



Minnesota Department of **Human Services**

FINAL NARRATIVE REPORT
Minnesota's Cash & Counseling Grant Project
Reference: I.D. #052105

October 1, 2004 – December 31, 2007

\$350,000

GOAL: To jumpstart Minnesota's implementation efforts to create permanent, statewide access to consumer-directed services for older or physically disabled adults and their family caregivers using publicly funded programs.

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1. What measurable goals did you set for this project and what indicators did you use to measure your performance? To what extent has your project achieved these goals and levels of performance?

The primary purpose of Minnesota’s Cash & Counseling Project was to jumpstart efforts to implement the federally and state-approved (effective 2004) Consumer-Directed Community Supports (CDCS) service option. CDCS is available under all of Minnesota’s five Medicaid home and community-based services (HCBS) waivers and the state-funded Alternative Care Program (AC). The project targeted older persons on the Elderly Waiver (EW) and AC Program, adults under the Community Alternatives for Disabled Individuals (CADI) Waiver program, and family caregivers under the Older Americans Act Title III-E funded National Family Caregiver Support Program.

Core activities focused on: (1) bolstering enrollment for the targeted population; (2) strengthening the CDCS infrastructure (e.g., fiscal support entity (FSE) and flexible case management (FCM) services); (3) creating competency and capacity within lead agencies responsible for informing people about CDCS and authorizing service plans; and, (4) creating a consumer demand for CDCS. This project also helped the Department respond to some of the presumed and identified enrollment barriers, fine tune operational policies and processes, explore promising practices, and better understand participant response to the model.

The project was extended from September 30, 2007 – December 31, 2007 to provide additional time to complete the enrollment assistance contract and the flexible case manager curriculum product. These were completed.

Table: Goals, Measurements, Targets, and Results

Major Goals	Measurement	Target (effective 7/06)	Baseline 1/05	Results 12/31/07
A. Expand enrollment of the CDCS option for the target population by supporting Minnesota’s efforts to create multi-point, statewide access.	<u>Enrollment:</u>			
	Elderly Waiver	228	0	138
	AC Program	132	0	59
	CADI Waiver	300	0	141
	Title III-E	83	6	96
	TOTAL	753	6	434 (58%)
	CILs Edu. sessions	830	NA	1190
B. Complement Minnesota’s efforts to develop the statewide CDCS infrastructure and capability within the lead agency system consisting of 87 counties, 9 managed care organizations, 8 Area Agencies on Aging (AAA) Title III service network, and tribal govt. system.	<u>Participating Lead Agencies:</u>			
	Counties	87	31	63
	Health Plans	9	0	8
	AAA	8	2	8
	Enrolled FSEs	16	11	17
	Certified FCMs	10% for elderly	157	368 (10% elderly)
	Participating case mgrs./care coord.	50	2	190

Major Goals	Measurement	Target (effective 7/06)	Baseline 1/05	Results 12/31/07
C. Create a market demand for the model by broadening community awareness and advocacy support.	<u>Aging network & advocacy org. participation</u>			
	State AARP	Yes	No	Yes
	Office of LTC Ombudsman	Yes	No	Yes
	Elder Rights Alliance	Yes	No	Yes
	Lvg Hm Nurses	Yes	No	Yes
	AOA-Alz. Grant	No	No	Yes
	SLL [®] Call Ctr	Yes	No	Yes
	CILs	No	no elderly	All pop.
	Consumer Group	Yes	No	Yes
	Caregiver Network	Yes	3	25
	Parish Nurse Ntwk	No	No	Unknown
Gov. DD Council	No	Yes	Yes	
D. Understand the participant response to the CDCS Model.	Final Evaluation & Focus Group Reports			See Biblio.
E. Develop customized web-based participant planning tools portable across funding streams.	<i>Goal deleted. Existing tools adequate.</i>			

Discussion

A. Enrollment

Background. Minnesota offers a rich menu of HCBS including flexible service options under the Medical Assistance (MA) state plan, HCBS waivers, the AC program, Title III funded services, and other state-funded grants. For example, the personal care assistance (PCA) option allows participants to hire friends and family and use services flexibly. Quality assurance surveys and lead agencies report that many EW and AC participants are highly satisfied with traditional services. Many potential CDCS enrollees

indicated they were reluctant to use CDCS because they did not want to do anything to jeopardize the trusted relationship and support they had with their lead agency case manager. Initial enrollment on CDCS for the target population has been slow. However, this project did achieve a 66% result of the established enrollment targets during 2005-2007. (*Note: Historical records show a similar enrollment pattern for the Developmental Disability (DD) Waiver when a consumer-directed option was first started in 1998 and, also with the new PCA Choice option in 1999.*)

Issue. No EW or AC Recipients Enrolling in CDCS. CDCS was a relatively unknown service to persons on EW and AC when CDCS became available in October, 2004. There was no known consumer demand for the option.

Issue. Lead Agency Resistance to CDCS. Early on there were many lead agency staff (e.g., case managers, management) reluctant to get involved with CDCS. Many commented that CDCS was too complicated for the elderly and they could not think of clients who would use it. Others thought it would create additional work for everyone, including the client. It was easier to use traditional services. Several disagreed with the policy of paying family and friends to provide care and support.

Some case managers/care coordinators eventually learned how to use CDCS when pressured by an interested client wanting to enroll. While many case managers/care coordinators are now working with CDCS and many “champions” have emerged, some resistance still exists today. However, overall support for CDCS is stronger today than at the beginning of the project.

Issue. Perception about CDCS Individual Budgets. The CDCS budget limits for EW and AC are lower than the budget limits for traditional EW services. This difference created a perception with case managers/care coordinators and consumers that CDCS budgets were therefore inadequate for addressing assessed needs. This belief was impacting CDCS enrollment. Some case managers reported that while some CDCS budget amounts did work for many people they did not particularly work for persons with the lowest case mix category. Case managers who focused on how CDCS would work for the individual on a personal level instead of the lower budget limits were having the greatest success with enrolling people.

Key Approaches. To address enrollment, the Department engaged in a variety of strategies including developing effective consumer outreach messages and materials; targeting training, education, and discussions directly to lead agencies; and, providing direct enrollment assistance to eligible persons on EW and AC. Activities included:

1. *Development of Outreach Materials and Tools. Project staff developed a wide range of informational and educational materials including:
 - A [web page](#) for CDCS information, tools, and resource materials, and participant stories.
 - A media kit for lead agencies and providers, an 8-minute program video, kiosk card, postcard mailer
 - Lead agency tool kits that included flow charts, checklists, and decision trees

2. Education and Training. Throughout the 3-year grant period, project staff provided information about CDCS to stakeholders at numerous statewide videoconferences, state trade association and county conferences and meetings; AAA meetings and provider conferences; departmental and regional meetings; Senior LinkAge Line[®] and Office of Long-Term Care Ombudsman trainings and meetings; project stakeholder group meetings, etc. In 2007 there were approximately 20 presentations made by project staff to about 1,100 stakeholders. *See Bibliography.* Technical assistance to lead agencies, flexible case managers, and fiscal support entities is also provided on an on-going basis by several Departmental staff.
3. *CILs Contract for Enrollment Assistance Services. In January 2007 a 9-month contract with three Centers for Independent Living (CILs) was established to *directly* provide enrollment assistance services (e.g., outreach, initial CDCS education) to EW or AC participants in 29 counties. They were required to provide 830 education sessions and enroll 86 persons. (*Result: They provided over 1190 education sessions and enrolled 88 persons.*) They used direct mailings, telephone calls, and in-person visits to reach eligible persons. By early summer broader interest and enrollment activity was now emerging for CDCS. Consumers were responding to direct outreach efforts provided by the CILs. The CILs also helped project staff identify and respond to enrollment barriers and regional issues and needs. By this point in the project, the timing was now better for CDCS as initial activities surrounding the new Medicare Part D enrollment and managed care enrollment for the elderly had subsided.
4. *Regional CDCS Meetings. Along with the CILs contract, project staff also orchestrated 12 regional meetings in the 3 CILs regions in an effort to bring CDCS stakeholders together on the local level. The purpose of these meetings was to address enrollment issues, foster relationships among key players, enhance understanding about the model, and offer individualized training and technical assistance. Participants in all 3 regions felt these meetings were quite valuable and requested they continue. The Department will continue the regional meetings and broaden the scope to include CDCS issues for all populations.
5. Peer Mentoring. Lead agency case managers/care coordinators were encouraged to contact peers with CDCS enrollment experience in their organization or in a neighboring county for assistance. This practice is helping many case managers better understand the model by learning from peers about their initial experiences and operational practices for CDCS.
6. Addressing the Budget Issue. Stakeholder focus groups held in September 2007 found that the issue about current CDCS budget limits being insufficient was still alive. Currently, the managed care and fee-for-service (FFS) delivery systems are using the same budget limits for persons on EW. However, MCOs have the authority to establish their own CDCS budget limits as well as authorize benefit exceptions. DHS will continue to work with the MCOs and help them use their authority to best address the needs of persons on CDCS. (Note: In 2008, about 90 percent of EW participants will be enrolled in managed care organizations. Concerns about the inadequacy of the CDCS budget could ultimately be resolved by the various MCOs.)

Under the FFS system the Department continues to solicit input regarding the impact of established CDCS budget limits. Currently, a 3-county pilot study allowing AC participants to use their full traditional budget amount when opting for CDCS is underway. Upon completion the Department will examine the study and its findings.

B. Quality Infrastructure Development

Flexible Case Management (FCM) Services

Background. One of the initial quality assurance measures for the *optional* FCM service is a one-time provider certification test offered through the Department. Most of the originally certified FCMs (157) were primarily serving persons with disabilities. The Department wanted to assure a sufficient number of FCMs serving older adults and particularly those persons on EW and AC.

Issue. *FCMs were operating with a broadly defined scope of practice. Lead agencies were becoming concerned about FCMs assuming lead agency responsibilities and consumers not understanding what FCM services they were buying.*

Key Approaches. The following approaches were used to improve access to and quality of flexible case management services:

1. Implementation of New FCM Service Standards in 2008. Project staff directed the development of new FCM service standards that will be implemented by mid-2008. *See Bibliography.* These seven service standards address the functions and limitations of FCM services; ethics and values; service and support planning and implementation; support of self-advocacy; fostering self-determination; the right to privacy; and diversity and inclusion. The Department is also considering a name change to the service to minimize confusion that exists between FCM services and lead agency case management services.
2. Implementation of Re-certification Requirement. When the new service standards are implemented FCMs will be required to be re-certified every two years. The Department is working out operational issues for this new requirement while awaiting CMS approval.
3. *Development of FCM Training Curriculum. A new 3-module (1 day each) FCM curriculum integrating the new service standards has been developed and pilot-tested by about 60 people in 2006 and 2007. *See Bibliography.* The Department will train approximately 100 certified FCMs in 2008 with the new curriculum. The curriculum product will also be expanded under the AOA-funded Nursing Home Diversion Modernization Grant Project (2007-2009) so FCM providers can effectively assist persons at-risk of nursing home placement and spend down to Medicaid.
4. Development of New FCM Networks. A few counties and FCMs have established FCM networking groups around the state. One group with about 25-30 members meets monthly. These groups discuss operational and practice issues and work to improve the quality of FCM services statewide. The Department obtains input from these groups on a wide range of FCM service issues.

Fiscal Support Entity (FSE) Services

Background: The use of FSE services is required under CDCS. FSEs are required to serve people statewide. The predominant FSE model in Minnesota is the Agency With Choice model for hiring domestic workers. Most of the certified FSEs had little previous experience in serving the elderly population. Project staff pursued the certification of an elderly-specific FSE provider in order to impact CDCS awareness and enrollment.

Issue. *Offering quality FSE services statewide for all populations including the elderly.*

Key Approaches. In 2007 there were 16 FSEs that participated in a rigorous re-certification process developed by DHS; all were re-certified. An aging network provider also received its initial FSE certification. However, this has yet to have an impact on enrollment for older adults and all FSEs are willing to serve the elderly population. An FSE network works closely with the Department on issues, policies, and operational practices and recertification processes.

Issue. *Lead agencies have been slow to enter into contracts with the FSEs.*

Key Approaches. Some lead agencies have been reluctant to contract with FSEs until clients are ready to use CDCS. And, many will only contract with a few FSE providers because of the time involved with managing multiple provider contracts. One way to address this has been the use of a “host county” contract arrangement where a county contracts with an FSE and allows other lead agencies to “piggyback” onto their contract.

Issue: *Lead agencies and providers not familiar with the new FSE services and/or working with the fiscal conduit and fiscal/employer agent models.*

The Department continues to offer periodic education about FSE services to lead agencies and stakeholders. Many FSEs and a few counties have also provided training directly to lead agencies and various stakeholder groups as well as making themselves readily available for on-going technical assistance.

C. Community Awareness and Advocacy Support

When this project started most persons on EW and/or AC were unfamiliar with CDCS. They are to learn about CDCS from their waiver or AC case managers/care coordinators, and county long-term care consultants during the pre-admission screening process. Other older adults and family caregivers also hear about CDCS from the Senior LinkAge Line[®], Disability LinkAge Line[®], providers, news articles, etc.

Highlights of the project outreach activities for CDCS include:

- Mailed approximately 13,000 postcards in Year 1 (2005) to all current eligible adults on EW, CADI waiver, and AC Program. Response was minimal and therefore not repeated.
- Prepared a variety of outreach and educational materials for lead agency staff, aging network providers, and Senior LinkAge Line[®] and Disability LinkAge Line[®] staff to use in telling people about the CDCS option. [Materials](#) included a Consumer Handbook, kiosk card, [program video](#), [web-site](#) (fall 2005), messaged scripts for consumer education sessions, quizzes, collection of personal stories, and other

materials. The kiosk card is still widely used and continues to be a primary outreach tool. Approximately 11,000 kiosk cards were distributed in 2007. A total of 2,174 program videos were distributed during the project period and also broadcast on 44 public access TV stations across the state in 2006.

- *Established regional (northeast, central, and southeast Minnesota) meetings (2007-current) with local CDCS stakeholders to directly address slow enrollment and low demand for the CDCS option. These meetings are also a key strategy for communicating information about CDCS policy, practice, roles, fostering working relationships among key players, and better addressing training and technical assistance needs of the lead agencies.
- Requested multiple stakeholders (e.g., lead agency organizations, providers, advocacy groups, etc.) statewide to use their internal communication resources (e.g., newsletters, training programs, written and web materials, and community forums) to inform the public about CDCS. Many organizations and networks responded including the MN- AARP office, Alzheimer's Association of Minnesota, Elder Rights Alliance, and Minnesota Governor's Council on Developmental Disabilities. AARP tax preparers distributed CDCS kiosk cards.
- *Directed a 25-member stakeholder group to inform and gather input for strategic development of CDCS implementation for older adults and this project. (6 meetings held October 2005-May 2007)
- Recruited Minnesota's member for the National Program Office-sponsored *National Participant Network* and helped that person also establish a "Self-Directed Services Advocacy Group" in Minnesota. The group consists of CDCS participants, family members, and other interested parties. They are working to become a strong voice for self-directed services and to help ensure the sustainability of the model in the future.

D. Understanding Participant Response

The project evaluation and focus group studies have helped the Department better understand how CDCS is working and identify strengths and weaknesses in Minnesota's approach to consumer-directed options. Minnesota's project evaluation conducted by *Paone & Associates found that older CDCS participants and their family members were enthusiastic about CDCS and that it could work for the elderly. They voiced a strong desire to keep CDCS a viable and growing option in Minnesota. Outstanding implementation and operational issues were also discovered and proposed strategies were captured. *See Bibliography for Paone & Associates Evaluation and Focus Group Reports.*

Several CDCS participants and case managers/care coordinators were interviewed and often spoken to during the grant period. Further evaluation of the CDCS option has been integrated into Departmental quality assurance activities for EW and AC.

E. Web-based Tool (Deleted)

2. ***Did the project encounter internal or external challenges? How were they addressed? Was there something RWJF could have done to assist you?***

External Challenge: During years 1 and 2 of the project (2005 and 2006) there were two significant environmental factors that had a tremendous impact on both lead agencies and the target population (e.g., dual eligibles) that dramatically impacted CDCS enrollment: (1) implementation of the new Medicare Part D benefit; and, (2) 2006 enrollment of about 35,000 Minnesota elderly into the managed care health care delivery system which affected about 68 percent of the EW population or about 11,208 people. These two issues were of greater significance to lead agencies and consumers than learning about CDCS. It is unclear whether RWJF could have assisted with this challenge. All other challenges and issues were addressed under question 1.

3. ***Have there been other sources of support?***

Approximately \$300,000 of state-funded Community Services/Service Development (CSSD) grant funds have helped support the expansion of consumer-directed services for older adults. For example, CSSD grant funds helped to establish consumer-directed respite services in several rural counties, certify an elderly-specific FSE, and broaden awareness about the model within the Living at Home Block Nurse Provider (LAHBNP) network (42 programs). Over \$200,000 of Title III funds were allocated for consumer-directed services in 2006 and 2007.

4. ***What lessons did you learn from undertaking this project?***

- Timing for CDCS implementation is critical, especially when there are competing major policy initiatives requiring the attention of lead agencies and consumers.
- Using dedicated enrollment staff to help people with CDCS enrollment was an extremely successful strategy. Communicating clear, non-biased information to potential participants is critical in helping people make an informed decision about the option. This strategy was also very useful in identifying and responding to enrollment issues as well as the concerns of lead agencies.
- The level of satisfaction that persons on EW and AC have with traditional services was somewhat underestimated as was the importance of the client – case manager/care coordinator relationship in some parts of the state.
- New EW or AC program participants are more likely than long-term users to opt for CDCS.
- Some state staff must be knowledgeable in all aspects of the fiscal management services and be able to address policy and practice issues not only within the Department but across other state and federal agencies.
- On-going stakeholder (state and local level) input on broad range of topics and issues is essential in developing a strong, viable service option.
- Personal stories from participants and lead agency case managers/care coordinators are an effective communication and training tool and help broaden support for the option.

- Obtaining quality enrollment and claims data in a timely manner on CDCS enrollees (EW) in MCO is critical for addressing CDCS policy and enrollment issues. However, this remains an arduous process as the collection and cross-checking processes involve 9 MCOs (most do not use Medical Management Information System) and 17 FSE providers.

5. *What impact do you think the project has had to date? Who can be contacted a few years from now to follow-up on the project?*

Minnesota's grant project has had a multi-level impact. To begin with there are several state legislators who continue to support the model with growing support for consumer-directed respite. Support for CDCS within the Department has also grown. Staff unfamiliar with CDCS now understand how it works for people served by the Department. And, skeptics are now supporting it. The success with this project helped the Minnesota Board on Aging obtain an Administration on Aging Nursing Home Diversion Modernization Program (2007-2009) grant.

Next, the consumer-directed services model continues to be a core Departmental and Minnesota Board on Aging strategy for helping older adults with long-term care needs and in supporting family caregivers. Because of CDCS, Minnesota's HCBS system is becoming more "consumer-centered." There are now 72% of the counties, 89% of the MCOs, and 100% of the Area Agencies on Aging participating in consumer-directed services across all publicly funded programs for older adults (e.g., Medical Assistance, EW, AC, Title III, state-funded grants, Alzheimer's Disease Demonstration Grants). (See Table on page 2) About 90% of the project's stakeholder group members reported an "in-house" champion for CDCS. Project activities also sparked the interest of other key LTC system stakeholders (e.g., nursing homes, assisted living) wanting to serve older adults in different and more consumer-directed ways.

Capacity within the system's CDCS infrastructure was strengthened because of this grant project. Quality assurance mechanisms, training and education activities, outreach materials, operational tools, web information, etc. developed under this project all helped to improve statewide access and quality of FSE and FCM services. Senior LinkAge Line[®] and Long-Term Care Consultation staff (i.e., HCBS system access points) and lead agency case managers/care coordinators are all now better equipped to work with CDCS. They now have another option to offer people.

Today, there is greater community awareness, acceptance, and advocacy for CDCS statewide. Outreach materials are widely distributed and operational tools are being used by lead agencies. A wealth of information is posted on the CDCS web-pages. More people know what CDCS is and are talking about it in various circles. CDCS enrollment for all populations beyond the project's target group continues to grow. Current enrollment for persons across all of Minnesota HCBS waivers and AC program is around 1,800 with many more people having used the option for many years.

Most importantly, this project has affected people's lives. People now have another way to address their needs. Elderly couples are able to stay together in their home and avoid or delay a move to a care facility; family caregivers who have quit work to care for family are now being paid and continue to pay into social security and access health insurance; quality home and community-based care/support is being provided by

familiar, trusted workers; and, nursing home residents have returned home to family life, familiar surroundings, home cooked meals, pets, and time in their yards to enjoy the sun and fresh air. The testimonials for CDCS are ample and heartwarming. CDCS is a valuable service with a bright future for touching many more lives.

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6. *What are the post-grant plans for the project if it does not conclude with the grant?*

Minnesota will continue to expand the use of CDCS for all populations. With all project activities completed, some project activities such as policy development for consumer-directed options, regional meetings, training, and technical assistance to lead agencies will continue. These activities are being absorbed through existing departmental staff positions across the Aging and Adults Services and Disability Services Divisions in the Continuing Care Administration. Minnesota's 2007 AOA-funded Nursing Home Diversion Modernization Grant Project will allow further work on this model for persons at high-risk of long-term nursing home placement and ineligible for MA.

7. *With a perspective on the entire project, what have been its key publications and national/regional communications activities? Did the project meet its communications goals?*

Throughout the grant period, Minnesota received many inquiries from other states pursuing consumer-directed options. Minnesota has participated in sessions at national meetings and conferences including those sponsored by the Administration on Aging, the National Association of Area Agencies on Aging, RWJF Cash & Counseling National Program Office, National Home and Community-Based Services Conventions (2006, 2007), and regional meetings for Centers for Medicare and Medicaid.

This grant project generated impressive attention from the local news media. This included press releases and articles being picked up by the state's largest newspapers, the *Minneapolis Star Tribune* and *St. Paul Pioneer Press* as well as other statewide media outlets. For example, there was a press release when Minnesota received recognition from the Administration on Aging as a "Choices for Independence Program Champion" for its work with consumer-directed services. Feature stories on CDCS participants can be found the Department's [web pages](#).

Yes. Communication goals were met.