

**Rebalancing Long-Term Care Systems in Minnesota:  
Experience up to July 31, 2005**

**Abbreviated Report**

submitted to the

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The overall project 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. The 3-year study calls for case studies of the experience of 8 states—other states in the study are: Arkansas, Florida, New Mexico, Pennsylvania, Texas, Vermont, and Washington. The baseline case study covers a period through July 31, 2005. Updates will be prepared for the period ending July 31, 2006 and 2007.

A slightly earlier version of this Abbreviated Report was presented for discussion at a CMS Open Door Forum, February 22, 2006. 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 Division, Minnesota Department of Human Services.

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## Re-Balancing Long-Term Care Systems in Minnesota: Abbreviated Report

### Highlights

Minnesota ranks high among states in its per capita expenditures on HCBS services; at the same time, Minnesota invests heavily in its nursing homes.<sup>1</sup> Overall Minnesota spent 56% of its Medicaid long-term care dollars on HCBS, ranking 5<sup>th</sup> among states on this measure. Minnesota's expenditures per capita were in the top 5 for most HCBS categories, including 5<sup>th</sup> highest for per capita waiver expenditures for aging and disabled consumers, 3<sup>rd</sup> for HCBS under MR/DD waivers, 2<sup>nd</sup> for total home care per capita (combining waiver, Medicaid home health, and Medicaid personal care, and 1<sup>st</sup> in overall waiver expenditures. Putting this together with its institutional expenditures on nursing homes and ICF-MRs, Minnesota was 4<sup>th</sup> in overall LTC Medicaid dollars expended per capita (\$550).

Minnesota has a strong commitment to long-term planning; various contracted research reports and landmark internal studies help guide its progress towards HCBS. The work proceeds in two rather separate streams: one for aging, and the other for people with disabilities under age 65. On the aging side, the efforts include an informative analysis of specific gaps in services (including housing) on a county by county basis. Recent initiatives related to both seniors and younger consumers have also been informed by a strong commitment to providing consumers with information to make better decisions.

The highlights in this case study include:

- Minnesota created financial incentives for nursing homes to close or downsize, including converting multi-bedded rooms to private rooms.
- Earlier than most states, Minnesota began a steady process of closing its state institutions for MR/DD in the 1970s, making financial settlements with state MR/DD institution staff, developing some state-run small group homes, and creating a rich mix of supportive services. This process was completed in 1999.
- Because long-term support programs under Medicaid operate through 87 independent county governments in Minnesota, the State has been challenged to achieve better accountability and equity across geographic areas and target populations, while also promoting individualized budgeting and service planning. Initiatives to rationalize the system include developing a universal assessment for 4 of the 5 HCBS waiver programs, improving individual budgeting mechanisms, redesigning case management, and restructuring the allocation mechanisms for state budgets.

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<sup>1</sup> This abbreviated report is a synopsis of a much longer report on rebalancing long-term care systems in Minnesota, performed under contract between the University of Minnesota and CNAC Corporation through a Master Contract between CMS and CNAC. The full-length report, which contains organizational charts, references, and much more detail, appear on the website [HCBS.org](http://www.hcbs.org) and on the University of Minnesota Principal Investigator's Website <http://www.hpm.umn.edu/LTCResourceCenter/>. Similar abbreviated and full case studies have been prepared for the States of Arkansas, Florida, New Mexico, Pennsylvania, Texas, Vermont and Washington; subsequent reports will update the information as of July 2006 and July 2007.

- Minnesota introduced mandatory Medicaid managed care (called Prepaid Medical Assistance Program, or PMAP) for acute care in 1985, and in 1997 developed an integrated managed care system using Medicaid and Medicare dollars for dually eligible seniors through a program called the Minnesota Senior Health Organization (MSHO). Legislation enacted in 2004 called for all services delivered under Minnesota's Elderly Waiver (EW) to be transferred to a mandatory managed care program and expanded prepaid coverage for nursing homes to include the first 180 days as of October 2005.
- Minnesota has developed an infrastructure and related training materials for Consumer Directed Community Supports (CDCS). CDCS options are available for all target populations, including for consumers who receive their long-term care through a managed care entity rather than fee-for-service; the state requires managed care organizations to offer the CDCS options.
- Case managers within the system for older people have been re-named Long-term Care Consultants, and are charged with assisting consumers to make informed choices from an array of options. The state has sponsored an effort to generate data-based information to bring to bear on those options.
- Minnesota's assisted living capacity is built on the concept of "housing with services." To that end, the state licenses the service providers under various home care licenses rather than licensing the housing-with-services buildings per se, and encourages collaborative arrangements between housing entities and outside agencies. An Assisted Living and Assisted Living Plus benefit was developed under HCBS waivers to allow people to age in place in existing low-income housing as well as to move to purpose built housing with services entities. This approach has required adjustment as the state discovered that Assisted Living services were accounting for increasing proportions of elderly waiver dollars, not necessarily serving a population with the greatest impairment, and accounting for high unit costs.
- Minnesota has made a marked push for information-driven decisions, attempting to use market forces and informational report cards to enhance consumer decision making. Using the Real Choice System Change Grant resources, a computerized consumer information system to help inform the choices of seniors has been developed for implementation in the next calendar year.

### **Context**

- Minnesota operates a rather separate track for HCBS programs for elderly people versus all people under age 65. Although the top administration of all long-term care (HCBS and nursing homes for all populations) is unified under an Assistant Commissioner of Continuing Care in the umbrella Department of Human Services, the policies, programs, and planning for consumers are quite distinct for those over and under age 65.

- Minnesota is comprised of powerful county governments with historical responsibility for long-term care. In Minnesota, Medicaid and social service programs are county-administered, state-supervised programs. Thus, at the local level, the state works with 87 counties, as well as several tribal jurisdictions and health plans (for those in capitated programs).
- The Aging Network (in Minnesota, the State board on Aging) plays a limited role in long-term care.
- Historically high supply of nursing home beds.
- A largely non-profit nursing home industry that is diversifying towards HCBS.
- The *Welsch* law suit, initiated in 1972, over alleged poor conditions in the state mental retardation institutions and a consent decree in the 1980s laid out expectations for HCBS for consumers with mental retardation and related conditions.
- Within Minnesota, receptivity to managed care for both acute care and long-term care is high.
- Minnesota has historically shown a strong emphasis on protection of vulnerable children and adults, and has invested in multiple ombudsman programs.
- Minnesota emphasizes assuring quality of care, especially in institutions, which has recently led to the development of a proposal for a Value-Based Reimbursement System for nursing facilities, and which includes direct independent surveys of residents' satisfaction and quality of life.
- The more recent context includes commitment to lean government, tax relief, and pursuing market solutions to long-term care issues, such as long-term care insurance, reverse mortgages, and estate recovery, and personal responsibility.
- The state affiliates of both the American Association of Homes and Services for Aging and the American Health Care Association collaborated in support of a "Long-term Care Imperative" that includes development of HCBS. The AASHA affiliate is called the Minnesota Health and Housing Alliance (MHHA) in recognition of this direction as well as the reality that MHHA has more housing with services and community care members than it does nursing homes.

## **Real Choice System Change (RCSC) Grants**

Minnesota received seven RCSC Grants totaling \$5,139,136 from 2001-2004.<sup>2</sup> The themes of choice, improved information, and consumer direction are evidenced in all the grants, including the C-PASS grant explicitly aimed at an infrastructure for consumer directed support services, the Nursing Home Transition Grant, and the Aging and Disability Resource Center grant. Products tend to include manuals, web-applications, and training sessions. Centers for Independent Living are integral to several of the project. Housing officials are also integrated into many of the grants, with the Nursing Home Transition Grant paying particular attention to housing issues. Several of the grants focus on Hennepin County, building capacity in the most populous part of the State. The grants have led to operational programs. For example, in the 2001 System Change proposal, the writers stated that Minnesota had “a comprehensive set of traditional prescriptive services” and a “partial patchwork of consumer-directed service options.” They aimed to make consumer-directed service options available through all programs for all target groups, and indeed modified all its waivers to achieve that outcome in 2004.

## **Programs and Services**

Minnesota operates 5 HCBS waivers. In Fiscal Year 2003-2004, the Elderly Waiver served 14,984 consumers over age 65; the MR/RC waiver served 14,532 children and adult consumers with mental retardation and related conditions in 2004; the Community Alternatives for Disabled Individuals (CADI) waiver served 7,424 children and adults with disabilities in 2004; the small Community Alternative Care (CAC waiver) served 159 children and adults with serious illnesses requiring hospital level of care; and the newest Traumatic Brain Injury (TBI) waiver, which expanded rapidly, served 1,196 children and adults with acquired brain injuries. Additionally, 1,513 Elderly Waiver consumers received long-term care through enrollment in the Minnesota Senior Health Network (MSHO) program. Minnesota’s Medicaid State Plan also funds substantial home health care in its mandatory services and a large state option program of personal care/private duty nursing. Minnesota has long maintained a state-funded program called Alternative Care (AC) for elderly people whose income and assets are within 6 months of spend-down to nursing home level. (Expenditures on AC are going down due in part to two policy changes: first, applying liens on houses to those on the AC program, and second, a 2005 change that prohibited use of AC to fund services for participants in assisted living settings.) These multiple sources of funding are used to support a wide array of services, including community group living arrangements.

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<sup>2</sup> Minnesota received a System Change Grant (\$2.2 million) in 2001 to create “Pathways for Choice,” an infusion of consumer-directed options through all State programs, and a Community-Integrated Personal Assistants Services and Supports (C-PASS) grant (\$900,000) to develop and sustain a high quality personal care assistant work force. In 2002, the State received a Nursing Facility Transition Grant (\$400,000), through which one of the Centers for Independent Living developed a structure and material to help consumers leave institutions. In 2003, the State received a Quality Assurance/Quality Improvement Grant (\$499,880), which it used to develop processes and procedures for mental retardation and related conditions; and an AoA Aging and Disability Resource Center grant (\$739,136), which is being used to pilot four Centers in Hennepin County (Minneapolis). In 2004, the State received a Mental Health Transformation Grant (\$300,000), which it is using to develop an evidence-based program of mental health services for children with serious mental illnesses.

## **Featured Management Approaches**

### **Incentives to Downsize Nursing Home Industry**

In a proactive effort to downsize nursing homes, the Minnesota legislature created a Voluntary Planned Closure Program to give nursing facilities financial incentives to voluntarily close beds under an approved application process. The legislation capped the number of closures at 5,140 beds. By 2004, about 4,900 applications for closed beds had been approved by DHS, with approximately 3,300 beds actually closed statewide (nursing facilities can choose not to close beds after receiving approved applications). About 20 nursing facilities closed altogether. This “planned closure” program is unique to Minnesota.

Minnesota also implemented a “lay-away” program that gives incentives to nursing facilities to temporarily close beds on a voluntary basis. A bed on “lay-away” status must remain in the program a minimum of one year and a maximum of 5 years. This approach has been a route to permanent closure. As of early 2003, 2,519 beds had been placed on lay-away status. After 2004 the program had to show budget neutrality and the costs of the services provided through HCBS to those not housed in the closed beds had to be considered. Consequently, fewer than 1000 beds have been placed on “lay away” since 2004. Minnesota does not pay for beds on “lay away” unless the facility’s occupancy rate is 93% or more.

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.

### **Deinstitutionalization for Mental Retardation/Related**

The closing of state MR institutions in Minnesota played out over at least four decades, accelerated by legal challenges and involving the interactive roles of press, elected and executive leadership on a bipartisan basis, court monitors, community advocates, and University-based personnel. The strategic approach included comprehensive planning; creation of a Governor’s Council on Developmental Disability (GCDD) in 1971 with 60% representation of persons with developmental disability or their family members, which was charged with becoming a focal point for advocacy, planning, and education efforts; drawing down whatever federal dollars were possible, including construction money in the 1970s and HCBS waiver money beginning in 1984; through the GCDD, supporting educational programs to enhance self-advocacy, including Partners in Policy-Making (an innovative training program begun in 1986, which has served as a national model); and deciding strategically to complete deinstitutionalization of children first. The strongest obstacle to this progress was the employees union for the state institutions. Notably, the State decided to disarm the opposition and utilize the expertise of these state personnel by creating a program of State Operated Services (SOS), through which the State operated community ICF-MRs and used State personnel to provide specialized treatment on a regional basis. Currently this SOS program is the vehicle for overall mental health services, including mental health services for persons with MR/DD, and also continues to operate a few ICF-MRs. In 2004, the State operated 16 of Minnesota’s 283 ICF-MR facilities, all but one of which were in the 4-15 person size range.

### **Consumer Directed Community Supports**

Minnesota began implementing a Consumer Directed Community Supports option within the Mental Retardation/Related Conditions (MR/RC) waiver in 1998, beginning in 3 counties and expanding over a 5 year period to 37 counties and more than 3000 consumers. In 2003 a Legislative Audit report flagged issues with the CDCS program, including that average costs exceeded average costs in the regular waiver program. Still, in 2004, CDCS was expanded to all 5 HCBS waivers, the Alternative Care Grant program (a state-funded program for older people who are not yet financially eligible for HCBS waivers), and 2 managed care plans offering waiver services. To control costs, program changes included requiring a new structured community support planning process with prior approval from the responsible county, tribe, or health plan; applying budget caps at 70% of the comparable regular waiver plan; prohibiting use of CDCS if the consumer lived in any licensed residential setting; prohibiting combining CDCS with other services paid directly; and introducing more accountability from the counties. At that point, the use of CDCS declined in the MR/RC waiver, partly because of consumers who lost eligibility, and partly because some consumers were unable to get sufficient services to meet their needs under the caps. During 2004, the State solicited Fiscal Support Entities (FSEs) to serve one or more functions: fiscal conduit, payroll, or agency with choice. Consumers pay different fee schedules from their allocations depending on their choice and the agency's prices. Consumers could also purchase "flexible case management" if they wished more help with their plans.

### **Long Term Care Consultation**

Minnesota has modified a prescriptive case management approach into a consultative approach wherein the Long Term Care Consultant (LTCC) assists consumers in choosing the services that best meet their needs. The LTCC process has replaced Minnesota's long-standing pre-admission screening program; consultants conduct the screenings required by state law before any Minnesotan enters a Medicaid-certified nursing home or boarding home. A nurse-social worker team serves as the LTCC. Any Minnesotan may request a Consultation free of charge. Through the Aging and Disability Resource Center, Minnesota has piloted a web-based decision tool that allows the consumer to enter his or her own profile of need and helps the consumer and the consultant consider local options. Educational materials about the LTCC emphasize the wide availability of community options and explicitly recommend considering them before a nursing home. LTCC is the mechanism to learn about services except for the MR/RC waiver, which has its own consumer screening process. In general, an array of web-based tools, including the Senior *LinkAge Line* established in 1994, the *Disability Linkage Line*, established in 2004, and the *Family Linkage Line* under construction, are all meant to provide information to consumers.

### **Universal Assessment and Related Initiatives**

In 2004, Minnesota began developing a universal assessment protocol that could be used to gain consistency and equity across all counties and all populations under age 65 with disabilities. Working with an advisory group including consumer and provider stakeholders, the planned assessment will ascertain consumer preferences, emphasize strengths and competencies as well as needs, include an employment segment, be organized in modules, and be computerized to assist counties "to manage quality and costs in real time." The State also envisages an individual

community supports planning process that is better tied to the assessment results, and a common service menu. With reference to the M/RC waiver, the State aims by 2007 to implement a new aggregate budgeted allocation system by which the State allocates funds to the Counties for the waiver. The funding of and quality assurance for case management itself is also under review. Minnesota spent approximately \$200 million for case management in 2004, some of it through targeted case management in the Medicaid state plan and some through the waivers. A recent report to the legislature suggested some redundancy in case management. These system-improvement initiatives at this time do not include the Elderly Waiver.

### **Managed Long-Term Care Initiatives**

In the 1980s, Minnesota introduced managed care for regular state plan Medicaid services to all its Medicaid populations (including most elderly people for components not covered by Medicare) through its Prepaid Medical Assistance Program (PMAP). From that base, Minnesota was early attracted to the concept of merging acute care and long-term care for dually eligible people into a single plan to achieve better coordination between Medicare and Medicaid covered services, between health care and social services, and between acute care and long-term care. The MSHO (Minnesota Senior Health Options) and MnDHO (Minnesota Disability Health Options) programs represent efforts to bring the management of medical conditions and chronic illness under the same coordinated entity that manages long-term care. They also illustrate how difficult it is to truly effect change in established health systems and to establish capitation schemes that benefit government agencies while attracting HMOs. MSHO's initial consumer base was largely comprised of persons already in nursing homes. MSHO is responsible for all health care covered by Medicare or Medicaid, but is liable for only 180 days of nursing home stays. MnDHO is responsible for all health care except prescription drugs. In MSHO, the combined Medicare and Medicaid capitation is held by Health Care Plans, which in turn contract with Care Management Organizations for service coordination and deliver.

Partly in anticipation of the potential chaos of introducing Medicare Part D and partly because it believed in potential cost savings, in 2004 the Legislature enacted a bill requiring that all Medicaid enrollees over age 65 be in a managed care plan for their long-term care by October 2005. Seniors may join MSHO as one way of fulfilling that requirement. Effectively, this new policy will require massive realignment of the county-based entry and case management system.

### **Quality Initiatives in HCBS and Nursing Homes**

Minnesota has undertaken a series of inter-related efforts to manage and improve quality in all its HCBS and long-term care services, while adhering to principles of consumer engagement in the process. Minnesota's HCBS Quality Assurance Plan is built around the CMS framework and is organized around focus areas, namely: access, services planning and delivery, provider capacity, participant health and safety, participant satisfaction and outcomes, and systems performance. The county or tribe has pivotal responsibilities in carrying out the quality monitoring, and, in turn, DHS is striving to create data bases that permit ready monitoring.

In the nursing home sphere, in 2001 the Legislature encouraged DHS to develop recommendations for a new reimbursement system that incorporated both cost and quality into its rate setting. As part of the ongoing effort to assess quality that will ultimately be linked to payment, direct interviews have been conducted with nursing home residents in all the state's

Medicaid nursing homes and the resultant information about satisfaction and quality of life are incorporated in a nursing home report card system. The Minnesota Nursing Home Report card, which was scheduled for release after the time period of this case study, has been billed at the first in the nation to provide consumers with objective data on a wide range of indicators, including quality of life, hours of direct care, staff turnover, proportion of single rooms, state inspection results, and the results of the individual surveys.

### **Region 10 VOICE Quality Program for Mental Retardation Services**

The Region 10 Quality Assurance Commission was established through Minnesota Statute (256B.095) in 1997 to develop and implement an alternative quality assurance licensing system. This was a direct result of grass roots organizing of stakeholders in Region 10 (an 11-county region including Rochester, Minnesota area) beginning in 1995. The program received the authority to combine licensure for all MR/DD programs ordinarily licensed by the counties and review of individual consumer's services in the light of their aspirations and wishes. VOICE stands for Value of Individual Choices and Experience, and a VOICE review entails visiting the participant in all his or her normal circumstances, including at work or school, and speaking to members of his or her circle of support. Teams of volunteer reviewers who receive extensive training spend 20-35 hours during a month for each VOICE review. The five participating counties receive the licensing recommendations from the Quality Assurance Commission. For each type of program licensed, a minimum of two randomly-selected participants receive VOICE reviews as part of the program licensure. Also any participant may request a VOICE review at any time. In 2005, about 150 VOICE review were performed. The program operates with rather modest funding of about \$300,000 from the Minnesota Legislature. In 2005, the Legislature renewed the program and gave it the mandate to do outreach to expand VOICE to other parts of the State. The State is presently developing mechanisms to involve the consumer in and improve quality assessment systems for Mental Retardation services under its RCSC QA/QI grant. The Region 10 group believes its approach to quality is superior to other approaches in that it is comprehensive (even including county care management), it is intensive, it builds on the participant's "dreams and aspirations," and it reinforces quality improvement. Interest in VOICE is building in other areas of the State.

### **Housing with Services Model**

Minnesota has opted to view assisted living as a service concept rather than a place. Licensing is for the service providers who offer assisted living services in registered housing-with-services establishments where the consumers live. Assisted living services have been included on the menu of elderly waiver services. This general strategy is being watched for its possible positive results (a more consumer friendly assisted living service based on housing values) and its possible negative results (consuming disproportionate amounts of the elderly waiver dollar without necessarily helping consumers with heavy care needs remain out of nursing homes). The housing with services industry in Minnesota has a high stake at making this model successful and avoiding nursing-home style regulation and has an ongoing task force working on how to ensure quality in housing with services.

### **Long-Range Planning**

Minnesota has consciously planned within state government for the aging of its population. Project 2030, housed in DHS and conducted in partnership with the Board on Aging, entailed 2

years (1996 to 1998) of public discussions involving more than 3000 Minnesotans, forums, and study activities to examine the meaning of demographic changes for aging in Minnesota and the kinds of collective and individual preparations needed. Numerous reports and position papers have emerged from this process, many of which were available for a 2003 Long-Term Task Force, comprised of legislative and executive leaders in Minnesota. A more recent planning initiative, *Financing Long-term Care for Minnesota's Baby Boomers*, explores new financing strategies, including reverse mortgages, long-term care insurance, and other mechanisms that reflect a greater role of individuals and the private sector. Whatever the political climate, these kinds of long-range planning efforts, incorporating input from large numbers of citizens, drawing on as much data as possible, and establishing a basis for an informed public is characteristic of Minnesota. So far, it appears that such processes continue to reinforce the desire of older consumers for HCBS rather than institutional care.

### Quantitative Markers of Rebalancing

#### Changing Patterns in Nursing Home Use as Marker of Rebalancing

To assess the potential effect of HCBS on nursing home use, we examined the MDS data on all Minnesota nursing homes for the years 2002, 2003, and 2004. We reasoned that if HCBS was having an effect, the case mix in nursing homes should become higher, i.e., the level of disability (both functional and cognitive) should increase. Because nursing homes serve at least two streams of clients, one requiring post-acute care (PAC) after discharge from hospitals and the more traditional long-term resident, we examined the case mix at two points in time: admission and three months after admission. The former would include the PAC population, but the latter should be a more direct reflection of long-term care that HCBS was intended to defray.

Table 1 shows the changes in the NH case mix on admission and 3 months after admission for 2002, 2003, and 2004. The latter is a better test of the long-term care population. Between 2002 and 2004, the functioning level of elders admitted to NHs in MN deteriorated slightly from the average ADL score of 13.46 in 2002 to an average ADL score of 13.74 in 2004 (the possible score of the ADL variable is between 0 and 24: a higher score means higher ADL dependence). During the same period of time, the cognitive functioning of elders admitted into NHs improved slightly. The average CPS score went down from 1.68 in 2002 to 1.58 in 2004 (the possible score for CPS is between 0 and 6: a higher CPS score means lower cognitive functioning). Moreover, the rate of persons with no cognitive impairment or mild impairment increased.

**Table 1: Change in Nursing Home Acuity at Admission and 3 Months Later**

	2002	2003	2004
<b>At Admission</b>			
Mean ADL	13.46	13.52	13.74
Mean CPS	1.68	1.60	1.58
<b>3 Months Post Admission</b>			
Mean ADL	12.44	12.33	12.21
Mean CPS	2.34	2.30	2.27

The functioning level of elders at 3 months after admission improved slightly between 2002 and 2004. The average ADL scores in 2002, 2003, and 2004 were 12.44, 12.33, and 12.21 respectively, suggesting less disability over time. Moreover, the proportion of persons with no ADL dependencies increased, although the rate for few dependencies changed little. These data suggest that HCBS has so far had little impact on its goal of deflecting clients with lower ADL needs to non-institutional sources of care. For cognitive functioning, the CPS scores improved slightly between 2002 and 2004. The CPS score in 2002 was 2.34, dropped slightly to 2.30 in 2003 and further dropped to 2.27 in 2004. Moreover the proportion with no cognitive impairment increased slightly.

### **Balance Between Institutional and Community Care**

Figure 1 shows the average monthly enrollment of clients for each of 5 years, 2000 to 2004. (This presentation is different from that used for most of the state reports in this series. The numbers of clients tracked here are reported as client-years, i.e., they are converted to full year equivalents. Because it counts fewer beneficiaries, it raises the average cost per beneficiary. Care should thus be taken in comparing this measure across states.) The chart shows a consistent decline in the number of persons served each year in nursing homes and a concomitant increase in persons served under elderly waivers and home care under the State Plan. The use of ICF-MRs declined while the use of MR/DD waivers increased on an independent path, peaking and then leveling off. By contrast, the use of CADI waivers has increased steadily. The State-funded Alternative Care program declined sharply in 2004 with no concomitant increase in the Elderly Waiver program.

Figure 2 traces the pattern of expenditures, this time using annual expenditure figures. The largest amount of money is spent on nursing home care, but this amount is being approached by the MR/DD waivers. Expenditures increased for home health care under the State Plan and fell for ICF-MRs. There was gradual growth in the other waivers, while Alternative Care fell in 2004.

Rebalancing Long-Term Care Systems in Minnesota

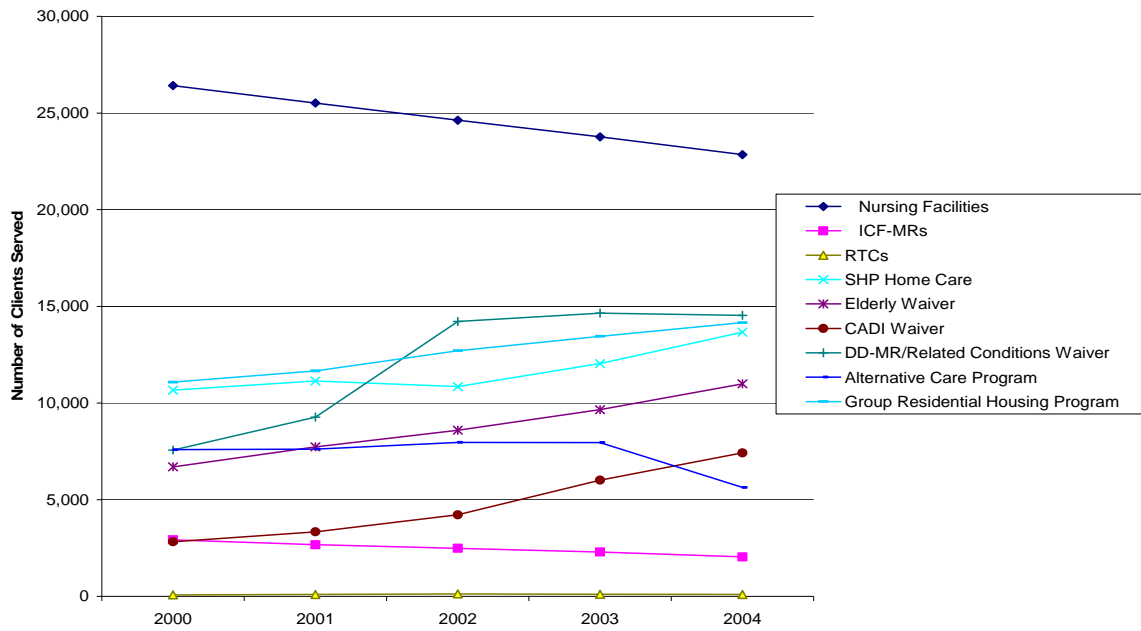


Figure 1. Clients Served in Selected Minnesota Programs, 2000-2004

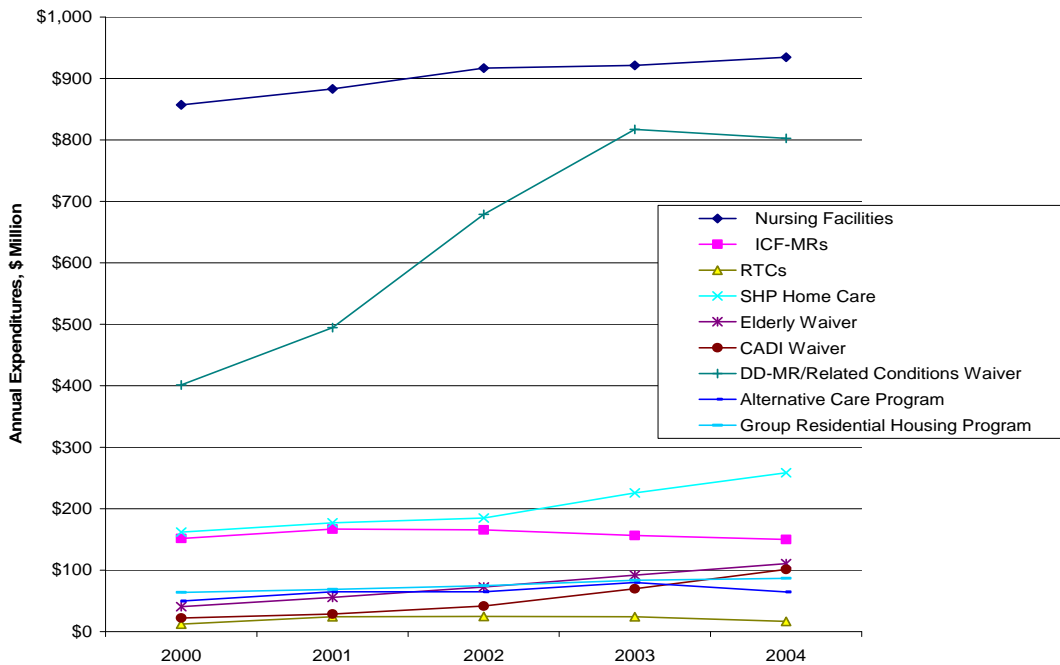
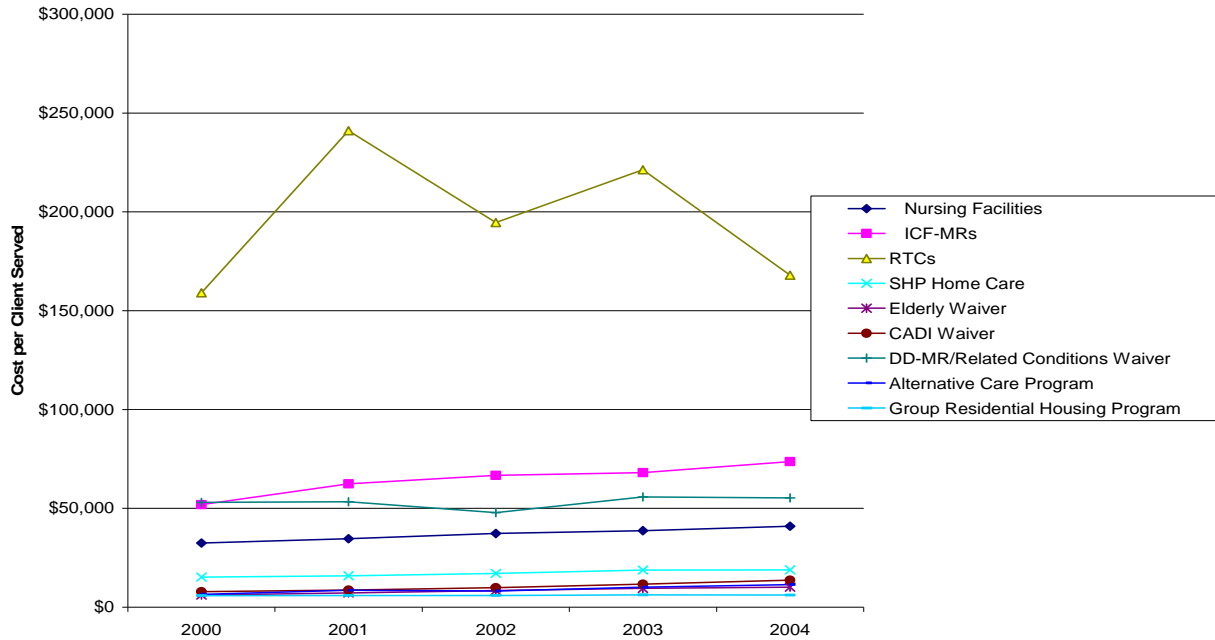


Figure 2. Expenditures for Selected Minnesota Programs, 2000-2004.

Figure 3 traces the costs per care recipient. The costs per case served in the regional treatment center eclipse all other care. Both ICF-MR and MR/DD waiver care exceed nursing home costs on a per client basis; the ICF-MR costs per case are growing as are those for nursing home care. Waiver costs per case are relatively stable. The costs shown here are costs per annualized beneficiary and hence will be larger than those calculated using the full count of beneficiaries served in a given year.



**Figure 3. Per Capita Expenditures for Selected Programs, 2000-2004.**

### Conclusion

Minnesota has determined to move towards HCBS for all populations. In so doing, it is relying on a process of continuous planning, an emphasis on creating the conditions for consumer choice, quality improvement initiatives that build on information and incorporate consumers (complete with consumer training, manuals, web-based information and the like). Minnesota has created incentives to encourage nursing homes to follow their own inclination to downsize, to diversity into HCBS residential provision, and to improve privacy and quality in remaining nursing homes.

Minnesota’s approaches to long-term support differ for people with disabilities based on whether they are under or over age 65. Persons over age 65 on Medicaid waivers are being transitioned from a county-based management to managed care organizations for their long-term care, building on an already established managed care approach for dually eligible consumers called the Minnesota Care Organization. People of all ages now have an option for Consumer-

Directed Community Supports (CDS), but as of the August 2005 date for this report, only a handful of older people have taken up the option. Directions to improve waiver services for people (including a universal assessment, a common service menu, and budget methodologies for individual service plans and for state aggregate allocations to counties) are being pursued only for the four waivers affecting children and adults under 65.

### **Issues for Further Observation**

- Observation of how managed care will affect rebalancing for seniors, including how consumer-directed community supports can be incorporated into managed care. Also of interest is how the county-based and Area Agency on Aging community infrastructure for seniors is affected by the move to managed care organizations as lead agencies.
- How the Housing with Services approach evolves and whether this model can lead to a consumer-oriented approach for seniors, or, conversely, whether it creates a new kind of institution.
- How making information available to consumers enhances quality and affects the choice of community care.
- How well the incentives to downsize nursing homes and create more private rooms work.
- Whether the State-funded Alternative Care Grant program continues to shrink under the disincentives of estate recovery.
- The outcome of current efforts to build individual budgets on the basis of a common assessment and a common service menu, and to achieve more equity across consumer groups and geographic regions. Minnesota should be a good place to observe the development of a life-span approach to equity (differentiating between those who need habilitation services in addition to support services) and to test whether any re-distribution occurs from mental retardation services to other services (and if so, how that affects participants with mental retardation).
- Whether approaches to long-term support for people under and over age 65 will converge, or whether the approaches continue to develop in parallel. Of particular interest is whether and how older people will use consumer directed community supports.