

# **Rebalancing Long-Term Care Systems in Minnesota**

**Long Version Report prepared by the Rebalancing Research Group**

**Submitted to the Centers for Medicare and Medicaid Services**

**Mary Beth Ribar, Project Officer**

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The overall project was 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 called 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. An abbreviated version of this case study is also available at

[http://www.hpm.umn.edu/lrcresourcecenter/research/rebalancing/attachments/baseline\\_state\\_case\\_studies/Minnesota\\_abbreviated\\_baseline\\_case\\_study.pdf](http://www.hpm.umn.edu/lrcresourcecenter/research/rebalancing/attachments/baseline_state_case_studies/Minnesota_abbreviated_baseline_case_study.pdf)

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.

# Rebalancing Long-Term Care Systems in Minnesota

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## Preface

The baseline case studies performed for this project were prepared in two forms: an abbreviated case study of approximately 15 pages, and a much longer report, of which this is an example.

Each longer report is organized in 4 sections: context; system assessment; management features, and quantitative markers of rebalancing. The first 2 sections use uniform headings for all reports. The Context section includes: demographics and economics, geography, rebalancing status in brief, political climate, vision and values for LTC, leadership, state government organization for LTC, local organization for LTC, litigation related to re-balancing, advocacy environment, service environment, and a historical and descriptive review of programs and Services. Maps, organizational charts, and statistical background tables are provided beyond the material in the abbreviated reports. The System Assessment categories found in most long reports are: access to services, array of services, consumer direction, quality initiatives, institutional downsizing, data capacity, links to acute care, and links to housing. The illustrative management approaches in Section III are presented in considerable detail. Section IV presents data on supply of services and quantitative comparisons of utilization and expenditures in home-and-community based long-term supports versus institutional long-term support services from 2000 to 2004.

In these baseline reports, we endeavored to trace the evolution of long-term supportive services in the State back to their post-Medicaid and post-Medicare beginnings, with particular emphasis on developments

## **Re-Balancing Long-Term Care in Minnesota**

### **Summary of Highlights<sup>1</sup>**

As with many Midwestern states, the State of Minnesota has historically had a high nursing home bed-ratio, and a large-sized Medicaid nursing home program. At the same time, Minnesota has historically invested in home and community-based services (HCBS) to all populations with a disability. HCBS services are administered through 5 HCBS waivers, the state Medicaid plan, and a state-funded Alternative Care Grant program for elderly people who do not qualify for waivers. Minnesota spends liberally on both nursing-home care and HCBS. Minnesota is proceeding with quality initiatives pertaining to both nursing homes and to HCBS services. Minnesota is also in the midst of applying a system of incentives to promote nursing homes to close or down-size, described in Section III.

In the 1980s Minnesota largely closed its state schools for mental retardation and related disorders—a success story in rebalancing that is also highlighted in Section III. Now 94% of consumers with mental retardation receive HCBS services, and the remaining consumers tend to be in small ICF/MRs.

Minnesota's HCBS programs operate through 87 county governments, which can lead to inconsistencies in application of programs and which requires a collaborative effort and

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<sup>1</sup>Note: The team site-visiting Minnesota, largely on June 1, 3, & 24<sup>th</sup>, 2005 included, at times, Rosalie Kane, Robert Kane, Reinhard “ Jake” Priester, Donna Spencer, and Terry Lum, with background support from K Charlie Lakin, all from University of Minnesota. This report is based on information gathered before, during, and after the site visit. In the baseline case study, we created a historical record and context for a period up to July 31, 2005, with the intent of up-dating the case study twice, as of July 31, 2006 and July 31, 2007. We thank our Minnesota study liaison, LaRhae Knatterud, Director, Aging Transformation, Continuing Care Administration, Minnesota Department of Human Services, and the many individuals in the public and private sector who provided us with insights for the report. The conclusions drawn are those of the authors and do not necessarily reflect the opinions of any officials in Minnesota or at CMS.

considerable communication and in-service education to bring about program change. In 2004 the State completed a process of making Consumer Directed Community Supports (CDCS) available through all its HCBS waivers and its two managed long-term care programs (discussed below). At the time our study concluded, only a handful of elderly had used CDCS. Although Minnesota opted to develop a separate fiscal intermediary service for CDCS rather than work through county-based case managers, the latter are a major referral conduit as are aging network personnel. They may not, as yet, perceive CDCS as an option for older people. CDCS is not available for consumers who live in assisted living or other kinds of supportive housing arrangements where the State considers it is paying for a built-in case management. Other efforts under way in relation to seniors include creating a universal assessment, redesigning case management and individual budgeting, and developing a new aggregate budget allocation method for the State to use in transferring funds to counties for the large mental retardation and related conditions (MR/RC) waiver.

The Continuing Care Administration within the umbrella Department of Human Services is the lead agency for all long-term care and long-term support services, including HCBS and nursing home services and services for persons with all disabilities and all ages. However, services to older people have tended to be planned and managed on a parallel rather track to those for persons under age 65. Until late 2005, offices for state aging services were geographically separated from those for other disability groups. Also, planning during 2004/2005 for an October 2005 transfer of EW services to private managed care organizations further put seniors out of step with other disability groups.

## Section I. Context for Re-Balancing

### Demographics and Economics

Minnesota, the largest state in the upper Midwest, had a population of 5.1 million people in 2004, ranking 21<sup>st</sup> highest among all states. Its population aging rate is slightly lower than the national average (Table 1).

**Table 1. Demographic Features Linked to LTC Needs in Minnesota**

Population Characteristic	Minnesota	United States
Total Population, 2004	5,100,958	293,655,404
Persons Age 65+, 2004	12.4%	12.1%
Persons Age 85+, 2004	1.4%	1.3%
Population Non-White, 2003	10.6%	24.3%
Population Non-White or Hispanic	11.8%	32.7%
Urbanicity, 2003 (population in MSA).	72.7%	81.7%
Persons per square mile, 2000	61.8	79.6
Community Population age 5-20 with disability, 2004	5.7	6.6%
Community Population, age 21-64 with a disability, 2004.	9.2	12.0%
Community Population 65+ with a disability, 2004	34.8%	39.9%
Percent non-elderly persons with a disability, 2003	8.6	10.9%
Men per 100 woman over age 85, 2002	46%	47.9
Percent persons over 65 with Self-Care Difficulty, 2002 <sup>b</sup>	5.6%	9.2%
Percent persons over age 85 living alone, 2002 <sup>b</sup>	61.2%	50.2%
Percent persons with disability living alone	27.2%	31.4%

Notes: These statistics are from the US Census Bureau, American Community Survey, which excludes people living institutions—e.g. nursing homes. A broad definition of disability is used, i.e. persons who report a disability in employment, mobility, and/or personal care. On web last visited 12/19/2005 at: <http://www.census.gov/acs/www/Products/Ranking/index.htm> More detailed analyses regarding older people are found in the 2004 AARP cross-state report by Gibson et al.<sup>2</sup> We also utilized statistics compiled on the Website of the U C San Francisco’s Center for Personal Assistant Services, last visited 2/2/2006, at <http://www.pascenter.org/home/index.php>

The state’s population is predominantly white (88.6 percent), although a recent influx of immigrants from Southeast Asia, Mexico and Central America, and African nations, particularly Somalia, has changed the demographic patterns somewhat. Minnesota has the largest Hmong, Somali, and Liberian communities in the U.S. One of the largest Native American urban

<sup>2</sup> Mary Jo Gibson, Steven R. Gregory, Ari N.Houser and Wendy Fox-Grage (2004). Across the States: Profiles of Long Term Care. Sixth Edition. Washington, DC. AARP. Also on Web last visited 12/18/2005 at [http://www.aarp.org/research/reference/statistics/across\\_the\\_states\\_profiles\\_of\\_longterm\\_care\\_2004.html](http://www.aarp.org/research/reference/statistics/across_the_states_profiles_of_longterm_care_2004.html)

populations in the nation is concentrated around Minneapolis. The state has the fastest growing total population in the upper Midwest.

Minnesota is consistently listed among the healthiest states and among those with the lowest rates of disability. An estimated 556,000 people in Minnesota have a disability, or 12.5% of the population age 5 and over (compared to 15.12% for the US). An estimated 93,000 people, or 2.0% of the population 5 and over, have difficulty performing self-care activities (ADLs).<sup>3</sup> Sixty-one percent of the people over age 85 live alone. Fewer than 6% of people age 65 and older have self-care limitations, 14.6% have mobility limitations and 7.6% have cognitive or mental limitations – all rates below the national average.<sup>4</sup> Among Minnesotans age 65 and older, 42.73% have a disability, compared to 46.1% of all elderly Americans.

Minnesota is among the wealthiest states in the nation in terms of per capita income, ranking 6th nationally in median household income -- \$61,417, compared to \$52,273 in the US (See Table 2). The state also has one of the lowest poverty rates; approximately 8 percent of the state's population lives in poverty (below the national average of 13.2%). Moreover, people with disabilities of all ages are less likely to be officially poor in Minnesota than nationally, and they are also less likely to be near-poor, as measured by being in households at 200% or 300% of poverty.

In Minnesota, only 8.2% of the population is without health insurance compared to 15.1% nationally, making Minnesota the best insured state in the nation.<sup>5</sup> Taken together, the socio-

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<sup>3</sup> ACS Disability data, 2003. [http://www.pascenter.org/state\\_based\\_stats/state\\_statistics\\_2003.php?state=us](http://www.pascenter.org/state_based_stats/state_statistics_2003.php?state=us)

<sup>4</sup> Mary Jo Gibson, Steven R. Gregory, Ari N.Houser and Wedny Fox-Grage. Across the States: Profiles of Long Term Care. Sixth Edition. AARP. Washington, DC. 2004

<sup>5</sup> DeNavas Walt, C., Proctor, B.D., & Mills, R.J. (August 2004). U.S. Census Bureau Current Population Reports P60-226, Income, poverty, and health insurance coverage in the United States: 2003. U.S. Government Printing Office: Washington, D.C. At: <http://www.census.gov/prod/2004pubs/p60-226.pdf> (accessed 8/24/05).

demographic data suggests that the demand for formal long term care services among Minnesotans is moderate to low.

**Table 2: Economic Characteristics Effecting Long-Term Care in Minnesota**

<b>Economic Characteristic</b>	<b>Minnesota</b>	<b>United States</b>
State Taxes Per Capita in 2004	\$2891	\$2026
Median household income, 2004	\$55,914	\$44,684
Mean personal income per capita (2005)	\$41, 158	\$37, 167
Percent of population in poverty (average 2002-2004)	8.1%	13.19%
Percent in labor force who are unemployed, 2004	3.9%	5.1 %
Persons without health insurance (3 year average, 2001-2003)	8.2%	15.1%
Households with cash public assistance, 2004.	3.4%	2.4%
Medicaid participation as % of population, 2003	14%	18%
Community dwelling persons age 65+ in poverty, 2004.	7.9%	4.9%
Community dwelling persons age 65+ with care limitation in poverty, 2002	4%	15.7%
Community dwelling persons age 5-17 with disability in poverty, 2004.	16%	27.0%
Community dwelling persons age 18-64 with disability in poverty, 2004	20.9%	24.5%
Community dwelling persons age 65 + with disability in poverty, 2004	11.5%	13.1%
Community dwelling persons 5-17 with disability up to 200% of poverty, 2004	35.4%	51.1%
Community dwelling persons age 18-64 with disability up to 200% of poverty	39.2%	46.9%
Community dwelling persons 65+ with disability up to 200% of poverty	39.9%	43%
Community dwelling persons 5-17 with disability up to 300% of poverty	60.4%	68.1%
Community dwelling persons age 18-64 with disability up to 300% of poverty	57%	63.5%
Community dwelling persons age 65 + with disability up to 300% of poverty	60.6%	63.4%

**Sources:** State and local tax data come from the Rockefeller Institute and the National Association of State Budget Officers.<sup>6</sup> Health Insurance data are from Mills & Bhandari, 2003.<sup>7</sup> The numerator for Medicaid enrollment is from a special study funded by the Kaiser Family Foundation in 2003,<sup>8</sup> and the denominator from the American Population Survey, the later based on estimates of the community dwelling population. Various poverty rates are courtesy of Stephen Kaye, PhD, Institute of Health and Aging, University of California at San Francisco, who performed special cross-tabulations of disability status, age group, and poverty status from the US Census American Community Survey.

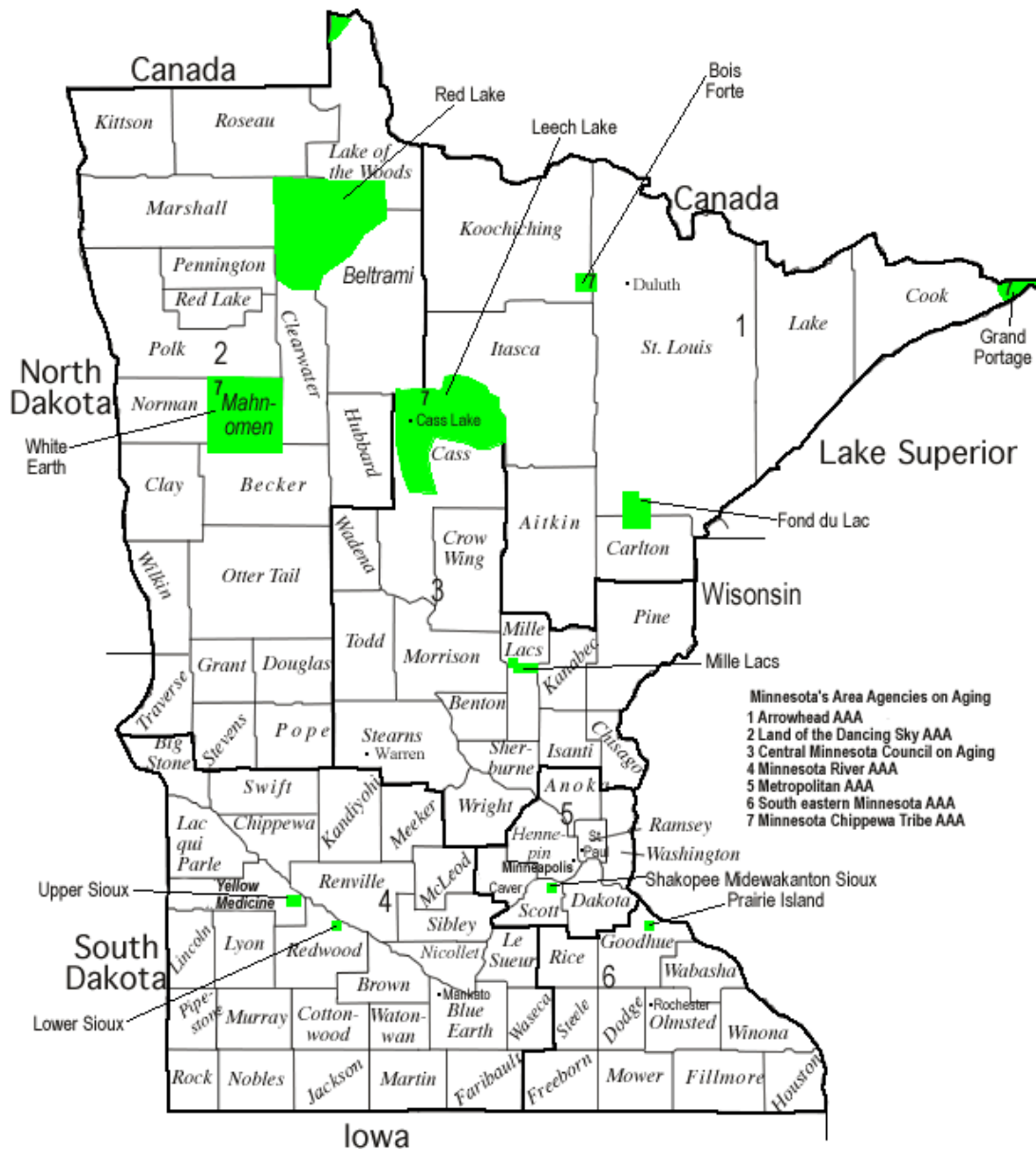
<sup>6</sup> The Rockefeller Institute of Government in Albany, NY generates reports on state and local revenues and expenditures, most of which are on its website at: <http://rfs.rockinst.org/>. Also state summaries can be found on Websites maintained by the Bureau of Economic Analysis, US Department of Commerce, including: <http://www.bea.doc.gov/bea/regional/bearfacts/statebf.cfm>. Both last visited 12/19/2005. See also National Association of State Budget Officers (NASBO) (2005). *The Fiscal Survey of States*. (Submitted June 2005). Washington, D.C.: National Governors Association. On web, last visited 12/20/2005 at: <http://www.nasbo.org/Publications/fiscalsurvey/fsspring2005.pdf>

<sup>7</sup> Mills, R J & Bhandari, S (2003). *Health Insurance Coverage in the United States, 2002*. (Economics and Statistics Administration, U.S. Census Bureau, Current Population Reports, P60-22, pp. 1-23.. Washington, D.C. Department of Commerce. Website at: <http://www.census.gov/prod/2003pubs/p60-223.pdf> Last visited October 11, 2005.

<sup>8</sup> Ellis, ER , Smith, VK & Rousseau, DM (2004). *Medicaid Enrollment in 50 States, June 2003 Update*. (Health Management Associates, Lansing, MI and Kaiser Commission on Medicaid and the Uninsured, prepared for Kasier Family Foundation, October 2004). On website: <http://www.kff.org/medicaid/upload/Medicaid-Enrollment-in-50-States-June-2003-Data-Update-Report.pdf> Last visited, December 1, 2005.

## **Geography**

Minnesota is the 12th largest state in the nation, located at the crossroads of three types of terrain. Agricultural plains (formerly grasslands and prairies) are to the west and south, coniferous forest is to the north, and the southeast corner is hardwood forest. Land of the 10,000 Lakes, nearly 9% of the state is inland water. Approximately half the state's population lives in the 7-county Twin Cities metropolitan area. Other population centers include St. Cloud in the center of the state, Duluth on the western tip of Lake Superior, and Rochester(home of the Mayo Clinic) in Olmstead County in the southeast, each with a population between 80,000 and 90,000. In contrast to these urban areas, the state contains large, somewhat isolated rural areas where access to services is limited, particularly in the far north (see Figure 1 for state map). The percentage of Minnesota residents living in urban areas is below the national average (72.72 percent in MN vs. 81.72 percent in the US).



**Figure 1. County Map of Minnesota (with Area Agencies on Aging)**

Minnesota is divided into 87 counties. Counties are the most important jurisdiction for the delivery of health and human services, and the state has limited authority to instruct counties on how to manage their programs. Figure 1 shows the 7 Area Agencies on Aging districts; as evident, they are multi-county entities with Area 7 being comprised of various Chippewa tribes (some Tribal areas on the map are not part of an AAA). Even Region V, comprised of the 7

county metropolitan area, includes some rural areas. Regions 1, 2, 3 and 6 are particularly vast with many rural areas.

### **Rebalancing Status in Brief**

Minnesota has been steadily working towards rebalancing long-term care services. For seniors, Minnesota started with a high liability for nursing home costs, Reports done by Richard Ladd and colleagues using 1992 and 1995 data from Medicaid and other public funding related to seniors found a reduction in the nursing home caseload between the dates of the two reports, but at both times rated Minnesota below average in progress towards rebalancing.<sup>9</sup> The study with 1995 data showed that Minnesota still devoted 94% of its expenditures on long-term care for seniors to nursing homes; it also pointed out that Minnesota had a high demand for long-term care because of the population over 85 living alone, but a low demand on public services. In the Mental Retardation and Developmental Disability area, the seminal study of trends from 1977 to 1996 found that Minnesota had made good progress, especially at the end of the period, In 1996 Minnesota's expenditures for community care for MR/DD was 83% above the national average, and 8<sup>th</sup> in the nation. The trends were all in the right direction, and Minnesota had the fourth highest per capita spending for supported employment in 1996; 360 people remained in state DD institutions, 1, 074 were in ICF/MRs serving 16 or more people, and Minnesota had 1, 074 people with DD living in the general nursing home population; this 27% increase from 1992-1996 suggested a re-institutionalization as the state schools downsized. In 1987, Minnesota reached the threshold where spending for community supports exceeded spending for

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<sup>9</sup> Ladd, RC, Kane, RL & Kane, RA (1999). State LTC Profiles Report, 1996 (Report submitted to US Office for Assistant Secretary for Planning and Evaluation, HHS, April 1999). Minneapolis, MN: National Long-Term Care Mentoring Program, School of Public Health, University of Minnesota; and Ladd, RC, Kane, RL, Kane, RA, & Nielsen, WJ (1995). State LTC Profiles Report. (Report under a grant from Administration on Aging,) November 1995). Minneapolis, MN: National LTC Mentoring Program, School of Public Health, University of Minnesota.

congregate care, and in 1996, Minnesota spent 81% of its MR/DD allocations on community services, at that time ranking 11<sup>th</sup> highest on that indicator.<sup>10</sup>

The most recent national tabulation of rebalancing or expenditures under Medicaid, the annual memo and accompanying tables prepared by Medstat,<sup>11</sup> shows that in 2004 Minnesota compared favorably to other states in its per capita expenditures on long-term care, and its proportional expenditures on community care. Minnesota ranked 5<sup>th</sup> in the balance of its overall long-term care expenditures; in 2004 the state spent 55.9% of total Medicaid LTC dollars on community care). The state's per capita expenditures on nursing homes and ICF/MRs ranked 16<sup>th</sup> and 22<sup>nd</sup> respectively, both down from the previous year. Minnesota had the highest expenditures of any state on HCBS services under waivers, the 3<sup>rd</sup> highest per capita expenditures for HCBS under DD waivers, the 3<sup>rd</sup> highest for home health under the state plan, and was 2<sup>nd</sup> highest (after New York) for all home care Medicaid expenditures (that is, home health, personal care option, and waiver.) The expenditures on waivers for seniors and persons with physical disabilities were not as high, yet Minnesota still ranked 7<sup>th</sup> nationally on that parameter.

### **Political Climate**

Over the years, Minnesota's political leadership has had a strong bipartisan (and during the term of Independent Party Governor Jesse Ventura) tri-partisan commitment to promote independence for its elderly residents and individuals with disabilities. Also over the years, considerable expertise emerged among state senators with long track records of working on long-

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<sup>10</sup> Braddock, D, Hemp, R, Parish, S, & Westrich, J (1998). The State of the States in Developmental Disabilities. Washington, DC, American Association on Mental Retardation, pp. 277-284.

<sup>11</sup> Tables distributed in May 2005 by Brian Burwell, The Medstat Group, 125 Cambridge Park Drive, Cambridge, MA 02140 in annual memo on state by state Medicaid expenditures. The institutional part of the expenditures includes nursing facilities and ICF-MRs, and the community expenditures includes Medicaid waivers, state plan personal care, and state plan home health services.

term care issues. Moreover, the support for long-term care is within a context of generally generous social service benefits in the State. Despite this track record, Minnesota has always been a mixed state politically, characterized on the one hand by respect for government and government planning, and stances that might be considered “liberal,” combined with strong right-to-life, anti-abortion, and pro-gun constituents.

The most recent political climate in the late 20<sup>th</sup> and 21<sup>st</sup> century has been one of divisive political wangling among the Governor’s Office, the Senate, and the House over tax relief versus social spending, made worse because of deficits, in part created by lowering taxes and foregoing reserves. These themes came into prominence during the administration of libertarian Governor Jesse Ventura, when the three power bases—Governor, Senate, and House—were often at odds. The themes of fiscal prudence became even more pronounced after the election of Republican Governor Tim Pawlenty, who made a firm “no new taxes pledge” to which he has adhered despite public opinion polls that the citizenry might prefer to pay taxes and receive services. The 2003 legislature needed to deal with a projected 3.6 billion state budget deficit in a climate where no new revenue could be raised.

Minnesota did not form an Olmstead-related Task Force or develop an Olmstead plan; rather the State takes the position that Minnesota already had alternative planning processes in place and was in compliance with the mandates of the Olmstead decision. Legislators have a strong interest in long-term care and long-term support programs and stakeholder involvement is actively sought with all initiatives. For the most part, separate planning initiatives at the legislative level have been developed to deal with aging, on the one hand, and with disability, on the other. A spate of legislatively mandated reports has been commissioned since 2003 to rationalize and improve the waiver programs for people under 65 with disabilities.

With reference to aging, in 2000 the Minnesota Legislature established in 2000 a tri-partisan Long Term Care (LTC) Task Force composed of Minnesota legislators and state agency commissioners. The LTC Task Force met throughout 2000 to discuss the state's long-term care system and develop consensus recommendations for systemic reforms for the 2001 Legislative session. The task force championed a new model for long-term care that included renewed emphasis on consumer self-determination and personal responsibility. One of its central recommendations to reshape the state's long-term care system was to expand home care and supportive housing to meet the growing demand for more HCB services. Public meetings conducted around the state in conjunction with the Commission, which were well covered in the daily Minneapolis and Saint Paul newspapers, left no doubt that older people preferred care in the community. The task force identified 6 major policy directions (and 15 priority recommendations for the 2001 Legislature) to implement its vision of a restructured long-term care system.<sup>12</sup> The Task Force report referred explicitly to the state's "heavy reliance on the institutional model of long-term care" by reducing the total number of nursing home beds. In 2003, the Minnesota legislature called for yet another study of long-term care options, this time centered on financing, and examining ways to minimize public expenditures. In keeping with the conservative cast to the legislature and predicated on alarm because of the aging of the baby boomers, this report analyzed a variety of insurance options, public-private partnership for LTC, reverse mortgages, and rendering asset transfer more difficult.<sup>13</sup>

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<sup>12</sup> State of Minnesota Long Term Care Task Force. "Reshaping Long-Term Care in Minnesota." 2001. <http://www.openminds.com/indres/mnltc.pdf>

<sup>13</sup> Financing Long-Term Care for Baby Boomers, A Report to the Minnesota Legislature, January 2005. On web last visited 2/2/2005 at [http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs\\_id\\_025734.hcsp](http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_025734.hcsp)

## **Vision and Values for LTC**

Minnesota clearly has endorsed a vision of community care for all populations needing service, though disagreements may ensue about the speed at which those goals will be made operational. The Long-Term Care Task Force, mentioned above, established the following value-based goals:

1. Maximize peoples' ability to meet their own long-term care needs
2. Expand capacity of community long-term care system
3. Reduce Minnesota's reliance on the institutional model of long-term care
4. Align systems to support high quality and good outcomes
5. Support the informal network of families, friends and neighbors
6. Recruit and retain a stable long-term care work force

The priorities of the Disability Services Division (DSD) are similar, but more specific:

- Continue to expand community living options, particularly for people under 65 who are living in nursing facilities or at risk of doing so
- Expand consumer-directed services, an option that gives consumers control to make life choices and to exert control over their own lives, including dollars spent for services and staff who provide them
- Build partnerships that help Minnesotans with disabilities successfully become and remain employed as valued staff within an organization.
- Build a good information and referral system to assist people with disabilities and other stakeholders.
- Improve quality in service areas and provide feedback to policymakers, administrators and providers about the quality of services.
- Expand housing options for people with disabilities

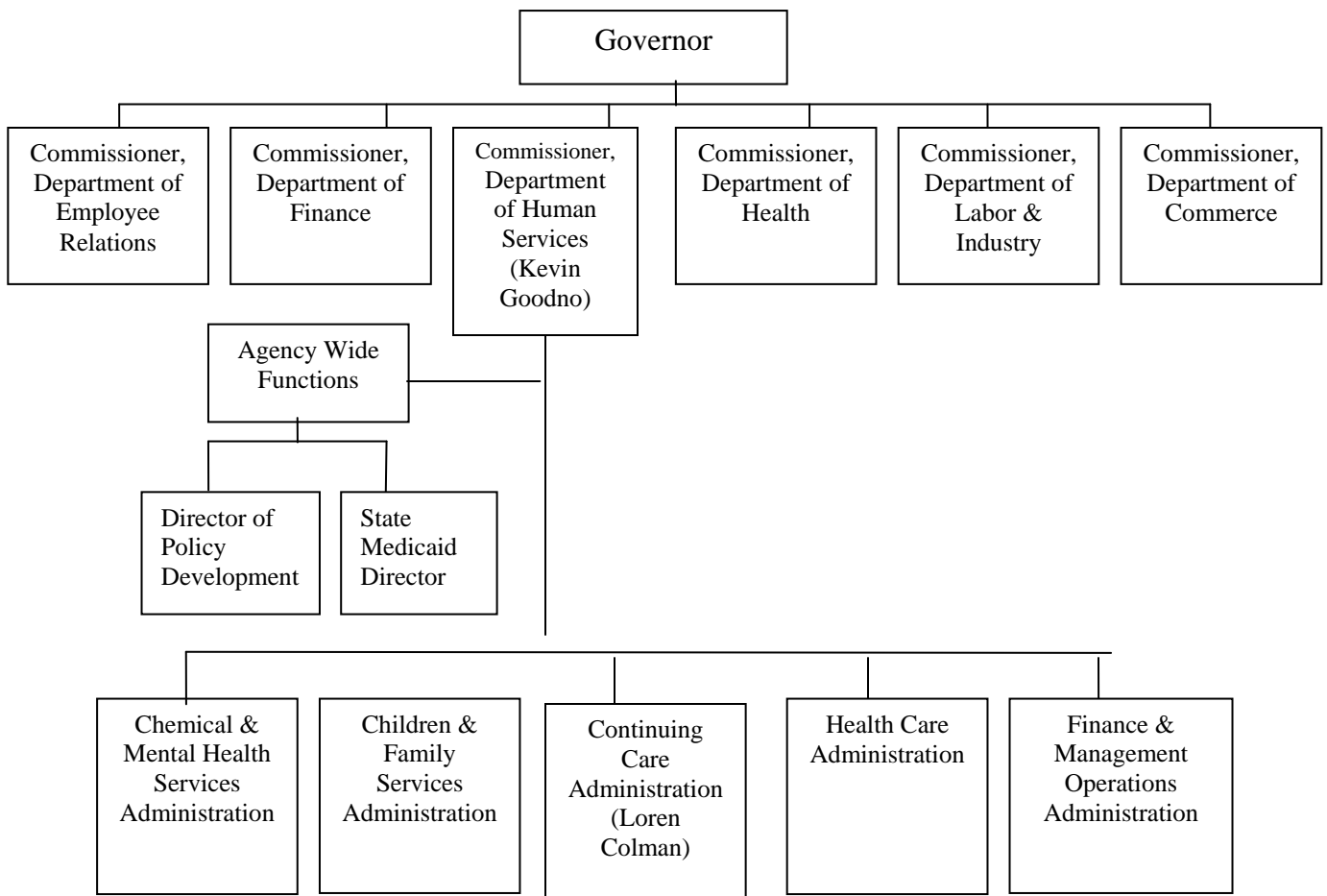
## **Leadership**

Minnesota's executive leaders in state government are often drawn from former legislators or from those occupying visible positions in the private sector. The Commissioner of Human Services, Kevin Goodno, served six terms in the state legislature, representing Moorhead, MN, at the northern border with North Dakota. He occupied leadership positions in the legislature, was engaged in welfare reform initiatives, and chaired the Health and Human Services Finance Committee, rendering him well informed about the substance of the agency. Commissioner Goodno is committed to customer focus and a results-orientation throughout his large Department. Within the Department of Human Services, the top and middle management is populated by many individuals with extensive experience with long-term supports in careers that sometimes bridge private and public sector, state and local levels of government, and/or multiple state leadership roles. The current Deputy Commissioner for Continuing Care (under which most disability and aging programs fall) is a licensed nursing home administrator who occupied executive positions with Extencare Health Services until being appointed to his present position in 2003. He is past Board Chair for Care Providers of Minnesota (the American Health Care Association state affiliate). Notwithstanding his nursing home background notwithstanding, he has proven to be an articulate leader on behalf of expanding HCBS services.

## **State Government Organization for LTC**

A single umbrella agency, the Department of Human Services, has responsibility for policy development, program administration, funding for nearly all long-term care and disability-related programs. That Department of Human Services is also part of Governor Pawlenty's recently created Health Cabinet, an entity that he organized as a vehicle for high-level cabinet level planning. The Human Services Division itself is organized with a number of Department-wide

functions, including the Medicaid Director, and five units: an Operations and Finance Unit, headed by a COO, and four operational units, each headed by an Assistant Commissioner: Continuing Care; Health Care; Children and Families; and Chemical and Mental Health Services. Figure 2 shows the cabinet agencies included in the Health Cabinet, (Human Services, Health, Finance, Employee Relations, Labor and Industry, and Commerce) as well as the general structure in the Department of Human Services.

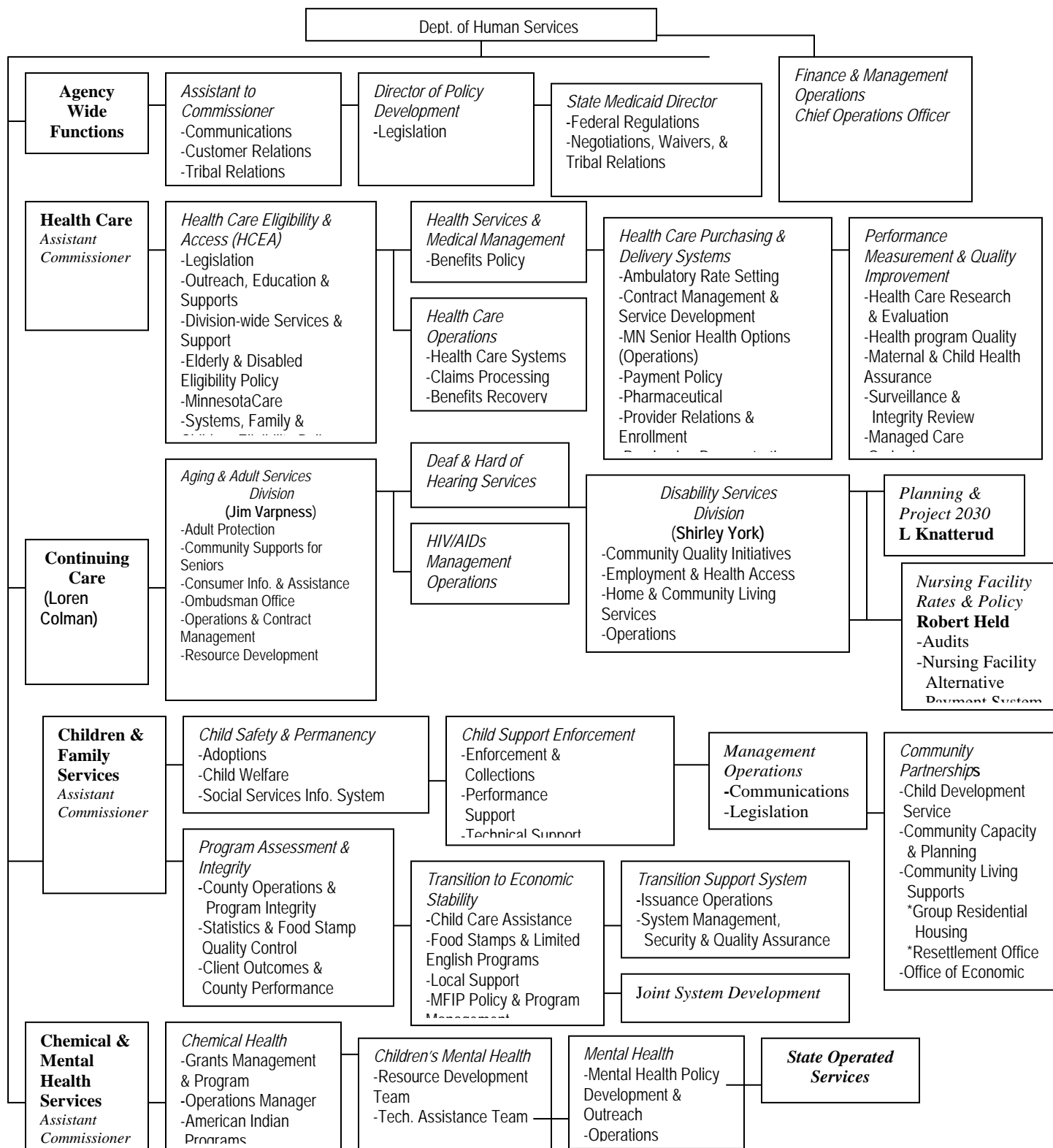


**Figure 2. Health Cabinet in Minnesota with Detail on Department of Human Services**

Figure 3 provides more detail on how the Human Services Division is organized. The Medicaid program and various other policy functions, including Licensing, are designed as

Department-wide functions. (Human Services licenses a variety of residential care providers, but the nursing home, ICF-MR, and home care licenses and certifications as well as various professional licenses and regulatory boards are in the Department of Health.) The central unit for long-term care is the Continuing Care Administration, headed by Loren Colman, Assistant Commissioner). Continuing Care itself is comprised of Aging & Adult Services, Disability Services, and Nursing Facility Rates and Policy, as well as smaller programs for Deaf and Hard of Hearing Individuals and persons with HIV AIDS. Planning functions for aging and Project 2030 are also in Continuing Care. Aging and Adult Services is responsible for Older Americans Act functions and the aging network functions, the Elderly Waiver, and the state-funded Alternative Care Grant Program for older people. The other HCBS waiver programs fall under the Division of Disability Services. The major divisions in the Continuing Care Administration are headed by highly experienced directors, including Jim Varpness who has had a long career in aging services; Shirley York, veteran of the deinstitutionalization of the state hospitals; and Bob Held, who has much experience with both nursing homes and HCBS in public and private sector roles.

The Chemical and Mental Health Services Division includes various mental health outreach services, including regional State Operated Services (SOS). The SOS program includes 5 state-operated regional mental health treatment centers, 3 campus-based forensic services units, some state-operated ICF-MRs, and a state-operated nursing home, which largely as a center for difficult to serve consumers. SOS has a large field staff, not shown on the diagram for space reasons.



**Figure 3. Minnesota Department of Human Services in July 2005**

Although most long-term care planning functions, stakeholder relations, and grant projects are Housed in the Continuing Care Administration, the Health Services Administration is responsible for managed care operations, including those for long-term care. Therefore, somewhat of an organizational disconnect occurs because the large policy and implementation decisions related to moving the Elderly Waiver from county management to managed care organizations does not fall under the general purview of Continuing Care; the individual given the responsibility is Pamela Parker, who had many years of experience running aging waiver programs prior to being assigned the role of developing Minnesota’s integrated acute care and long-term care demonstration, Minnesota Senior Care Options, under an 1115 waiver (see below).

### **Local Organization for LTC**

Minnesota refers to its organizational form as “a county-administered, state-supervised” structure. Most health and social service programs are administered by Minnesota’s 87 counties or (when applicable) one of its tribal jurisdictions. For entry into a wide variety of programs, the consumer applies to his or her county social service agency. Financial and functional eligibility assessment is done by the county, as are case management functions. Minnesota had a longstanding preadmission screening process for all Minnesotans entering a nursing home or an alternative waiver, regardless of whether they were public or private pay. That function has been reconfigured as Long Term Care Consultation (LTCC) to connote its broader function as an aide to consumer decision making. LTCC teams are comprised of social workers and nurses; they are involved in all applications to nursing homes and HCBS waivers except for the Mental Retardation/Related Conditions waiver, which uses its own screening process.

Applications for Medicaid and for programs are usually processed efficiently, although after the consumer is deemed eligible, he or she may need to be on a wait list for some waivers. Depending on the county, social workers may have specialized caseloads for a target group of consumers, or they may be assigned a varied caseload in a geographic area. If they are already enrolled in Medicaid, consumers may apply directly to some managed care plans. The Area Agencies on Aging in Minnesota are all multi-county entities; they operate traditional aging network services such as senior centers and meal programs and they also are engaged in resource development. The Minnesota Board on Aging (the term for the State Unit on Aging) has developed telephone and web information and assistance services, but these direct consumers to the counties for entry into a wide range of programs.

### **Litigation Related to Re-Balancing<sup>14</sup>**

The downsizing and closing of state institutions for people with mental retardation in Minnesota, a trend already begun in the 1970s, was accelerated by the *Welsch* case, a class action initiated in 1972, challenging the living conditions of patients in one of the state's State Hospitals (*Patricia Welsch, et al. v. Arthur Noot* (U.S District Court in Minnesota 1980). Under the *Welsch consent* decree, Minnesota's Department of *Public Welfare* (now the Department of Human Services) committed to achieving significant reductions in the population of people with developmental disabilities in the state hospital system, restructuring the Regional Treatment Center (RTC) system, transitioning people

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<sup>14</sup> The cases discussed here are not necessarily inclusive of all Minnesota lawsuits in this arena. More details regarding these cases are at: Smith G.A. "Status Report: Litigation Concerning Home and Community Services for People with Disabilities." Human Services Research Institute. 2005. [www.hsri.org/index.asp?id=news](http://www.hsri.org/index.asp?id=news) and, Kitchener, M. Willmott, M. and Harrington, C. "Home and Community Based Services: Olmstead and Olmstead-Related Lawsuits". UCSF National Center for Personal Assistance Services. 2005. <http://www.pascenter.org/olmstead/>

with mental retardation and related disorders into the community, and developing state-operated group homes for this target population as part of the phasing out of institutions. The process for moving people into the community was completed in 1999, 27 years after the suit was initially brought."

In Minnesota, two similar lawsuits sought to halt the state's "rebasings" of funds allocated to counties for HCBS waiver services for persons with mental retardation and related conditions. In *Association of Residential Resources in Minnesota et al. v. Goodno et al.* plaintiffs requested a temporary restraining order (TRO) to stop "rebasings," which they argued would result in reductions in budgets for individual waiver participants. The TRO was granted in March 2003. The suit was dismissed when the parties reached a settlement agreement in November 2004. In *Masterman et al. v. Goodno*, four individuals and the Arc of Minnesota filed a similar lawsuit in April 2003 to halt rebasing. Parties to this suit, presided over by the same judge as in the *ARRM* case, also reached a settlement in 2004. The settlement commits the state to increase county allocations in 2005 and 2006 over prior year levels and to issue new guidelines for counties in establishing individuals' budgets that will specifically prohibit across-the-board service cuts based purely on budgetary concerns. DHS also agreed to contract with an independent consultant to develop a new funding methodology for the MR/RC waiver and to seek input from the plaintiffs' counsel, the Minnesota Disability Law Center (MDLC), in developing this methodology.

### **Advocacy environment**

In Minnesota, as in the other Rebalancing states, there has been little collaboration between advocacy on behalf of the elderly and disability advocates and the state's

disability advocacy community has been much more organized and active on long-term care system reform. For example, reforming the long-term care system is a top priority for the Consortium of Citizens with Disabilities (CCD), a coalition of disability organizations in Minnesota, but rebalancing is not even on the agenda of the Minnesota Senior Federation, whose primary focus is on prescription drug reform. Notably, in the late 1990's, the Aging and Adult Services Division of the Minnesota Department of Human Services sought to build stronger advocacy on behalf of older adults for LTC reform. The division organized meetings of older Minnesotans across the state to brainstorm and strategize long-term care systems reform. The outcome of this process, however, had little to do with such reform. Rather, the outcome was a call for changing the social perception of seniors – away from vulnerable, frail elderly in need of services to one of “vital” older persons in the prime of their lives – which ultimately led to formation of the Minnesota Vital Aging Network, which (similar to the Senior Federation) has not been particularly focused on long-term care.

Minnesota has a long tradition of public/private partnerships to address social problems and involving consumers in planning and policy discussions. The Disability Services Division of the Minnesota Department of Human Services, for instance, is seeking to add more consumers to its existing advisory committees (although it is not clear if this strategy is to strengthen consumer advocacy or to obtain the unfiltered views of direct service recipients. The state has also funded advocacy organizations directly. For example, the Department of Employment and Economic Security has provided funding for Advocating Change Together (ACT), a grassroots disability rights organization that promotes self advocacy. ACT uses these unrestricted funds to “build a

self-advocacy leadership base” by training a cadre of “self-advocates.” Minnesota is also directly involved with a coalition of advocacy organizations for the elderly -- the Senior Organization Network in Minnesota. The state’s Board on Aging (BoA), housed in the Department of Human Services, provides staff support to the network, is itself a member, and the BoA chair currently chairs the network.

The current Commissioner of DHS has actively solicited advice and feedback from advocacy organizations on new programs and policy proposals. Leadership at the Consortium for Citizens with Disabilities maintains its ability to influence long-term care policy rose sharply after Kevin Goodno, a former legislator with a long and well-known personal interest in disability issues (not shared by his predecessor), was appointed DHS Commissioner. Unlike most Rebalancing states, Minnesota did not establish a formal Olmstead process.

**Service environment**

The supply of nursing homes and nursing home beds continues to decrease in Minnesota, continuing a long decline that began over 10 years ago. The number of nursing facilities declined from 389 in 2000 to 382 in 2004 (See Table 3). The number of nursing home beds peaked in 1987 at 48,307 beds and by the end of 2004 had decreased to 34,837, a decrease of 13,470 beds. Minnesota’s nursing home bed supply is now about 25 percent smaller than it was at its height in 1987.

Table 3: Supply of Nursing Facilities, Bed, Residents, and Occupancy Rate, Minnesota 2000-2004

Year	2000	2001	2002	2003	2004
Nursing Facilities	380	371	368	377	382
Nursing facility beds	37,190	35,080	34,572	34,225	34,873
Nursing facility	34,873	32,995	32,010	31,630	32,130

Residents					
Occupancy Rate	93.8	94.0	92.6	92.4	91.5

Source: C. Harrington, H. Carrillo, and C. Mercado-Scott. Table 1, "Nursing, Facilities, Staffing, Residents, and Facility Deficiencies, 1998 Through 2004," Department of Social and Behavioral Sciences, University of California, San Francisco. Available at <http://www.pascenter.org>.

In Minnesota “assisted living” is a service concept rather than a place, whereas “housing-with-services” establishments are where the consumers live.<sup>15</sup> In 2004, Minnesota had 907 registered housing with services establishments. These establishments include 40,086 units that serve an estimated 35,000 older people. Between 1997 and 2004, the numbers of housing with services establishments doubled (426 to 907) and the number of available units tripled, rising from 13,000 units to 40,086 units. Thus in 2004, Minnesota had more housing with services establishments and units than nursing homes and nursing home beds -- 382 nursing facilities compared to 907 housing with services establishments, with 34,873 nursing home beds compared to 40,086 housing with services units.

### **Historical Evolution of Long-Term Care**

Table 5 below contains a timeline for some of the major milestones in Minnesota toward rebalancing its long-term care system.

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<sup>15</sup> The Minnesota housing with service establishment definition: . . .*an establishment providing sleeping accommodations to one or more adult residents, at least 80 % of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment* (MN Statutes Chap. 144D.01, subd.4). The State’s Medicaid waiver program defines “assisted living services” as “up to 24-hour oversight and supervision, supportive services, home care aide tasks and individualized home management tasks...” provided in all settings that are registered as “housing with services” establishments and provided by management or by providers under contract with the establishment.

**Table 4. Selected LTC Milestones in the State of Minnesota**

<b>Year</b>	<b>Policy of Programmatic Development</b>
1980	<ul style="list-style-type: none"> <li>• Consent decree issued in Welsch v. Noot et al. to develop HCBS for mental retardation.</li> </ul>
1982	<ul style="list-style-type: none"> <li>• Elderly Waiver (EW) established</li> </ul>
1984	<ul style="list-style-type: none"> <li>• Mental Retardation/Related Conditions (MR/RC) waiver established</li> </ul>
1985	<ul style="list-style-type: none"> <li>• Community Alternative Care (CAC) waiver established</li> </ul>
1987	<ul style="list-style-type: none"> <li>• Community Alternative for Disabled Individuals (CADI) wavier established</li> </ul>
1991	<ul style="list-style-type: none"> <li>• State funded Alternative Care (AC) program established</li> </ul>
1992	<ul style="list-style-type: none"> <li>• Traumatic Brain Injury (TBI) waiver established</li> </ul>
1995	<ul style="list-style-type: none"> <li>• 5-year demonstration to test Senior Health Options (MSHO) under 115 waiver Regan</li> </ul>
1997	<ul style="list-style-type: none"> <li>• DHS Project 2030 created</li> </ul>
	<ul style="list-style-type: none"> <li>• Region 10 Quality Assurance Commission pilot project established</li> </ul>
2000	<ul style="list-style-type: none"> <li>• Tri-partisan Long-Term Care (LTC) Task Force created</li> </ul>
2001	<ul style="list-style-type: none"> <li>• RCSC System Change Initiative (\$2,300,000) for Pathways to Choice</li> <li>• RCSC C-PASS Grant (\$900,000) to create Consumer Directed Community Services in MR/RC waiver.</li> <li>• Voluntary Planned Closure Program for nursing facilities implemented</li> <li>• Legislature established regional LTC planning process.</li> <li>• Legislature expanded LTC consumer information.</li> <li>• Modifying Preadmission Screening to form the Long-Term Care Consultation (LTCC) program.</li> <li>• County-by-county “gaps analysis” of LTC by DHS</li> <li>• MSHO continued and Minnesota received expanded authority to develop Minnesota Disability Health Options (MnDHO) under 1115 Waiver</li> </ul>
2002	<ul style="list-style-type: none"> <li>• RCSC Grant for Nursing Home Transitions (400,000)</li> </ul>
2003	<ul style="list-style-type: none"> <li>• RCSC QA/QI grant (499,880)</li> <li>• RCSC ADRC grant (\$739,136)</li> </ul>
2004	<ul style="list-style-type: none"> <li>• MinnesotaHelp.info Web-based consumer information program initiated</li> <li>• RCSC Mental Health Transformation grant (\$300,000)</li> <li>• RWJF Cash &amp; Counseling grant</li> <li>• CMS approved waiver amendments to add Consumer Directed Community Services to all waivers, the Alternative Grant Program, and MSHO and MnDHP.</li> </ul>

## Programs and Services

**Table 5. Overview of HCBS Waivers in Minnesota**

Waiver	Year Begun	Number Served	Costs in 2004	Major Services**	Eligibility***
MR/RC Mental Retardation and Related Conditions	1984	14,677	\$799,400,194	Supported employment services; supported living and day training; adult day care; consumer directed community supports; live-in personal caregiver expenses	Any age. Person with MR/RC requires 24-hour care and needs a level of care normally provided by ICF-MRs but requests community care
Elderly Waiver	1982	9,644	\$93,973,690	. Adult day care; assisted living, adult foster care, home delivered meals; residential care service; transitional supports	Age 65 or older. Person needs a level of care normally provided in a nursing facility but requests community care.
CADI Community Alternatives for Disabled Individuals	1987	6,014	\$73,646,159	Supported employment services; adult day care; foster care; assisted living services.; independent living skills; family counseling and training	Under age 65 at time of screening. Clients who turn 65 are allowed to continue if other eligibility factors met. Person with a certified disability needs a nursing facility level of care but requests community care.
TBI Traumatic Brain Injury	1992	736	\$37,646,159	Supported employment services; behavior programming by professionals; extended cognitive rehabilitation therapy	Under age 65 at time of screening. Clients who turn 65 are allowed to continue if other eligibility factors met. Person certified as disabled with TBI needs a level of care that is provided in a specialized nursing home or in a long-term neurobehavioral hospital, but requests community care.
CAC Community Alternative Care	1985	132	\$7,556,016	Extended prescription medications; extended home health aide and nursing; extended nutritional therapy; extended home health therapies; extended supplies and equipment family counseling and training; foster care	Under age 65 at time of screening. Clients who turn 65 are allowed to continue if other eligibility factors met. Person certifies as disabled with a chronic illness needs a level of care normally provided in a hospital and would require frequent or continuous inpatient hospitalization over a year, but requests community care

\* Average monthly enrollment  
3,667 for MR/RC waiting list

\*\*Services common to all waivers include case management; homemaker services; equipment, home, or vehicle modifications; extended personal care assistant services; respite care; transportation

\*\*\*For MR/RC, CAC, CADI, and TBI waivers, person must meet Medicaid financial eligibility requirements based solely on the individual's income and assets, disregarding income and assets of spouses and parents. Parents with incomes above 100 percent of federal poverty guidelines pay parental fees for their child's services. For elderly waiver, must be eligible for Medicaid based on one of two income limits. People with monthly incomes at or below \$1692 are eligible without having to spend down their incomes but must pay for part of waiver services if incomes are above \$752. Those above \$1692 are required to spend down.

### Alternative Care Program

The Alternative Care (AC) program, created in 1980, is a state-funded program providing access to home- and community-based services for Minnesotans age 65 and over.

Enrollees must be in need of nursing facility level of care but choose home-or community-based services and have income and assets that are inadequate to fund nursing facility stay for more than 180 days but are too high to qualify for Medicaid and other public programs. The purposes of the AC program are to limit nursing facility admissions, support and extend independent living, and to support informal caregivers in their efforts to provide care. Covered benefits (including services such as adult day care, adult foster care, homemaker services, home health aides, personal care assistance, case management, respite care, home-delivered meals, and transportation) are to address only those chronic aging needs that would otherwise lead to permanent nursing home care. The state's consumer directed service option (CDCS) is available in the AC program.

The AC program is designed to prevent the impoverishment of older Minnesotans and future reliance on the Medicaid (MA) program by providing them access to HCB services at an earlier point of need, before they reach MA eligibility status. This voluntary, non-entitlement, publicly-funded program requires a voluntary expanded role for enrollees through cost-sharing and monthly premiums using a sliding fee structure based on income and assets.

In FY2004, 9,128 Minnesotans were enrolled in the AC program, of whom 45% were age 85 and older. Total program expenditures were about \$65 million.

## HCBS waivers in Minnesota

Minnesota has 5 section 1915(c) Medicaid HCBS waivers -- Elderly Waiver (EW), Community Alternative Care Waiver (CAC), Community Alternatives for Disabled Individuals Waiver (CADI), Traumatic Brain Injury Waiver (TBI), and HIV/AIDS waiver. All are administered by the Department of Human Services, the EW waiver by the department's Aging and Adult Services Division, the other 4 by the department's Disabilities Services Division.

- The Elderly Waiver (EW) program, established in 1982, funds HCB services for people age 65 and older who are eligible for Medicaid and require nursing facility level care but choose to reside in the community. Minnesota counties administer the EW program. Covered services, in addition to those common to all Minnesota waiver programs (see Table 6), include e.g., adult day care, assisted living, adult foster care, and residential care service.
  - EW recipients can receive services through the traditional fee-for-services system or the state's 2 managed care programs – Prepaid Medical Assistance Program (PMAP) and the Minnesota Senior Health Options (MSHO). The consumer directed option became available to EW enrollees in 37 counties in October 2004, and then statewide as of April 1, 2005. This option is not available to clients in residential settings (e.g., assisted living, foster care).
  - Enrollment in the EW program in FY 2004 was 14,781. Total long-term care expenditures for EW enrollees were \$149 million, of which \$110 million was for waiver-funded services and an additional \$39 million was for State

Plan Home Care services (both PMAP and fee-for-services) for EW enrollees. Average per-enrollee monthly costs were \$1087 (based on an average monthly persons served of 11,433).

- The MR/RC waiver is for persons with mental retardation or related condition of any age who have mental retardation or related conditions that require 24-hr care of level of care normally provided in ICF-MRs. Covered services include all Medicaid services, HCB services common to all waivers, and additional services such as supported living services, day training and habilitation, and supported employment services . Enrollment in FY 2004 was 14,677, with total expenditures of \$799,400,194 (\$54,466/enrollee)
- The Community Alternatives for Disabled Individuals (CADI) waiver is for persons with disability in need of nursing facility level of care who are under age 65, have a “certified disability” in need of nursing facility level of care. Covered services include all Medicaid services, services common to all waivers; and additional services such as supported employment services. Enrollment in FY2004 was 6,014, with total expenditures of \$73,485,533 (\$12,219/enrollee).
- The Community Alternative Care (CAC) waiver is for persons under age 65 disabled with a chronic condition, needing level of care normally provided in hospital who require frequent or continuous inpatient hospitalization over a year. Covered services include all Medicaid services, HCB services common to all waivers, and additional services such as:extended prescription medication. Enrollment in FY2004 was 132, with total expenditures of \$7,556,016 (\$57,242/enrollee).

- The Traumatic Brain Injury (TBI) waiver is for persons under age 65 disabled with traumatic brain injury needing level of care that is normally provided in specialized nursing home or long-term neurobehavioral hospital. Covered services include all Medicaid services, HCB services common to all waivers, and additional services such as supported employment services. Enrollment in FY2004 was 736, with total expenditures of \$37,646,159 (\$51,149/enrollee).

The 4 waivers administered by the Disability Services Division have been managed using individual cost caps. Until 1999, approximately 600 MR/RC Waiver allocations were awarded annually, fewer than the annual increase in the number of people applying for this waiver. In 2001, the legislature enacted new policies that allowed access to the waiver for over 5,000 new people, increasing the total number of waiver participants to over 14,000. As of September 1, 2004, approximately 14,530 people were receiving services through the MR/RC Waiver.

Also in 2001, the Minnesota Legislature required the Department of Human Services to change to an aggregate funding management methodology to improve access to HCB services for people with the most severe disabilities. Because growth in the waivers was outpacing state budget resources, the 2003 Minnesota Legislature limited caseload expansion in both the CADI and TBI waiver programs by placing a fiscal limit on growth in TBI and an enrollment limit on CADI. As predicted by the DHS, these new limits to program growth resulted in waiting lists. Because county agencies did not have a history of managing waiting lists, systems were developed and brought on line in late 2004 to assist counties and the Department to track, manage and monitor waiting lists. DHS

reported that during FY2004, 713 people were placed on waiting lists (combined total for the CAC, CADI, and TBI waivers). By the end of the year, 228 of those people were able to enroll in a waiver program. The average age of persons on the waiting list was 38.9 years and the average time between assessment and enrollment in a waiver program was 73.7 days.

## **Section II. System Assessment**

### **Access to Services**

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). Financial and functional eligibility consolidated in nurse-social worker teams from county departments of human services and/or health. County-administered LTC consultation has replaced more top-down case management concept. Mental retardation lead agencies operate in a separate system. Because long-term support programs under Medicaid operate through 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 (UA) for 4 of the 5 HCBS waiver programs (comprising all the waivers that serve participants under age 65), improving individual budgeting mechanisms, redesigning case management, and restructuring the allocation mechanisms for state budgets. The UA

effort has a steering committee consisting of state, county, consumer, and provider representatives that meets on a quarterly basis. The state is seeking the input of stakeholders to assure a culturally sensitive tool and one that responds to issues affecting different populations, including children and persons with mental illness.

### **Array of Services**

Minnesota has a wide array of in-home providers of home care and personal care services, and developmental disability services. Through its consumer directive initiative, the State is developing a capacity for independent providers as personal care workers and attendants, and the fiscal intermediary system needed to manage such services when the State is paying. Minnesota is also pursuing the development of assisted living (“housing with services” model) for older people that combine a service capacity with a desirable living environment. Its strategy, however, remains unclear and the role of assisted living in the state’s array of services has not yet been defined.

### **Consumer Direction**

Consumer-direction in Minnesota is on the increase, moving (as in other states) from an unfamiliar term 20 years ago to a concept that is becoming embedded in state policy and programming, particularly for programs that provide long-term care for younger persons with disabilities. In recent years, its application has spread to all of the state’s populations in need of long-term care. Consumer directed community supports (CDCS) have been developed, along with related materials and manuals and, in 2004, Minnesota modified all its HCBS waivers to include CDCS as a service. In 2005, the state completed readiness reviews for and established a system of state-wide fiscal

intermediaries for CDCS, incorporating 3 levels of activity for the fiscal intermediaries, ranging from fiscal conduit to agency with choice.

Consumer direction has also been incorporated into the state's Older Americans Act family caregiver programs. Managed care organizations in Minnesota that deliver waiver services under capitated program are required to include the consumer-directed option. Finally, Minnesota is piloting a Cash and Counseling Program, as one of the 12 states in the first wave of the C&C program replications

### **Quality Initiatives**

Quality initiatives in Minnesota have been focused more on improving institutional services and less on designing approaches to manage or improve the quality of HCBS services. 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.

Minnesota has also undertaken a series of inter-related efforts to manage and improve quality in 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.

Minnesota has a pilot program in one region of the state to assure quality 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.

### **Institutional Downsizing**

Minnesota has several programs explicitly designed to control the size of its nursing facility industry, large relative to other states in terms of nursing homes and nursing home beds per capita. 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, unique to Minnesota, the state is closing NF beds at the rate of 1000/year. In 2005 a 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. The Voluntary Planned Closure Program is discussed in more detail under "Featured Management approaches" below.

### **Data Capacity**

Minnesota has a well-designed relational database in place that contains information on screening, client characteristics, assessment, claims/utilization, and providers. However, there are issues with the quality of some of the data – e.g., for certain programs assessment-related data and encounter and utilization information on managed care clients. The data system is further limited by the fact that it is set up for payment as opposed to policy/planning purposes. Medicaid eligibility and claims data for both aging- and MR/DD-related clients are centralized in the Health Care Administration.

Although data are available, it is not a simple task to describe the characteristics of persons covered by various Medicaid programs.

### **Mental Health Linkages**

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.

### **Housing Linkages**

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.

### **Section III: Featured Management Approaches**

#### **Nursing Facility Bed Closure Program**

Minnesota has had a moratorium on NH beds since 1983. The Voluntary Planned Closure Program<sup>16</sup> was created to give nursing facilities financial incentives to voluntarily close beds under an approved application process. The program was designed to better match the supply of beds with anticipated future demand and to offset increased spending from expanded HCBS programs. The legislation set a cap of 5,140 beds to be closed. Although the legislative language does not state how long the earmarked beds must remain closed, when combined with the state's existing moratorium on creating new beds, the assumption was they would be closed forever. 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 have closed altogether. It is estimated that about 95 percent of displaced nursing facility residents transferred to other nursing facilities, while the other 5 percent went to less restrictive settings; however accurate figures have not been collected. This "planned closure" program is unique to Minnesota.

Minnesota also implemented a "lay-away" program that allows nursing facilities to temporarily close beds on a voluntary basis. In this program, incentives for nursing facilities include exemptions from paying license and surcharge fees on beds placed in lay-away, reimbursement of an adjusted rate equal to the reallocation of the property rate, and "bed-hold" rates (an added compensation paid when facility occupancy is 93% or higher). A bed on "lay-away" status must remain in the program a minimum of one year

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<sup>16</sup> Minnesota statutes 256B.437.

and a maximum of 5 years. As of early 2003, 2,519 beds had been placed on lay-away status. At present about 1800 beds are on lay away. This approach has been a route to permanent closure. After 2004 the calculation had to show budget neutrality. The costs of the services provided through HCBS to those not housed in the closed beds had to be considered. Nonetheless, most closed beds got the \$2080. Fewer than 1000 beds have been affected since 2004.

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. The formula was 20% of the ratio of the number of new single beds/all beds in the facility as of 7/1/05 times a weighted average operating rate. The ratio component cannot exceed 50% because of the way it is calculated. This incentive interacts with the rate equalization policies in effect in MN. Since the mid-1980s Minnesota has requires that any nursing homes participating in Medicaid charge their private pay residents no more than Medicaid's rate for an individual of the same case mix. Facilities can elect to have single rooms exempted from rate equalization and they will receive an additional 15% from Medicaid if the use is medically necessary. However, doing so also results in a lowering of the property rate for all beds. Because single rooms are rated at 1.5 a usual bed, this lose could be costly.

The surcharge became an important factor in 2003, when it was increased from \$990 per bed per ear to \$2815. If the bed is occupied, the rate will slightly more than over this tax. However, if a facility has more than 10% of their beds vacant, they will not recover the costs, and if they have less than 10% vacant they will do fine with it. So keeping chronically unused beds in active service is very costly to the facility

## Consumer Direction

In Minnesota, consumer direction is available through four mechanisms: the Consumer Support Grant, the Family Support Grant, the Personal Care Assistance Option, and the Consumer Directed Community Support (CDCS) service. The CDCS option gives individuals more flexibility and responsibility for directing their long-term care services and supports. Under this option, Minnesotans receiving HCB services can work within a set budget to customize their services and have family and friends as well as personal care and home care agencies provide those services. The CDCS began as a pilot program in three grant demonstration counties in 1998. During the next 5 years, 37 counties signed memoranda of understanding with the Department to offer the CDCS option, initially available only to participants on the state's MR/RC waiver. As shown in Table XX, enrollment costs in the CDCS option in the MR/RC waiver grew rapidly from 1999 to 2004.<sup>17</sup> In a 2003 review, the Minnesota Legislative Auditor determined that the Department of Human Services lacked sufficient controls over Consumer-Directed Community Supports, leading to questionable purchases, inequitable variation in administration, and unmet prospects for cost efficiencies.<sup>18</sup>

In December of 2003, DHS submitted waiver amendments to expand CDCS statewide and across all five HCBS waivers and to provide for consistent administration in all 87 counties. These amendments were approved in April of 2004. As of April 1,

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<sup>17</sup> Schmitz, CC, Luxenberg MG, and Eustis N. "Interim Report: Evaluation of the Consumer Directed Community Support Service," Submitted to DHS March 2005

<sup>18</sup> MN Legislative Auditor. "Medicaid Home and Community-Based Waiver Programs for Persons with Mental Retardation or Related Conditions." 2003.  
<http://www.auditor.leg.state.mn.us/ped/pedrep/0403all.pdf>

2005, the CDCS option became available as a statewide service for Medicaid-eligible individuals enrolled in any of the following programs:

- Minnesota Disabilities Health Options (MnDHOP) for people with disabilities
- Minnesota Senior Health Options (MSHO) for dually eligible seniors
- Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), Traumatic Brain Injury (TBI), Elderly (EW), Mental Retardation/Related Conditions waivers

In 2004, the Robert Wood Johnson Foundation awarded a \$350,000 grant to Minnesota as 1 of 11 states funded under the expansion of the Cash and Counseling program.

Minnesota will use the funds to support expansion of the consumer-directed support option to all Medicaid-funded home and community based services programs. The state will use the Cash & Counseling funds to provide additional training (for county workers, service providers, and consumers) and improve communications, consumer advocacy efforts, and computer.

### **Report Cards**

Minnesota is in the process of developing a Nursing Home Report Card, envisioned as an interactive web-based program that will provide consumers with information on all Medicaid-certified nursing homes in a manner that will allow consumers to comparison-shop. The report card is being developed jointly by DHS and MDH, with technical assistance from the University of Minnesota. 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.

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

The dramatic story of closing state MR institutions in Minnesota played out over at least four decades with legal challenges, the press, bipartisan elected and executive leadership, community advocates, and University-based personnel playing interacting roles. Advocates and government leaders in Minnesota had been engaged in critiquing and trying to improve state institutions from the 1960s, and in trying to improve public awareness of and attitudes about MR. Three governors lent their weight to the effort (Youngdahl in 1946, Wendell Anderson and Rolvaag in the 1960s). In 1961, when 6565 consumers were housed in state institutions and 900 were on waiting lists, Governor Anderson began piloting community day activities. Minnesota was the first state to capture construction dollars to develop regional programs and the first to develop a comprehensive plan. An investigative reporter published exposes in the Minneapolis StarTribune in 1965 and again in 1967. Muriel Humphrey was an active advocate through Arc in the 1960s. In 1966 Governor Rolvaag proclaimed the rights of people with developmental disabilities: the right to live without privation, the right to be useful, and the right to individual care help, education, acceptance, jobs, clarity, and efficiency. In 1971, Minnesota started using ICF/MR federal funding, certifying state hospitals and being the first state to certify group homes for Medicaid payments. Preceding the *Welsch* class action suit of 1972, Minnesota had a number of efforts in place, including regionalizing the institutions, developing education and employment programs. The Governor's Council on Developmental Disability (GCDD) was formed within the

Department of Administration in 1971 to serve as an advocate for people with disability; ; 60% of the 25 appointed members have a developmental disability or are families and guardians to people with developmental disabilities. The GCDD is active to the present time, maintaining a planning function, and running a number of 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).

In the years after the Welsch case was initiated in 1972, up to and following the 1980 consent decree, the State adopted every national funding opportunity in the MR field. With federal funds, the Community Alternatives and Institutional Reform Project (CAIR) was initiated, staffed by the GCDD and chaired by Robert Bruninks (now President of the University of Minnesota). The 1980 consent decree set targets for closure (reduction to 1850 people in 7 years), emphasized adequate staffing for all programs, and availability of therapies. Minnesota first HCBS waiver request for MR/DD was approved in 1983. A state ombudsman program for Mental Health and Mental Retardation, also part of the decree was begun in 1987.

Opposition to closing of the state hospitals was intense, led by the AFSCME union but joined by some parents of consumers in the state institutions. Opponents went to the legislature, and 6 bills were introduced when the 1984 session began to repeal the new waiver. Concerns about premature closure and lack of community infrastructure were repeatedly countered by studies and reports—some through government task forces, some through the Court monitor's office, and some in the private sector. The Union insisted on state-operated community programs to preserve jobs, and in 1985 the state issued an RFP to create such programs. The State Operated Services program, now part

of the purview of the Assistant Commission for Continuing Care, grew out of that decision to deploy former state institution personnel in the community.

Reflecting on the success of the efforts in a 2001 recognition program (now retained as a series of well-illustrated slides and video clips, called ‘With An Eye to the Past,’ various actors emphasized the following: beginning the deinstitutionalization with children even those with the most severe disabilities (accomplished by 1987), which tends to remove any rationale that severely impaired children need this level of care; advocates speaking with a unified voice to the legislature; capitalizing on federal funds; using numerous public hearings; studies which elicited the consumers own voices; preparation of position papers, including a seminal 1986 document, “A New Way of Thinking,” which emphasized strengths not test scores; on the GCDD website u, some of the following strategies were

### **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.

In a more recent planning initiative, the Minnesota legislature in 2003 mandated the DHS to study alternative financing options for long-term care, addressing head-on the

policy debate on “what the balancing should be between the responsibility of individuals to protect themselves against the risks and vicissitudes of old age, and the responsibility of government to provide universal programs that spread this risk across a whole population.” (Financing Long-Term Care for Minnesota’s Baby Boomers. Report to the Legislature, DHS 2005). The study analyzed 9 financing options for their potential to “maximize private dollars and minimize Medicaid liabilities.” Informing this study was the state’s goal of providing long-term care in the most cost-effective settings -- home- or community-based settings, for most people in need of such services. The 9 options were:

- Long-term care insurance (LTCI) options, including the use of medical assistance funds to subsidize the purchase of private LTCI by individuals who would be unlikely to purchase it without a subsidy (specifically mentioned in the legislation).
- The Partnership for Long-Term Care program (specifically mentioned in the legislation).
- Adding a nursing facility benefit to Medicare-related coverage (specifically mentioned in the legislation).
- Health insurance options that combine health and long-term care coverage.
- Life insurance options that include long-term care coverage.
- Reverse mortgages.
- Family loan and line of credit program (specifically mentioned in 2003 legislation).
- Universal long-term care savings plans, called CarePlus, passed by the Hawaii Legislature in 2003 and subsequently vetoed by the governor.
- Long-term care annuities

Included in the 2001 Legislature’s comprehensive long-term care reform proposal was a requirement for DHS to develop recommendations for a new nursing facility reimbursement system that is based on “value” (a combination of the facility’s quality and efficiency). The current reimbursement system, according to the legislature, is a historical artifact that no longer meets the needs of nursing facilities, consumers, or

policy makers. DHS issued an initial proposal for “value-based reimbursement” in 2004, but the legislature has so far taken no action.

### **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.

#### **Section IV. Quantitative Markers of Rebalancing**

##### **Markers of Change in Nursing Home Residents**

In order 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 another 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 HCBS was intended to defray. We used all MDS admission assessment records in 2002, 2003, and 2004 to calculate the NH Case Mix at admission. The numbers of new admissions in 2002, 2003, and 2004 were 38,941, 43,736, and 42,992 respectively. This included multiple admissions of the same individual in the same or different NH.

We used MDS quarterly records in 2002, 2003, and 2004 to calculate to calculate the NH Case Mix at 3 months after admission. First, we selected all MDS quarterly records into a separate data file. Then we merged this data file with the admission records data

files using the resident ID and the facilitate ID. Then, we calculated the day difference between the admission date and the assessment date of the quarterly file. The first quarter assessment was identified if the day-difference is between 75 days and 105 days. Finally, we used these first quarter assessment records in our analysis

## Methods

We calculated the ADL score following the method developed by Morris, Fries, & Morris (1999) for the MDS ADL Long-Form. Specifically, we used variables G1AA (bed mobility), G1BA (transfer); G1EA (locomotion on unit), G1GA (dressing), G1HA (eating); G1IA (toilet use), and G1JA (personal hygiene). The original coding for these variables were between 0 and 4 (0 for independent, 1 for supervision, 2 for limited assistance, 3 for extensive assistance, and 4 for total dependence) and a number 8 was used when the activity did not occur during the entire 7 days of assessment. We recoded the number 8 (activity did not occur during the entire 7 days) as 4 (total dependence). We finally created a summation score of total ADL dependence by adding the value of these 7 variables. Therefore, the possible score of our ADL variable is between 0 and 28. A higher score means higher ADL dependence.

We used the CPS developed by Morris J, Fries B, Mehr D, et al (1994) to measure the cognitive functioning of elders in NH. The CPS was calculated using variables from section B (B1: Comatose; B2A: Short term memory), section C (C4: making self understood), and section G (GHA: eating) of the MDS. The possible score of CPS is between 0 and 6. A higher CPS score means lower cognitive functioning.

## Results

Table I. shows the results of the NH case mix for Minnesota. Between 2002 and 2004, elders admitted to NHs in MN had become more ADL-dependence. The average ADL score in 2002 was 13.46 and was slowly increased to 13.74 in 2004. During the same period of time, the cognitive functioning of elders admitted into NHs in MN had improved slightly. The average CPS score went down from 1.68 in 2002 to 1.58 in 2004.

**Table 8. Change in NH Case Mix Based on Admission Values – Minnesota**

	2002	2003	2004
ADL score	%	%	%
0	7.0	6.7	6.4
1	1.8	1.8	1.6
2	3.2	2.9	2.6
3	2.5	2.5	2.2
4	2.6	2.5	2.3
5	2.0	2.1	2.0
6	2.9	2.7	2.6
7	2.4	2.4	2.1
8	2.9	2.7	2.6
9	2.9	2.6	2.6
10	3.7	3.6	3.2
11	3.6	3.4	3.4
12	4.8	5.3	5.3
13	4.5	4.5	4.6
14	4.3	4.5	4.7
15	4.8	5.1	5.3
16	4.5	4.7	4.7
17	5.0	5.2	5.6
18	6.8	7.9	9.0
19	6.2	6.7	7.4
20	4.2	4.2	4.5
21	3.4	3.5	3.6
22	2.6	2.8	2.6
23	2.2	1.9	1.8
24	1.8	1.7	1.5
25	1.5	1.2	1.1
26	1.4	1.1	1.1
27	1.3	1.3	1.1
28	3.1	2.7	2.5
Mean ADL	13.46	13.52	13.74
N*	38,891	43,669	42,935
CPS score			
0	33.4	36.0	36.6
1	16.9	16.6	16.0
2	17.0	16.9	17.1
3	22.3	21.0	21.1
4	3.6	3.4	3.5
5	4.4	3.9	3.6
6	2.3	2.3	2.1
Mean CPS	1.68	1.60	1.58
N*	38,872	43,627	42,885

Table II. shows the NH case mix 3 months after admission for 2002, 2003, and 2004. The ADL functioning at 3 months after admission improved slightly over the 3 year period. The average ADL score in 2002, 2003, and 2004 were 12.44, 12.33, and 12.21 respectively. For the cognitive functioning, the CPS score also 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.

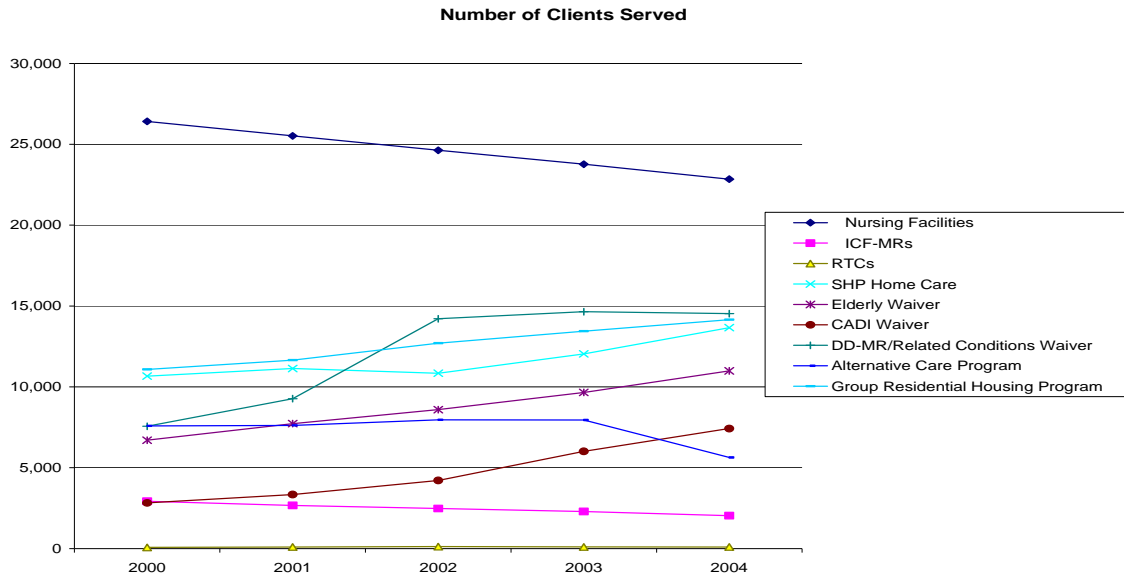
**Table 9. NH Case Mix Based on Values at Three Months after Admission**

	2002	2003	2004
ADL score	%		
0	10.4	11.4	12.7
1	2.9	2.8	3.0
2	4.5	4.8	4.2
3	4.1	3.9	3.9
4	3.3	3.5	3.0
5	2.4	2.3	2.6
6	3.0	2.8	2.7
7	2.4	2.6	2.1
8	3.2	2.7	2.6
9	2.8	2.7	2.7
10	3.5	2.9	2.8
11	3.0	2.3	2.5
12	3.3	3.2	2.6
13	3.5	3.2	3.0
14	3.0	3.2	3.0
15	4.0	3.9	4.6
16	3.6	3.5	3.4
17	4.3	4.7	4.6
18	5.3	6.5	6.9
19	5.0	5.1	6.5
20	3.9	4.1	4.0
21	3.6	3.8	3.8
22	2.4	3.0	2.7
23	2.6	2.0	1.7
24	2.3	1.9	1.8
25	1.8	1.6	1.6
26	1.6	1.5	1.2
27	1.6	1.7	1.5
28	3.0	2.7	2.4
Mean ADL	12.44	12.33	12.21
N	7,089	8,758	8,424
CPS score			
0	16.1	16.8	16.8
1	15.2	15.6	15.5
2	18.9	18.7	18.3

3	32.9	32.4	34.1
4	5.6	5.4	6.1
5	8.4	8.4	6.7
6	3.0	2.7	2.4
Mean CPS	2.34	2.30	2.27
	7,090	8,762	8,410

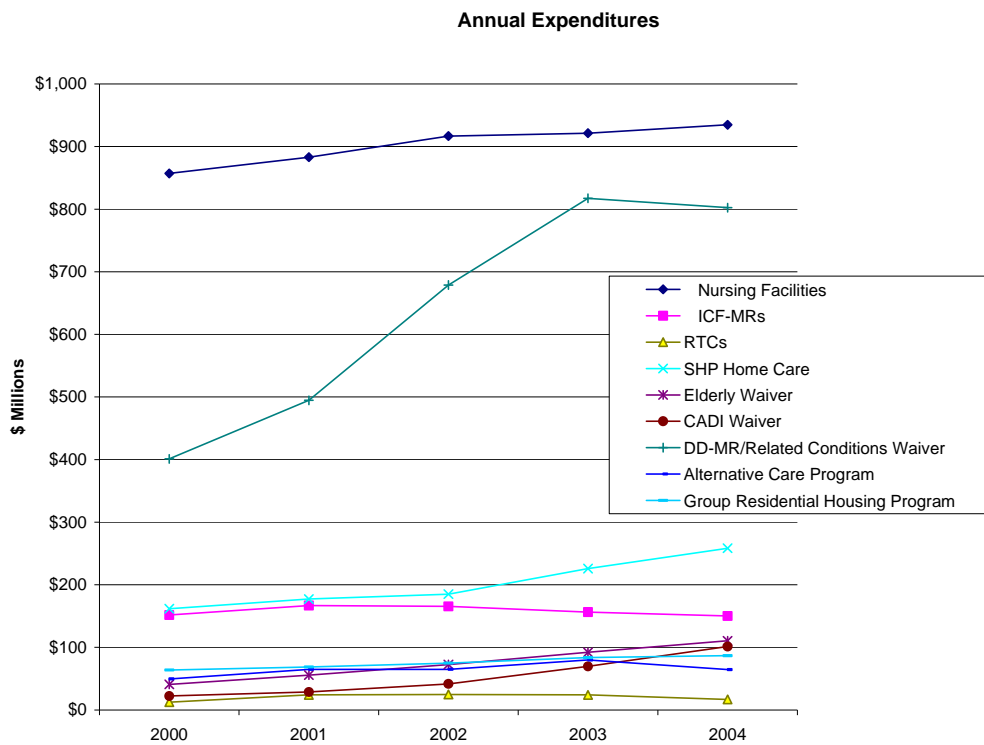
### **Relationships between HCBS and Institutional Care**

Figure 4. shows average monthly caseload for each of 5 years. (In Minnesota, we do not as yet have annual caseload data for all state plan services and thus graphed the ratio with monthly averages. (The absolute numbers are substantially understated, therefore, because the annual number served are about 1/3 higher for most waivers than the number served in any month.) There has been 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.



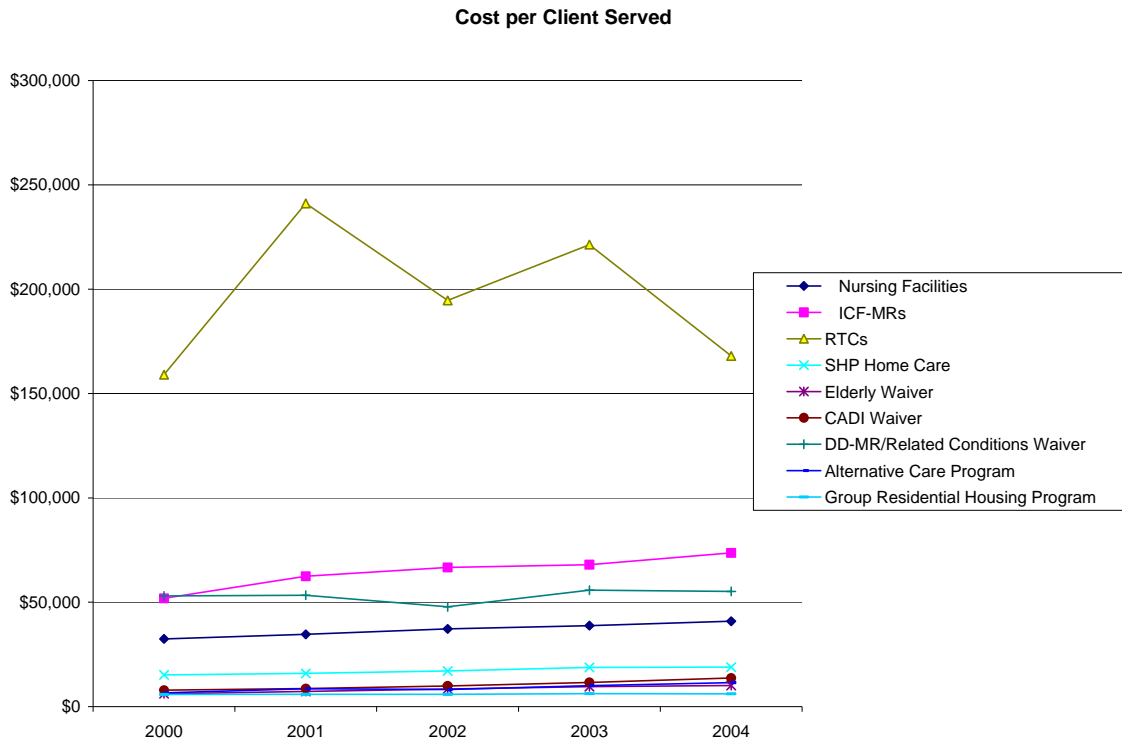
**Figure 4. Change in Program Participation from 2000 to 2004**

Figure 5 traces the pattern of expenditures for the entire year by program. 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.



**Figure 5. Change in Expenditures for Long-Term Care Programs, 2000 to 2004**

Figure 6. 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.



**Figure 6. Expenditures Per Person Served in 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 (CDSD), 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.