be eligible for assistance programs BEFORE they reach

eligibility.”

If no, please give comments, if any. Comments include:

“All clients are treated the same no matter where their payment comes from. Our caregivers do not see where payment comes from.”

“Care and rooms are the same for MA and private pay consumers.”

“In our county, there is effective coordination between the county and the HWS providers. We are working to coordinate a successful transition for the potential resident by providing them with the resources they need to determine affordable housing.”

“No; family helps ...with rent in order to stay here.”

“The persons receiving MA get better care than persons paying privately. They get free transportation and have no limit to how many times they can visit their physician.”

“There are financial barriers to the facility, but as far as the tenants, they receive the same care and treatment as anyone else...”

“There don’t appear to be barriers spending down or participating in MA, but there are barriers because so few HWS settings accept or are approved for MA.”

“I do not see any barriers. There is some difficulty for individuals who are in the process of applying. It puts both families and facilities in a difficult place. The facility

Housing With Services-Assisted Living Medical Assistance Study

does not want to admit the individual unless they know that they will qualify for EW.

The family, if there is one, is unable to take care of the individual who needs....services. When the application process drags on the individuals in need does not have their needs met.”

“I do not see any barriers because our homes have no limitation to the number of MA, spend down or CADI waiver clients that we admit.”

“I have not seen any barrier for consumers participating in MA. I think the system is working fine.”

APPENDIX 5

Lead Agency Case Manager/Care Coordinator Survey Summary

On-Line Survey

- 217 Lead Agencies invited to participate
186 Case managers and Care Coordinators responded:
 - 154 County case managers
 - 29 Health plan/managed care organization care coordinators
 - 1 Tribal case managers
 - 2 No response

Questions relating to Giving Consumers Information

There are two steps for consumers seeking to participate in Medical Assistance (MA) and wanting home care services: Complete a Medical Assistance application and have a Long-Term Care Consultation.

Question: *How do counties you work with inform consumers (who are seeking waiver services) about both the Medical Assistance application process and the Long-Term Care Consultation application process?*

65%	Both verbally and in writing
19.9%	Verbally only
12.4%	Don't know
2.7%	In writing
0.0%	Information is not given

Question: *How do counties you work with inform consumers and or family members who are applying for MA (while already living in HWS or are about to move into HWS) that they are responsible to pay for their home care services until the effective date of their MA eligibility?*

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33.5% Verbally

32.8% In writing

26.9% Don't know

4.3% Other

2.7% In writing

Comments from some respondents:

"MA applications (are) through financial workers [so] unsure what they tell clients."

"The eligibility worker is usually the one who informs them."

"Financial unit would explain this when they come in to apply."

"Intake workers explain to clients/families on the phone that they are responsible to pay until MA is determined. The assessor also verbally states that at the LTCC."

"All counties we work with have policies in which to inform new enrollees of spend downs and MA, but most clients say they were not aware of this information when the case is transferred to us."

"Most of my clients say they are unaware of this as they don't understand what is being sent to them and have no idea about GRH or other services unless the case manager tells them about it."

"Families I work with or have worked with...seem very confused about this process. Some have expressed being told that they are NOT responsible for payment and I have been...the one to explain to the client/family what the reality is and how much they could end up having to pay."

"We tell clients that we can only go back to the date of screening...[which is] good for 60 days and they are responsible for R&B [room and board] costs at a minimum. We do not tell them they are not to pay the provider."

Question: *How do you inform your waiver clients about additional services in HWS that are not paid by MA?*

54.3% Verbally

37.1% Both verbally and in writing

5.4% Information is not given

1.6% In writing

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1.6% No answer

Comments from some respondents:

“HWS agency is responsible for that information.”

“HWS provider will contact us in the event that they require such services.”

“Clients are told about the services that are not covered by MA/waiver. Any additional services that are private pay would be explained by the provider.”

“MA state plan services are accessible but not typically utilized. ...the case manager has a conversation with the consumer to set up a plan of care with choice.”

“I do not have any clients accessing MA state plan services in HWS...the HWS provider meets all of their needs.”

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Question: *How do you inform your waiver clients who are seeking housing in HWS about their rent or room and board obligation?*

52.7%	Verbally
38.7%	Both verbally and in writing
5.9%	Information is not given
1.6%	In writing
1.4%	No answer

Comments. Of the 19 comments, the great majority said that the county financial worker (and the HWS) are the ones who inform their clients about this topic.

Questions Relating to Consumer Access to MA Home Care Waiver Services, Other MA State Plan Services and Additional Services in HWS.

Question: *Some HWS establishments require that consumers live in the building for a certain time period and use their own resources for their home care services before the HWS will accept these consumers as MA waiver clients. Of the HWS that you contract with, what percent have this requirement?*

46.2%	Less than 10%
5.4%	10 – 25%
6.5%	25 – 50%
3.8%	50 – 75%
2.2%	75 – 100%
36.0%	Don't know

Question: *Of the HWS you work with, what percent limit the number of waiver clients it serves?*

14.0%	No limit
10.8%	25%
10.8%	50%

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16.1% 75%
11.8% 100%
36.0% Don't know

Question: MA consumers can access other state plan services (such as nursing, home health aide, PCA) that do not duplicate waiver services. Of your current MA waiver clients living in HWS, are these services accessible to them?

52.7% Most of the time
20.4% Some of the time
16.1% Almost never
9.7% Don't know

Questions Relating to the Impact To Consumers Who Participate in Medical Assistance

Question: Because of spending down their financial resources, which of the following circumstances occurred with your waiver clients living in HWS within the past 12 months? Check all that apply.

(Unrelated roommate means someone a tenant agrees to live with in order to continue living in the residence. An unrelated roommate is not a spouse, partner, other relative or friend.)

42.5% Moved to a more affordable unit (no unrelated roommate)
17.7% Moved to another unit with an unrelated roommate
11.8% Stayed in the current unit and accepted an unrelated roommate
1.6% Moved to another unit with two unrelated roommates
.5% Stayed in the current unit and accepted two unrelated roommates

Question: In addition to issues already addressed in this survey, which of the following other reasons affect your waiver clients who are seeking housing in a HWS establishment? Check all that apply.

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58.1%	Lack of affordable or available unit regardless of private or shared
46.8%	Rent deposit
38.2%	Diagnosis or disability
34.4%	Service fees (also called Community Fee; Wellness Fee; Health Fee; or Application fee) requested of tenants in addition to the rent charge)
26.9%	Special dietary needs
21.5%	Cultural or language needs
5.4%	Other (see Comments)

Comments about Other option selected:

“...wheelchair accessibility and some may not take person [unable to] transfer self..”

“Additional charges for laundry; transportation only offered on certain days to medical appointments.”

“Assistance with moving and moving costs.”

“Facilities asking for \$500 housing cost, non-refundable prior to moving in.”

“Having to move to a smaller room once on MA after being private pay for years.”

“Lack of waiver units.” “Legal problems.”

“HWS offers rooms to private pay first on their waiting list...”

“Lack of HWS in our county for CADI clients; DHS policy does not allow.”

“Money to pay for TV cable and phone has to come out of \$92/month personal needs.”

“Moving into an apartment that would be potentially shared by an unrelated roommate until a single unit is available...”

“There is a real shortage of options for those with cognitive impairments or significant behavioral issues...”

Question Relating to Differential Treatment

Question: *In your experience as a Lead Agency Case Manager or Care Coordinator, do you see any barriers for consumers who participate in Medical Assistance or are spending down to Medical Assistance eligibility?*

54.3% Yes

25.3% No

18.8% Do not know

90 Examples given

Examples include:

“A provider referred to them directly as ‘county clients.’”

“...unable to afford (MA) spenddown therefore services are cut off.”

“I also find that HWS will only accept clients with higher case mixes on EW, so difficult to get lower needs clients, especially with cognitive impairments, into HWS; most HWS only consider shared rooms for EW clients so difficult to relocate clients with equipment because rooms are small and too crowded.”

“All have limitations on how many MA clients [HWS] will accept.”

“...wanting families to pay extra rent fees. In addition, a new trend appears to be emerging with (HWS) accepting and meeting the needs of clients while they are private pay then within weeks or months of going on a waiver the facility claiming the client’s needs are too high and [need to move.]”

“Clients must live with a roommate in a shared apartment of on EW.”

Housing With Services-Assisted Living Medical Assistance Study

“Difficulty providing for personal needs with current [GRH] allowance, including additional charges from the facility.”

“Due to dementia and memory problems, clients are not always able to process forms or keep MA recertification up to date; our FAS department is overwhelmed and cannot process MA paperwork fast enough due to the high volume; clients are often closed to MA and have to re-enroll which can take up to 5 months; in the meantime we are unable to bill for EW and facilities cannot bill for services...”

“...Having someone to talk with about their MA application. Many will call the MA line and it is either busy or they have to hold for over an hour. This is a major barrier ... also, (there is) no specific person in the MA area to talk with; every time they get someone, which is rare, it's someone [different;] the phone numbers for the MA workers are a 'secret' and the phone numbers to the teams are a 'secret.'”

“Lack of community education about MA eligibility and spend down guidelines. Often have people applying for MA who gave assets away, with no intention of ever applying for MA...”

“More facilities are requiring clients to private pay for 2 years...”

“...spend down does not allow for even marginal living expenses. Clients end up getting behind on rent and are not able to catch up. End up facing eviction.”

“Limited choices in rural area.”

Housing With Services-Assisted Living Medical Assistance Study

“We’ve encountered multiple facilities that ‘promise’ once a client private pays for a certain number of years that they will then be available for MA/EW room if necessary.

However, once the client spends down, the facility declines MA and forces them to move.”

APPENDIX 6 Written comments submitted by the following Work Group participants/entities during the meetings in which their perspectives about the legislative charge were invited:

- AARP Minnesota – Page 53
- Angie McCollum, Consumer Family – Page 56
- Crow Wing County – Page 57
- Long-Term Care Imperative (Aging Services of Minnesota and Care Providers of Minnesota) – Page 58
- Office of Ombudsman for Long-Term Care – Page 64
- PrimeWest Health and Renville County Human Services – Page 66



Housing and Services Issues from a Consumer Perspective

Information and Disclosure Issues:

- Consumers want better information upfront on what they can expect to pay for services as well as information about the providers' discharge criteria regarding resident's on Medical Assistance (MA).
- Consumers feel it is difficult to understand what they are paying for in rent/or for other services and that it can be challenging to compare providers because of the variety of service packages that are available.
- We find that residents may be spending their resources faster than expected—and then wind up not knowing their options. Some examples:
 - One family when shopping for Assisted Living said the description of how and when services would be charged was very vague—they did not have an understanding of what the process is for doing this, they felt very uneasy about what they were buying.
 - For another family, the bills for services doubled in one month from \$3,000 to \$6,000 and they were never informed as to what had caused the increase. After investigating, they determined that their father was calling for assistance in the middle of the night, and the charges were deemed appropriate. However, better communication and information to the family on the change of their father's behavior would have been more appropriate and greatly appreciated by the family.

Disclosure issues around facilities policies regarding residents on Medicaid (MA):

- Consumers want better information upfront about the providers' discharge criteria and information about the facilities policies regarding Medical Assistance.
- Consumers said there was a wide range of answers from providers regarding their policies for residents on MA. Experiences ranged from facilities providing very detailed

information upfront to finding it very difficult to get the facility to tell you what their policy was at all.

- When one family asked what would happen if their mother became eligible for MA , the provider said it was good question and they should be concerned. The provider then proceeded to review the new NOLC (Nursing Home Level of Care) with the family which determines MA eligibility and suggested that the mother might not qualify. The provider implied that the family would be responsible for the charges. The family was given the Linkage line to call—as is required in law now—for the options counseling and became aware of the look-back period for Medical Assistance, which was very helpful to them.
- When another family was looking for a facility to care for their father with dementia they had a difficult time getting answers on what each facilities policy were for MA consumers. They said several facilities had different wings or different buildings for people on private pay vs MA, many facilities said they do not accept anyone on MA, and other facilities determined this on a "case by case" basis.

The family was concerned that they would have very few options if their father was on MA. In their words: *“they are not aware of any facility in the metro that accepts someone who is both on MA and qualifies for a behavioral unit. Since he also cannot be cared for at home, due to lack of trained PCAs who could care for him, we can't go that route. He has done very well in his current facility, thanks to very good staff and quality care. But we are aware that he would not be able to stay if he were on MA.”*

Possible Solutions:

LTC Options Counseling:

AARP supports the law that passed last year requiring Housing with Services (HWS) providers to offer consumers long-term care options counseling. This has been effective in helping consumers know what the financial risks are to them. One of the families we spoke to was very happy with their experience. They had no idea about the MA look-back period and were in the process of selling their mother's home-- and gifting some of the money-- even though the mother was most likely going to be in need of services. Other ideas include better upfront disclosure on pricing and the ability to receive comparative data on facilities pricing.

Disclosure Information When People Become Eligible for MA:

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Last year legislation was passed that required housing with services providers to disclose in the contract, whether a consumer is required to move to a different room or to share a room if the consumer can no longer pay the current rent. (Article 4, section 4.) Is the contract the right place or should this be included in the uniform consumer guide instead? .In addition, the disclosure *should include whether a consumer would be required to move out of the building.*

Housing With Services-Assisted Living Medical Assistance Study

Date: October 16, 2012
To: HWS/AL MA Study Work Group Meeting
From: Angie McCollum, Consumer Representative
Re: Consumer Issues

- As delivery models change to keep people out of hospitals and nursing homes, consumers must be kept informed in succinct and meaningful ways.
- Systems information must be simplified; today's information is too confusing.
- Application process must be simplified; i.e., combining all programs that apply: housing, food stamps, health care and social services.
- Timing of renewals must allow more time to gather information and submit timely.
- Federal and state programs must coordinate programs; for example, HUD and MA. Another example: QMB, SLMB, QI included in the MSHO program.
- There are multiple players with multiple requirements; these must be streamlined.
- Partnership with acute care and other to create increased delivery models to keep people out of hospitals and nursing homes.
- Incorporate all funding streams into the most efficient way for consumers to understand
- Don't want to lose the good delivery systems that are currently working.
- Must have complete and inclusive quality reporting so consumers are able to make informed decisions (among all systems, programs, health plans and facilities.)
- ACA legislation requires a systems "navigator" to assist consumers. It is not known yet if this will be a government entity or non-profit agency. A similar system must be in place for this complex housing with services/assisted living MA process. Consumers must be informed that they have resources to assist them. Many are unaware during this difficult planning process that there is help with decision-making.

Housing With Services-Assisted Living Medical Assistance Study

Ombudsman HWS MA Study Stakeholder meeting

October 16th, 2012

Presentation outline

Luke Simonett, Social Services Supervisor

Crow wing County Community Services

- I. The positive collaboration between Crow Wing County and the Customized Living and Nursing Facilities allow us to serve a growing Senior population at a high level of customer service.
- II. Demographics: U.S Census 2011 estimates a county population of 62,763. 19.0% over the age of 65 (Minnesota 13.1%) with the prediction of the elderly dependency ratio to double by year 2030. Crow Wing County has three Skilled Nursing facilities and 21 customized Living facilities. Crow Wing County Community Services serves 640 senior clients primarily utilizing the Elderly Waiver with Managed Care entity insurer.
- III. Private Pay and the Elderly Waiver. Residency agreements and the tenancy criteria for determining fitness to reside in the facility can provide challenges for the consumer, family members and placing social worker. Community Service fees, Scooter fees, and waiting list fees can be a barrier for an individual on public assistance. Discharge policies. Customer survey initiative.
- IV. Customized Living tool. CWC Social Workers complete this tool with the facility personnel present. CL facilities may request the case mix of last assessment prior to admission. It should be noted that the case mix alone does not replace the CL tool in determining the payment. Prior to 2010 Counties used their own tool or a tool developed in their region. Current tool is standard throughout the State. Understanding the CL plight and employment factors.
- V. Ideas to increase customer satisfaction. A defined procedure to communicate changes in facility policy and how communicated to the resident, family and social worker. Establish payer source prior to move in. People eligible for MA may not always be eligible for the EW. Applicants should be encouraged to apply for MA before all of their assets are depleted to avoid a lapse of service or a non-payment issue.



October 2, 2012

Dear Members of the Ombudsman for Long Term Care Medical Assistance Study

Members of the Long Term Care Imperative appreciate having a seat at the Ombudsman Medical Assistance Study table. Thank you for allowing time for us to present the landlord and service provider perspectives, the challenges we face, and our suggestions for improvements.

Providers currently serve those that are private pay, those that receive Group Residential Housing (GRH) support and those whose services are paid for by the Elderly Waiver (EW) Program. Providers are serving low income seniors despite the fact that public resources are declining and often do not currently cover the cost of care. Providers have to balance their budgets to stay in business and to maintain the quality of their services and pay their staff for the hard work that they do. EW and GRH policies and funding may limit the options and choices available to low income clients and tenants, however, those limitations based on state policies and funding do not constitute discrimination by providers.

We offer the following comments in the context of the challenges that providers face but we also offer solutions. If these challenges can be addressed, and this workgroup adopts some of our suggestions as proactive recommendations in the report, we believe it will improve consumer choice in housing and in services.

The growth of the Elderly Waiver program has benefited Minnesota and Minnesota seniors in a number of ways. In addition to promoting independence and choice of living in a community setting, the program can be a cost effective alternative to the nursing home setting for all payors, both public and private.

However, as the state has faced continued budget deficits at the same time as more seniors are enrolling in EW, providers have borne the brunt of the effort to control costs. EW Customized Living provider rates have been cut 15% over the past four years. The average reimbursement rate is \$2017, which is \$1,101 below the average \$3,118 cost of care.¹ For the Housing with Services providers that have designated themselves as assisted living, these reductions and changes in payment policy have posed challenges that need to be addressed for the future.

¹ LTC Imperative 2012 Legislative Survey

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Four years ago, the Long Term Care Imperative advanced legislation called The Elderly Waiver Accountability and Simplification Reform Act. Some of the challenges that are being discussed by this group today were identified by providers in forming our legislation. While the 2012 legislature passed a provision to require information sharing from the provider to the case manager (with the client's permission), more improvements to the EW program would be helpful. We believe it is worth revisiting these issues and also discussing some emerging trends that providers have more recently identified.

Additionally, a number of policy developments during the past few years have led to a program that lacks transparency and accountability relating to sharing of information and clear delineation of roles. These developments include:

- **Managed Care and the EW market** - Nearly all of EW is controlled by managed care organizations. In 2003 managed care organizations (MCOs) oversaw 7.7% of the annual EW clients. By 2009, managed care organizations oversaw 85% of the annual EW clients. Many of the MCOs have developed separate and distinct policies for the EW program, yet very few utilize a definitive contracting process; and they all have different billing codes and procedures. Lengthy payment delays by MCOs are common in contrast to the efficient billing and payment process using the state's electronic system in place before EW clients were shifted to health plans. Each MCO has different standards of practice and providers must work within a system that is not efficient, is confusing and is time/resource consuming.
- **EW Rate Setting Tool** - While positively addressing certain long-standing systemic concerns, the introduction of a new Customized Living rate setting tool in 2010 has introduced both complexity and confusion for clients and providers. Further, there are many inconsistencies from county to county and health plan to health plan in how the tool is completed. The CL tool, and the resulting service plan was intended to reflect each client's individualized needs, but case managers have used shortcuts, such as allowing only 5 minutes for each medication administration for all clients, whether a client takes one vitamin or 12 medications, including insulin. When the amount of time entered in the tool to provide various tasks is completely inadequate (e.g., 5 minutes per med administration or 30 minutes for a bath for a person with dementia who needs lots of coaxing), it appears that every task can be completed within the service rate cap when in fact the provider is absorbing part of the cost of the service. Case managers frequently reduce the amount of time authorized for needed services to stay within the client's service limits—and in a previous meeting DHS staff explained how the tool automatically reduces the time allowed when a client's authorization is slightly above the service rate limit. In many such situations, payment for the provider's service is short-changed. In addition, providers frequently provide other disallowed services for EW CL clients (such as licensed nurse visits) without any compensation at all. EW policy does not allow families to pay for services that the client may want or need—such as more than 1 bath a week—if the service is an allowable service under EW CL. Thus, even when a family has the means to pay for extra services that the EW client wants or needs, they are prohibited from doing so. Providers often provide uncompensated services because they do not fit within the service rate limit per the CL tool. Although EW clients may fully participate in the provider's program and services, they suffer limitations imposed as a result of the payor program, not the provider.

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- **Case Manager/Care Coordinator roles** - The state has identified the case manager/care coordinator as the primary agent responsible for the client's health care. However, the provider delivers the vast majority of needed services and the on-site nurse is the health care professional who sees the client frequently and best knows the client's care needs. The on-site nurse plays an important care coordination role and frequently contacts the physician or other health care provider about issues and concerns, with no compensation under EW. DHS has created barriers regarding the communication of information between the case manager/care coordinator and the provider, making who is responsible and who is accountable indiscernible. Additionally, there are inconsistent practices and policy interpretations by case managers (which may be county or MCO employees) which causes the rates for clients with similar needs to vary widely.
- **Information sharing about service needs** - The state has adopted a policy where the provision of and access to information is not equitably distributed to all stakeholders. Providers, who interact with their clients daily, are not provided the basic health care information case managers/care coordinators use to determine the client customized living plan and payment. These basic items include the Long-Term Care Consultation assessment and the case mix classification, which provide the data points used to determine the EW-CL Workbook Tool payment. Since the rate cap available for services is based on the case mix classification, if the determination is inaccurate, the process is flawed from the beginning.

Emerging concerns identified since our EW Accountability and Simplification Work Group met:

- **MA eligibility delays** – Providers report significant delays in MA eligibility determinations. Providers have no control over the family completing the MA financial eligibility and the LTCC assessment runs out in 60 days. Providers have reported service cost arrears for their clients, often amounting to thousands of dollars. To add to this, many counties are telling families they are not required to pay the provider for services or rent while the MA waiver application is pending. In counties where there is a backlog there may be delays in making the eligibility determination and in some case denial of eligibility, it can be months before the waiver payments are authorized, and these payments are not retroactive beyond the most recent LTCC date. In addition to the delayed MA application process timing, there is a delay in nurses from the county coming out to the HWS settings to screen EW clients. As a result of these delays, by the time the process is complete, the client can owe a large bill with which he/she has no means to pay.
- **Higher needs clients** - Many providers of EW services care for clients with higher needs that if not being cared for in HWS setting, they will go to more expensive nursing home care. The reimbursement rate under EW CL has been cut by over 15% in the past 4 years. These cuts are impacting provider's ability to recruit and maintain quality staff. Additional funding is needed to continue to provide high quality of care to the people we serve.
- **Group Residential Housing rates** - In many settings/counties/locations, the Group Residential Housing rate does not pay the full amount of market based price for rent. The typical GRH payment of \$867 for rent plus meals, including a minimum of \$200 for raw food, is inadequate to cover the costs of most senior buildings. Unlike other apartment buildings for younger

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tenants without significant service needs, senior buildings serving frail seniors need rental payments that support the cost of congregate dining rooms, activity rooms, areas for the home care office, accessibility features, etc. In addition, GRH does not pay for absences of more than 18 days per episode when a tenant may be in the hospital or a care center. Buildings have very few options to receive payment for this time away, yet most try to hold an apartment for a tenant who expects to return from a hospital or nursing home stay. A private pay person would be expected to pay full rent even if in the hospital.

- **Level of Care changes** – The changes to level of care are intended to go into effect in January of 2014 (sooner if CMS approves) and will have significant impact on EW eligibility for lower needs clients. Although the service needs of the client will remain unchanged, the amount being paid for those same services and the payor source will be altered to the detriment of the clients and the providers. Some clients may lose EW eligibility entirely yet remain in need of housing and support services. Providers have already seen the impacts of lowered service rate caps for clients who were Case Mix A but have been shifted to Case Mix L, but still need the same services they previously received in order to remain stable.
- **Prior to move in** - There has been discussion about what landlords require of tenants prior to move in. Typically, they require a full month's rent, plus a security deposit against future damage to the apartment. If a person moving in is going to be on EW, either immediately or at some time in the future, the landlord can require the same housing-related payments since there is no requirement that MA waiver tenants receive rent discounts or other rent accommodations. In addition, new tenants who are approved for GRH support may not be charged a security deposit. This means that if one of these tenants damages the unit or other areas of the building, the building must absorb the cost. The costs to replace carpeting or make other repairs can be substantial.

We have offered the above comments in the context of the challenges that providers face but we also want to offer solutions. If these challenges can be addressed, and this workgroup adopts our suggestions as proactive steps to take, there will be improvements to the programs which will equate to continued consumer choice in housing and in services:

- **Managed Care and the EW Market** - Creating single standards of practice and policies, including consistent billing procedures in these areas would go a long way to freeing up time, frustration, and confusion for the EW clients.
- **EW CL Rate Setting Tool** - Our suggestion for improvement in this area is to learn more about how data is collected on how many EW clients are at the cap currently and how often the service needs are reduced so as to fit under the cap. Along these lines, it would be helpful if the tool could represent accurate estimates of the time needed to complete authorized tasks. We also would like to ask for more specific information from DHS related to how DHS has determined the rates for CL and suggest that a review of providers' actual costs in the provision of services covered by the CL program should be conducted.

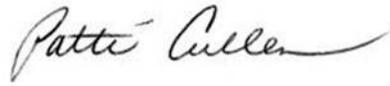
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- **Case Manager/Care Coordinator Roles** - More training and consistency would be helpful to solve this problem. Recognition of the important role that the home care RN's play in care coordination – and appropriate compensation – would be an important step.
- **Information sharing about service needs for EW Clients** - While legislation passed during 2011 to make small strides in this area, there are still barriers to obtaining the best information to serve our clients that are EW recipients. Clients would be served best if we can come to agreement on how to share additional information about clients and their service needs.
- **MA eligibility delays** - We must have more conversation about how to address the issues of non-payment and delays. What can the counties do to help make this process operate and what can the provider do to assist? Also, if family has transferred and spent money, not anticipating the need for services accurately, the provider should have a means to be paid if eligibility is denied and the family no longer has the means to pay for services needed by the vulnerable adult.
- **Higher needs clients** - We recommend that this workgroup ask that EW rates be increased to address the service needs of higher needs clients.
- **Group Residential Housing rates** - We recommend taking a look at the non-payment after 18 days to see if there are alternative ways to provide funding for absences and high market rent.
- **Level of Care changes** - Since this implementation date is in the future, we suggest that there is time to look again at who will be losing MA eligibility, whether it is the appropriate course of action to take, and, whether we can recommend changes to ensure that those who are currently eligible for MA continue to be able to access the services they need.
- **Prior to move in** - It is time again to look at GRH rules and regulations about what can be paid for and whether we can come up with alternative solutions to some of these issues. For example, it would also be helpful if the state could address some compensation for damages caused by a GRH client since they cannot be charged a security deposit.

There are important issues and significant challenges that this work group is faced with. The solutions are challenging as we have a lot of anecdotal evidence and data is difficult to come by. Our goal is to continue to work and find common ground where common ground can be found to ensure that consumers continue to have options for home and community based services. The Long Term Care Imperative will be advancing legislation during the 2013 legislative session to provide rate increases as reimbursement for services is a significant source of any issue.

Sincerely,

Housing With Services-Assisted Living Medical Assistance Study



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Housing With Services Medical Assistance Study

Stakeholders Work Group

October 16, 2012

1. Differential treatment based on economic factors

In the experience of Regional Ombudsmen, HWS consumers are sometimes treated differently in the terms and condition of their tenancy/receipt of services in HWS establishments. Examples of this differential treatment are listed in Sections II and III.

The Office wants to emphasize however, the factors that may drive this differential treatment are not based on negative stereotypes or malicious attitudes about people who receive public benefits to support rent or services.

Rather, our work with consumers and their families, indicates that differential treatment stems from economic factors, including financial constraints for providers (e.g. needing to “keep the doors open,”) policies related to reimbursement rates/rent subsidies (Elderly Waiver, Community Alternatives for Disabled Individuals, Group Residential Housing) and the complexity and administrative requirements related to these programs.

2. General Issues related to differential treatment

Lack of Housing Options

- A. Limitations in the amount of units/apartments for MA consumers

- B. Limitations manifest somewhat differently between rural and urban areas

Consumer Education

- C. Differences in regulations between nursing homes and HWS establishments:
 - 1. Landlord/tenant law; HWS contract; home care service plan/service agreement
 - 2. Information given to or understood by consumer about policies when consumers spend down to MA eligibility
 - a. Shared room
 - b. Termination of tenancy
 - c. Move to smaller unit
 - d. Limitations to services related to the waiver rate cap
- D. Reasons Consumers may not understand
 - 1. HWS marketing material/staff information/policies and lease or service agreement vary about availability of public funds for rent or services.
 - 2. Consumers may be experiencing difficult emotions or life changes that may impact hearing or remembering what is communicated to them – regardless of how well the information is presented.
 - 3. Challenges in information sharing among the case managers or care coordinators with their clients about options.

3. Examples of differential treatment from Ombudsman casework

- a. Meals/dining
- b. Move to shared room
- c. Move to smaller room
- d. Termination of tenancy



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Housing with Services (HWS)/Assisted Living Medical Assistance Study Stakeholders Workgroup, October 16, 2012

Perspectives on the Medical Assistance Study from PrimeWest Health

Maureen Melgaard-Schneider, Senior Services Manager

Cindy Grosklags, Social Services Supervisor, Renville County Human Services

- PrimeWest Health is unaware of public funding disparity issues or differential treatment in Housing with Services (HWS) and/or arranged home care services.
- PrimeWest Health's care management model, which includes contracted case management services provided by county Public Health and Human Service agencies within the 13 PrimeWest Health counties, ensures interdisciplinary care team (ICT) involvement and contributes to high member satisfaction and lack of identified disparity issues for members.
- PrimeWest Health's HWS established standards of clinical practice and contracting policies and procedures with concurrent oversight and annual evaluation throughout the PrimeWest Health 13-county service area contribute to consistency of network requirements.
- In 2011, a rural HWS provider chose to discontinue operating its ten-bed HWS facility, citing fiscal concerns. The potential impact on their business model of an optional alternate rate reimbursement methodology for small providers is undetermined.