

**Rebalancing Long-Term Care Systems in Minnesota:
State Case Study as of December 2007**

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**Submitted to the
Centers for Medicare & Medicaid Services (CMS),
Advocacy and Special Initiatives Division
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April 13, 2008

Revision Submitted June 26, 2008

The overall Rebalancing Research is being conducted through a Task Order under a CMS Master Contract between CMS and the CNA Corporation, Arlington, VA, and subcontracts and consultant agreements between CNAC and the various researchers. Rosalie A. Kane is the principal investigator from the University of Minnesota and Elizabeth Williams is the CNAC project director. This final case study for the State of Washington covers a period through December 2007. The statements and opinions in the report are those of the writers and do not necessarily reflect the views of CMS or any of its staff, or the State liaisons to the project, or any other state staff or persons who spoke to us from participating states. We thank the Minnesota Liaison to the study, LaRhae Knatterud, Director, Aging Transformation, Continuing Care Administration, MN Dept of Human Services.

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Preface

In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study in up to 8 States to explore the various management techniques and programmatic features that States have put in place to rebalance their Medicaid long-term care (LTC) systems and their investments in long-term support services towards community care. The States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in this 3-year Rebalancing Study. For the study, CMS defined rebalancing as reaching “a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services (i.e., Nursing Facilities [NF] and Intermediate Care Facilities for the Mentally Retarded [ICFs-MR]) and those used for community-based supports under its State Plan and waiver options.” CMS further clarified that a balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The products for the study include 3 iterations of State-specific case studies that qualitatively and quantitatively examine each State’s management approaches to rebalance its long-term care systems, six crosscutting topic papers on issues in rebalancing, and a series of 5 Chartbooks presenting quantitative analyses of Medicaid expenditures for consumers in HCBS versus nursing homes, as well as Medicare expenditures for individuals dually eligible for Medicaid and Medicare. A list of these products with web links for completed documents is provided in the Appendix.

For the final case studies—in this instance for the State of Minnesota, we concentrated on the perspective of State officials on accomplishments in rebalancing their long-term support systems for all clientele, and the future directions for the State. We also updated particular strategies that we had highlighted in the 2005 case study and the 2006 Updates. The report is based on comprehensive review of web and print materials, a site visits conducted by Reinhard Priester, Rosalie Kane, and/or Lois Cutler during December 2007. We also benefitted from ongoing contacts with personnel in the Continuing Care Division and other parts of the Department of Human Services, including the work of Robert L. Kane as contractor and at times advisor to the State. Because the researchers are located in Minnesota, we have been able to arrange in-person contacts as needed to fill out details in this report.

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Executive Summary

Minnesota was included in the Rebalancing Research as a state with long-standing and extensive commitments to long-term care, a generous state Medicaid program with additional state-funded support for those who do not yet qualify for Medicaid coverage for long-term care based on either financial or functional eligibility, a high degree of autonomy for its 87 counties, and a state historically heavily bedded with nursing homes that has systematically pursued a program designed to increase community supports. Management strategies discussed in the baseline report included: a focus on planning, systematic policies to downsize nursing homes, new quality initiatives, efforts to equalize community programs across waivers and counties through uniform assessment and budget planning; use of managed long-term care; development of consumer directed community supports; evolving a system of housing-with-services; and enhancing consumer information and decision-making.

Much of Minnesota's rebalancing has come from increased investments in community care, but of late, there are signs that the nursing home supply and investments have been reduced. The State has made more progress in moving towards community care for persons with developmental disabilities than for seniors. Virtually all of the state institutions are closed and a variety of community options, including active use of consumer direction is available. In the past several years the State has taken substantial steps to increase the use of waivers for aging and physically disabled participants as well, and to make consumer directed community supports (CDCS) available to them; a network of approved fiscal intermediary agencies has been approved for the CDCS program.

This case study highlights the following:

- Minnesota has evolved a housing-with-services program where the services not the settings are licensed and where it is hoped that fair housing rules may prevail. The assisted living sector currently is characterized by a confusing patchwork of regulations and coverage, which is currently being re-examined.
- Minnesota relies heavily on managed care for its Medicaid program. By the end of 2007, virtually all of the aging and disabled recipients have been brought under managed care for long-term as well as acute care.

- Minnesota is one of only a few states that operate a managed care program for dually eligible older persons, Minnesota Senior Health Options (MSHO). This program begun in the Twin Cities metropolitan area but has spread almost statewide. Managed care coverage of elderly waiver clients' long-term care was enhanced with the introduction of Minnesota Senior Care in 2005, which covered Elderly Waiver services.
 - A parallel managed care program for persons with disabilities, Minnesota Disability Health Options (MnDHO), was much slower than MSHO to get going, has had considerably more participation from the disability community in its planning, and presently models a managed care program with a high degree of consumer participation.
 - By contrast, advocates for participants in the MR/DD waiver programs have resisted managed care for the most part.
 - Although PACE programs seem compatible with the initiatives that bring seniors into managed care, the presence of MSHO may have impeded their development in Minnesota. The PACE program represents a more integrated model of care because it consolidates medical care in the hands of physicians who subscribe to the program's philosophy and PACE programs bear financial risk for nursing home care more completely than MSHO, but MSHO may be more attractive to State officials and providers because it minimally disrupts the way medical care is delivered.
- The State has taken several steps to reduce its stock of nursing home beds, including offering financial incentives to close beds and to convert multiple occupancy rooms to single rooms. Minnesota has made considerable efforts to improve the quality of nursing home care including a Nursing Home Report Card that makes available to consumers information on a broad array of nursing home performance measures, including a survey of residents' quality of life and satisfaction. It has provided add-on payments for better quality and has introduced a program of Performance Incentive Payments to reward quality improvement.
 - Minnesota has sought to involve consumers actively in planning for the future, for example, through participation on task forces to study the problems and make recommendations.
 - A strong guiding principle has been efforts to encourage people to plan for their own long-term care by setting aside funds to cover those costs privately and developing strategies designed to delay spend-down to Medicaid.

Rebalancing Long-Term Care Systems in Minnesota: State Case Study as of December 2007

Introduction and Background

Summary of Early Rebalancing Case Studies

Minnesota brought to the Rebalancing Research Project an example of a State with a strong county system of governance, and a history of above average expenditures in both community and institutional long-term supports. Although a state with a historically high supply and utilization of nursing homes (most of which are not-for-profit and many owned by mission-driven religious organizations), Minnesota has been steadfast in its determination to move towards greater home and community based services for all populations. For several decades, it has relied on a process of continuous planning, emphasizing consumer choice (as well as personal financial responsibility), pursuing quality improvement initiatives that build on information and incorporate consumers, aggressively expanding managed long-term care, and providing financial incentives to downsize nursing homes while improving their quality, including their quality of life, and providing incentives for privacy.

Over a period of decades, fueled by law suits and consumer advocacy, Minnesota completed the process of closing state institutions for people with developmental disabilities, replacing them with in-home services and a variety of group homes and community residential settings. This process of closing state facilities was complete well before the year 2000 when we began tracking rebalancing quantitatively for this project, and is described in the baseline Rebalancing Report.

For the rebalancing study, strategies that we emphasized at baseline were: a movement towards managed care in long-term care, particularly for seniors; the evolution of a housing-

with-services model of assisted living for seniors; an emphasis on providing consumer information and strategies to engage consumers in informed choices and quality feedback; deliberate strategies to downsize nursing homes; various initiatives to rationalize and systematize assessment, service allocation, and individual budgeting to achieve equity across waivers and geographic areas (initiatives that tended to exclude seniors in the Elderly Waiver and concentrate on the 4 other HCBS waivers in the state; and (despite the differences between long-term supports for seniors and for other populations, which were accentuated by the planning for mandatory managed long-term care for seniors) a growing convergence of aging and disability and joint planning at the state level. A short and long baseline case study on rebalancing in Minnesota was released in 2005 and an update of activities in Minnesota between July 2006 and July 2007 was part of a report released in April 2007.¹

General Background

Changes during this decade in Minnesota's long-term care policies and programs should be examined in the context of the state's 2001 legislation to "rebalance" its long-term care system (S.F. 4 2001 1st Special Session). This comprehensive reform legislation, enacting selected recommendations developed by the state's tri-partisan Long-Term Care Task Force, is designed to expand the capacity of home and community-based services for older persons, to help them remain in their homes and communities longer, and reduce the state's reliance on the institutional model of long-term care. The 2001 legislation continues to serve as the framework for the state's long-term care reform efforts going forward.

¹ Links to the short case study *Rebalancing Long-Term Care Systems in Minnesota: Experience up to July 31st, 2005* and to the update report, *A Year in State Management Practice for Rebalancing Long-Term Care Systems: Update of Activities in 8 States*, July 2005 to July 2006 are on the CMS New Freedom website, last visited on April 8, 2008 at http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage. A long baseline case study on Minnesota is on the website of the Long-Term Care Resource Center at University of Minnesota, at http://www.hpm.umn.edu/lcresourcecenter/on_going_research/Rebalancing_state_ltc_systems_case_studies.htm.

Driven by the concern that demographic projections render the state's long-term care programs unsustainable, Minnesota is rethinking the government's role regarding long-term care in at least two important aspects. Minnesota aims to reduce the sharp divide between the private and public LTC systems by adopting a "whole population" approach in its long-term care reform efforts. This means focusing not only on the Medicaid component but taking into account the entire LTC system for all people. The state's effort to reform the financing of long-term care, for instance, embraces the whole population approach by stressing personal responsibility for preparing for retirement and old age and for paying for LTC. Similarly, DHS seeks to emphasize helping individuals remain self-sufficient and thus less likely to need public assistance, supplementing the government's long-standing emphasis on providing services and support to persons who are no longer self-sufficient. Strategies for persons with disabilities could include, for example, promoting consumer-owned or controlled housing and expanding employment opportunities. The state as employer could pilot small programs to allow employees to continue to work (part-time) past the mandatory retirement age.

State Initiatives

Update on previously identified state initiatives

Planning initiatives. Minnesota has extended its strong commitment to long-term planning for the aging of its population. Since 2005, the state has initiated or established several additional studies, task forces, and advisory committees that, as with previous efforts, are expected to incorporate input from various stakeholders and draw on as much data as possible to help guide its progress towards a more rebalanced long-term care system. The State also developed an extensive Gaps Analysis process to clarify needs across the spectrum in each county. Among the new planning efforts are:

- Transform 2010 -- a partnership between the Department of Human Services, the Minnesota Board on Aging, the Department of Health and 13 other state agencies to help prepare the state for “the coming age wave of baby boomers.” The purpose of Transform 2010 is to identify the impacts of the aging of our state’s population and to “transform the state’s policies, infrastructures and services so that Minnesota can survive and even thrive as this permanent shift occurs.” The year “2010” was chosen as the target for action because it is the year before the large baby boom generation begins to turn age 65. The initiative’s first product is A Blueprint for 2010: Preparing Minnesota for the Age Wave, incorporating suggestions for actions needed to prepare for an aging Minnesota gleaned from a series of public meetings held across the state in early 2006.² Transform 2010 also repeated parts of the county-by-county GAPS analysis done some years earlier to identify needs and issues at the county level. The new analysis concluded that for the most part services were readily available; however, specific gaps were identified in various counties.
- Long-term Care Financing Reform – a partnership between DHS and the Minnesota Board on Aging. Financing Long-Term Care for Minnesota’s Baby Boomers, a 2005 report to the Minnesota Legislature summarizes the financial issues facing the state as its baby boomer residents age and begin to need long-term care and makes recommendations on what the state should do to preserve Medicaid dollars for those who have exhausted their personal resources and on alternative financing to help those with limited private resources.³ The report emphasizes new financing strategies, including reverse mortgages, long-term care insurance, and other mechanisms that reflect a greater role of individuals and the private sector. Public forums were held across the state in 2005 to further explore the reports recommendations.
- In 2007, DHS created a statewide consumer-directed advisory task force (that included representatives of consumer-directed service users and providers, advocacy organizations and counties) to advise the commissioner on policy, implementation and other aspects of consumer and self-directed services in anticipation of pursuing a federal 1915(j) self-directed waiver option. The task force will advise the DHS commissioner on the following aspects of the development of the 1915(j) option (any future role for the task force will be made at the point of the waiver’s implementation):
 - Implementation plan
 - Quality assurance and risk management techniques
 - Requirements and guidelines for the person-centered plan assessment and planning processes
 - Self-directed plan formats
 - Standards and requirements

² <http://edocs.dhs.state.mn.us/lfsrver/Legacy/DHS-5059-ENG>; a 12-page Summary of the Blueprint is at: <http://edocs.dhs.state.mn.us/lfsrver/Legacy/DHS-5059B-ENG>.

³ *Financing Long-Term Care for Minnesota’s Baby Boomers: A Report to the Minnesota Legislature. January 2005.* St Paul” MN Department of Human Services. On Website at <http://edocs.dhs.state.mn.us/lfsrver/Legacy/DHS-4393-ENG>

- A broad-based “rebalancing task force,” including representatives from DHS, the Department of Health, and other state agencies, as well as from other stakeholder groups (including health plans, provider organizations, and consumers) to prepare a report on long-term care reform for the 2009 legislative session. Whereas many previous efforts (including the Long-Term Care Task Force and the 2001 reform legislation it engendered) proceeded separately for persons age 65+ and for people with disabilities under age 65, more recent planning initiatives relate to both seniors and younger consumers, such as the internal advisory committee to the DHS Commissioner on the 1915(j) waiver option.

Managed Long-Term Care. Minnesota has embraced managed care for both acute care and long-term care. The state has long relied on managed care to cover most of its Medicaid program under a program called Prepaid Medical Assistance Program (PMAP). Since 2005 the state has aggressively moved to expand its Medicaid managed long-term care options. Medicaid enrollees age 65 and older are required to enroll in Minnesota Senior Care (MSC) or, in counties with county-based purchasing plans, through Minnesota Senior Care Plus (MSC+). They also have the option of enrolling in the Minnesota Senior Health Options (MSHO) program, a voluntary program for elderly dually eligible enrollees.

In counties that exercised their option to act as Managed Care County-Based Purchasing agents, seniors in MSC+ are enrolled with the county purchasing organization for their managed care. Effective January 1, 2008, 29 counties availed themselves of that option: 14 were combined in the South County Health Alliance, 13 were combined in the Prime West Health System; Olmstead County (location of Rochester, MN) operated its own Stedfast Health Plan; and a northern isolated county, Itasca, also operated its own plan. State informants note that the county purchasing consortiums seem to be operating efficiently within the capitation rates and achieving surpluses that can be plowed back into county services. Seniors in the remaining 58 counties are required to enroll with a managed care provider operating in their counties.

The evolution to the point that most seniors receive long-term care waiver services through managed care was gradual until it dramatically accelerated in 2007 as managed care providers became more widely available.⁴ Seniors (65+) have been required to enroll in Medicaid managed care for their acute care since 1983 in counties where available health plans are operating. As of March 2008, when the final 4 counties were added, all 52,000 Medicaid seniors are required to choose from managed health plan options available in their counties. . Health plans provide additional member services, transportation, primary care/care system/medical homes, interpreter services, monitoring and facilitation of access to services above what is normally provided in fee for service. DHS contracts with 9 health plans to serve seniors statewide.

MSC covers the same services as PMAP (except prescription drugs for dual eligibles are covered by Medicare part D) and also covers the first 90 days of nursing facility care for enrollees not residing in a nursing facility at the time of enrollment. MSC+, also implemented as of June 1, 2005, adds home and community based waiver services and an additional 90 days of NF care (for a total of 180 days) to the basic MSC benefits. Per legislation passed in 2006, Minnesota Senior Care is transitioning to Minnesota Senior Care Plus, adding Elderly Waiver (EW) and nursing facility services. As of December 2007, MSC+ is operating in 25 counties and is being phased in statewide, and is expected to replace MSC by 2009.

The Minnesota Senior Health Options (MSHO), implemented in 1997, provides a combined Medicaid and Medicare benefit and fully integrates acute and long-term care (as with MSC+,

⁴ Information in the following section is largely drawn from an Elderly Waiver Fact sheet on the DHS website at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_137092, last visited April 11, 2009.

MSHO covers home and community based services and 180 days of NF care). A key feature of MSHO is to match each enrollee with a “care coordinator” who is the enrollee’s primary contact person for both care planning and service access.

The Minnesota Senior Care (MSC) and Minnesota Senior Care Plus (MSC+) programs provide eligible seniors, age 65 and older residing in participating counties, their acute care, home care, Elderly Waiver services and the first 180 days of care in a nursing facility for enrollees who enter a nursing facility after enrollment. MSC+ is similar to MSHO in the long term care services it covers but does not include Medicare services or Medicare Part D drugs. Seniors enrolled in MSC+ must obtain their Medicare Part D drugs through a separate Medicare prescription drug plan. Enrollment in MSC or MSC+ is mandatory. MSC is being phased out as the State moves to MSC+.

The Minnesota Senior Health Options MSHO program integrates Medicare and Medicaid primary, acute, drugs, home care, and other long term care services as well as Elderly Waiver (EW) services and the first 180 days of care in a nursing facility. MSHO plans provide all Medicare services including Part D drugs. Enrollment is voluntary. Enrollees do not pay a premium to join. MSHO experienced dramatic growth in association with the implementation of Medicare Part D. All dually eligible elderly individuals in counties with an MSHO program were passively enrolled to facilitate the coordination of drug coverage. Beneficiaries could decline to be enrolled but few did.

In early 2007, DHS issued an RFP to expand MSC+ to all counties except the seven-county Twin Cities metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington). An additional RFP will be issued in 2008 to expand MSC+ in these seven counties starting January 2009.

Passive enrollment was used widely to distribute Medicaid waiver clients into MSC+. Going forward, except in counties that act as Managed Care County-Based Purchasing agents, enrollment is done through the county Long Term Care Consultation unit, the managed care plans, and tribal authorities.

As of December 2007, most Elderly Waiver services are received through Managed Care. The implementation of this change was accompanied by considerable confusion among county-based case management agencies (called Long Term Care Consultation) though it appears that managed care organizations are purchasing care coordination from former county lead agencies. To date, the State of Minnesota has been unable to receive good information about long-term care expenditures and services delivered under the managed long-term care option. The jury is still out in terms of the cost-effectiveness of the initiative or its effect on quality of care. This topic is also discussed below in the section on “Integration of Acute and Long-Term Care.”

Systematic Modification of Assessment Protocols and Allocation Approaches. Minnesota began developing in 2004 an assessment protocol, including the initial screen to establish eligibility and need for services and the subsequent annual screens to ensure continued functional eligibility, in order to ensure greater consistency across all counties. The effort involved developing standards and protocols, a common data collection tool, and strategies to best utilize the assessment tool to improve the reliability and equity of service provision. The vision was to have a universal assessment process that improves the quality and efficiency of LTC supports. Although the scope of this effort originally only included individuals with disabilities under age 65 it was expanded in 2005 to include older adults. The completed universal assessment tool, now called the Comprehensive Assessment (Minnesota COMPASS), is an automated modular tool that combines population-specific components with those that are common to all populations

and encompasses collecting “initial contact information; the assessment of individual preferences, strengths, and needs; and the development of the support plan. The state intends that the Comprehensive Assessment will ultimately be linked directly to the Medicaid Management Information System (MMIS).⁵

Consumer Directed Community Supports (CDCS). Minnesota expanded its infrastructure and developed related training materials for its Consumer Directed Community Supports (CDCS) program. This further development was undertaken as part of the Cash and Counseling national expansion program, which notes that Minnesota developed an ambitious plan to expand the cash and counseling model beyond the basic Cash and Counseling model, and was awarded additional grant funds to do so. CDCS is available statewide for participants in all the community HCBS waiver programs and for participants in the state-funded Alternative Care Grant program. An elaborate readiness review was conducted to designate fiscal support entity provider services as the consumer’s agent for purposes of obtaining public funds for service budget, employing or paying workers, and paying for other services or goods purchased by the consumer. Consumers can opt to use counselors to help with developing a personal plan and budget and employing personal workers. Some issues have arisen related to the CDCS program:

- Waiver participants (usually in the Elderly Waiver) who live in assisted living settings are not permitted to opt for CDCS as the service model because it is assumed that considerable oversight is needed in Assisted Living and that the fees paid through the waiver encompass this management. Some key informants believe that consumers living in assisted living would benefit by being able to use a CDCS budget to arrange the service component in a more flexible manner.
- CDCS is meant to be available whether participants receive LTC services through fee-for-services or through a managed care organization; CDCS is a required option in Medicaid managed LTC programs. Compared to younger persons with disabilities, relatively few elderly Medicaid enrollees select the consumer-directed option, and it is unclear how well the option is clarified to them by county long-term care consultants and by the managed care

⁵ The Universal Assessment tool is at: <http://www.hcbsstrategies.com/univassess%20current%20version.htm>

organizations themselves. Minnesota began enrolling consumers in November 2004, and by December 2007, they had enrolled 434 consumers, and 278 were recipients of services under the Cash and Counseling budget.

- Persons with developmental disabilities have been using consumer-directed community supports before the program was expanded as a Cash and Counseling Program and became subject to a budget methodology for all CDCS clientele. Some consumers with developmental disabilities received higher allowances and some lower allowances under the new budget methodology, which engendered confusion and concerns among those whose allocations were reduced.⁶

New State Initiatives

- In 2007, the state implemented the Minnesota Long-Term Care partnership, a public/private arrangement between long-term care insurers and Medicaid enabling Minnesotans who have LTC insurance to have the state pay for their long-term care through Medicaid. In return for buying a private insurance policy, individuals are allowed to keep more of their assets if they later enroll in Medicaid. The goal is to give persons greater control over how they finance their long-term care and to help shore up the public safety net against coming demographic pressures.⁷ (As of October, 2007, no insurer had a product that was certified for Minnesota's LTC partnership program.)
- Minnesota's Home and Community Based Waiver Review Process, initiated in 2006, includes detailed reviews of lead agencies that manage the waivers in each of Minnesota's counties. Reviews are staggered, to be completed over a 3 year period. By combining information from site visits, record reviews, interviews, and focus groups, the state contractor's evaluations are designed both to review the extent to which the programs meet the standards of the CMS framework for quality and to identify barriers to community services.⁸
- In September, 2007, CMS awarded a \$500,000 "State Profile Tool" (SPT) grant to the Minnesota Department of Human Services. As 1 of 10 states receiving such a grant, Minnesota will use a shared template (developed for CMS) to complete The State Long-Term Care Profile to "describe the state's long-term care delivery system for seven

⁶ Common questions and answers on the budget allocation issue for CDCS have been posted at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_028431. General information about CDCS is found at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&Redirected=true&dDocName=id_017635. Both sites visited on 4/12/2008.

⁷ The official web site for the Minnesota Long Term Care Partnership is at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ltpc_consumers Last visited January 11, 2008

⁸ Reports by county for the waiver review project are posted on the DHS website at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_136600, last visited on January 7, 2008.

population groups that account for the majority of people who need home and community-based services in Minnesota.”

Goals, Objectives, and Accomplishments

Pursuant to the 2001 legislative framework, in 2003 the Minnesota Legislature required the Department of Human Services to specify and then track progress toward benchmarks (“comparative measures”) for rebalancing the state’s long-term care system. A mandated June 2006 report to the legislature noted steady progress on four benchmarks.⁹ (See Table 1.) On a more global measure, according to a recent CMS report, Minnesota now ranks 4th in the country in rebalancing long-term care -- 60.6% of Medicaid long-term care dollars were expended in community-based rather than institutional settings in FY 2006.¹⁰

Table 1. Benchmarks for Rebalancing Minnesota’s LTC System

Benchmark	2002	2005
Percent of public LTC dollars spent on institutional vs. community care for persons 65+	83.6 / 16.4	79.5 / 20.5
Percent of nursing home residents 65+ with low acuity	19.9	16.7
Percent of Elderly Waiver and Alternative Care recipients with high acuity	37.2	42
Ratio of nursing home beds per 1000 persons 65+	65.7	60.4

Minnesota’s twin goals of expanded community care and increased personal financial responsibility are joined in DHS’s goal statement: “Older Minnesotans will receive the long-term care services they need in their homes and communities, will be able to choose how they receive services, and will have more options for using their personal resources to pay for long-term care.”¹¹

⁹ Department of Human Services. June 2006. *Status of Long-Term Care in Minnesota 2005: A Report to the Minnesota Legislature*. Minnesota Department of Human Services, Aging Initiative. St. Paul, MN: DHS.

¹⁰ *CMS 64 data*, Center for Medicaid and State Operations, Division of Financial Operations, August, 10, 2007

¹¹ See Department of Human Services Website at <http://www.departmentresults.state.mn.us/hs/index.html>, last visited January 7, 2008.

State Organization

The umbrella Division of Human Services (DHS) is organized around 5 functions, each constituting an organizational unit under the leadership of an Assistant Commissioner of DHS: Health Care, Continuing Care, Children and Family Services, Chemical and Mental Health Services, and Operations. Agency-wide functions in external relations, communications, tribal relationships, and county relationships serve all the operational units.

Most long-term care and long-term support services are integrated into Continuing Care, which is comprised of 4 operational divisions: Aging and Adult Services Division, Nursing Facility Rates and Policy Division, Disability Services Division, and the Deaf and Hard of Hearing Division. Also under Community Care is Planning and Project 2030, mentioned above, which analyzes the impacts of the aging of Minnesota's population and creates momentum within all sectors to prepare for the demographic shifts that will culminate in 2030 when the first baby boomers begin turning 85. Thus, the State Unit on Aging functions are integrated into the Aging and Adult Services Division, and the nursing home program falls under the same Assistant Commissioner as the HCBC services. With the opening of a new building near the state capitol in St. Paul, the Aging and Disability Services divisions have been collocated and key informants indicate that they are able to collaborate much more closely because of this proximity.

Points of organization disconnection do exist, however. The managed long-term care initiative for seniors falls under the Assistant Commission for Health in the Division of Managed Care and Payment Policy. Given that this implementation has had a major impact on planning for community services for older people, some key informants expressed frustration that the planning is not more closely done under the Continuing Care unit. Also programs falling under

the Assistant Commissioner for Chemical and Mental Health Services are integral to permitting people with disabilities to live in the community so coordination is also needed with that unit.

Access

Under the aegis of the Aging and Disability Resource Center, the State of Minnesota is trying to improve the information available to consumers about community long-term care programs. Minnesota has added to its portfolio of instruments to enhance consumer decision making. In 2006, the state implemented (using ADRC funding) its computerized consumer information system to help inform consumer decisions. MinnesotaHelp.info is an evolving, web-based assistance system for helping seniors and families decide about long term care supports by ascertaining what their needs are, finding services to help meet those needs, and making connections with those services. Long-term Care Choices is a step-by-step, web-based, decision-making tool available on the MinnesotaHelp.info Web site that helps seniors and their caregivers figure out what they need to live well and age well; it guides them to resources in their community, and creates an individualized plan Web-based self-assessments and decision-making tools have been developed for this purpose.¹² Nonetheless, access to services is somewhat complicated by multiple lead agencies in each county (Long-Term Care Consultation, Developmental Disability Lead Agencies, managed care organizations, and, when applicable, tribal authorities.) In 2008, DHS commissioned the Wilder Foundation to conduct a study in how consumers reach decisions about long-term care; originally construed as a study of decisions about assisted living; the focus has been broadened to all long-term care options. Results are expected in 2009.

¹² For more detail about Minnesota's efforts, see Topic Paper # 4, *State Long-Term Care Support Systems to Promote Informed Consumer Decisions: Information Provision, Decision Tools, and Options Counseling* by Rosalie Kane, Reinard Priester and Robert Kane, December 2007, available on the web, last visited April 12, 2008 at http://www.hpm.umn.edu/ltrresourcecenter/on_going_research/Rebalancing_state_ltc_systems_topic_papers.htm.

Array of Services

Minnesota continues to offer a wide array of services through 5 HCBS waivers, the State Medicaid Plan, and an Alternative Care state-funded program for those ineligible for Medicaid. An effort is being made, as described in an earlier section to integrate Consumer Directed Community Supports as an option across all waivers and programs. The scope of consumer direction in LTC remains uncertain, however, due, in part, to the lack of a consensus on the level of risk that we, as a society, are willing to accept for others. According to DHS officials, public LTC programs have yet to find the appropriate balance between respecting individual autonomy and choice and the public's desire for protection of vulnerable individuals and accountability for public expenditures. Thus, for example, these officials are leery of expanding, without additional protections or oversight, consumer directed programs to vulnerable individuals, such as persons with advanced dementia, for whom decisions are made by proxy.

Quality

Minnesota has embarked on a series of inter-related quality assurance efforts for long-term care, adhering to principles of consumer engagement in the process. Initiatives to manage and improve the quality of long-term care in community-based and institutional settings include:

- Nursing Home Report Card— an interactive web-based program developed jointly by DHS and MDH providing consumers with information on all Medicaid-certified nursing homes to allow consumers to comparison-shop. The Report Card provides scores, using a 5-point system, on 8 quality measures that the consumer selects as most important. The quality measures are:
 - Quality of life and satisfaction
 - Clinical process and outcomes
 - Amount of direct care staffing
 - Direct care staff retention
 - Direct care staff turnover
 - Use of temporary staff from outside pool agencies
 - Proportion of beds in single bed rooms

- Inspection findings from certification surveys¹³
- DHS developed an innovative payment system for nursing homes that used the 8 quality measures to create a score that would affect each home’s payment after adjustments for case mix.¹⁴ The proposal was not adopted by the legislature, however. Instead a “quality add-on” payment to nursing home payment rates was introduced as an initial step to link payment to quality. The add-on payment is based on 5 of the 8 quality measures of the NH Report Card.
- A Performance Incentive Program has been operating since 2007 under which nursing homes submit proposals for quality improvement projects. If accepted they are funded with additional payments (up to 5% of the facility’s base rate). Each project must have an evaluation plan that uses the quality measures developed for the Report Card.
- The Region 10 Quality Assurance Commission, highlighted in the baseline report, was established by Minnesota Statute (256B.095) in 1997 to develop and implement an alternative quality assurance licensing system for MR/DD programs in an 11-county region in southwest Minnesota. The program continues with strong support from stakeholders, including clients and their families. In 2005, the Legislature renewed this modestly-funded program and gave it the mandate to expand. Despite interest in other areas of the State, however, the model has not been fully replicated elsewhere.
- In response to a 2005 Legislative request for a study of local and regional quality assurance models for home or community-based services, the DHS established a Quality Assurance Panel of “citizen experts” and charged it with responsibility to recommend an approach to quality assessment and management of HCBS and related disability programs. In its 2007 report to the Legislature, the QA Panel recommended adoption of five key components of a reformed statewide quality assurance program
 - A State Quality Commission
 - Regional Quality Councils
 - Annual independent statewide survey of a sample of service recipients
 - An outcome based quality assurance program
 - An effective program of incident reporting, investigation and analysis¹⁵
 - Quality System Architecture—a DHS-led initiative that developed business process maps for all 5 waiver programs supporting, respectively, older adults, adults and children with physical disabilities, adults and children with developmental disabilities, adults and children with traumatic brain injuries; and seriously ill or disabled adults who need the hospital level of services. .

¹³ *The Nursing Home Report Card* home web page is at: www.health.state.mn.us/nhreportcard

¹⁴ Kane, R. L., Arling, G., Mueller, C., Held, R., & Cooke, V. (2007). A quality-based payment strategy for nursing home care in Minnesota. *The Gerontologist*, 47(1), 108-115.

¹⁵ *Quality Assurance in Minnesota 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel (Final Report)*. February, 2007. <http://rtc.umn.edu/docs/QAPanel-Final2-19-2007.pdf>

Housing and Housing-with-Services

Assisted living in Minnesota is based on the concept of “housing with services.” In this setting, residents rent the “housing” from one entity and purchase (from the same or different entity) assisted living “services.” Assisted living has grown rapidly in Minnesota and even though only 5% of AL is public funded, it is the fastest growing portion of the state’s Elderly Waiver. Assisted Living is now at a crossroads DHS officials are unsure if the AL facilities in MN will become the new nursing facilities or “homes” with services. Key informants also expressed concern that many privately paying assisted living residents have spent down to Medicaid and need to relocate, prompting questions about the kinds of information seniors receive in the first place about what is covered in the base rate and the likely increase in charges as their care needs increase.

In 2006, Minnesota enacted chapter 144G, Assisted Living Services, a “branding bill” that restricts the use of the words “assisted living” to providers who meet certain criteria.¹⁶ These criteria do not align with services covered under the Elderly Waiver, resulting in a name change from assisted living to “customized living.” The definitions and components of customized living service are the same as those of the former assisted living. Customized living requires that clients have an “individualized” service plan based on their documented needs. The consumer may choose which of their needs will be addressed by customized living, by quasi-formal supports, by informal supports or by other services on the Medicaid state plan or the EW menu. To provide EW customized living, providers must meet all standards in EW but do not need to

¹⁶ See: http://www.revisor.leg.state.mn.us/bin/getpub.php?pubtype=STAT_CHAP&year=current&chapter=144G

meet the requirements of 144G if they do not use the term “assisted living” to describe or market their service.¹⁷

Since “individualized” means that services are chosen and designed specifically for each client’s needs, Minnesota Statute (section 256B.0915) was amended to require that rate negotiations for customized living services must be conducted within the parameters established by the DHS commissioner, including, for example, that the negotiated rate must a monthly rate and be based on the services to be delivered, not on the individual’s assessed needs or a base rate established by the provider. Among the shortcomings with Minnesota’s Housing with Services program that DHS officials identify are:

- A section of the Assisted Living Services legislation (Chapter 144G) required the Minnesota Department of Health to develop a uniform format for a “consumer information guide.” The consumer guides, completed by each assisted living provider, would include information about “services offered by that provider, service costs, and other relevant provider-specific information, as well as a statement of philosophy and values associated with assisted living, presented in uniform categories that facilitate comparison with guides issued by other providers.” However, the regulations Developed by MDH do not require assisted living providers to specifically disclose the “base rate” for housing, i.e., the rent portion, which is not negotiable and not covered by Medicaid. Thus the guides meant to inform consumers’ decisions about assisted living do not disclose to clients who spend down to Medicaid eligibility the amount of rent for which they are responsible.
- The established sets of complex laws and regulations, such as landlord-tenant law and “fair housing” regulations, govern many aspects of assisted living and other long-term care housing alternatives, rendering such housing very complicated for consumers and their families.
- Contrary to most social services, there is not an administrative agency to resolve housing problems, forcing residents to go to court for redress – typically a more complex, lengthy and costly resolution.

Legislation in 2006, effective October 2008, requires housing with services establishments that provide AL to inform all prospective residents of the availability of “transitional

¹⁷ “24-hour customized living” is an individualized package of component services that, for a person living in a qualified setting, adds to the customized living components 24 hours of supervision of the person, provided in a way which is designed to meet that person’s documented, assessed needs.

consultation services.” These services are to help persons make informed choices among housing options that include “the most cost-effective and least restrictive settings and to delay spend-down to eligibility for publicly funded programs by connecting people to alternative services in their homes before transition to housing with services.”

Future of Nursing Homes

Minnesota has several programs explicitly designed to control the size of its nursing facility industry. A statewide moratorium on new nursing facility construction has been in effect since 1984. Minnesota’s voluntary Planned Closure Program has given nursing facilities financial incentives to voluntarily close beds since its implementation in 2003. Under this program, the state is closing NF beds at the rate of 1000/year. In 2005 the single bed incentive program was introduced. In addition to the planned closure payment, facilities got an additional rate increase if the closed beds yielded more single rooms.

Another strategy resulting in permanently closed beds is Minnesota’s “lay-away” program, which provides incentives to nursing facilities to temporarily close beds on a voluntary basis. With more stringent eligibility requirements the number of “lay-away” beds has declined from more than 2,500 in early 2003. Nonetheless, a substantial proportion of beds initially placed on lay-away are ultimately closed. Minnesota does not pay for beds on “lay away” unless the facility’s occupancy rate is 93% or more.

The state continues to fine-tune its nursing home planned closure program (which has so far, according to DHS, taken the “easy beds” out of the system), seeking to ensure a proper balance in the supply of beds and facilities. A priority for DHS is to articulate the future of the nursing home in Minnesota’s restructured LTC system, viewed by the department as both a qualitative and quantitative issue. For the quantitative dimension, the state has offered preliminary

projections for the future size of the nursing home industry. Combining the projected bed availability based on changes in the number of beds with the projected bed need, based on changing utilization rates of NH services (for both 65+ and 85+ age groups) and population estimates, the Department “cautiously” concluded that if present trends and policies continue (including the state’s three incentive programs to reduce nursing home beds), “a shortage of beds is unlikely to be seen, except in isolated regions of the state, before about 2015.” (cite 2006 report to the Legislature)

Despite Minnesota apparent success in right-sizing its nursing home industry, and nationwide publicity about this program, the state’s approach has not been adopted elsewhere. The unique combination of historical factors – historical oversupply of beds, high occupancy rates, single rate for all private and public payers, large not-for-profit sector – and political and economic environment may make this bed reduction program hard to replicate elsewhere.

Capacity reductions in institutional care for persons with MR/DD followed a different path. The closure of state institutions has played out over four decades, accelerated by legal challenges and involving the interactive roles of press, elected and executive leadership, court monitors, community advocates, and University-based personnel. The strongest obstacle to this progress was the employees union for the state institutions.

Integration of Acute and Long Term Care

As discussed above, Minnesota has moved aggressively to expand managed long-term care, both for persons age 65 and older and persons under age 65. As of November 2007, 49,000 of the state’s elderly Medicaid enrollees were enrolled in managed care -- MSHO enrollment was about 38,000 (including over 9,000 seniors in the Elderly Waiver program), compared to a combined enrollment in MSC and MSC+ of about 11,000. Among the state’s future plans are to

require the EW enrollees still in FFS (about 9% of enrollees in June 2007) to participate in managed care.

Minnesota also has two voluntary managed care programs for Medicaid enrollees under age 65. Patterned after MSHO, the Minnesota Disability Health Options for persons with Physical Disabilities (MnDHO - PD) integrates Medicare and Medicaid financing, provides all Medicare and Medicaid acute and LTC care services (HCBS and NF), and assigns a “health coordinator” to each enrollee. Eligibility is limited to physically disabled adults and the program is available only in the 7-county Twin Cities metro area, with no plans for expansion despite legislative authority to do so. As of November 2007, MnDHO enrollment was about 900. Distinguishing feature of the program include its development with significant input from consumers with physical disabilities and inclusion of enrollee self-direction among its 6 core principles of program design; namely, “the managed care system strives to include a maximum level of enrollee choice and self-direction.” The Developmental Disabilities pilot project, MnDHO – DD, enrolls adults between ages 18 - 64 with developmental disabilities and began operation in 3 Twin Cities metro area counties in February 2006. All services, including Medicaid, Medicare and home and community based waiver services, are provided by a fully capitated private managed care organization.

Although the disability community in Minnesota remains concerned that managed care organizations may not have the requisite expertise to provide or assure access to non-health care services, representatives of the community continue to work with the state in developing new managed care products for persons with disabilities. Through participation on the Special Needs Basic Plan Advisory Committee, the disability community was directly involved in the development of Special Needs BasicCare (SNBC), a new voluntary managed care option for

adults with disabilities that will be available in most Minnesota counties beginning January 1st, 2008. SNBC will integrate Medicare and basic state plan Medicaid services. People on HCBS waivers may also enroll in SNBC; however, they will continue to receive waiver services and targeted case management on a fee-for-service basis.¹⁸ Table 2 provides an overview of Minnesota's Medicaid managed LTC programs.

Table 2. Overview of Minnesota's Medicaid Managed LTC Programs

Managed care program	Population	Year established	Voluntary or Mandatory	Enrollees	Service area	Benefits (HCB, Waivers, LTC, PCA)
MSHO	Seniors	1997	voluntary	38,009	Statewide	PCA, EW, 180 days NF
MSC	Seniors	2005	mandatory	9,850	Statewide (Phased out by 2009)	PCA, 90 days NF
MSC+	Seniors	2005	mandatory	1,086	25 counties (statewide by 2009)	PCA, EW, 180 days NF
MnDHO – PD	Persons with physical disabilities or chronic illness		voluntary	750	7 metro counties	PCA, CAC, CADI, TBI, 180 days NF
MnDHO – DD	Persons with DD	2006	voluntary	120	3 metro counties	PCS, DD Waiver, ICF-MR
SNBC	Adults with Disabilities	2008	voluntary	Begins 1-08	Statewide	HCB and LTC services remain FFS

Minnesota is the only state in the Rebalancing Research group without any PACE (Program for All-Inclusive Care for the Elderly) activity. Such programs coordinate and provide all needed preventive, primary, acute and long term care services so that older individuals can continue living in the community on a capitated basis and constitute an innovative model that enables individuals who are age 55 or older and certified by their state to need nursing home care

¹⁸http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_139506. Last visited January 30, 2008.

to live as independently as possible. PACE programs tend to enroll relatively small numbers of participants in a geographic area, they are characterized by staff model physician service and use of adult day health centers as an organizing focal point, and the PACE program is fully at risk for all acute and long-term care services in all settings with the capitation payments they receive from Medicare and Medicaid. During 2004, the DHS received a CMS-funded, PACE technical assistance grant. The purpose of the grant was to educate state staff and providers within Minnesota and to encourage development of one or more PACE programs in Minnesota. The 2005 special legislative session passed PACE enabling legislation—conditional on obtaining outside funding to cover additional DHS expenses to administer PACE for the biennium. As of this writing, such outside funding has not been obtained. Although PACE programs seems quite compatible with the state-wide initiative to bring all seniors into managed care, there is considerable resistance from some quarters because PACE represents a more totally integrated model than the current predominant managed care vehicle, MSHO. It differs in two important respects: 1] it consolidates medical care in the hands of PACE physicians, thereby increasing the coordination of medical and social care. 2] It covers all of the nursing home costs for enrollees. By contrast, MSHO was designed to minimally disrupt the way medical care was being delivered. Some informants believe that PACE should be added to the repertoire in Minnesota to demonstrate a different model with acute care and long-term care more closely aligned and incentives more clearly against nursing home use.

Conclusion

Minnesota's recent effort to reduce differences in LTC policies and programs for people with disabilities based on whether they are under or over age 65 was directly aided and reinforced by the relocation of the aging and disability divisions in the new DHS headquarters building. Due

to the new level of cooperation this move engendered, programs or policies (such as Consumer-Directed Community Supports, universal assessment, and budget methodologies for individual service plans) that previously applied to only one population now apply to persons of all ages. Still, some differences remain: Medicaid managed long-term care will be mandatory for persons over age 65 on Medicaid but voluntary for most persons with disabilities under age 65.

Minnesota stands out because of its “whole population” planning focus for long-term support, regardless of payment status. Minnesota has also successfully used state policy levers to downsize and improve privacy and quality in its nursing homes. To address quality and consumer choice, the State has emphasized consumer information. A consumer report card system now operating for nursing homes will be expanded to assisted living and in-home programs. The State remains a generous one in its level of funding for both community and institutional long-term supports. Challenges exist for the State in developing an information system to manage a complex operation with considerable delivery through managed care, and also in developing an access system that is clear to consumers and equitable across counties and target populations.