

Terminology disclaimer

The terminology used to describe people with disabilities has changed over time. The Minnesota Department of Human Services ("Department") supports the use of "People First" language. Although outmoded and offensive terms might be found within documents on the Department's website, the Department does not endorse these terms.

Minnesota State Profile Tool: An Assessment of Minnesota's Long-Term Support System

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The opinions expressed in this report are those of the authors and do not reflect the views of Thomson Reuters or the University of Minnesota Institute for Community Integration.

Introduction

This report is a comprehensive, high-level assessment of Minnesota's progress toward a balanced long-term care system – a system that relies less on institutional services and provides greater opportunities for in-home and community-based services to ensure people have adequate choices of services that meet their needs. It describes all publicly funded long-term support programs and shows recent utilization and expenditures data for these programs. This State Profile Tool is a resource that can inform decision-making about long-term care and support for people of all ages and diagnoses. It also includes demographic data that policy makers can use to estimate demand for long-term care, and includes information on privately funded long-term supports where data are available (primarily for institutional services).

In addition, this report describes the degree to which Minnesota's system includes system components that were found in a majority of states that had reformed their long-term term support system, as described on pages two and three. This profile can inform Minnesota's strategic planning efforts because the system components relate to principles that the Minnesota Department of Human Services (DHS), Continuing Care Administration wants to use “to design, implement, evaluate, and improve services”.¹

The Minnesota State Profile Tool is based on the model State Profile Tool developed by the Healthcare Business of Thomson Reuters (then known as Thomson Medstat) for the U.S. Centers for Medicare & Medicaid Services (CMS) in 2006.² In September 2007, CMS awarded grants to Minnesota and nine other states to produce similar profiles. DHS contracted with Thomson Reuters to complete this report, with a subcontract to the University of Minnesota Institute for Community Integration.

Methods

The Minnesota State Profile Tool is based on a variety of state and federal data sources and interviews with public and private leaders in Minnesota's long-term support system. The authors analyzed several national sources that provide data about each state's long-term supports. In addition, the authors collected data from Minnesota state agencies regarding utilization and spending for public long-term care programs, focusing on State Fiscal Years (SFY) 2004 through 2008 to show trends. Data for services provided in SFY 2009 were not included because complete data were not available for most services at the time this report was being compiled. For qualitative information, the authors reviewed state laws, regulations, policy documents, and research reports regarding Minnesota's system.

In addition, the Minnesota State Profile Tool is informed by the considerable input of the Home and Community-Based Services (HCBS) Expert Panel, a stakeholder group created under the State Profile Grant to assist in developing the state profile and to identify and discuss strategies to improve HCBS in Minnesota.³ The HCBS Expert Panel provided input regarding the organization of the profile and types of data collected for the profile and provided important comments upon review of a draft of the profile.

¹ Minnesota Department of Human Services *Guiding Principles* Revised December 1, 2008

² Eiken, Steve; Nadash, Pamela; and Burwell, Brian *Profile of Pennsylvania: A Model for Assessing a State Long-Term Care System* Thomson Medstat: December 2006

³ Colman, Loren invitation letter to HCBS Expert Panel members January 25, 2008

In addition, the authors interviewed HCBS Expert Panel members to learn about the long-term support system from their perspectives. The authors thank the HCBS Expert Panel members for volunteering their valuable time and insight to this profile.

Definitions

Several terms used throughout the State Profile are defined below to ensure readers understand the use of each term:

“Long-term care” and “long-term support” – these phrases are used interchangeably and defined as “a variety of services and supports to meet health or personal care needs over an extended period of time” intended to help a person maximize independence and functioning.⁴

“Institution” – a facility that is one of three types of licensed providers that traditionally have provided room and board and long-term care: 1) state-operated hospitals and forensic facilities serving people with developmental disabilities or serious mental illness; 2) intermediate care facilities for people with mental retardation (ICFs/MR); and 3) nursing facilities. This is an operational definition of an institution that reflects institutional services defined in Federal law (hospitals, ICFs/MR, nursing facilities) and facilities in Minnesota that provide a similar combination of housing and services. The authors recognize there are limits to defining an institution in this manner. Some institution residents may not perceive their residence as an institutional environment, while other residential settings can be perceived as institutional in nature by a resident if he or she has limited control over his or her environment and outside activities.

“Community services” – long-term care provided in locations other than an institution as defined above.

“Residential setting” – a residence owned or managed by an entity that provides long-term support at the location or contracts with an agency to provide services at that location. Residential settings include community residential settings such as adult foster care homes and registered housing with services establishments as well as the institutions defined above.

Organization of the Profile

The profile is organized in two parts. Part I is an overview of the long-term support system, including the following:

1. Data regarding demographic indicators of long-term support demand (i.e., age and disability prevalence)

⁴ U.S. Department of Health and Human Services, National Clearinghouse for Long-Term Care Information “Understanding LTC” Web site at <http://www.longtermcare.gov>, last updated October 22, 2008

2. An overview of service utilization and expenditures data
3. A description of available public programs and services

The authors used data from several national sources to compare Minnesota to other states regarding demographic indicators and services utilization, as described in *Section 1: Demographic Indicators of Long-Term Care Demand* and *Section 2: Service Utilization and Expenditures Data*. State comparisons can identify where Minnesota is making more or less progress in providing community supports and where demographic data indicate Minnesota should expect greater or lesser demand for services than in other states. The authors' review of these data sources at the national level identified regional variation in long-term supports, with more use of formal long-term care services and more public spending in the Upper Midwest. As a result, the authors chose to focus state comparisons on the four states that border Minnesota: Iowa, North Dakota, South Dakota, and Wisconsin.

Part II describes the long-term support system in relation to nine system components that are consistent with DHS Principles for providing long-term care services and have been found in states that have reformed their systems to encourage home and community-based services (See Table 1 on page four and DHS principles on page five).⁵ Eight components were named in the model State Profile Tool.⁶ The names and definitions of some of these components were changed based on suggestions from the HCBS Expert Panel. Furthermore, the authors added a ninth component, coordination with other services, because Minnesota has implemented several initiatives to improve coordination between long-term care and other health and social services. Also, this component reflects the DHS Principle of Coordination.

Part II of the Minnesota State Profile contains a section for each system component. This is different from the model State Profile Tool, which was organized primarily by target populations based on age or type of disability (e.g., physical disability or developmental disability). HCBS Expert Panel members noted several concerns about describing a state system based on target population:

- Many individuals fit within multiple populations (e.g., people with both developmental disabilities and mental illness)
- The target populations did not cover all people who need long-term supports (e.g., people under age 65 with dementia)
- Organization by target population suggested that the type of long-term supports a person needed were based on diagnosis, rather than a person's functional capacity and personal goals and preferences

⁵ See, for example: Crisp, Suzanne et al. *Money Follows the Person and Balancing Long-Term Care Systems: State Examples* Medstat: September 29, 2003; Eiken, Steve and Heestand, Alexandra *Promising Practices in Long Term Care System Reform: Colorado's Single Entry Point System* Medstat: December 18, 2003; Horvath, Jane and Thompson, Rachel *Promising Practices in Long Term Care System Reform: New Hampshire's Community-Based Service System for Persons with Developmental Disabilities* Medstat: December 5, 2003; Justice, Diane *Promising Practices in Long Term Care System Reform: Vermont's Home and Community Based Service System* Medstat: September 8, 2003; Justice, Diane and Heestand, Alexandra *Promising Practices in Long Term Care System Reform: Oregon's Home and Community Based Services System* Medstat: June 18, 2003; Kane, Rosalie A.; Kane, Robert L.; Priester, Reinhard; Hornyak, Patricia *Research and State Management Practices for the Rebalancing of State Long-Term Care Systems: Final Report* University of Minnesota: June 2008; Mullen, Dorothy et al. *Promising Practices in Long Term Care System Reform: Pennsylvania's Transformation of Supports for People with Mental Retardation* Medstat: March 3, 2003; Reinhard, Susan C. and Fahey, Charles J. *Rebalancing Long-Term Care in New Jersey: From Institutional toward Home and Community Care* Milbank Memorial Fund: March 2003.

⁶ Eiken, Steve; Nadash, Pamela; and Burwell, Brian *Profile of Pennsylvania: A Model for Assessing a State Long-Term Care System* Thomson Medstat: December 2006

Table 1: System Components Described in the Minnesota State Profile

Systems Component	Examples of Related DHS Principle(s)
Coordinated state agencies – state agencies coordinate policies and budgets for institutional and community services ⁷	Equity
Information and referral – resources to ensure people understand the full range of available service options ⁸	Transparency Cultural Diversity
Variety of housing options – availability of support services in multiple housing options to ensure people can live in the least restrictive setting that meets their needs and preferences ⁹	Authority and Responsibility Flexibility
Infrastructure development – recruitment, training, and technical assistance to develop a sufficient supply of providers with the necessary skills and knowledge to encourage consumer independence and implement innovative practices	Relationships Outcomes
Participant direction – people who receive HCBS having primary decision-making authority over their direct support workers and/or their budget for supports	Authority and Responsibility Relationships
Quality management – an effective system that: a) measures whether the system achieves desired outcomes and meets program requirements and b) identifies strategies for improvement	Outcomes Safety
Transition from institutions – outreach to identify residents who want to move and assistance with their transition to the community	Transparency Authority and Responsibility
Institution supply controls – mechanisms such as Certificate of Need requirements that enable states to limit or reduce institutional beds	No specific principle
Coordination with other supports – Effective coordination between long-term support providers and other supports a person needs such as physical and mental health services, employment supports, housing, and transportation	Coordination

⁷ The model State Profile used the phrase “Consolidated State Agencies” to refer to a single agency managing both institutional and community supports for a particular target population. The authors changed this component because a consolidated state agency for all target populations is not common among a majority of states described in previous case studies (see citation 6 on the previous page).

⁸ The model State Profile used the phrase “Single Access Points” to refer to an organization managing access to a wide variety of community supports and ensuring people understand the full range of available options. The authors changed this component because a single access point for all target populations is not common in states described in previous case studies (see citation 6 on the previous page). HCBS Expert Panel members noted people learn about services from many sources and that effective information and referral was important to ensure people have the correct information no matter where they start.

⁹ The model State Profile used the phrase “Continuum of Residential Options”. The authors changed the name of this component because HCBS Expert Panel members expressed concern the word “continuum” could be interpreted to imply that a person’s housing options depended only on his or her disability rather than other factors such as the person’s preferences.

MINNESOTA GUIDING PRINCIPLES

TO DESIGN, IMPLEMENT, EVALUATE, AND IMPROVE SERVICES FOR SENIORS AND PEOPLE WITH DISABILITIES Revised 12/1/2008

I. AUTHORITY AND RESPONSIBILITY

People who participate in long-term care services are fully supported in exercising authority to direct and manage their services to the extent they wish, and in accepting responsibility for their personal choices.

II. COORDINATION

Health and long-term care supports and services are effectively coordinated and provided in accordance with each person's unique needs, expressed preferences, and personal decisions to promote and enhance quality of life and well-being.

III. CULTURAL DIVERSITY

Information, communications, supports, and services are culturally and linguistically sensitive, accessible, and appropriate.

IV. EQUITY

People with similar needs have access to comparable resources.

V. FLEXIBILITY

System design and funding are sufficiently flexible to allow people to develop and use available resources and supports in ways that best meet their individual needs and personal choices.

VI. OUTCOMES

The effectiveness of programs and services in achieving both participant-chosen and system-wide desired outcomes is measured, reported, evaluated and redefined to achieve continuous quality improvement.

VII. RELATIONSHIPS

Personal relationships are promoted, nurtured and honored so that people are able to plan with and be supported by those who know and care about them.

VIII. SAFETY

People are safe and secure in their homes and communities, taking into account their informed and expressed choices as well as their tolerance for risk and personal responsibility.

IX. TRANSPARENCY

People have ready access to easy-to-understand information on programs and services, quality measures, regulations, and costs so they and other purchasers of long-term care services can effectively compare and make meaningful, informed choices among program and service options.

PART I: SYSTEM OVERVIEW

Section 1: Demographic Indicators of Long-Term Care Demand

A combination of age and disability data indicates Minnesotans are less likely to experience disability than other Americans. This may also indicate Minnesotans are less likely to need long-term care, although the definition of disability used in available state comparison data includes many people who do not need long-term care. In 2007, using the latest national data available, Minnesota had a higher proportion of people age 85 or older than the national average. However, it had lower disability rates for people of all ages than the national average. These data are explained further below.¹⁰

Approximately one of every eight Minnesotans was age 65 or older in 2007, the latest data available from the U.S. Census Bureau. As Table 1.1 indicates, Minnesota had a lower percentage of adults 65 and older than in neighboring states, although Minnesota had a relatively high percentage of people age 85 and older.¹¹ This “oldest old” cohort is more likely to need long-term care than younger individuals. The older adult population is expected to grow significantly in future decades. In 2030, 19% of Minnesotans will be age 65 or older, and 2.7% will be age 85 or older.¹²

**Table 1.1: Percentage of Population Age 65 or Older,
Minnesota, Neighboring States and United States, 2007**

	65 - 74	75 - 84	85+	Total 65+
Minnesota	6.1%	4.1%	2.0%	12.2%
Iowa	6.9%	5.1%	2.6%	14.7%
North Dakota	6.7%	5.2%	2.7%	14.6%
South Dakota	6.7%	5.0%	2.5%	14.3%
Wisconsin	6.5%	4.6%	2.1%	13.1%
United States	6.4%	4.3%	1.8%	12.5%

Source:

U.S. Census Bureau, Population Division “Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007” May 1, 2008

¹⁰ The State Profile focuses on state-level data and does not capture regional and local variations in Minnesota regarding age and disability rates. Local data are available at <http://www.census.gov/acs>. A summary of data for the seven-county metropolitan area is available at <http://www.tccompass.org/demographics/>.

¹¹ U.S. Census Bureau, Population Division “Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007” May 1, 2008.

¹² Data for 2010 – 2030 were obtained from U.S. Census Bureau, Population Division “Interim Projections of the Population by Selected Age Groups for the United States and States: April 1, 2000 to July 1, 2030” April 21, 2005.

The U.S. Census Bureau's American Community Survey estimated that Minnesota had the lowest disability rate for people age 65 or older in community settings in 2007.¹³ The Census Bureau defines disability as a long-lasting sensory, physical, mental, or emotional condition or conditions that make it difficult for a person to do functional or participatory activities such as seeing, hearing, walking, climbing stairs, learning, remembering, concentrating, dressing, bathing, going outside the home, or working at a job.¹⁴ This definition includes people who do not need long-term care.

Since the American Community Survey does not include nursing facility residents, the authors added the number of nursing facility residents on a single day in 2007 (June 30) to estimate a disability rate for the entire older adult population.¹⁵ This analysis assumes all nursing facility residents have a disability.¹⁶ As Table 1.2 shows, Minnesotans age 65 and older had lower disability rates than their cohorts across the nation and in most neighboring states. The difference between Minnesota and Wisconsin was within the American Community Survey's margin of error.

Table 1.2: Estimated Number of Persons Age 65 or Older with a Disability, Minnesota, Neighboring States and United States, 2007

	In Community Settings	In Nursing Facilities	Total	Percentage of 65+ Population
Minnesota	209,763	28,157	237,920	37.4%
Iowa	146,664	23,634	170,298	38.8%
North Dakota	33,732	5,355	39,087	41.9%
South Dakota	39,479	5,915	45,394	40.0%
Wisconsin	246,837	29,651	276,488	37.6%
<i>United States</i>	<i>14,734,979</i>	<i>1,200,906</i>	<i>15,935,885</i>	<i>42.1%</i>

No data was used for residents of other institutions, such as ICF/MR and mental health institutions, because a small portion of this age group used these services. The number of people in institutions was less than the margin of error for the estimated number of people with disabilities in the community.

Source:

U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008

U.S. Census Bureau, American Community Survey, 2007 "Table B18002. Sex by Age by Disability Status for Civilian Noninstitutionalized Population 5 Years and Over" September 23, 2008 for community disability data

U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2007* Undated for nursing facility data

¹³ U.S. Census Bureau, American Community Survey "Table R1803. Percent of People 65 Years and Over With a Disability" September 23, 2008.

¹⁴ U.S. Census Bureau, *American Community Survey and Puerto Rico Community Survey: 2007 Subject Definitions* Undated

¹⁵ Nursing facility data were obtained from U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2007* Undated.

¹⁶ Some nursing facility residents receive post-acute, rehabilitative care and do not have a disability that meets the American Community Survey's definition. A precise number of these residents is not available because nursing facility data do not define disability in the same manner.

The American Community Survey also estimates Minnesotans age 21 to 64 had a lower disability rate than the national average and a lower rate than most neighboring states (See Table 1.3). For children age five to 20, Minnesota's disability rate was not significantly different from the national average or from most neighboring states (i.e., the differences were within the survey's margin of error).¹⁷ The American Community Survey does not estimate disability rates for children under age five.

Table 1.3: Estimated Number of Persons Under Age 65 in the Community with a Disability, Minnesota, Neighboring States and United States, 2007

	Age 5 - 20	Percentage of Population	Age 21 - 64	Percentage of Population
Minnesota	67,161	6.0%	314,942	10.3%
Iowa	45,754	7.1%	205,002	12.2%
North Dakota	8,103	5.9%	36,447	10.1%
South Dakota	9,523	5.3%	52,317	11.9%
Wisconsin	78,780	6.5%	375,584	11.5%
<i>United States</i>	<i>4,233,179</i>	<i>6.4%</i>	<i>22,231,265</i>	<i>12.8%</i>

No source was used for institutional data because a small portion of this age group used institutional services. The number of people in institutions was less than the margin of error for the estimated number of people with disabilities in the community.

Source:

U.S. Census Bureau, American Community Survey, 2007 "Table B18002. Sex by Age by Disability Status for Civilian Noninstitutionalized Population 5 Years and Over" September 23, 2008 for community disability data

Table 1.4 on the following page shows the estimated disability prevalence for all individuals age five and older in 2007. Thirteen percent of Minnesotans age five and older had a disability, less than the average among neighboring states of 14.5%.¹⁸

¹⁷ U.S. Census Bureau, American Community Survey, 2007 "Table B18002. Sex by Age by Disability Status for Civilian Noninstitutionalized Population 5 Years and Over" September 23, 2008 for community disability data

¹⁸ U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008 for population; U.S. Census Bureau, American Community Survey, 2007 "Table B18002. Sex by Age by Disability Status for Civilian Noninstitutionalized Population 5 Years and Over" September 23, 2008 for community disability data; and U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2007* Undated for nursing facility data

**Table 1.4: Estimated Number of Persons Age Five and Older with a Disability,
Minnesota, Neighboring States and United States, 2007**

	In Community Settings	in Nursing Facilities	Total	Percentage of Population Age 5+
Minnesota	591,866	30,874	622,740	13.0%
Iowa	397,420	25,661	423,081	15.3%
North Dakota	78,282	5,789	84,071	14.3%
South Dakota	101,319	6,443	107,762	14.8%
Wisconsin	701,201	32,335	733,536	14.1%
<i>United States</i>	<i>41,199,423</i>	<i>1,394,781</i>	<i>42,594,204</i>	<i>15.4%</i>

No data was used for residents of other institutions, such as ICF/MR and mental health institutions, because a small portion of this age group used these services. The number of people in institutions was less than the margin of error for the estimated number of people with disabilities in the community.

Source:

U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008

U.S. Census Bureau, American Community Survey, 2007 "Table B18002. Sex by Age by Disability Status for Civilian Noninstitutionalized Population 5 Years and Over" September 23, 2008 for community disability data

U.S. Centers for Medicare & Medicaid Services Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2007 Undated for nursing facility data

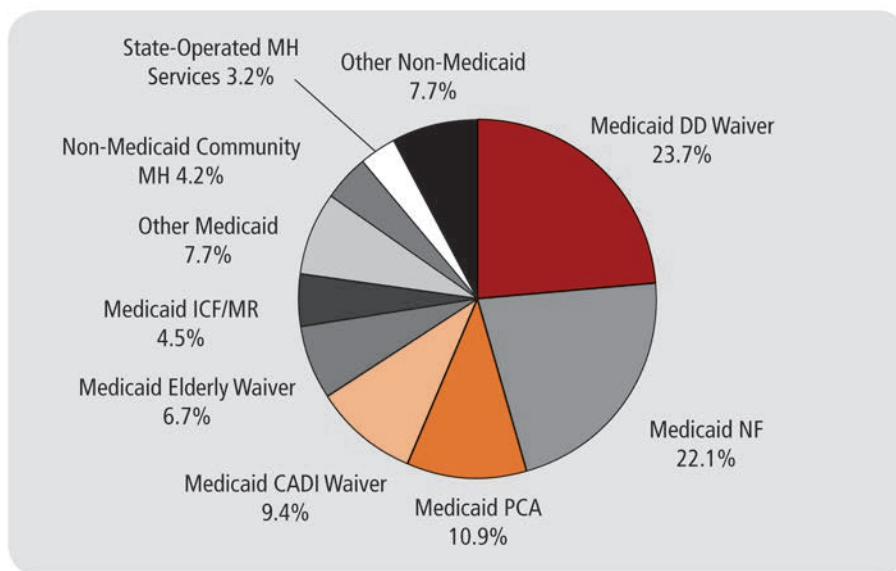
Section 2: Service Utilization and Expenditures Data

This section provides a brief overview of service and utilization data to provide perspective regarding Minnesota's long-term care system and how it compares to other state systems. This section refers to some specific long-term support programs, which are described in *Section 3: Available Public Services and Programs*. First, this section provides an overview of all public funding for long-term support for services and programs defined in state policy. The authors are aware that many counties fund additional supports with county dollars, but collecting data regarding these services was beyond the scope of this project. Second, this section presents data regarding Medicaid, the largest payer of long-term support services in the country, from Minnesota and neighboring states.¹⁹ This section concludes with state comparison data for all payer sources regarding several types of residential services.

Public Spending for Long-Term Supports

Federal, state, and local governments spent approximately \$3.9 billion to provide long-term support to Minnesotans with disabilities and older Minnesotans in SFY 2008 – the latest year with complete data.²⁰ Chart 2.1 shows the distribution of expenditures among programs. Expenditures data for particular programs are in Appendix A.

Chart 2.1: Minnesota Expenditures for Long-Term Support, SFY 2008



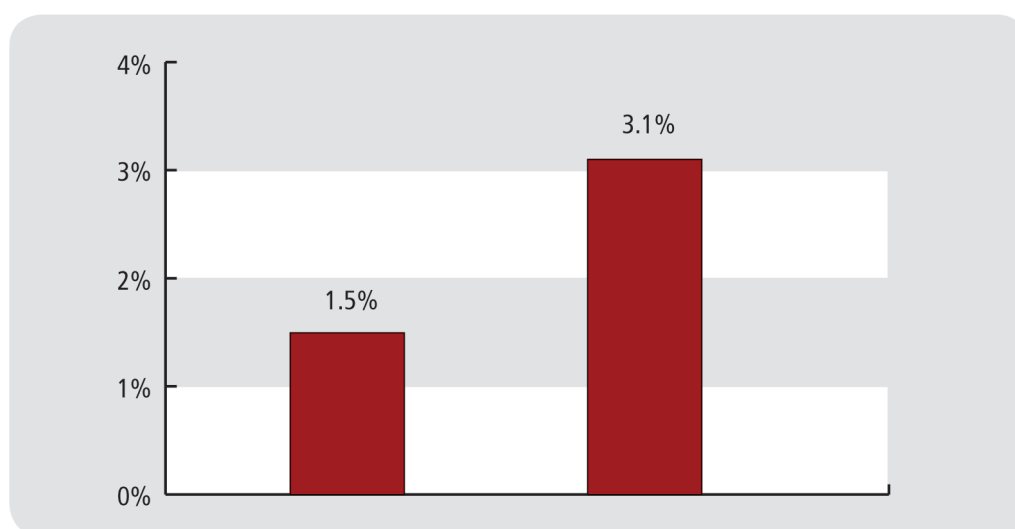
See Tables A.1 and A.2 for a complete list of sources and of services and programs identified in Other Medicaid and Other Non-Medicaid

¹⁹ Georgetown University, Long-Term Care Financing Project "National Spending for Long-Term Care" February 2007

²⁰ See Tables A.1 and A.2 in Appendix B for sources. This figure does not include \$1.5 billion in expenditures for special education and early intervention services. Special education is discussed at times in this report because the special education system provides important support for children with disabilities. When the children transition to adulthood, long-term support programs such as Medicaid home and community based services waivers provide some of these services for those with the most severe disabilities. However, expenditures are not included in Charts 2.1 and 2.2 because many of these expenditures are for educational services rather than long-term support.

Long-term support expenditures were \$750 per state resident in 2008.²¹ Medicaid was the largest public payer, accounting for 85% of total public spending. Long-term care spending has increased by approximately 5.5% per year from SFY 2006 through SFY 2008.²² The inflation rate was 3.2% per year during this time, and state population grew 0.7% per year. As a result, per capita spending increased only 1.5% per year.²³ As shown in Chart 2.2 below, total Medicaid expenditures in Minnesota increased 7% per year during this time (from \$5.5 to \$6.3 billion), a real per capita rate of 3%.²⁴

Chart 2.2: Percentage Increase in Real Per Capita Expenditures, Public Long-Term Care (LTC) and Total Medicaid, SFY 2006-2008, in 2008 Dollars



Data for Public LTC increase does not include three types of Medicaid managed care services for which 2006 data were not available: home health, personal care, and disability waiver services.

Sources:

See Tables A.1 and A.2 for public long-term care expenditures data sources
 Minnesota Department of Human Services, Reports and Forecasts Division February 2009
 Forecast March 3, 2009 for total Medicaid expenditures
 U.S. Department Of Labor, Bureau of Labor Statistics "Consumer Price Index for All Urban Consumers (CPI-U), Midwest Region" January 26, 2009 for inflation data
 U.S. Census Bureau, Population Division "Annual Population Estimates, Estimated Components of Population Change, and Rates of the Components of Population Change for the United States, States, and Puerto Rico: April 1, 2000 to July 1, 2008" December 22, 2008 for population data

²¹ Total expenditures divided by total state population in U.S. Census Bureau, Population Division "Annual Population Estimates, Estimated Components of Population Change, and Rates of the Components of Population Change for the United States, States, and Puerto Rico: April 1, 2000 to July 1, 2008" December 22, 2008

²² See Tables A.1 and A.2 for expenditures data sources. This calculation does not include data for three types of Medicaid managed care services for which 2006 data were not available: home health, personal care, and disability waivers services in managed care (i.e., waiver services provided through MnDHO).

²³ Thomson Reuters analysis based on inflation data from U.S. Department Of Labor, Bureau of Labor Statistics "Consumer Price Index for All Urban Consumers (CPI-U), Midwest Region" January 26, 2009 and U.S. Census Bureau, Population Division "Annual Population Estimates, Estimated Components of Population Change, and Rates of the Components of Population Change for the United States, States, and Puerto Rico: April 1, 2000 to July 1, 2008" December 22, 2008

²⁴ Minnesota Department of Human Services, Reports and Forecasts Division February 2009 Forecast March 3, 2009

The above expenditures total does not include Medicare services because Medicare focuses payment on acute and rehabilitative services. Medicare pays for a few services that are sometimes considered long-term care. In calendar year 2007, the most recent year with complete data, Medicare paid \$578 million in fee-for-service payments for nursing facility, home health agency, and hospice services provided in Minnesota. This figure does not include spending for these services provided through Medicare Advantage managed care organizations. In December 2007, 30% of Medicare beneficiaries in Minnesota were enrolled in a Medicare Advantage plan.²⁵

Medicaid Expenditures and Utilization

Minnesota's Medicaid program spent \$3.3 billion in SFY 2008 on long-term supports for older adults, people with disabilities, and people with serious mental illnesses or severe emotional disturbances. This figure includes Federal, state, and local expenditures.²⁶ Since 2004, utilization of Medicaid institutional services has decreased while utilization of several Medicaid community services has increased (See Table 2.2).²⁷ See *Section 3: Available Public Services and Programs* for brief descriptions of the programs listed below.

One Medicaid home and community-based service program that had fewer participants in 2008 was the Developmental Disabilities (DD) Waiver, which saw a slight decrease. The number of people on a waiting list for DD Waiver services grew from 3,140 in December 2005²⁸ to 4,974 in December 2008.²⁹ An estimated 1,000 of these persons have not had a subsequent re-screening in four years. Beginning in 2009, DHS will require that people requesting the DD Waiver be re-screened at least once every three years to ensure the person continues to be interested in and qualified for DD Waiver services. Most individuals on the waiting list receive other public long-term support services, the most common of which are case management (4,879), special education (3,875), and Medicaid State Plan home care (1,305), which includes both personal care and home health agency services.³⁰

²⁵ Centers for Medicare & Medicaid Services 2008 *Medicare/Medicaid Supplement* 2008

²⁶ See Table A.1 for sources.

²⁷ Minnesota Department of Human Services, Reports and Forecasts Division February 2009 Forecast March 3, 2009 for most services. Alter, Joel; Meyerhoff, Carrie; Connor, Lolyann Evaluation Report: Personal Care Assistance Minnesota Office of the Legislative Auditor: January 2009 for personal care. Data received from the Minnesota Department of Human Services in March 2009 for nursing facility care.

²⁸ Minnesota Department of Human Services, Disability Services Division *Resource Availability and Utilization of the Mental Retardation and Related Conditions Waiver, the Community Alternative Care Waiver, the Community Alternatives for Disabled Individuals Waiver and the Traumatic Brain Injury Waiver* May 2006

²⁹ Minnesota Department of Human Services, Disability Services Division *Annual Report on the Use and Availability of Home and Community-Based Services Waivers for Persons with Disabilities* February 2009. In addition, 692 people were waiting for services in CADI, CAC, or TBI Waivers (CCT Waivers). This figure includes people who are waiting for services because of limits on waiver growth as well as people who choose waiver services but are not served for other reasons. For example, the county need to develop a resource that meets the person's needs.

³⁰ *Ibid.*

Table 2.2: Average Monthly Participants of Minnesota Medicaid Long-Term Care Services, 2004 – 2008

	2004	2008	Average Annual Percentage Change, 2004 - 2008
Institutional Services			
Nursing Facility – fee-for-service (SFY)	22,998	19,488	-4%
Nursing Facility – managed care (CY)*	329	670	19%
ICFs/MR (SFY)	2,046	1,859	-2%
HCBS Waivers			
Elderly Waiver – fee-for-service (SFY)	10,976	4,643	-19%
Elderly Waiver – managed care (CY)*	1,019	13,724	92%
Developmental Disabilities Waiver (SFY)	14,514	14,036	-1%
Community Alternatives for Disabled Individuals Waiver (SFY)	7,393	11,855	13%
Traumatic Brain Injury Waiver (SFY)	1,015	1,316	7%
Community Alternative Care Waiver (SFY)	160	279	15%
State Plan Community Services			
Personal Care – fee-for-service (SFY)	7,336	12,769	15%
Personal Care – managed care (CY)*	2,378	5,170	21%
Home Health Agencies – fee-for-service (SFY)	6,004	5,116	-4%
Home Health Agencies – managed care (CY)*	5,407	6,982	7%
Private Duty Nursing – fee-for-service (SFY)	324	477	10%
Private Duty Nursing – managed care (CY)*	450	102	-31%

* Managed care data are reported by calendar year (CY) to show changes in managed care following the enrollment of many older adults on January 1, 2006.

Mental Health Services were not included because most Medicaid mental health services are reported together with non-Medicaid services

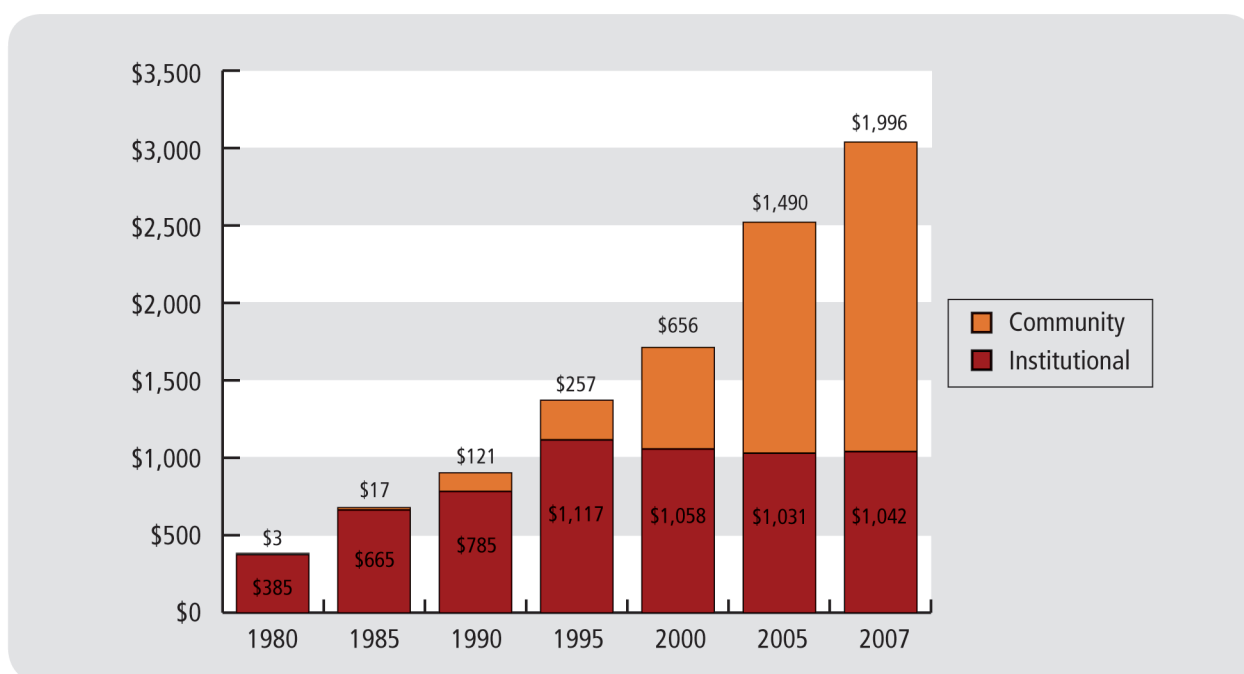
Sources:

Data received from the Minnesota Department of Human Services in September 2009 for fee-for-service personal care and private duty nursing

Data received from the Minnesota Department of Human Services in August and September 2009 for managed care services
Minnesota Department of Human Services, Reports and Forecasts Division February 2009 Forecast March 3, 2009 for other services

Minnesota's public long-term care system has moved steadily toward home and community based services since 1980 (See Chart 2.3). Minnesota led the nation in per capita Medicaid long-term care spending in 1980. Like most states at that time, almost all spending was for nursing facility and ICF/MR services. For more than two decades, Minnesota has encouraged home and community-based services instead of institutional care. Minnesota now is a leader in the number of people served by HCBS relative to state population.³¹

Chart 2.3: Minnesota Medicaid Long-Term Care Expenditures in Millions of Dollars, Federal Fiscal Years 1980 – 2007



Sources:

Centers for Medicare & Medicaid Services, Form 64 Reports. These reports do not include long-term care provided through managed care organizations.

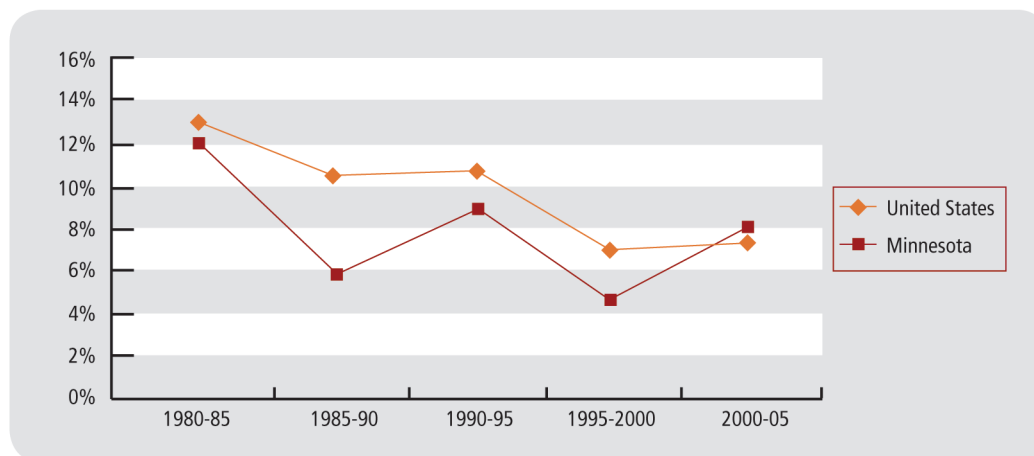
Managed care data for 2007 from Wachenheim, Leigh M. Trend & Surplus Adjustments for 2009 Payment Rates – Seniors – Version3 Milliman, Inc.: October 21, 2008; CMS 372 report for the DD Waiver for July 1, 2006 through June 30, 2007; and data provided by Minnesota Department of Human Services in August and September 2009.

Since 1980, Minnesota expenditures have increased at a lower rate than spending in other states (See Chart 2.4). In addition to inflation and population growth, the expenditures increase also reflects the fact that new Medicaid services fulfilled the function of previously state- and county-funded services such as state nursing facilities, case management, crisis services, and day training and habilitation services. In the most

³¹ Hendrickson, Leslie and Blume, Randall *Issue Brief: A Summary of Medicaid Brain Injury Programs* Rutgers Center for State Health Policy: March 2008; Ng, Terence; Harrington, Charlene; and O'Malley, Molly *Medicaid Home and Community-Based Service Programs: Data Update* Kaiser Family Foundation: December 2008; and Prouty, Robert W.; Alba, Kathryn; Lakin, K. Charlie (eds.) *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007* University of Minnesota Institute for Community Integration: August 2008

recent example, new mental health services – funded by Medicaid for eligible individuals – are supporting people who previously received state-funded services in Regional Treatment Centers and other long-term residential settings. The use of Medicaid-funded rehabilitative services, personal care, and HCBS waiver services has helped Minnesota reduce its reliance on Regional Treatment Centers. It also helped Minnesota transform mental health facilities licensed under Rule 36 from long-term residential services to intensive residential treatment settings that focus on improving skills and helping people transition to supportive housing. In SFY 2008, home and community-based services (HCBS) waivers serve thousands of people who need services because of a mental illness or severe emotional disturbance.³²

Chart 2.4: Five-Year Average Annual Rate of Growth, Minnesota and U.S. Medicaid Long-Term Care Expenditures, Federal Fiscal Years 1980 – 2005



Sources:

Centers for Medicare & Medicaid Services, Form 64 Reports. These reports do not include long-term care provided through managed care organizations.

The authors compared Minnesota Medicaid data to the national average and to neighboring states. These state comparison data do not include mental health expenditures because the available data sources for all states do not identify most Medicaid mental health expenditures.³³ Mental health is often provided as part of rehabilitative services, which also includes physical rehabilitative services. The following state comparison data can provide a useful perspective regarding a state's long-term care system. However, there are limits to any comparison of utilization to other states. For example, all of these states except Wisconsin have smaller and more rural populations than Minnesota, which can affect utilization patterns.

Minnesota ranked fourth in Medicaid long-term care expenditures per state resident in Federal Fiscal Year 2007, with spending 74 percent above the national average (See Table 2.3 below).³⁴ Minnesota ranked fifth

³² Data received from the Minnesota Department of Human Services in January 2009 for the Elderly Waiver and in June 2009 for other waivers.

³³ Burwell, Brian; Sredl, Katherine; and Eiken, Steve *Medicaid Long-Term Care Expenditures in FFY 2007* Thomson Reuters: September 28, 2008

³⁴ *Ibid.* New York, Connecticut, and the District of Columbia (in order) spent more per capita for Medicaid long-term care.

in the nation in spending per state resident for programs targeting older adults and people with disabilities,³⁵ and ranked fourth in expenditures per state resident for programs targeting people with developmental disabilities.³⁶

Table 2.3: Medicaid per Capita Spending for Long-Term Care, Federal Fiscal Year (FFY) 2007

	Programs for Older Adults and People with Disabilities*	Programs for People with Developmental Disabilities	Other (e.g., TBI, AIDS)	Total
Minnesota	\$360	\$209	\$16	\$585
Iowa	\$203	\$181	\$10	\$389
North Dakota	\$281	\$208	\$0	\$489
South Dakota	\$192	\$129	\$0	\$321
Wisconsin**	\$255	\$116	\$6	\$377
<i>United States**</i>	<i>\$225</i>	<i>\$108</i>	<i>\$2</i>	<i>\$336</i>

Long-Term Care in these data services include nursing facility, ICF/MR, HCBS waiver, home health, and personal care. Data do not include most Medicaid mental health services. FFS expenditures are based on Federal Fiscal Year. Minnesota Managed Care Expenditures for services for older adults are for calendar year 2007. Managed Care Expenditures for MnDHO for people with physical disabilities are for calendar year 2008. Managed Care Expenditures for the pilot of MnDHO for people with developmental disabilities are for State Fiscal Year 2007.

* The national source refers to this as “Older Adults and People with Physical Disabilities” because the waivers that serve people under age 65 typically serve people with physical disabilities. The authors removed the word “physical” to reflect that Minnesota’s waivers for people who need nursing facility care include people with mental health needs and people with developmental disabilities.

** Data do not include large managed long-term care programs in Wisconsin and a few other states

Sources:

Fee-for-service data from Burwell, Brian; Sredl, Katherine; and Eiken, Steve *Medicaid Long-Term Care Expenditures in FFY 2007* Thomson Reuters: September 28, 2008

Managed care data for nursing facility care for older adults and the Elderly Waiver are from data provided by Minnesota Department of Human Services in August 2009. Data for nursing facility payments are based on a capitation rate called the Nursing Facility Add-On, which is paid for all community-dwelling members for the risk of future nursing facility admission. Data for EW is based on an EW Add-On capitation rate paid for people eligible for EW. The capitation rates were multiplied by the number of member months for community-dwelling individuals.

Data for Personal Care and Home Health for older adults were calculated by multiplying the number of member months (see above) by per member per month claim costs from Wachenheim, Leigh M. Trend & Surplus Adjustments for 2009 Payment Rates – Seniors – Version3 Milliman, Inc.: October 21, 2008.

Data for MnDHO for people with physical disabilities were provided by Minnesota Department of Human Services in September 2009. Data for nursing facility payments are based on the Nursing Facility Add-On, a capitation payment for all community-dwelling members for the risk of future nursing facility admission. Data for CADI and TBI are based on capitation rates for people eligible for those waivers. Data for personal care and private duty nursing are based on rate cells for people eligible for those services. The same rate cells are used for both personal care and private duty nursing; both expenditures are included under personal care.

Data for the MnDHO – developmental disabilities pilot are from the CMS 372 lag report for the DD Waiver for July 1, 2006 through June 30, 2007.

³⁵ *Ibid.* New York, the District of Columbia, Connecticut, and Alaska (in order) spent more per capita on nursing facility care, personal care, home health, and HCBS waivers for older adults and people with physical disabilities. In the data tables, the authors removed the word “physical” when describing these services to reflect that Minnesota’s personal care program and waivers for people who need nursing facility care include people who need services primarily because of mental illness or a developmental disability.

³⁶ *Ibid.* New York, Maine, and Rhode Island (in order) spent more per capita for ICFs/MR and waivers for people with developmental disabilities.

Minnesota was third in the country in the percentage of long-term care spending devoted to community services (See Table 2.4).³⁷ This percentage is a common measure of balance: the degree to which a state's Medicaid program reduces use of institutional services and encourages use of in-home and community-residential services.

Table 2.4: Percentage of Medicaid Long-Term Care Expenditures Used for Community Services, FFY 2007

	Total	Programs for Older Adults and People with Disabilities	Programs for People with Developmental Disabilities
Minnesota	66%	54%	84%
Iowa	38%	26%	50%
North Dakota	26%	6%	52%
South Dakota	39%	11%	80%
Wisconsin**	46%	31%	77%
<i>United States**</i>	<i>42%</i>	<i>31%</i>	<i>63%</i>

Long-Term Care in these data services include nursing facility, ICF/MR, HCBS waiver, home health, and personal care. Data do not include most Medicaid mental health services. FFS expenditures are based on Federal Fiscal Year. Minnesota Managed Care Expenditures for services for older adults are for calendar year 2007. Managed Care Expenditures for MnDHO for people with physical disabilities are for calendar year 2008. Managed Care Expenditures for the pilot of MnDHO for people with developmental disabilities are for State Fiscal Year 2007.

* The national source refers to this as "Older Adults and People with Physical Disabilities" because the waivers that serve people under age 65 typically serve people with physical disabilities. The authors removed the word "physical" to reflect that Minnesota's waivers for people who need nursing facility care include people with mental health needs and people with developmental disabilities.

** Data do not include large managed long-term care programs in Wisconsin and a few other states

Sources:
See Table 2.3.

Both Tables 2.3 and 2.4 divided most Medicaid long-term care expenditures into two categories that reflect common eligibility requirements for long-term supports: 1) older adults and people with disabilities and 2) people with developmental disabilities. Within Minnesota, the category of supports for older adults and people with disabilities includes:

- Nursing facility services
- Personal care assistance (PCA)
- Home health agency services
- The Elderly Waiver (EW)
- The Community Alternatives for Disabled Individuals (CADI) Waiver
- The Community Alternative Care (CAC) Waiver

³⁷ *Ibid.* New Mexico and Oregon each spend 73% of total Medicaid long-term care expenditures on home and community-based services.

The category of supports for people with developmental disabilities includes:

- Intermediate Care Facilities for People with Mental Retardation (ICFs/MR)³⁸
- The Developmental Disabilities (DD) Waiver.

Minnesota's Traumatic Brain Injury (TBI) Waiver is not typically included within either category and is included in the "Other" column in Table 2.3.

In reality, individuals or programs often fit more than one category. People with developmental disabilities and serious mental illness use PCA. More than 1,200 people age 65 or older received ICFs/MR or DD Waiver services in SFY 2008. Over 4,700 CADI participants have a primary diagnosis of mental illness or severe emotional disturbance, and over 1,300 participants have a primary diagnosis of a developmental disability.³⁹ Thousands of children received home health, PCA, and/or a waiver such as DD, CADI, CAC, or TBI.⁴⁰ Some of these children may have developmental disabilities as defined in the Federal Developmental Disabilities Act: a disability that occurs before age 22 and affects two of seven types of function. However, the authors find the two target population categories (i.e., people with developmental disabilities and older adults and people with physical disabilities) remain useful for state comparisons because states often have different policies for the two categories.

Residential Services Utilization

The tables below show state comparison data regarding the use of several types of residential services, regardless of payer. The authors were not able to identify reliable data sources that included most or all states for some residential supports, including mental health residential services other than state hospitals. Data are included to the extent available and only include a subset of residential services:

- Nursing facilities
- Assisted living providers
- Residential services for people with developmental disabilities
- State institutions for people with serious mental illnesses

As shown in Table 2.5, Minnesotans had higher nursing facility utilization on a single day in 2008 than the national average, but lower nursing facility utilization than all neighboring states except Wisconsin.⁴¹

³⁸ The authors prefer to use the phrase "intellectual disabilities" instead of "mental retardation". When describing ICFs/MR, the authors use "mental retardation" to reflect the name for these facilities in Federal law and regulation.

³⁹ Data received from the Department of Human Services, June 2009, based on the LTC screening document.

⁴⁰ Minnesota Department of Human Services, Disability Services Division *Annual Report on the Use and Availability of Home and Community-Based Services Waivers for Persons with Disabilities* February 2009

⁴¹ U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008 for population age 65 or older; and U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2008* Undated for nursing facility data

Table 2.5: Nursing Facility (NF) Residents per 1,000 Residents Age 65 or Older, June 30, 2008

	NF Residents per 1,000 65+ population
Minnesota	49.6
Iowa	58.1
North Dakota	60.8
South Dakota	56.1
Wisconsin	43.2
<i>United States</i>	<i>36.4</i>

Sources:

U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008 for population age 65 or older as of 2007 (latest data available)

U.S. Centers for Medicare & Medicaid Services Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2008 Undated for nursing facility data

Nursing facility utilization increases significantly with age, reflecting the greater incidence of disability with age. The trend is more pronounced in Minnesota (See Table 2.6). While Minnesotans over age 65 were more likely to be in a nursing facility than other Americans, Minnesotans under age 65 were less likely to use nursing facility services than their cohorts across the country. For all age groups, Minnesota had lower utilization than all neighboring states except Wisconsin.⁴²

Table 2.6: Percentage of State Residents in a Nursing Facility by Age, June 30, 2007

	0 - 30	31 - 64	65 - 74	75 - 84	85 and older
Minnesota	0.003%	0.11%	0.96%	4.0%	15.8%
Iowa	0.008%	0.15%	1.15%	4.8%	17.8%
North Dakota	0.006%	0.15%	1.27%	4.9%	18.3%
South Dakota	0.004%	0.15%	1.21%	4.7%	16.9%
Wisconsin	0.003%	0.10%	0.92%	3.8%	14.3%
<i>United States</i>	<i>0.007%</i>	<i>0.14%</i>	<i>0.94%</i>	<i>3.3%</i>	<i>10.7%</i>

Sources:

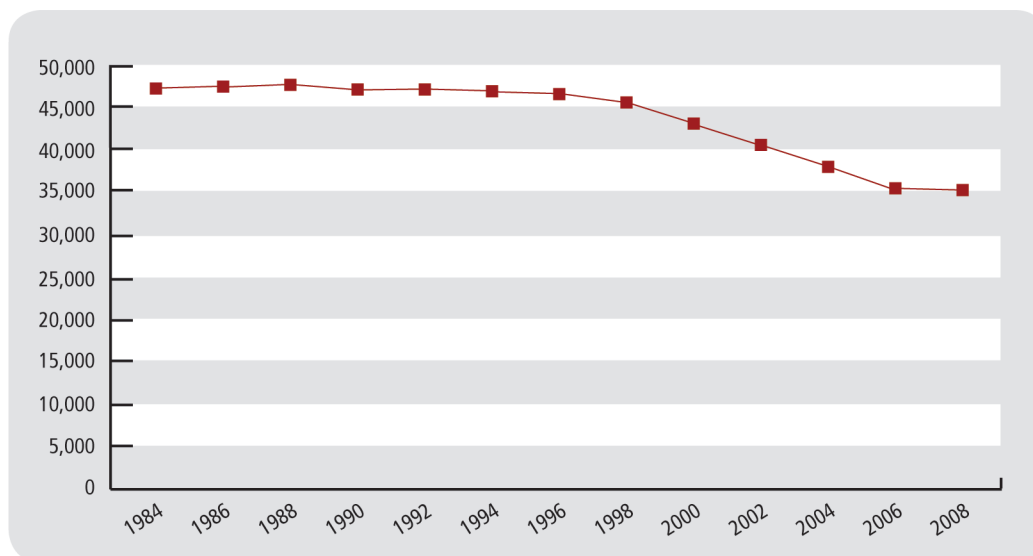
U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008 for population age 65 or older

U.S. Centers for Medicare & Medicaid Services Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2007 Undated for nursing facility data

⁴² U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008 for population age 65 or older; and U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2007* Undated for nursing facility data

Minnesota's nursing facility utilization has decreased 27% since its peak in 1987 (See Chart 2.5). This decline coincides with the increasing availability of home and community-based services and has occurred while the number of people age 85 and older has increased.

Chart 2.5: Total Nursing Home Beds in Minnesota, 1984 – 2008



Source:

Minnesota Department of Human Services, Continuing Care Administration summary of data from Minnesota Department of Health

The number of nursing facility residents declined about 3% per year from 2004 to 2008, as shown in Table 2.7. This decline occurred for all of the three most common payment sources for nursing facility care. Minnesota had a more rapid decrease in nursing facility beds during these years than all neighboring states except South Dakota.⁴³ In 2008, Minnesotans were more likely than other Americans to pay for their own nursing facility care and more likely to receive Medicaid-funded care.⁴⁴

⁴³ American Health Care Association *Nursing Facility Beds by Certification Type: CMS OSCAR Data Current Surveys* June 2008 and American Health Care Association *Nursing Facility Beds by Certification Type: CMS OSCAR Data Current Surveys* June 2004

⁴⁴ U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2007* Undated for nursing facility data and U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008 for population age 65 or older

Table 2.7: Number of Nursing Facility Residents of All Ages by Major Payer Categories, 2004 – 2008

	June 30, 2004	June 30, 2008	Average Annual Percent Change
All Residents	33,609	29,876	-2.9%
Medicaid – Full Payment	17,477	14,699	-4.2%
Self or Family – Full Payment	8,704	7,527	-3.6%
Medicare Per Diem	7,157	6,570	-2.1%

Sources:

U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2008* Undated

U.S. Centers for Medicare & Medicaid Services *Minimum Data Set 2.0 Active Resident Information Report: 2nd Quarter 2004* Undated

As in many states, assisted living is increasingly available in Minnesota. A comparison of Minnesota registration data and a national source on assisted living suggests that Minnesota has a greater supply of assisted living than any other state. The authors compared 2009 Minnesota data to a 2007 national study of assisted living and residential care for older adults and people with disabilities (the most recent study available). In the national study, Oregon had the highest rate of residential care beds per 1,000 people age 65 or older, with 45 beds per 1,000 seniors. As shown in Table 2.8 below, housing with services establishments in Minnesota that have registered to provide assisted living have 57 beds per 1,000 people age 65 or older, 25% more than Oregon. State comparisons of assisted living data are imperfect because states vary in how they define assisted living. Data for several states in the national study include facilities that do not offer the range of services provided as part of assisted living.⁴⁵

⁴⁵ Mollica, Robert; Sims-Kastelein, Kristin; and O’Keeffe, Janet Residential Care and Assisted Living Compendium: 2007 November 30, 2007

Table 2.8: Number of Regulated Assisted Living or Residential Care Beds Serving Older Adults and/or Other People with Disabilities, Latest Year Data Available

	Units or Beds*	Units or Beds per 1,000 Population 65+
Minnesota (2009)*	35,998	57
Iowa (2008)*	15,739	36
North Dakota	3,472	37
South Dakota	3,578	31
Wisconsin	31,782	43
<i>United States</i>	<i>974,585</i>	<i>26</i>

Data include all residential care models serving older adults and/or people with physical disabilities included in the report. Data do not include residential services specifically licensed or certified to serve children, people with mental illness, or people with developmental disabilities.

* Some states reported capacity data in terms of units available, while other states reported beds available. A unit may include more than one bed (e.g., for a married couple).

** Minnesota data reflect beds in housing with services establishments that have registered to offer assisted living.

Sources:

Minnesota capacity data for housing with services establishments that offer assisted living are from data provided by the Minnesota Department of Health in August 2009

Iowa capacity data was provided by the Iowa Department of Inspections and Appeals in November 2008

Assisted living and residential care data for other states are from Mollica, Robert; Sims-Kastelein, Kristin; and O'Keeffe, Janet Residential Care and Assisted Living Compendium: 2007 November 30, 2007

State population age 65 or older data from U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008

Minnesotans are less likely than other Americans to live in facilities serving six or more individuals with developmental disabilities. These data include both ICFs/MR and other facilities that may be covered under Medicaid home and community-based services waivers or state general revenue. Minnesota's use of facilities serving seven or more people was lower than all neighboring states (See Table 2.9).⁴⁶

⁴⁶ Prouty, Robert W.; Alba, Kathryn; Lakin, K. Charlie (eds.) *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007* University of Minnesota Institute for Community Integration: August 2008

Table 2.9: Number of People with Developmental Disabilities Living in Facilities with Seven or More residents, per 100,000 Residents, June 30, 2007

	Facilities Serving 16 or More People	Facilities Serving 7 to 15 People	Total Facilities with 7 or More
Minnesota	9.2	12.6	21.8
Iowa	55.1	33.1	88.2
North Dakota	28.0	78.4	106.4
South Dakota	21.9	64.7	86.6
Wisconsin	18.1	47.8	65.9
<i>United States</i>	<i>20.7</i>	<i>19.5</i>	<i>40.2</i>

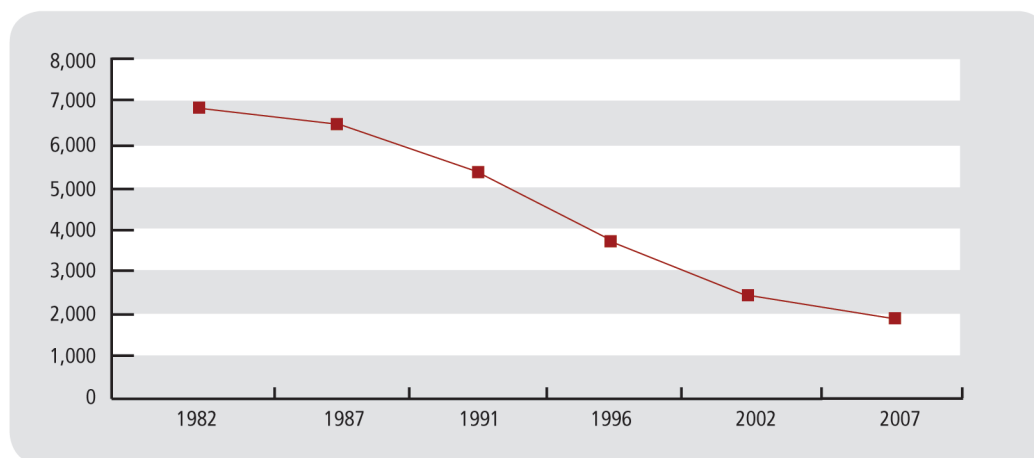
Sources:

Minnesota data from Minnesota Department of Human Services: Disability Services Division Plan for ICFs/MR in Minnesota January 2009

Data from other states Prouty, Robert W.; Alba, Kathryn; Lakin, K. Charlie (eds.) Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007 University of Minnesota Institute for Community Integration: August 2008

As shown in Chart 2.6, Minnesota significantly reduced its use of ICFs/MR since the 1980s. As in the decline of nursing facility beds, this decrease coincides with increasing use of community-based services. During this time, Minnesota closed all its large, state-operated ICFs/MR and reduced its private ICFs/MR supply, as described in Component 8: Institutional Supply Controls.

Chart 2.6: Minnesota Residents in ICFs/MR, 1982 – 2007



Sources:

2002 and 2007 data from Minnesota Department of Human Services: Disability Services Division Plan for ICFs/MR in Minnesota January 2009

Data from 1982, 1987, 1991, and 1996 from Prouty, Robert W.; Alba, Kathryn; Lakin, K. Charlie (eds.) Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007 University of Minnesota Institute for Community Integration: August 2008. Data for 1992 and 1997 were not available, so the nearest years with available data were used.

Minnesota also has a relatively low rate of state hospital utilization for people with serious mental illness (See Table 2.10). Further, most people have short stays in the state hospitals, unlike some states where these facilities provide long-term services.⁴⁷

Table 2.10: Number of People in State Hospitals for People with Mental Illness per 100,000 Residents, last day of State Fiscal Year 2006

	State MI Hospital Residents per 100,000
Minnesota	7.7
Iowa	7.4
North Dakota	41.2
South Dakota	32.3
Wisconsin*	8.5
<i>United States**</i>	<i>15.6</i>

* Wisconsin data do not include county-operated hospitals that perform a similar function.

** United States data are based on 43 states.

Source:

National Association of State Mental Health Program Directors Research Institute, Inc.
 "State Mental Health Agency Profiling System: System: 2007" October 2008.

⁴⁷ National Association of State Mental Health Program Directors Research Institute, Inc. "State Mental Health Agency Profiling System: System: 2007" October 2008.

Section 3: Available Public Services and Programs

This section provides brief descriptions of all long-term support programs that provide publicly funded services to older adults and people with disabilities on an ongoing basis. Because of the large role of the Medicaid program in long-term support, the authors describe Medicaid Services first and present several Medicaid State Plan services and Medicaid Home and Community-Based Services Waivers separately. This section then discusses non-Medicaid programs. The state and local administrative structure for these public programs are described in the following section, *Component 1: Coordinated State Agencies*.

Medicaid Services

Institutional Services

Nursing facility care: Certified nursing homes and boarding care homes provide room and board, nursing, rehabilitation, and personal care services to individuals. These facilities can also be licensed but not receive Federal certification if they do not receive Medicare or Medicaid payment. According to HCBS Expert Panel members, nursing facilities are providing comparatively more short-term rehabilitative care, such as helping a person recover after hip replacement surgery, rather than extended care. Medicaid nursing facility care is primarily paid on a fee-for-service basis. Medicaid managed care plans are responsible for the first 100 to 180 days of nursing facility care for people who are admitted to a nursing home after they were enrolled in the managed care program (the number of days varies by program).

The 2009 Legislature authorized a change in Medicaid nursing facility level of care criteria. Effective January 1, 2011, people must meet one of four conditions to receive Medicaid nursing facility services:

1. High need for assistance with four or more activities of daily living or dependence in one or more critical activities of daily living (i.e., toileting, bed mobility, and transferring)
2. Ongoing need for daily clinical monitoring, such as vital signs
3. Significant difficulty with memory, using information, daily decision making, or behavioral needs
or
4. Risk of institutionalization

Intermediate Care Facilities for people with Mental Retardation (ICFs/MR): ICFs/MR provide room and board, training, habilitation, and transportation to people with developmental disabilities. The majority of these facilities serve four to six residents, although several facilities serve 16 or more people.⁴⁸

Medicaid Home and Community-Based Services Waivers

Elderly Waiver (EW): EW provides a variety of services for people age 65 or older who qualify for nursing facility care. The nursing facility level of care change described on the previous page will also apply to EW

⁴⁸ Minnesota Department of Human Services: Disability Services Division Plan for ICFs/MR in Minnesota January 2009

participants. People who do not meet the criteria effective January 2011 may qualify for Medicaid state plan services or for Essential Community Services, a grant that will start at that time that provides up to \$400 per person per month for a smaller array of services.⁴⁹

A majority of EW participants have received services through managed care organizations since 2006, when the Medicare prescription drug benefit, Medicare Part D, began. At that time, many participants were automatically enrolled in Minnesota Senior Health Options (MSHO), a managed care program that includes traditional Medicare, Medicare Part D, and Medicaid services. Participants had the option to opt out before auto-enrollment and MSHO remains a voluntary program. Now, almost all EW participants must receive services through managed care starting in January 2009. Participants can enroll in Minnesota Senior Health Options (MSHO) or Minnesota Senior Care Plus (MSC+), which includes only Medicaid services.

The most common EW services used in State Fiscal Year (SFY) 2008 were case management; customized living; supplies and equipment in addition to what is covered in the Medicaid State Plan; homemaker; and home-delivered meals.⁵⁰ Customized living is a bundled service where a monthly rate is established to purchase the services an individual needs and chooses.⁵¹ Customized living was used by 30% of EW participants during a six-month span from October 2007 to March 2008.⁵² It is provided by home care agencies licensed by the Minnesota Department of Health (MDH) and in housing with services establishments. Some customized living home care providers have registered with MDH to provide assisted living services.

Four Medicaid HCBS Waivers serve people with disabilities, primarily people under age 65:

- The Developmental Disabilities (DD) Waiver provides services as an alternative to ICFs/MR. In SFY 2007, almost all participants received case management, and a majority of participants received residential and day habilitation. Other common services included respite, personal support, and consumer-directed community supports.⁵³
- The Community Alternatives for Disabled Individuals (CADI) Waiver provides services as an alternative to nursing facility care. Data from October 2006 through September 2007 indicate more than 90% of participants received case management. Other common services included supplies and equipment, homemaker, independent living skills counseling, transportation, home delivered meals, and adult foster care.⁵⁴ Some CADI participants will no longer be eligible when

⁴⁹ Essential Community Services will offer service coordination, caregiver support and education, homemaker, chore services, and emergency call devices (e.g., PERS). Persons who need home delivered meals will be referred to the Aging Network for meals funded from the state or the Older Americans Act.

⁵⁰ Data received from the Minnesota Department of Human Services in February 2009 (fee-for-service) and September 2009 (managed care). Common services are defined as services used by at least 10% of participants. The same services met this definition in both fee-for-service and managed care.

⁵¹ Minnesota Department of Human Services *Bulletin 09-25-01: DHS Issues Proposed EW Customized Living Tools and Instructions and Implementation Plan for Feedback and Comment* January 30, 2009

⁵² Data received from the Minnesota Department of Human Services in June 2009 including fee-for-service and managed care.

⁵³ Minnesota Department of Human Services CMS 372 lag report for DD Waiver, dates of service July 1, 2006 – June 30, 2007. Common services are defined as services used by at least 10% of participants.

⁵⁴ Minnesota Department of Human Services CMS 372 lag report for CADI Waiver, dates of service October 1, 2006 – September 30, 2007. Common services are defined as services used by at least 10% of participants.

the nursing facility level of care change described on page 22 is implemented in 2011. People who do not meet the new criteria still may qualify for Medicaid state plan services.

- CADI Waiver participants in the seven-county metropolitan area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties) have the option of receiving HCBS waiver and other services through a managed care organization in the MnDHO program described on page 26.
- The Community Alternative Care (CAC) Waiver serves people with complex medical needs who require a hospital level of care. Data from April 2006 through March 2007 indicate all participants received case management. Other common services included supplies and equipment, home modifications, homemaker, adult foster care, consumer-directed community supports, and nursing services in addition to what is available in the state plan home health and private duty nursing benefits.⁵⁵
- Traumatic Brain Injury (TBI) Waiver serves people with traumatic brain injuries as an alternative to a nursing facility or a neurobehavioral hospital unit. Data from April 2006 through March 2007 indicate almost all participants received case management. Other common services included adult foster care, transportation, independent living skills counseling, behavioral program, supplies and equipment, structured day program, supported employment, customized living, and prevocational services.⁵⁶ TBI Waiver participants in the seven-county metropolitan area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties) have the option to receive HCBS waiver and other services through a managed care organization in the MnDHO program described on page 26.

Most participants in these waivers are under age 65. For CADI, CAC, and TBI, a person must be under age 65 when he or she starts the waiver. When a participant in one of these waivers reaches his or her 65th birthday and qualifies for EW, he or she can choose the waiver that best meets his or her needs. People over 65 can enroll in the DD Waiver. If the person qualifies for both the DD Waiver and EW, he or she can choose between these waivers.

State Plan Community Services

Several State Plan services provide long-term supports. Unlike an HCBS Waiver, a person does not need to meet institutional level of care criteria to qualify for these services, but the person must be eligible for Medicaid and the services must be medically necessary. These services can be used in conjunction with an HCBS waiver and by people who do not need waiver services.

⁵⁵ Minnesota Department of Human Services CMS 372 lag report for CAC Waiver, dates of service April 1, 2006 – March 31, 2007. Common services are defined as services used by at least 10% of participants.

⁵⁶ Minnesota Department of Human Services CMS 372 lag report for TBI Waiver, dates of service April 1, 2006 – March 31, 2007. Common services are defined as services used by at least 10% of participants.

Personal Care Assistance (PCA): PCA services provide assistance with activities of daily living. Minnesota is implementing several changes to this benefit that the 2009 State Legislature enacted, including:

- Standardized training requirements for both agencies and individual personal care attendants
- Annual documentation that the provider agency meets state provider standards
- Supervision and evaluation of personal care attendants by a qualified professional as defined in statute
- A limit on the number of hours per month a personal care attendant can work⁵⁷

Home Health Agency: In the Medicaid program, home health agencies provide 1) short-term care following an acute care episode such as a hospitalization, and 2) long-term care for people with ongoing needs related to medical care or daily living activities. Data for home health agencies in this report include three services provided by these agencies: skilled nursing, home health aide services, and therapies (physical, occupational, speech, and respiratory therapies). In order to qualify for Medicaid reimbursement in Minnesota, home health agencies must be Medicare-certified home health agencies.⁵⁸

Private Duty Nursing (PDN): The PDN benefit provides several hours per day of in-home care by a licensed nurse.

Rehabilitative Services: Minnesota provides several community mental health services in the Medicaid State Plan rehabilitative services benefit. Since 2000, Minnesota had added services to the Medicaid rehabilitation benefit in order to direct the mental health system toward individualized services and recovery.⁵⁹ Services added to the rehabilitation benefit include:

- Adult Rehabilitative Mental Health Services: Services to enable people to develop and enhance psychiatric stability, emotional adjustment, and independent living skills. Services are typically delivered in the person's home or in a community setting.
- Assertive Community Treatment: An intensive, multidisciplinary rehabilitative service that includes case management; support and skills training for daily life skills and social and interpersonal skills; education regarding mental illness provided to the person and family members; medication management; and assistance in obtaining housing.
- Intensive Residential Treatment Services: Treatment in a residential setting that serves five to 16 adults with mental illness. Services are designed to last only a few months, with an average length of stay of approximately 45 days. Services are provided in adult mental health treatment facilities licensed under Rule 36, which previously provided long-term residential supports.

⁵⁷ Minnesota Department of Human Services, *Continuing Care Administration 2009 Legislative Session Summary* June 15, 2009

⁵⁸ Stratis Health *Home Care Reimbursement Methodologies* Prepared for the Minnesota Department of Human Services: April 2008

⁵⁹ Minnesota Department of Human Services *Uniform Application FY 2009 – State Plan: Community Mental Health Services Block Grant* Submitted to SAMHSA Center for Mental Health Services October 5, 2008

- **Children's Therapeutic Services and Supports:** A rehabilitative service with a lower functional eligibility threshold than previous Medicaid services. This service is available to any Medicaid-eligible child with a mental health diagnosis to facilitate early intervention before symptoms become more severe.⁶⁰

For people age 65 or older, the state plan community services described above are typically provided as part of the person's managed care program. Participants can enroll in Minnesota Senior Health Options (MSHO), which includes both Medicare and Medicaid services, or Minnesota Senior Care Plus (MSC+), which includes only Medicaid services.

For people under age 65, state plan community services are typically provided on a fee-for-service basis except for home health and rehabilitative services, which are covered under the Prepaid Medical Assistance Program (PMAP), the managed care program that serves families with children. PMAP is voluntary for people with disabilities or a serious mental illness, but mandatory for most individuals without disabilities.

Adults under age 65 with disabilities may enroll in three managed care programs. These programs are voluntary unless otherwise noted:

1. Minnesota Disability Health Options (MnDHO) serves people who have a physical disability and provides all services described above as well as HCBS Waiver services for CADI and TBI Waiver participants. MnDHO includes all Medicare services for people eligible for both programs (dual eligibles). MnDHO is available in the seven-county metropolitan area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties).
2. Special Needs Basic Care (SNBC) is a managed care option for people age 18 – 64 with disabilities that includes most Medicaid services and all Medicare services for dual eligibles. It is available in most counties and will be available statewide in January 2010. SNBC provides home health and rehabilitative services, but not other long-term care services such as PCA, PDN, and HCBS Waiver services. Eligible SNBC enrollees can receive these services on a fee-for-service basis.
3. Preferred Integrated Networks (PINs) are managed care programs specifically designed to integrate behavioral and physical health care for people with serious mental health needs. PINs includes all state plan services described on pages 24 and 25 and Medicare services for dual eligibles. DHS contracts in each region with a health plan that has a coordination agreement with a county. The expectation is that the two entities will work together to coordinate health care, mental health and other services needed by the enrollees. Enrollment began in the first PIN in Dakota County on September 1, 2009.

⁶⁰ *Ibid.*

Non-Medicaid Services

State-Operated Mental Health Services: State-Operated Services, Minnesota's specialty health system, includes the Anoka Regional Treatment Center and several 16-bed Community Behavioral Health Hospitals established as part of a mental health reform initiative in 2006. The mental health hospitals are primarily used for stays of a few days or weeks when there is not another facility willing and able to serve the individual. The Medicaid program covers services in mental health hospitals for all Medicaid-eligible people provided the hospital is enrolled in Medicaid. If the hospital is larger than 16 beds or is not certified for Medicaid, state and county funds cover hospital services. If the hospital is larger than 16 beds and certified for Medicaid, Medicaid covers Medicaid-eligible people under age 21 and age 65 and older, while state and county funds pay for people ages 22 to 64. The Minnesota Department of Human Services also operates community services for people with serious mental illness.

State-Operated Developmental Disabilities Services: State-Operated Services provides a broad array of services for individuals with developmental disabilities, including community based acute inpatient psychiatric care; specialized residential, crisis, and consultative services; chemical dependency treatment; as well as long-term residential and vocational services. These services are geographically dispersed and available statewide. Services are accessed voluntarily by the individual, although there are a small number of individuals who are ordered by a court to receive care. A small number of individuals with developmental disabilities are under commitment as mentally ill and dangerous and are served through the State Operated Forensic Services.

Aging Network services: The Minnesota Board on Aging (MBA) and regional Area Agencies on Aging administer grants from the Federal Administration on Aging and state General Revenue appropriations. AAAs and their contracted providers offer nutrition services, provided both at congregate dining sites or through home delivered meals, and other services such as caregiver support, transportation, chore, and information and assistance.

Alternative Care (AC): AC is a state-funded program that provides a variety of services for people age 65 or older who are functionally eligible for nursing facility care but do not meet Medicaid financial criteria. The most common services in SFY 2008 were case management, supplies and equipment, homemaker, home delivered meals, home health nursing, home health aide, and personal care assistance.⁶¹ Some AC participants will be affected by the nursing facility level of care change effective January 2011 and described on page 22. People who do not meet the new criteria may qualify for Essential Community Services, a grant that will start at that time and offer fewer services.

Day Training and Habilitation (DT&H): DT&H are licensed services to help adults with developmental disabilities improve and maintain independence; enhance personal skills; empower choice making abilities; and improve integration into the community. Services include vocational supports, such as supported employment and work crews, as well as non-vocational supports. Medicaid pays for most day habilitation through the DD Waiver and ICFs/MR (which are required to provide day services, which

⁶¹ Data received from the Minnesota Department of Human Services in February 2009. Common services are defined as services used by at least 10% of participants.

can include DT&H). Counties may pay for DT&H for individuals who do not receive ICFs/MR or DD Waiver services.⁶²

Consumer Support Grant (CSG): CSG is a state-funded alternative to Medicaid-reimbursed home care. Eligible participants receive monthly cash grants to pay for a variety of home and community based services in lieu of home health aide, personal care attendant and/or private duty nursing.⁶³

Semi-Independent Living Services (SILS): SILS include training and assistance in managing money, preparing meals, shopping, personal appearance and hygiene and other activities needed to maintain and improve the capacity of an adult with an intellectual disability to live in the community. The state provides 70% of funding for SILS, with the county providing the remainder. Some counties also fund 100% of costs for some persons not served through the state supported allocations.⁶⁴

Family Support Grant (FSG): FSG provides state-funded cash assistance to prevent the out-of-home placement of children with disabilities and promote family health and social well-being. Approved categories of expenses include medications, education, day care, respite, special clothing, special diet, special equipment and transportation.⁶⁵

Public Mental Health Services: The Minnesota Department of Human Services administers state-funded grants to counties to provide mental health services to people who otherwise cannot afford them. Minnesota has made significant changes in its public mental health system in the past decade to encourage individualized services and individualized supportive housing rather than long-term facility-based services. These changes include establishing the Medicaid rehabilitative services mentioned on page 25.⁶⁶ In addition, the 2007 Mental Health Initiative includes a variety of infrastructure improvements; the development of PINs described on the page 26; and the establishment of a common mental health benefit set in Medicaid and in two state-funded programs for low-income individuals ineligible for Medicaid: General Assistance Medical Care and MinnesotaCare.⁶⁷

According to several stakeholders, the mental health system provides less ongoing support for people who are not showing improvement but have significant needs. Individuals with mental health needs have increasingly used personal care and HCBS Waiver services to receive ongoing support for activities of daily living. For example, 32% of CADI Waiver participants have a mental illness indicated as their primary diagnosis.⁶⁸

⁶² Minnesota Department of Human Services, Disability Services Division *Continuing Care Matrix of Services to People with Disabilities: FY 2007 Service Costs* April 2008

⁶³ Minnesota Department of Human Services *Continuing Care Matrix of Services to People with Disabilities: FY 2007* April 2008

⁶⁴ *Ibid.*

⁶⁵ *Ibid.*

⁶⁶ Minnesota Department of Human Services *Uniform Application FY 2009 – State Plan: Community Mental Health Services Block Grant* Submitted to SAMHSA Center for Mental Health Services October 5, 2008

⁶⁷ Minnesota Department of Human Services *Fast Facts: 2007 Legislative Session: Governor's Mental Health Initiative* June 2007. Funding for General Assistance Medical Care is scheduled to expire in 2010.

⁶⁸ Data received from the Minnesota Department of Human Services in June 2009.

AIDS Assistance Programs: The AIDS Drug Assistance Program (ADAP) pays for drugs to treat AIDS for low-income individuals who are not fully covered by Medicare, Medicaid, or other insurance. The program also provides case management, dental, mental health, nutrition, and transportation services if not available from other payers such as Medicare and Medicaid. Participants must have AIDS or an HIV infection and meet financial eligibility criteria. The Minnesota Department of Human Services helps people purchase insurance that covers the medications and other health care, or assists persons in directly purchasing drugs from its formulary. The ADAP program is funded primarily by a Federal grant under the Ryan White CARE Act, with state funds enabling additional people to be served.

Group Residential Housing (GRH): Minnesota provides a few hundred dollars a month for Federal Supplemental Security Income (SSI) participants to pay for rent in licensed or registered residential facilities that provide room, board, and personal assistance. During SFY 2009, the maximum state supplement was \$496.87 a month for adults who receive General Assistance, have an initial diagnosis of chemical dependency, and an eventual diagnosis of mental illness. A majority of GRH participants receive services from Medicaid home and community-based services waivers.⁶⁹ The provider receives most of the payment for care-related expenses, but the resident is able to keep a personal needs allowance of \$89 per month as of January 2010.⁷⁰

Minnesota Supplemental Aid (MSA): Minnesota also provides a supplement to SSI participants who do not live in licensed residential settings. For most individuals living alone, the payment is \$81 per month. Two participants sharing a household receive no more than \$112 in total per month. Additional special needs payments are available for certain individuals with specific, usually time-limited costs such as medically prescribed diets, costs for relocating from an institution to the community, and non-recurring home repairs.⁷¹ Starting in July 1, 2009, one of these special needs payments, MSA – Shelter Needy Option, is also available for people who live in provider-controlled, multi-family housing that has six or more units, as long as 50% or fewer of the residents receive MSA – Shelter Needy Option.⁷²

Independent Living Services: Centers for Independent Living (CILs) provide services and training to help people with disabilities live independently in the community. The four core independent living services are: individual and systems advocacy; information and referral; skills training; and peer counseling. These services are funded with state funds and grants from the Federal Department of Education, Rehabilitation Services Administration. In counties where CILs are not operational, independent living and vocational rehabilitation counselors for the Department of Employment and Economic Development (DEED) provide the core services.⁷³

Vocational Rehabilitation: The Vocational Rehabilitation program helps adults and adolescents with disabilities prepare for and obtain employment. DEED manages the program, which is funded by the

⁶⁹ Minnesota Department of Human Services “Group Residential Housing Program” Updated October 6, 2008

⁷⁰ Social Security Administration State Assistance Programs for SSI Recipients, January 2008 2008

⁷¹ Minnesota Department of Human Services “Minnesota Supplemental Aid” Updated March 16, 2009

⁷² Minnesota Department of Human Services “Bulletin 09-48-02: 2009 Legislative change to the MSA Supports Options Initiative with extra allowance for Shelter-Needy clients with special needs” August 12, 2009

⁷³ Minnesota Management And Budget FY 2010-11 *Governor’s Budget Recommendation: Agency Level Narratives* January 27, 2009

Federal Department of Education, Rehabilitation Services Administration (RSA) and state matching funds.

Extended Employment: The Extended Employment program helps employed people with disabilities maintain their job. This state-funded program assists people who need help for a longer duration than allowed in Vocational Rehabilitation.⁷⁴

Special Education: Part B of the Federal Individual with Disabilities Education Act (IDEA) requires local school districts to provide services and supports to children and young adults, ages 3-21, to help them learn in the least restrictive environment.

Early Intervention: Minnesota provides developmental and supportive services to children under age three with developmental delays through education agencies in the Early Intervention program, which is funded in part by Federal grants under Part C of IDEA.

⁷⁴ Kavita, Anita Extended Employment Program: Compliance Audit & Program Evaluation Report July 1, 2006 – June 30, 2007 Minnesota Department of Employment and Economic Development: June 17, 2008

PART II: NINE SYSTEM COMPONENTS

Component 1: Coordinated State Agencies

Minnesota's umbrella human services agency, the Department of Human Services (DHS), administers most long-term supports. Several units within DHS play significant roles in the public long-term support system:

- The Continuing Care Administration is the lead agency in policy and program development for services for older adults and people with disabilities
- The Chemical and Mental Health Services Administration performs a similar role for mental health supports
- The Health Care Administration oversees eligibility determination for Medicaid and General Assistance Medical Care, which fund most of the supports managed by the above units. It also administers managed care programs that provide long-term care services to many individuals, especially older adults
- The Licensing Division ensures several types of providers meet state standards, including adult foster care, adult day care, and community mental health residential facilities
- State-Operated Services provides direct services to people with mental illness, chemical dependency, developmental disabilities, and traumatic brain injuries. State-operated services typically serve people who have difficulty being served by other providers

While DHS provides most funding for long-term supports, other state government organizations play important roles in the system:

- The Minnesota Board on Aging (MBA), a governor-appointed board that is the State Unit on Aging, manages Aging Network Services. The MBA is housed within DHS and shares staff with the Continuing Care Administration
- The Minnesota Department of Education (MDE) oversees special education services, the largest public funding source for services to children with disabilities
- The Minnesota Department of Health (MDH) licenses, certifies, and registers many long-term care providers, including nursing facilities, ICFs/MR, and home health agencies. MDH also manages health improvement initiatives for people with chronic conditions and a program for Children with Special Health Care Needs funded through Title V of the Social Security Act.

- The Department of Employment and Economic Development (DEED) 1) determines eligibility for disability-related income support from the Social Security Administration; 2) administers Federal and state programs for vocational rehabilitation services to adults and transition-age youth with all types of disabilities; and 3) administers Federal and state grants for independent living services.
- Ombudsman offices advocate for the rights, health, and welfare of individuals who need long-term support services. Two offices support people regardless of payer. The Office of Ombudsman for Mental Health and Developmental Disabilities is an independent state agency that advocates for people with mental illness, developmental disabilities, chemical dependency and emotional disturbance. The Office of the Ombudsman for Long-Term Care (part of the Minnesota Board on Aging) advocates for people who receive nursing facility, home health, HCBS waivers, and other long-term care services. A third ombudsman office, the Ombudsman for State Managed Care Programs, operates within the Department of Human Services and helps people enrolled in a publicly funded managed health care plan.
- The Minnesota Housing Finance Agency (Minnesota Housing) provides rental assistance to help older adults and people with disabilities afford housing; development assistance to increase the supply of affordable and accessible housing; and offers home improvement loans for eligible homeowners that can improve housing accessibility.
- The Department of Transportation (MnDOT) funds public transit programs in 80 of Minnesota's 87 counties, including accessible transit programs for older adults and people with disabilities in the Duluth, Moorhead, Rochester, Saint Cloud, and Twin Cities areas.⁷⁵
- The Minnesota State Council on Disabilities (MSCOD) advises the Governor, the Legislature, state agencies, and others about legislation and policies that affect Minnesotans with disabilities.
- The Minnesota Governor's Council on Developmental Disabilities, which provides information, education and training to promote the independence and inclusion of people with developmental disabilities.

Many states that have reformed their long-term care system (e.g., Oregon, Washington and Vermont) established a single agency responsible for planning and delivery of services for a particular population (e.g., older adults, people with developmental disabilities). In these states, a single agency for a range of institutional and community services enabled the state to develop coordinated policies that promoted common goals across funding streams and services.⁷⁶ Some of these states have taken the additional step of creating a single organization for the full range of disabilities, to align services with individuals' functional needs regardless of diagnosis.⁷⁷

⁷⁵ Minnesota Department of Transportation *Minnesota Statewide Transportation Plan: Moving People and Freight from 2003 to 2023* August 2003

⁷⁶ Eiken, Steve *Promising Practices in Long Term Care Systems Reform: Common Factors of Systems Change* Medstat: November 9, 2004 and Kane, Rosalie A.; Kane, Robert L.; Priester, Reinhard; Homyak, Patricia *Research and State Management Practices for the Rebalancing of State Long-Term Care Systems: Final Report* University of Minnesota: June 2008

⁷⁷ Kane, Rosalie A.; Kane, Robert L.; Priester, Reinhard; Homyak, Patricia *Research and State Management Practices for the Rebalancing of State Long-Term Care Systems: Final Report* University of Minnesota: June 2008

The Department of Human Services' Continuing Care Administration is close to the latter model. It manages most institutional and community services, including services for most population groups identified in Minnesota's State Profile Grant: older adults, people with developmental disabilities, people with physical disabilities, people with HIV/AIDS, and people with brain injuries. Continuing Care includes Medicaid long-term support; services for people with HIV/AIDS funded by the Federal Ryan White Act and state dollars; and state-funded programs such as Alternative Care and the Consumer Support Grant. These supports are also coordinated with Aging Network Services. The Executive Director of the Minnesota Board on Aging has a dual reporting relationship – working for both the Assistant Commissioner for Continuing Care as well as the Board on Aging.

Also within DHS, a single Chemical and Mental Health Services Administration manages almost all publicly funded mental health and substance abuse services, providing an opportunity to coordinate services for the large number of people with co-occurring mental health and substance abuse issues. State-Operated Services – which includes both institutional and community supports – operates separately within the Chemical and Mental Health Services Administration.

As in other states,⁷⁸ multiple agencies support children with special health care needs. Many programs and services may be necessary at some point in a child's life. The Department of Education is the largest funding source specific to children. In addition, all departments and divisions listed above serve children or provide oversight for services to children.

Local and Regional Administration

Most of the above state agencies administer services in partnership with a network of local entities. The local agencies can provide information and assistance, determine eligibility for public services (sometimes called the need determination), assess need for services, develop service plans, and help people obtain necessary services.

In Minnesota, counties have historically played a significant role in publicly funded services. Counties assess eligibility for most public services provided on a fee-for-service basis, including mental health services, personal care, private duty nursing, nursing facility care, ICFs/MR, and HCBS Waiver. Counties provide case management for all these services except personal care and private duty nursing. The county or its contracted case management agency develops a service plan to meet the person's needs identified in the assessment, and helps the person obtain services. In addition, counties offer Long Term Care Consultations (LTCC) to people who are not eligible for public programs but who want information and assistance in selecting options. The state also has contracted with two tribes for assessment and case management for HCBS Waivers and Alternative Care. Residents living on the Leech Lake and White Earth reservations can receive services from either their county or their tribe. Counties perform additional administrative functions such as provider enrollment and contracting that may change based on federally required changes described in the section regarding *Component 6: Quality Management*.

⁷⁸ See, for example, Eiken, Steve; Iwan, Mary Jo; Gold, Lisa *Iowa State Profile Tool: An Assessment of Iowa's Long-Term Support System* Thomson Reuters: March 31, 2009 and Eiken, Steve; Nadash, Pamela; and Burwell, Brian *Profile of Pennsylvania: A Model for Assessing a State Long-Term Care System* Thomson Medstat: December 2006

Managed care organizations (MCOs) assess functional eligibility and coordinate services in public managed care programs targeted to older adults and people with disabilities and/or mental illness (e.g., MSHO, MSC+, MnDHO, and SNBC). The managed care plan assesses eligibility for nursing facility placement and is responsible for the first 100 to 180 days of nursing facility care (the number of days varies by program). Several of these managed care organizations also provide health insurance to most Minnesotans in the private market. These health plans employ their own staff to conduct assessment and service planning or contract with private care coordination organizations and/or counties for these functions. Other managed care organizations are regional collaborations of county governments (called county-based purchasing). Effective July 1, 2009, managed care organizations also provide targeted mental health case management for children and adults who are enrolled in managed care, including people enrolled in PMAP, the managed care program that serves families with children. Some MCOs have contracts with counties and other vendors who provided fee-for-service mental health case management.

Other local and regional agencies involved in long-term supports include:

- Local school districts for special education and early intervention services
- Regional Area Agencies on Aging (AAAs) that administer state and federal grants to provide services to older adults
- Centers for Independent Living that provide community services for people with disabilities
- Local public housing authorities – at a city or county level – that administer public housing funding

Component 2: Information and Referral

This component was originally called single access point, because states that have improved their long-term support systems often have a common access point for public institutional and community services for a particular target population. For example, one would contact a county health or social services agency for nursing facility, assisted living, or home care services. This entry point can ensure people know the full range of options before making long-term care or support choices. The authors changed the focus of this component for the Minnesota State Profile, because 1) a single access point for all target populations is not something that has occurred in other states; 2) HCBS Expert Panel members noted many other agencies also provide information and assistance to help connect people to services. This section provides a summary of common sources that help people find out about services (either publicly or privately funded), explains information challenges that arise for people learning about the service system, and describes state efforts to improve access to services.

Information Resources

The local and regional administrative entities described in *Component 1: Coordinated State Agencies* all function as the official “entry point” for public services because they determine eligibility for long-term support and have a formal duty to connect people to other service agencies. These agencies include:

- County health and/or social service agencies
- Care coordinators for managed care organizations
- Local school districts
- State and county contracted case managers for HIV/AIDS services
- State-employed counselors for vocational rehabilitation
- Area Agencies on Aging
- Centers for Independent Living

The above access points can help people obtain important services, but only if people know to contact them. When asked how people learn about services, HCBS Expert Panel members mentioned many referral sources that inform people about both public and privately available supports. Some felt that word of mouth from family and friends was most effective, particularly in rural areas. Others cited the role of the county, particularly county social workers or financial eligibility workers. The health risk assessment required by managed care organizations also was credited with identifying people who needed long-term support, especially for people in cultural minority communities who are less likely to seek assistance. A service provider may be the most visible long-term care organization in a community, and refer a person to a county, managed care organization, or other agency for eligibility determination. Many people reportedly turn to health care providers, especially their physician.

At times, how people learn about services varies by type of disability or when the disability occurs during the lifespan. For example, health care professionals are common referral sources, especially for systems related to particular diagnoses such as mental health services and services for people with HIV/AIDS and brain injury. Minnesota’s Early Childhood Screening for pre-school children detects potential disabling

conditions, allowing the medical community to connect parents or guardians with appropriate services. Finally, schools are a common referral source to connect people with developmental disabilities to the adult service system.

People also use on-line and telephone resources developed by the state to provide information and referral. In addition, the 2005 Survey of Older Minnesotans by the Minnesota Board on Aging found other common resources people turn to include disease-specific advocacy organizations, their church, and their human resources office at work.⁷⁹

Information Challenges

Many HCBS Expert Panel members spoke of the complexity of the long-term supports system across populations and the need for someone to help people understand available supports and options. The system is more complex when a person needs publicly funded services, because one must consider the requirements of the funding system as well as what supports best meet a person's needs. Either too little or too much information can be a problem. HCBS Expert Panel members noted that abundant information sources can overwhelm people when they need fast answers. System navigators are particularly important for people new to the system and during critical decision points such as transitioning to adulthood, during a hospital stay, or upon the diagnosis of a disabling condition.

Some access points for publicly funded services – e.g., counties, health plans, schools, tribes, and the MinnesotaHelp Network™ – have case management or supports coordination staff charged with helping people navigate the support system. A 2007 report by the Office of the Legislative Auditor noted wide variation in county intake and assessment practices across the state,⁸⁰ and HCBS Expert Panel members said variation exists among other access points as well. Our conversations with HCBS Expert Panel members identified challenges in providing information and referral.

Understanding the long-term support system itself is a challenge. Long-term care systems frequently change and navigators need to remain up-to-date regarding new policies, new providers, innovative services, and changing expectations among participants and families. In addition, people often have complex needs, requiring coordination across multiple funding streams. A study of case management services for people with disabilities noted that even an expert navigator in one part of the system or for one population often struggles to assist someone needing supports from another part of the system.⁸¹ Understanding systems outside one's day-to-day work is likely a challenge for other information and referral sources as well.

In addition, effective communication with the person and his/her family can be a challenge. Too much information for one person may be too little for another. Effective communication includes culturally competent dialogue with people who are in ethnic or cultural minority groups, who may have less information about potential supports as well as different perspectives regarding whether supports are

⁷⁹ Minnesota Department of Human Services Data Tables: 2005 Survey of Older Minnesotans undated

⁸⁰ Minnesota Office of the Legislative Auditor *Human Services Administration* January 2007

⁸¹ Amado, A., Smith, G., Larson, S., Roehl, A., Fortune, J., Fields, J., Sauer, J., & McBride, M. (2007). *Redesigning Case Management Services for People with Disabilities in Minnesota: A Report to the Legislature*. Minneapolis, MN: Institute on Community Integration, University of Minnesota.

necessary and what should be provided. For example, the Department of Human Services' survey of Elderly Waiver recipients in 2007 revealed a statistically significant difference in the percent of English speaking clients who can identify their case manager (88%) versus non-English speaking clients who are able to do so (71%).⁸² In addition, 14% of non-English speaking recipients do not know whom they would contact to report problems with their services, a rate nearly twice that of English speaking clients.⁸³ These findings likely are not unique to the EW program.

Finally, helping a person and his/her family navigate the long-term support system can be labor intensive. Given limits on public funds and competing priorities, it can be difficult to set aside sufficient resources to help people navigate the system effectively.

Initiatives to Support Individual Long-Term Care Decision-Making

Minnesota has undertaken important efforts to help individuals differentiate among service and support options for themselves. Long-Term Care Consultations (LTCCs) can help keep people in their homes or return them home more quickly from a nursing facility. LTCCs are usually conducted by a county social worker in conjunction with a public health nurse, though tribes or health plans may conduct them as well.⁸⁴ They include an overall assessment, a screening to determine public program eligibility, and help in navigating service and support options to help people live independently.

The Department of Human Services is working to develop an information, intake, and assessment network model across these multiple access points to create a "virtual" single point of entry to long-term care. Minnesota is using a "governing by network" philosophy to plan and develop the MinnesotaHelp Network™, the state's version of the Aging and Disability Resource Center (ADRC) strategy. The MinnesotaHelp Network™ utilizes direct telephone and face-to-face assistance, a web-based consumer resource base, and community outreach sites (such as clinics, community centers, libraries, CILs and AAAs) to expand information accessibility.

New information technology (LinkLive™) enables chats, secure e-mail, document sharing, real-time file transfers and Voice-over Internet Protocol (VoIP) telephony. Together, these features provide advanced call routing to Linkage Line agents at various contact centers, call transfers, third-party conferencing among unlimited numbers of parties, and records all calls – all on a secure, HIPAA-compliant Web-based system. The Linkage Line agents include Senior LinkAge Line®, Disability Linkage Line®, and Veterans Linkage Line™.

The telephone resources mentioned above provide information to people needing long-term care and their families. A 2008 report reveals that the top request among callers, by far, was health insurance counseling (61% of calls).⁸⁵ MinnesotaHelp.info® is an online resource database offering information on a variety of community services for older adults and persons with disabilities, and hosts the Long-term Care

⁸² Myott, Sarah *Elderly Waiver Statewide Consumer Experience Survey Report* on 2007 results May 2008

⁸³ *Ibid.*

⁸⁴ Minnesota Department of Human Services *Long-Term Care Consultation Services*, undated

⁸⁵ Minnesota Department of Human Services, Senior LinkAge Line, Disability Linkage Line report, September 2008

Choices Navigator to help people make decisions regarding their own care when they are able and to assist caregiver planning. HCBS Expert Panel members noted MinnesotaHelp.info® has been particularly useful for professionals that help people navigate the long-term care system. This resource is funded in part by a Federal Aging and Disabilities Resource Center (ADRC) grant.

For people with HIV/AIDS, the Minnesota AIDS Project operates an AIDSLine both online and via phone. In addition, Hennepin County (the most populous county in the state) has created Front Door Access, providing phone-based assistance for county residents to field requests related to developmental disabilities, children's mental health, and chemical health, as well as information on financial assistance for various needs.

Component 3: Variety of Housing Options

Housing is a fundamental necessity regardless of whether or not one needs other types of support. Offering a sufficient variety of affordable and accessible housing options for people with disabilities and older adults is particularly difficult because 1) people with disabilities are nearly twice as likely as those with no disability to have incomes below the federal poverty level,⁸⁶ and 2) many people need not only affordable housing but also physical accessibility features and/or on-site supportive services.

Individuals' needs for housing and support vary greatly. For example, some people already have housing, either alone or with family members, but may need to modify their home to make it accessible. Other individuals need to establish a new household for different reasons such as homelessness; discharge from an intensive service setting that is no longer necessary; moving away from one's parents at an age-appropriate time; or the disability or death of a caregiver. Still others may need around-the-clock monitoring or other supports for which small group settings might be the most cost-effective. Finally, some individuals prefer to live where opportunities to participate in the array of activities in the community are more easily accessed.

An insufficient supply of housing options can lead to homelessness and unnecessary institutional placement. In 2006, 79% of adult homeless Minnesotans had a disability. Sixty percent had multiple disabilities.⁸⁷ Common types of disabling conditions included:

- Serious mental illness (52%)
- Chronic physical health conditions (44%)
- Cognitive disabilities such as feeling confused or having trouble remembering things (33%)
- Head injuries (30%)
- Substance abuse (27%)⁸⁸

Homeless individuals are more likely to use crisis services, including emergency shelters, hospitals, jails, and child foster care.⁸⁹ In addition, the most frequently cited challenge in most programs to help people move from nursing facilities has been a lack of affordable, accessible housing.⁹⁰

In Minnesota and other states, service systems for different populations address housing differently. Component Table 3.1 below shows the type of housing arrangements for participants in the Medicaid HBCS Waivers and the state-funded Alternative Care program. Approximately 60% DD and TBI Waiver participants live in congregate settings, which include facilities licensed as adult foster care, child foster care, board and lodge, and non-certified boarding care homes. For other waivers, between 19 and 29% of participants live in congregate settings. Only three percent of Alternative Care participants live in

⁸⁶ U.S. Census Bureau, American Community Survey "Table S1201. Disability Characteristics from the 2005-2007 American Community Survey 3-Year Estimates" August 2008

⁸⁷ Wilder Research *Overview of Homelessness in Minnesota 2006: Key Facts From the Statewide Survey* 2007

⁸⁸ *Ibid.*

⁸⁹ Minnesota Department of Human Services, Minnesota Department of Corrections, and Minnesota Housing Finance Agency *Ending Long-Term Homelessness in Minnesota: Report and Business Plan of the Working Group on Long-Term Homelessness* March 2004

⁹⁰ O'Keeffe, Janet; O'Keeffe, Christine; Osber, Deborah; Siebenaler, Kristin; Brown, David *FY 2002 Nursing Facility Transition Grantees: Final Report* RTI International: July 2007

congregate settings. Unlike the waivers, Alternative Care does not have a service that pays for around-the-clock supports in a residential setting, such as customized living.

Component Table 3.1 – Percentage of HCBS Waiver and Alternative Care Participants by Type of Housing, SFY 2008

	Living Alone	Living with Spouse or Parent	Living with Family or Friend	Congregate Setting
Elderly Waiver	44%	12%	15%	29%
CADI Waiver	36%	21%	16%	27%
CAC Waiver	3%	59%	19%	19%
TBI Waiver	17%	12%	8%	62%
Alternative Care	69%	11%	17%	3%

The DD Screening Tool uses different categories:

	Own Home	Home of Immediate Family	Home of Extended Family	Foster Care – Family or Live-In Staff	Foster Care – Shift Staff	Other
DD Waiver	5%	32%	1%	7%	54%	2%

* The DD Waiver uses a different screening tool than the other programs, and options regarding housing type and living arrangement are different.

Source:

Data provided by the Minnesota Department of Human Services February 2009 (AC and EW) and July 2009 (other waivers)

States that improved their long-term support systems have increased access to a variety of options in order to meet different individuals' housing needs and preferences. This involves providing alternatives to the common paradigm for a particular population, like offering residential models such as assisted living for older adults and offering alternatives to provider-owned homes for people with developmental disabilities.⁹¹ This section describes options developed in Minnesota for 1) supportive housing where people live in their own homes, apartments, or other non-licensed settings with access to care and support; and 2) regulated residential services options that combine housing and services.

⁹¹ See, for example: Crisp, Suzanne et al. *Money Follows the Person and Balancing Long-Term Care Systems: State Examples* Medstat: September 29, 2003; Horvath, Jane and Thompson, Rachel *Promising Practices in Long Term Care System Reform: New Hampshire's Community-Based Service System for Persons with Developmental Disabilities* Medstat: December 5, 2003; Justice, Diane *Promising Practices in Long Term Care System Reform: Vermont's Home and Community Based Service System* Medstat: September 8, 2003; Justice, Diane and Heestand, Alexandra *Promising Practices in Long Term Care System Reform: Oregon's Home and Community Based Services System* Medstat: June 18, 2003; Reinhard, Susan C. and Fahey, Charles J. *Rebalancing Long-Term Care in New Jersey: From Institutional toward Home and Community Care* Milbank Memorial Fund: March 2003.

Supportive Housing

This report uses the term supportive housing broadly to refer to affordable housing “with linkages to services necessary . . . to maintain housing stability, live in the community, and lead successful lives.”⁹² A wide range of supports can fit this definition, including:

- Modifications to make a home accessible, which some people pay for privately. Public assistance includes low-interest loans from the Minnesota Housing Finance Agency (MHFA)⁹³ and the Medicaid HCBS waivers, which pay for certain home modifications.
- Rental assistance to reduce a person’s rent, usually to 30% of their income
- Development funding such as the Low-Income Housing Tax Credit and the Community Development Block Grant
- On-site service coordinators to link residents in multi-unit buildings with support services in the community
- In-home services such as personal care to help a person perform activities of daily living in the home, often funded by programs described in *Section 3: Available Services and Programs*
- Monitoring technology to reduce the need for on-site staff

The above assistance can be used in “integrated housing,” where people with disabilities live among people without disabilities; or at sole-purpose sites that serve people with a common long-term support need, such as a serious mental illness or a developmental disability.

Most rental assistance and development is funded through a variety of HUD programs such as: Section 8 vouchers; development and rental assistance programs targeted for older adults (Section 202), people with disabilities (Section 811), or people with AIDS (Housing Opportunities for People with AIDS, or HOPWA); and the HUD Continuum of Care targeted to ending homelessness. Over 16,800 people in households that included adults with disabilities received Section 8 vouchers or lived in low-rent public housing between May 2008 and August 2009. During the same time period, over 11,800 people in households that included older adults received Section 8 vouchers or lived in low-rent public housing.⁹⁴ These data do not include people living in housing that received development assistance. In addition to HUD-funded assistance, Minnesota offers a Bridge Program for people with serious and persistent mental illness on a Section 8 waiting list and a special Ending Long-Term Homelessness Initiative Fund for rental assistance, operating subsidies, and capital for permanent supportive housing.

⁹² Minnesota Department of Human Services, Minnesota Department of Corrections, and Minnesota Housing Finance Agency *Ending Long-Term Homelessness in Minnesota: Report and Business Plan of the Working Group on Long-Term Homelessness* March 2004

⁹³ Minnesota Housing Finance Agency “Home Improvement Loans” undated

⁹⁴ U.S. Department of Housing and Urban Development *Resident Characteristics Report* August 31, 2009. Data reflect the characteristics of housing residents in low-rent public housing and of people using Section 8 vouchers. Data do not reflect the type of the housing occupied. For example, some older adults and people with disabilities live in housing units designed for general occupancy.

Other initiatives are improving access to information about the housing that is available. In June 2009, the Department of Human Services awarded a grant to The Arc of Minnesota to provide training and technical assistance to help people with disabilities and their families acquire housing. Also, people can obtain online information about housing resources and availability through the MinnesotaHelp Network™ described in *Component 2: Information and Referral* and through www.housinglink.org, an online database created by Housing Link, an independent non-profit organization with many funding sources, including state and local government agencies and private foundations.⁹⁵

The 2007 Gaps Analysis, a survey of counties regarding locally available services and supports, indicates gaps in housing capacity in several areas including subsidies for low income persons needing housing modifications (77% of counties); resources to track available housing (67%); and subsidized rental apartments with support services or supervision and health care services (71%).⁹⁶

Regulated Residential Services

Several types of regulated settings have been established to serve people who need more support than has traditionally been available in one's own home or apartment. This section does not discuss facilities that meet the definition of institutions on page 2 of the state profile: 1) state-operated hospitals and forensic facilities serving people with developmental disabilities or serious mental illness; 2) intermediate care facilities for people with mental retardation (ICFs/MR); and 3) nursing facilities. These facilities are discussed in *Component 8: Institutional Supply Controls*. Component Table 3.2 below lists each type of residential setting, 2008 licensed capacity (i.e., number of beds), and – where available – the four-year trend in licensed capacity. Trends in the two most common residential settings are then discussed.

⁹⁵ Housing Link "Acknowledgements" 2008

⁹⁶ Myott, Sarah 2007 *Long-Term Care Gaps Analysis* Minnesota Department of Human Services: September 2008

Component Table 3.2 – Licensed Residential Settings in Minnesota

	2008 Capacity (As of August 1, 2008 unless otherwise noted)	Percent Change in Capacity, 2004 - 2008
Registered Housing with Services Establishments (August 2009)	59,131	n/a*
Adult Foster Care	16,724	4%
Children's Residential Facilities (includes Department of Corrections)	3,609	0%***
Licensed Supervised Living Facilities (January 2009)**	3,184	n/a*
Residential Facilities for Adults with Mental Illness (Rule 36)****	1,187	-2%
Residential Services for People with Physical Handicaps (Rule 80)	307	0%
Developmental Disabilities Residential Services Programs**	162	-6%

* Historic data for housing with services establishments and supervised living facilities were not available at the time this report was written

** Supervised living facility and developmental disabilities residential services programs data do not include ICFs/MR, which are licensed under both categories. There were 1,936 certified ICFs/MR beds in 2008 and 2,074 beds in 2004. ICFs/MR trends are described in Section 11: Institutional Supply Controls.

*** Percentage change calculated based on 2005 – 2008. Data show the number of facilities doubled in from 2004 to 2005, which may reflect when juvenile justice facilities were included.

**** Rule 36 facilities now provide Intensive Residential Treatment Services for a few months at a time instead of long-term residential services, consistent with mental health system changes to emphasize supportive housing instead of facility-based services. During the past decade, the mental health system has moved from providing facility-based services to emphasizing long-term supportive housing.

Sources:

Data provided by Minnesota Department of Health in September 2009 regarding facilities licensed as of August 27, 2009
Supervised living facility data provided by Minnesota Department of Health in June 2009, regarding facilities licensed as of January 2009.

Minnesota Department of Human Services: Disability Services Division Plan for ICFs/MR in Minnesota January 2009 for ICFs/MR data

All other data provided by Minnesota Department of Human Services in February 2009, regarding facilities licensed as of August 1 of each year.

Housing with Services Establishments

Minnesota has an unusual licensing structure for residential services for older adults. Most states license a facility that provides both housing and services. Minnesota and a few other states such as Connecticut have separate regulatory structures for housing and for services.⁹⁷ Buildings in which a package of services is offered to residents must be registered with the Minnesota Department of Health (MDH) as housing with services establishments if 80% of the residents are age 55 or older. As of August 2009, Minnesota had 1,373 registered housing with services establishments with a total capacity of 59,131 beds.⁹⁸

Establishments that serve a higher percentage of people under age 55 may also register as housing with services establishments if they meet the regulatory criteria. As of August 2009, 200 establishments with capacity to serve 6,618 residents registered but were not required to do so.⁹⁹ Establishments may register

⁹⁷ Mollica, Robert; Sims-Kastelein, Kristin; and O'Keeffe, Janet *Residential Care and Assisted Living Compendium: 2007* November 30, 2007

⁹⁸ Data provided by Minnesota Department of Health in September 2009 regarding facilities licensed as of August 27, 2009

⁹⁹ *Ibid.*

to meet requirements from a funding source such as Medicaid or even as a marketing decision – to add their name to an official list.

The separate housing registration and services licensure allows an establishment to contract with a service provider instead of furnishing services directly. Providers often have a separate licensure that authorizes their services. The most common licensure types are home care licensure and licensure as a board and lodging establishment.¹⁰⁰ The most common types of home care licensure are Class A, which authorizes provision of home care in any community residence (and includes Medicare-certified home health agencies), and Class F, which is specific to housing with services establishments.

The number of housing with services establishments has grown by an average of 7% per year since March 2001, when 780 housing with services establishments were registered. In August 2009, there were 1,373 establishments (See Component Table 3.3).

Component Table 3.3 – Growth of Housing with Services Establishments in Minnesota

	2001	2003	2005	2007	2009	Increase from 2001 - 2009
Number of Establishments	780	1,049	1,111	1,358	1,373	593
Average annual percentage increase		16.0%	2.9%	10.6%	0.6%	7.3%

Sources:

Data provided by Minnesota Department of Health in September 2009 regarding facilities licensed as of August 27, 2009

Minnesota Department of Human Services Status of Long-Term Care in Minnesota: 2008 August 2008 for earlier years

Since in January 2007, housing with services establishments have been able to register with the Minnesota Department of Health as an “assisted living” provider if they meet additional criteria.

Registration as an assisted living provider and services provided by a licensed Class A or Class F home care provider are required if an establishment or provider uses the term “assisted living” in marketing. This legislative change was intended to define assisted living services and criteria.¹⁰¹ As of August 2009, 858 establishments were registered to offer assisted living, with capacity for 35,998 residents. Assisted living capacity is 61% of total capacity for housing with services establishments.¹⁰² The criteria for “assisted living” include:

- A system for checking on people who receive assisted living daily
- For facilities serving 12 or more people, on-site, awake staff available at all times either in the building or on the same campus as the housing with services establishment (e.g., in an adjacent nursing facility)

¹⁰⁰ *Ibid.*

¹⁰¹ Minnesota Department of Human Services *Status of Long-Term Care in Minnesota: 2008* August 2008

¹⁰² Data provided by Minnesota Department of Health in September 2009 regarding facilities licensed as of August 27, 2009

- An on-call registered nurse available at all times
- Provision of two or more meals per day
- Weekly housekeeping and laundry service
- Assistance with medication administration
- Assistance with three of seven activities of daily living (bathing, dressing, grooming, eating, transferring, continence care, and toileting)
- Provision of a Uniform Consumer Information Guide to prospective and current residents¹⁰³

As described in *Section 2: Services Utilization and Expenditures Data*, Minnesota has a higher supply of assisted living than most states. The capacity of establishments registered to provide assisted living (35,998) is 57 beds per 1,000 people age 65 or older, using 2007 state population estimates (the latest available). This is double the most recent national average capacity of 26 beds per 1,000 people age 65 or older in 2007.¹⁰⁴ State comparisons of assisted living data are imperfect because states vary in how they define assisted living. Data for several states in the national study include residences that do not provide the range of services provided as part of assisted living.¹⁰⁵

Adult Foster Care

The second most common licensed setting in Component Table 3.2, adult foster care, provides services in small-group residential settings. DD Waiver participants account for about half of adult foster care capacity (8,783 participants during SFY 2008), and all other waivers have participants receiving adult foster care services. For waiver participants, the waiver pays for services and room and board is covered by Group Residential Housing and a portion of the resident's income.

Legislation in 2009 made two significant changes regarding adult foster care. First, a moratorium on new licensure was established to prevent additional growth. This change is meant to encourage more balanced use among supportive housing options for people with disabilities by limiting the supply of this common group housing model. Several stakeholders expressed concern that people with developmental disabilities did not have sufficient choice in housing options. State-comparison data indicates Minnesota serves more people in provider-owned housing and fewer people in their own homes and apartments, when compared to neighboring states (See Component Table 3.4 below).

The second legislative change was a temporary increase in the maximum number of beds per adult foster care site from four to five (pending CMS approval for sites serving waiver participants). This change is effective until June 30, 2011 and will be reevaluated at that time. The five-bed home option gives providers flexibility in how they adapt to rate reductions approved in the SFY 2010-2011 budget. A provider can establish a five-bed adult foster care home only when it does not result in additional beds across all

¹⁰³ Minnesota Statutes, Chapter 144G.03

¹⁰⁴ Thomson Reuters analysis of data provided by Mollica, Robert; Sims-Kastelein, Kristin; and O'Keeffe, Janet *Residential Care and Assisted Living Compendium: 2007* November 30, 2007; and U.S. Census Bureau, Population Division "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007" May 1, 2008

¹⁰⁵ Mollica, Robert; Sims-Kastelein, Kristin; and O'Keeffe, Janet *Residential Care and Assisted Living Compendium: 2007* November 30, 2007

homes the provider operates. For example, a provider with five four-bed homes could change its model to have only four five-bed homes.

Component Table 3.4: Number of People with Developmental Disabilities Receiving Services in Residential Settings per 100,000 State Population, by Type of Setting, June 30, 2007

	Participant's own home	Home of a Family Member	Host Family or Family Foster Care	Agency Owned Setting (e.g., ICF/MR and Corporate Foster Care)
Minnesota	42.6	261.1	19.3	216.5
Iowa	179.4	165.6	0.2	112.1
North Dakota	169.2	104.1	4.5	139.7
South Dakota	73.7	91.2	1.0	213.1
Wisconsin	105.3	101.7	42.3	114.6
<i>United States</i>	<i>38.3</i>	<i>183.2</i>	<i>12.3</i>	<i>92.3</i>

Source:

Prouty, Robert W.; Alba, Kathryn; Lakin, K. Charlie (eds.) Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007 University of Minnesota Institute for Community Integration: August 2008

Component 4: Infrastructure Development

The long-term support system faces several important challenges, including difficulty recruiting and retaining staff, limited funding, and the looming impact of an aging population. Minnesota has taken several steps to develop a sufficient supply of providers with the necessary skills and knowledge to encourage participant independence and community integration and to help communities be more prepared for an aging population. Multiple efforts throughout the state are helping to assess current and projected support needs, fund promising community-based initiatives, and help recruit and retain healthcare workers. In addition, numerous innovative practices are underway to assist various target populations.

Planning, Technical Assistance and Service Development Grants

This section focuses on state-level or state-led planning and technical assistance efforts. The authors recognize considerable efforts are also occurring in the private sector, through regional entities such as Area Agencies on Aging, and at the local level with county and city planning activities. Planning and developing infrastructure so people with disabilities and older adults can be active and integrated in their communities is important at all levels of government and in the private sector. It will be increasingly important as our population ages. This section starts with initiatives particularly focused on preparing communities for the aging population in a holistic sense and then describes initiatives related specifically to long-term care services and to promoting employment for people with disabilities.

Planning for the Aging Population

In 1997 the Department of Human Services (DHS) and Minnesota Board on Aging (MBA) launched a special project now known as Transform 2010 to prepare the state for the aging baby boomers. It has since partnered with the Minnesota Department of Health (MDH) and many additional state agencies to address the coming “age wave,” a permanent shift in the state’s population for which individuals and many entities (e.g., businesses, civic groups, faith groups, and governments) must prepare. The most recent report from this project, *A Blueprint for 2010: Preparing Minnesota for the Age Wave*, was released in 2007 and highlighted feedback obtained directly from Minnesota residents on five key themes:

1. Redefine Work and Retirement
2. Support Caregivers of all Ages
3. Foster Communities for a Lifetime
4. Improve Health and Long-Term Care
5. Maximize Use of Technology.¹⁰⁶

Since releasing the, Transform 2010 has continued to encourage preparation for the aging population by holding educational forums and conducting a feasibility study on the cost to provide health insurance for direct care workers in the state.

¹⁰⁶ Minnesota Department of Human Services *A Blueprint for 2010: Preparing Minnesota for the Age Wave* June 2007

To encourage “communities for a lifetime,” the 2009 Minnesota Legislature required the Minnesota Board on Aging to identify a process and criteria for designating a community with that title. The legislation defined communities for a lifetime as partnerships of towns, cities, or counties that extend “opportunities, supports, and services” that will enable people age 65 and older to remain active and engaged in their communities.¹⁰⁷ Communities for a lifetime must provide several types of opportunities, including options to work in paid or non-paid roles; the opportunity to choose a variety of housing options; access to quality long-term care including home and community-based services; access to health care; and access to public transportation including door-to-door assistance.¹⁰⁸

Services Planning

Since 2001, DHS has surveyed the state’s 87 counties biennially to assess their community-based long-term care capacities and report findings back to the Legislature.¹⁰⁹ This survey originally only applied to services for older adults. Starting in 2007, the survey began examining capacity to serve people with disabilities under age 65.¹¹⁰ The 2007 Long-Term Care Gaps Analysis report (the most recent report available) reveals that most counties either maintained or increased their overall service capacities.¹¹¹ Services that increased the most consisted of Fiscal Support Entities (for those in the Consumer Directed Community Supports plan, 48%), Long-Term Care Consultations and Assessments (41%) and Transportation (41%).¹¹² Among the most reported challenges to service availability were relatively low provider reimbursement rates for public programs and difficulty in recruiting and retaining workers.¹¹³ Transportation and affordable housing were frequently reported as areas in which more capacity and development was necessary.¹¹⁴ Counties also conveyed the challenge of finding services for those with disabilities as they age, noting budget and service differences between the disability waivers and the Elderly Waiver.¹¹⁵ Finally, counties reported concern that some providers accustomed to serving only older adults were not fully capable of serving people with disabilities and vice versa.¹¹⁶

Another method by which the state is boosting home and community-based supports is through Community Service/Community Services Development (CS/SD) grants. Established by the Legislature in 2001, CS/SD-appropriated funds are administered by DHS for public and private agencies to promote changes that strengthen communities’ abilities to provide home and community-based services for older adults.¹¹⁷ Since 2003, DHS has placed greater priority on projects where partners collaborate, such as Area

¹⁰⁷ Minnesota Legislature Conference Committee Report on H.F. No. 936, April 30, 2009

¹⁰⁸ *Ibid.*

¹⁰⁹ Myott, Sarah 2007 Long Term Care Gaps Analysis Minnesota Department of Human Services: September 2008

¹¹⁰ *Ibid.*

¹¹¹ *Ibid.*

¹¹² *Ibid.*

¹¹³ *Ibid.*

¹¹⁴ *Ibid.*

¹¹⁵ *Ibid.*

¹¹⁶ *Ibid.*

¹¹⁷ Minnesota Department of Human Services *Ideas in Action: A report on Minnesota’s Community Service and Community Services Development Grants* November 2008

Agencies on Aging working with healthcare providers and counties.¹¹⁸ In 2009, DHS worked with the Department of Health and The Minnesota Housing Finance Agency (Minnesota Housing) to pool grant funds to support Older Adult Services Community Consortia to support demonstrations to address housing, chronic care management, and long-term care needs.¹¹⁹

CS/SD grants have been used to implement many components of the action steps called for by Transform 2010 and have further spurred innovative, cost-effective solutions for Minnesotans.¹²⁰ These grants help build HCBS capacity for all age and disability groups because CS/SD grantees provide supportive services to local residents across all target groups. Key accomplishments have been made in the areas of strengthening community capacity, promoting health, improving chronic care management, supporting caregivers, investing in technology, and expanding housing options.¹²¹

The Collaborative Action Network Developing Opportunities (CAN DO) initiative was a collaboration between state agencies, stakeholder organizations, and individuals to establish and maintain a network of information and coordinated action to improve outcomes for people with disabilities. As part of this initiative, DHS summarized recommendations from various reports about disability services, focusing especially on areas such as control over supports, employment earnings and stable income, and living in one's own home.¹²² DHS also conducted eight regional "action conferences" to hear from stakeholders on what matters most to them, foster local collaborative networks, and develop local plans for action to improve services and outcomes for people with disabilities.¹²³

In recognition of an aging population and increased needs for health care services, several groups are working to recruit and retain health care workers. Several stakeholders mentioned partnerships between healthcare providers and higher education, such as Healthforce Minnesota and the Healthcare Education Industry Partnership (HEIP). These partnerships include the healthcare industry, state agencies, trade associations and higher education to address healthcare workforce challenges. Efforts include increasing exposure of elementary and secondary students to health sciences, promoting the role of Community Health Workers, expanding clinical laboratory placements, and developing programs to recruit and train people from ethnic and cultural minority groups for nursing and long-term care careers. In addition, the Minnesota Department of Health offers loan forgiveness programs for certain healthcare professionals working in underserved areas. The Department of Human Services also provides a Nursing Facility Employee Scholarship Program, which enables recipients to pursue higher education, particularly in nursing, or to obtain specialized training in areas such as social work or business management.

¹¹⁸ *Ibid.*

¹¹⁹ Minnesota Department of Human Services "Community Consortia" Undated

¹²⁰ Minnesota Department of Human Services *Ideas in Action: A report on Minnesota's Community Service and Community Services Development Grants* November 2008

¹²¹ *Ibid.*

¹²² Minnesota Department of Human Services *Collaborative Action Network Developing Opportunities (CAN DO) Initiative*, undated

¹²³ *CAN DO Project Charter* October 23, 2007

Promoting Employment

The Pathways to Employment initiative uses a variety of approaches to increase employment rates and wages for people with disabilities. It is a partnership between DHS, the Department of Employment and Economic Development (DEED), and the Minnesota State Council on Disability. Activities include creating partnerships with employers to expand job opportunities, coordinating employment services and supports from multiple agencies, and improving public policies to promote competitive employment – jobs where people with disabilities earn market wages.¹²⁴ Since 2001, Pathways to Employment has provided support to the Medical Assistance for Employed Persons with Disabilities program (MA-EPD), which enables approximately 7,000 Minnesotans with disabilities to earn income and maintain Medicaid eligibility.¹²⁵ Accomplishments include integrating employment into DHS Disability Services Division policies and increasing the capacity and accessibility of Disability Program Navigators in the Minnesota Workforce Centers.¹²⁶ Pathways to Employment also funded the 2009 establishment of the Minnesota Employment Training and Technical Assistance Center, which will provide training to individuals and businesses regarding employment of people with disabilities. Stakeholders familiar with Pathways to Employment emphasized a need to raise awareness that employment is a life activity, and not a service. While services may help a person obtain and maintain employment, a job is work by a person that should be compensated.

Other Innovative Practices

In addition to the above initiatives, Minnesota has taken several steps to identify and encourage adoption of innovative and sustainable models for home and community-based services.

A common practice has been to obtain grants from Federal agencies and foundations to implement particular models that these funding sources have declared an “evidence-based practice” because of benefits shown in research trials. Usually, these models have also been implemented outside of a research setting in other states. A portion of these grants – and/or state grants – is awarded to local providers to adopt the models. The state and local providers then use a train-the-trainer approach to teach the model to other providers to develop and expand expertise around the state. Finally, the state collects data from providers to monitor and measure the degree to which on-site implementation matches the initial model. As in many states, the use of these practices is growing, but many providers have not yet adopted them. Minnesota is currently implementing the following “evidence-based practices:”

¹²⁴ Minnesota Department of Employment and Economic Development “Pathways to Employment” 2009

¹²⁵ Minnesota Department of Human Services *Medicaid Assistance for Employed People with Disabilities (MA-EPD) Semi Annual Data Report July – December 2007* December 2007

¹²⁶ Minnesota Department of Human Services, Minnesota Department of Employment and Economic Development, and Minnesota State Council on Disability *Pathways to Employment: Progress Report Quarter 1, CY 2009*

- The Family Memory Care Initiative, a program for supporting family caregivers of people with dementia
- A Matter of Balance, a falls prevention program for older adults that addresses fear of falling and increases physical activity¹²⁷
- EnhanceFitness, a program that increases older adults' physical activity¹²⁸
- The Arthritis Self-Management Program, a six week series of workshops that teaches problem solving and coping strategies, exercise, nutrition, and other topics to empower people with rheumatic diseases¹²⁹
- The Chronic Disease Self-Management Program, a program similar to the Arthritis Self-Management Program designed for people with a variety of chronic conditions¹³⁰
- Supported Employment, a model for helping people with serious mental illness obtain jobs and integrated employment supports with mental health services¹³¹
- Assertive Community Treatment, an interdisciplinary team approach serving small groups of people with serious mental illness¹³²
- Illness Management and Recovery, a series of workshops for adults with serious mental illness that teaches strategies for coping with stressors and symptoms, problem solving, building social support, and navigating the mental health system¹³³
- Integrated Dual Disorder Treatment, a model for providing individualized treatment and counseling for people with co-occurring mental illness and substance abuse in a single setting¹³⁴
- The "Hawaii Model," an expansive database of mental health research that identifies research-supported treatment for children based on diagnosis and other factors¹³⁵
- The DIAMOND project, a care management model for adults with major depression¹³⁶

¹²⁷ National Council on Aging, Center for Health Aging "Evidence-Based Health Promotion Programs" undated

¹²⁸ *Ibid.*

¹²⁹ Stanford University School of Medicine "Arthritis Self-Management Program" 2009

¹³⁰ Stanford University School of Medicine "Chronic Disease Self-Management Program" 2009

¹³¹ U.S. Substance Abuse and Mental Health Services Administration "About Evidence-Based Practices: Shaping Mental Health Services Toward Recovery" undated

¹³² *Ibid.*

¹³³ *Ibid.*

¹³⁴ *Ibid.*

¹³⁵ Minnesota Department of Human Services *Uniform Application FY 2009 – State Plan: Community Mental Health Services Block Grant* Submitted to SAMHSA Center for Mental Health Services October 5, 2008

¹³⁶ Institute for Clinical Systems Improvement *DIAMOND FAQs for Patients* October 24, 2008

A few stakeholders emphasized the limits of evidence-based practices, which do not work for everyone. Concern was expressed that a person could feel particular stigma if he or she did not improve with the support of an “evidence-based practice.” These comments show the importance of setting realistic expectations for participants in evidence-based practices and providing alternatives to help people increase independence if they do not meet their goals.

HCBS Expert Panel members identified additional innovative practices in Minnesota that have been or are being implemented, including:

- The Vector program for assisting students with disabilities in an individualized approach to the transition to adulthood
- The Metro Crisis Coordination Program for people with developmental disabilities to assure availability within community settings for the crisis and “last resort” placements that previously had been provided by the state institutions
- Consumer-directed community supports as described in the following section (Component 5: Participant Direction)
- Performance incentive funds for nursing facilities
- Medicaid Assistance for Employed People with Disabilities (MA-EPD), which allows people with disabilities to earn income and pay a premium to maintain Medicaid benefits.

Component 5: Participant Direction

Participant direction is an important option for people who want to hire, train, and manage their caregivers and to control how service dollars are spent. Participant direction also brings more direct support workers into the long-term care system because people often hire a family member or friend. Minnesota offers options for participant-directed services in many publicly funded programs. All Medicaid HCBS Waivers and a few state-funded programs allow employer authority (i.e., hiring and managing one's support workers) and budget authority (i.e., flexibility to determine how money for one's services is spent). Employer authority is also available for people who use the Medicaid state plan personal care service. In addition, waivers allow payment of spouses and parents of minor children as caregivers, which is not common in Medicaid programs.

The flexibility in public programs is consistent with the DHS Guiding Principle of Authority and Responsibility, which states, "People who participate in long-term care services are fully supported in exercising authority to direct and manage their services to the extent they wish, and in accepting responsibility for their personal choices."¹³⁷ This section primarily describes the public programs that offer participant-directed services in Minnesota. In addition, this section briefly presents information regarding private purchase of supportive services.

Public Programs

Participant-directed services are available to people with all types of disabilities, including all target populations described in the state profile tool grant.¹³⁸ Participant-direction is an option for participants in all Medicaid HCBS waivers and the state-funded Alternative Care program. For two state-funded programs, the Consumer Support Grant and the Family Support Grant, all services are participant-directed.

Except for state plan personal care services, the participant-direction options mentioned above offer both employer authority and budget authority. The participant-directed option in the personal care program, PCA Choice, uses an agency with choice model where the person is responsible for recruiting, hiring, and training staff but the agency is the employer of record and is responsible for financial management and Medicaid documentation requirements.¹³⁹ Minnesota is considering the use of authority under Section 1915(j) of the Social Security Act to offer budget authority for state plan personal care services. The State Legislature authorized a workgroup on the 1915(j) option in 2008 which has made recommendations for implementing the option.

For the HCBS waivers, optional support planner services (previously called flexible case management) can be used to help the participant determine how to use his or her budget and can help the person find staff and other supports if necessary. In addition, most people choose to use fiscal support entities to

¹³⁷ Minnesota Department of Human Services "Guiding Principles to Design, Implement, Evaluate, and Improve Services for Seniors and People with Disabilities" Revised December 1, 2008

¹³⁸ The populations identified in Minnesota's State Profile Tool grant are older adults, people with physical disabilities, people with developmental disabilities, people with mental illness, people with traumatic brain injuries, people with HIV/AIDS, and children with special health care needs.

¹³⁹ Minnesota Office the Legislative Auditor *Evaluation Report: Personal Care Assistance* January 2009

help manage the financial details involved in self-direction, such as processing checks and paying payroll taxes. A person's individual budget is based on a waiver-specific formula using data from an assessment of his or her needs that is conducted at least annually to inform service planning. Several stakeholders expressed concern that the formulas do not allow sufficient funding for services that individuals need. Some participants reportedly must choose between agency services to promote independence – such as day habilitation and supported employment – and consumer-directed community supports that pay family members or friends for important support that helps a person stay at home.

In 2004 Minnesota received a Cash and Counseling Grant from the Robert Wood Johnson Foundation to promote Consumer Directed Community Supports (CDCS) enrollment for older adults on the Elderly Waiver and Alternative Care Program. Minnesota also was one of two states awarded an innovation grant to support the CDCS option for services under the Older Americans Act. The RWJF grant also worked to strengthen the CDCS infrastructure. There are now 17 certified Fiscal Support Entities (FSE) providing fiscal management services and about 250 support planners serving CDCS users across all five Medicaid HCBS waiver programs and the Alternative Care program. Several caregiver and memory care coaches funded under Title III are also completing support planner and person-centered planning training courses to help support persons opting for participant-directed services.

Minnesota's HCBS waivers allow payments for CDCS to spouses and parents of minor children as caregivers. Payment to legally responsible relatives is not allowed for state plan services such as personal care. In HCBS waivers, however, CMS allows payment for "extraordinary care" by legally responsible relatives that is beyond what a spouse or parent of a minor child would ordinarily perform for a person without a disability.¹⁴⁰ These payments can help address the financial hardship caregivers may face, such as job loss. A few stakeholders mentioned that CDCS increases the parent's responsibility for all of a child's services because parents have budget authority. Parents can face a difficult choice of whether to forego payment for hours of support they provide in order to pay for other services or equipment.

As described above, Minnesota offers more flexibility than most states in participant direction. However, use of this option is not consistent across the state. A 2007 report by the Office of the Legislative Auditor noted wide variation in the use of CDCS across the state.¹⁴¹ According to HCBS Expert Panel members, some counties do not openly offer participant-directed services (such as CDCS in HCBS waivers and Alternative Care, as well as the Consumer Support Grant) to eligible persons. CDCS are reportedly less likely to be introduced and discussed as an option for eligible individuals in small, rural counties that may have limited administrative capacity to operate both CDCS and traditional services, which have different administrative requirements. Use of CDCS also varies among health plans. Even within a county or health plan, effective access to participant-directed services may vary by target population, such as not introducing it to older adults as a service option, but openly offering it to other populations. As Component Table 5.1 on the following page illustrates, the percentage of participants using participant-direction varies among the waivers and AC.

¹⁴⁰ Centers for Medicare & Medicaid Services *Application for a 1915(c) Home and Community Based Waiver [Version 3.5]: Instructions, Technical Guide, and Review Criteria* January 2008

¹⁴¹ Minnesota Office of the Legislative Auditor *Human Services Administration* January 2007

Component Table 5.1 – Number of Participants Using Participant-Directed Supports, June 30, 2009

	June 30, 2008 CDCS Participants	Average Monthly Participants, SFY 2008	Percentage of Average Monthly Participants SFY 2008*
Elderly Waiver	138	18,367	1%
CADI Waiver	468	11,855	4%
CAC Waiver	80	279	29%
TBI Waiver	19	1,316	1%
DD Waiver	1,404	14,036	10%
Alternative Care	56	5,069	1%

* The percentages in this table should be considered an estimate. The number of total waiver participants in June 2008 is likely to be different from the average monthly total for the full state fiscal year.

Sources:

Pat Yahnke "Current CDCS Population by County, Health Plan, and Waiver Type as of June 30, 2008"

Minnesota Department of Human Services: July 31, 2008 for number of CDCS participants

Minnesota Department of Human Services, Reports and Forecasts Division *February 2009 Forecast* March 3, 2009 for average monthly participants.

Private Services

By definition, people have budget authority over privately purchased services, which they can purchase from agencies or individuals. Minnesota also recognizes that people who need long-term supports often use employer authority to hire their own support staff. Minnesota has long had a home health licensure category specifically for individuals who independently provide home care services. This category is little used, and awareness of it in the private market is reportedly limited. Only 50 providers were listed in this category in January 2009.¹⁴²

At the same time, responses to the Survey of Older Minnesotans – a periodic statewide survey by the Minnesota Board on Aging – indicate an increased hiring of people from the community to assist with long-term care needs, independent from a home health agency. Prior versions of the survey had a question asking respondents to identify those who help them with activities of daily living: whether spouse, child, friend, an agency, or "other." After seeing an increase in the response "other," the Minnesota Board on Aging added a response category of "hired help" in the 2005 survey to capture the hiring of individuals outside an agency. That year, 7% of respondents over age 65 indicated they paid for "hired help."¹⁴³

¹⁴² Data provided by the Minnesota Department of Health sent June 2009 regarding licensed providers in January 2009

¹⁴³ Minnesota Department of Human Services *Data Tables: 2005 Survey of Older Minnesotans* undated

Component 6: Quality Management

This section summarizes plans for monitoring or ensuring long-term care quality, examining two types of quality management efforts common in long-term support systems:

- Requirements such as licensure and maltreatment reporting that apply regardless of who pays for services
- Quality oversight by state agencies that manage publicly funded programs and services

This report does not evaluate the quality of Minnesota's long-term support services or the quality of oversight by the state. States that reformed their long-term support systems had comprehensive quality management plans, but the content of those plans varies appreciably across the individual states.

Quality Requirements Regardless of Funding Source

Three types of quality management resources apply regardless of whether an older adult or person with a disability receives publicly funded services. Minnesota's maltreatment reporting systems provide a means to investigate and, if necessary, address allegations of maltreatment of minors and vulnerable adults. Complaints are investigated by state and/or local lead investigative agencies (including health and human services and law enforcement agencies, among others) depending on the nature of the complaint. Ombudsman offices also investigate complaints and help individuals exercise their rights. Licensure or certification processes ensure many long-term care providers meet state and/or Federal requirements.

Maltreatment Reporting and Investigation

State law requires each county to establish a Common Entry Point that receives reports of suspected maltreatment of vulnerable adults (including abuse, neglect, and financial exploitation) and ensures investigations occur as warranted. For reports involving minors, a broad network of state and local agencies across health and human services, education, public safety and law enforcement is required to provide intake functions. Inconsistencies regarding the intake and processing of suspected maltreatment reports have been noted, and a coalition of stakeholders called the Vulnerable Adult Justice Project has recommended a centralized state-based reporting system and improved online reporting mechanisms to address these concerns.¹⁴⁴ Minnesota is examining the feasibility of information system improvements to the vulnerable adult maltreatment reporting system recommended by a 2007 Quality Assurance Panel and a 2009 Quality Assurance Advisory Group, such as a Web-based reporting option, the sharing of critical incident data between local and state protection agencies, and integrating maltreatment report and investigation data with other data sets to further facilitate quality improvement.

¹⁴⁴ Minnesota Department of Human Services Disability Services Division *Quality Management in HCBS 2009: The Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services, Report to the Minnesota Legislature* March 2009

Ombudsman

The state's Ombudsman for Long-Term Care, Ombudsman for State Managed Health Care Programs, and Ombudsman for Mental Health and Developmental Disabilities also play a significant role in ensuring quality services through the investigation of complaints regarding quality of care, access to services, and a person's exercise of his or her rights. The Long-Term Care Ombudsman – part of the Minnesota Board on Aging – serves as an advocate for all participants in long-term care services. The Ombudsman for Managed Care, operating within the Department of Human Services, helps people in Minnesota's Health Care Programs (MHCP) who are required to be enrolled in a managed health care plan. The Ombudsman for Mental Health and Developmental Disabilities is a stand-alone state agency charged with providing advocacy and assistance to persons receiving services because of a mental illness, severe emotional disturbance, developmental disability, or chemical dependency. This ombudsman office also reviews all deaths or serious injury of people with these conditions who are receiving services.

Licensure and Certification

Minnesota's Department of Health (MDH), Compliance Monitoring Division licenses and/or certifies several types of long-term care providers, including nursing facilities, home health agencies, residential care facilities, ICFs/MR, and hospice. Home health licensure includes providers of in-home services in registered housing with services establishments operating as assisted living sites. Providers of these home care services cannot operate without a state license. MDH monitors Medicare-certified nursing facilities, ICFs/MR, and home health agencies according to Federal Medicare guidelines, which include an annual on-site review. As is common for licensing agencies, MDH does not have sufficient staff to monitor other providers on-site on an annual basis. As a result, these providers may receive one monitoring visit over several years. For all providers it licenses, MDH will conduct additional monitoring when warranted by quality of care concerns, such as a report of substandard care.

Within MDH, the Office of Health Facilities Complaints is responsible for receiving, triaging and investigating complaints about MDH-licensed and certified facilities, including nursing homes, supervised living facilities and home care agencies. As an important quality monitoring tool, data on complaints are reviewed at both the individual facility level, to determine the rate of substantiated complaints, as well as across all providers. Trends in corrective orders and deficiencies issued for violation of regulations can prompt quality improvement interventions.

The Department of Human Services (DHS) Licensing Division is responsible for ensuring several types of providers meet state standards, including certain residential habilitation services, multiple categories of adult day services, and other community services for people with developmental disabilities and mental illness. On-site monitoring visits are typically scheduled every two years. Under Minnesota statutes and authorized by DHS, county social service agencies process license applications and provide on-site monitoring for family child care, child foster care and adult foster care programs.

Quality Management by Program Agencies

In addition to provider licensure and other regulatory requirements, many state agencies that fund long-term support have their own quality management processes. This section describes processes for several funding streams where quality oversight approaches have changed in recent years or will change with recent legislation. These services include Medicaid nursing facility care; Medicaid home and community-based services (HCBS) waivers and Alternative Care; Medicaid State Plan personal care; Medicaid managed long-term care; community mental health services; and special education.

HCBS Waivers and the Alternative Care Program

DHS is currently revising the quality management process for the HCBS waivers to reflect Federal specifications released in 2008 that enhance quality assurance and improvement. This revised process will also be implemented for the state-funded Alternative Care program and affects all populations identified in the State Profile Grant.¹⁴⁵ The new CMS specifications require states to use performance measures to indicate whether a waiver meets requirements specified in Federal regulations regarding level of care; the participant's service plan; provider qualifications; health and welfare; financial accountability; and Medicaid administrative authority.¹⁴⁶ DHS collects data for performance measures from:

- Waiver service utilization and cost statistics
- A survey of waiver participants regarding their experience in the waiver (currently in place for the Elderly Waiver and Alternative Care and planned for the other waivers)
- Record reviews of a statewide sample of service plans
- Lead agency reviews of HCBS programs that include review of participant case files, interviews and focus groups with lead agency staff; and lead agency-level data analysis (15 counties are reviewed each year and reviews include files for people who receive managed care)
- An incident management system to monitor trends in incidents that may indicate abuse and neglect
- Periodic re-enrollment of providers to ensure they continue to meet provider requirements¹⁴⁷

County, tribe, and managed care lead agencies also respond to a DHS planning survey to describe how the lead agency complies with state and federal requirements.

DHS established a Quality Essentials Team in the Continuing Care Administration to ensure Minnesota meets Federal quality management requirements. This team includes staff from DHS' Disability Services Division, which operates four of the five HCBS Waivers, and the Aging and Adult Services Division, which operates the Elderly Waiver and Alternative Care.

¹⁴⁵ The populations identified in Minnesota's State Profile Tool grant are older adults, people with physical disabilities, people with developmental disabilities, people with mental illness, people with traumatic brain injuries, people with HIV/AIDS, and children with special health care needs.

¹⁴⁶ U.S. Centers for Medicare & Medicaid Services Application for a 1915(c) Home and Community-Based Services Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria January 2008

¹⁴⁷ Minnesota Department of Human Services Continuing Care Administration *Home & Community Based Services Quality Sampler* May 2008

In 2008 and 2009 reviews of DHS waiver programs, CMS has raised concerns about state quality management and oversight for the waiver programs, which DHS is in the process of addressing. In particular, CMS questioned:

- The adequacy of monitoring of non-licensed providers
- The role of the counties in contracting with providers, instead of direct contracts between the state and providers
- The role of counties in setting provider reimbursement rates, rather than a statewide methodology for rate setting

In order to create greater consistency in contracting and rate-setting, DHS is currently developing new statewide provider standards and enrollment processes, as well as statewide rate-setting methodologies. The statewide rate-setting methodologies do not necessarily require a statewide rate, provided rate variations are based on standard criteria. This work is being supported by two workgroups, composed of stakeholders and convened especially for this purpose.

DHS is in the process of establishing a Quality Commission workgroup, representing different stakeholder communities, to improve public reporting on long-term care quality. This Commission is to support the Department's efforts to define, collect, analyze and publicly report data on program quality. The initial scope of this effort will encompass the HCBS waivers and home health and personal care services, with special attention to the reporting requirements for programs with recent legislative activity.

Two other Department activities related to quality measurement include development of a participant survey and exploration of potential HCBS provider performance measures. First, DHS has developed participant survey instruments for the four HCBS waivers that serve people with disabilities under age 65. Development and testing of the survey was completed in June 2009, resulting in two versions (one for adults and one for minors) that seek waiver participant feedback on a wide range of quality topics, including access to care, participation in service planning, health and welfare, and participant rights. The themes of these surveys complement the survey tool currently used for a sample of participants on the Elderly Waiver, the Consumer Experience Survey. Second, DHS has worked with the HCBS Expert Panel to identify a candidate list of provider performance measures that could be used by participants and the state to compare individual providers in two broad categories: residential services (assisted living and adult foster care) and day services (supported employment, adult day care, and day training and habilitation). Thomson Reuters and the University of Minnesota Institute for Community Integration have been assisting DHS in both initiatives as well as in development of this State Profile Tool.

Nursing Homes

The state has implemented several quality initiatives to improve quality of care and to improve the information available to participants and families when choosing a nursing home. These initiatives are described in brief below.

To assess and compare the quality of care provided by individual nursing homes, DHS has developed seven quality measures that it calculates and publishes for facilities participating in the Medicaid program. These are:

- Quality of life and resident satisfaction
- Clinical outcomes
- Amount of direct care staffing
- Direct care staff retention
- Use of temporary staff from outside agencies
- Proportion of beds in single rooms
- Inspection findings from certification surveys

These measures are derived from multiple data sources, including the Federally-required Minimum Data Set assessment, a resident satisfaction survey, MDH inspection results, and data provided by the facilities themselves.

Starting in 2006, the measures were disclosed publicly through the Nursing Home Report Card Web site, <http://www.health.state.mn.us/nhreportcard/>. The Nursing Home Report Card includes the above measures, which provide information not included in the Federal Nursing Home Compare Web site. This interactive site allows users to view measures for a specific facility, or identify and compare multiple facilities in a specific geographic area. Users can also choose which quality measures they consider most important when selecting a facility. Recent data show approximately 2,000 unique visits to the Web site each month, with users generally prioritizing the quality of life, clinical outcome, and inspection results as the most important. DHS also calculates trend data with regards to the quality measures, to monitor nursing facility quality overall.¹⁴⁸

In addition to public reporting, the quality measures are also used by DHS to support pay-for-performance for nursing facilities. Starting in 2006, a small portion of a facility's operating payment rate was linked to their performance on select quality measures. A Performance Incentive Program was added in 2007, to provide financial incentives for innovative projects that increase quality or efficiency, or contribute to shifting the long-term care system away from institutional settings. Approved projects receive temporary increases in the operating payment rate. A planned evaluation of this demonstration activity will examine economic impact and the potential business case for the Performance Incentive Program.

Medicaid Personal Care

There is no licensure requirement for Medicaid personal care assistance (PCA) providers. A January 2009 report from the Minnesota Office of the Legislative Auditor found minimal oversight of the State Plan personal care benefit and that the program was "vulnerable to fraud and abuse."¹⁴⁹ As described in *Section 3: Available Public Services and Programs*, Minnesota is implementing several changes to this benefit that the 2009 State Legislature enacted to increase program oversight. Changes include standardized training

¹⁴⁸ Data provided by the Minnesota Department of Human Services in September 2009

¹⁴⁹ Alter, Joel; Meyerhoff, Carrie; Connor, Lolyann *Evaluation Report: Personal Care Assistance* Minnesota Office of the Legislative Auditor: January 2009

requirements for both agencies and independent personal care attendants and required supervision and evaluation of personal care attendants.¹⁵⁰

Managed Care

Specific long-term care services for Minnesotans, including limited nursing facility care, are included in three Medicaid managed care programs: Minnesota Senior Health Options (MHSO), Minnesota Senior Care Plus (MSC+), and Minnesota Disability Health Options (MnDHO). As part of the contracting process, the state specifies quality management expectations for participating providers in these programs. Each participating managed care organization (MCO) must operate a Quality Assessment and Improvement program that conforms to federal and state requirements. In addition, the MCO is a lead agency in the HCBS Waiver and is subject to the DHS oversight described above for HCBS Waivers.

The quality expectations articulated in the state's model managed care contract include the following:

- An annual evaluation of the quality and appropriateness of services delivered to enrollees, including an assessment of care coordination activities
- An evaluation of service quality specific to individuals with special health care needs
- Operation of an utilization management program
- Preventive and chronic disease practice guidelines
- Disease management programs for heart disease and diabetes
- Uniform provider credentialing processes

Each MCO must submit an annual work plan that describes the quality improvement projects for the coming year and also must evaluate the implementation of the work plan. A key feature of the work plan is the proposed performance improvement projects (PIPs) each MCO is required to undertake annually. PIPs must be designed to yield significant improvements in clinical and non-clinical care that contribute to favorable health outcomes and enrollee satisfaction. Within MSHO and MSC+, MCOs typically have worked with DHS to select common PIPs for the entire program. These projects have often traditionally focused on chronic conditions, such as heart disease and asthma. Plans must submit written proposals for their PIPs, consistent with CMS guidelines, for approval by the state, and are required to report periodically on the status and success of implementation.

Additional quality oversight is provided through external quality review organizations (EQRO). As part of federal CMS requirements, Minnesota contracts with an EQRO to review the quality of managed care services independently. All plans in the MSHO and MSC programs are expected to cooperate with the review, including collecting and providing relevant data, such as enrollment and Healthcare Effectiveness Data and Information Set (HEDIS) data.

¹⁵⁰ Minnesota Department of Human Services, Continuing Care Administration 2009 Legislative Session Summary June 15, 2009

Community Mental Health Services

The DHS Chemical and Mental Health Services Administration requires a biennial grant application specifying county service needs, priorities, and goals for state and Federal mental health grants. The state application has been revised to increase emphasis on participant outcomes as part of the 2007 Mental Health Initiative passed by the State Legislature. The state sends an Evaluation of Mental Health Services survey to a random sample of adults receiving community mental health services each year to measure participants' experiences with services.¹⁵¹ In addition, the state requires specific outcome data for all adults receiving rehabilitation mental health services, assertive community treatment, or day treatment from the community mental health system. Data collected in the Program Outcomes Status Report include employment status; housing status; use of evidence-based practices; and instances of incarceration, homelessness, hospitalization, or use of residential services.¹⁵² Outcome measures for children's mental health services are under development.

Special Education

For special education and early intervention services, the federal Individuals with Disabilities Education Act (IDEA) requires a State Performance Plan and annual performance reports be submitted to the U.S. Department of Education that evaluates implementation of requirements and describes improvement measures. The state must assess its performance related to indicators developed by the U.S. Department of Education regarding outreach, the use of the least restrictive educational environment, graduation rates, suspensions and expulsions, complaints, and mediations.

¹⁵¹ Minnesota Department of Human Services *Uniform Application FY 2009 – State Plan: Community Mental Health Services Block Grant* Submitted to SAMHSA Center for Mental Health Services October 5, 2008

¹⁵² Minnesota Department of Human Services *Program Outcome Status Report – Paper Version and Instructions* July 2008

Component 7: Transition from Institutions

Two sections specific to institutional services are toward the end of the Minnesota State Profile because they require a capable community services system, ideally one that possesses the six components previously discussed. This section describes state initiatives to help people move from institutions to community residential settings (e.g., assisted living or adult foster care) or to a person's own home or apartment. The following section, *Component 8: Institutional Supply Controls*, describes state initiatives to reduce institutional provider supply.

Expert Panel members noted that an effective community-based supports system is necessary to provide supports when people move from an institution. Both state and national studies have identified lack of housing and inadequate community-based services as two significant barriers for people who transition from institutions.¹⁵³

Institutions are defined as three types of licensed providers that traditionally have provided room and board and long-term support:

- State-operated hospitals and forensic facilities serving people with developmental disabilities or serious mental illness
- Intermediate care facilities for people with mental retardation (ICFs/MR)¹⁵⁴
- Nursing facilities

The authors recognize limits to defining institutional supports in this manner. As discussed in *Component 8: Institutional Supply Controls*, stays of 90 days or less are now common in nursing facilities and in state hospitals for people with mental illness. In addition, some facility residents may not perceive their residence as an institutional environment. This may be particularly true if a provider creates a home-like environment using a model for facility culture change. In addition, some HCBS Expert Panel members noted that other provider-owned facilities – such as adult foster care homes or housing with services establishments – can be perceived as institutional in nature by a resident if he or she has limited control over his or her environment and outside activities. These stakeholders expressed a desire for more options supporting people to live in individual homes or apartments, as is discussed in *Component 3: Variety of Housing Options*.

This section focuses on assistance beyond routine discharge planning that is now common in many of these facilities. As noted in *Component 8: Institutional Supply Controls*, the roles of many institutions have changed in recent years. The increased emphasis on short-term placement makes routine discharge more likely.¹⁵⁵

¹⁵³ See, for example, Willshire, Joan; Roscoe, Ann; Hansen, Eva; Griffith, Maggie “Options Too Nursing Home Relocation: Survey Results on Successful Relocation” (presentation) Metropolitan Center for Independent Living and Minnesota State Council on Disability: 2009 and Siebenaler, Kristin; O’Keeffe, Janet; Brown, David; and O’Keeffe, Christine *Nursing Facility Transition Initiatives of the Fiscal Year 2001 and 2002 Grantees: Progress and Challenges, Final Report* Research Triangle Institute: 2005

¹⁵⁴ The authors prefer to use the phrase “intellectual disabilities” instead of “mental retardation”. When describing ICFs/MR, the authors use “mental retardation” to reflect the name for these facilities in Federal law and regulation.

¹⁵⁵ For a review of research on this topic for nursing facilities, see Arling, Greg; Kane, Robert L.; and Bershadsky, Julie *Targeting Criteria and Quality Indicators for Promoting Resident Transition from Nursing Homes to Community* Minnesota Department of Human Services: Revised January 5, 2009

Minnesota offers a robust array of supports for people transitioning from institutions, and also provides incentives for county agencies to facilitate transitions. A few transition policies do not apply to nursing facility residents age 65 or older. This section first describes incentives and assistance that apply to people leaving other institutions or people under age 65 leaving a nursing facility. It then describes assistance available to people of all ages.

Transition Assistance for People under Age 65

Minnesota created an incentive for counties to reduce institutionalization in 2003, by requiring counties to pay a portion of the public expenses for people in institutions. Counties are currently required to pay 10% of the state share (5% of total spending) of ICFs/MR expenditures, Regional Treatment Center expenditures, and nursing facility spending for people under age 65 with a length of stay greater than 90 days. Counties do not pay a similar share for community alternative services, so they have an incentive to identify community services. A 2006 study of county case management services, which included interviews with staff from 19 counties, identified variations in the presence and nature of county nursing home relocation initiatives. Relocation initiatives in these counties included 1) staff working only on relocation and 2) partnerships between a county and hospitals when a new admission is likely to need post-acute rehabilitation care.¹⁵⁶ Centers for Independent Living also provide nursing home relocation coordination services. The CIL involved in the most transitions, the Metropolitan Center for Independent Living, helped 55 people in Hennepin and Ramsey Counties move between 2004 and 2007.¹⁵⁷

If a person moves to an unlicensed home or apartment and receives Medicaid personal care or HCBS waiver services, he or she can receive a state-funded addition to Supplemental Security Income of up to \$200 per month under Minnesota Supplemental Aid - Shelter Needy Option. The person must be under age 65 and have moved from a Regional Treatment Center, another hospital, an ICFs/MR, a nursing facility, or an intensive residential treatment program (such as Intensive Residential Treatment Services in the mental health system). The supplement can be used for ongoing shelter-related costs including rent, mortgage, insurance, property taxes, and utilities. Starting in July 1, 2009, the MSA – Shelter Needy Option is also available for people who live in provider-controlled, multi-family housing that has six or more units, as long as 50% or fewer of the residents receive MSA – Shelter Needy Option.¹⁵⁸

For nursing facility residents under age 65, Minnesota requires a face-to-face follow-up to the Long-Term Care Consultation (LTCC) assessment within 40 days of admission and every 12 months thereafter.¹⁵⁹ The LTCC assessment is often conducted over the phone before admission, such as when a person is transferring from a hospital to a nursing facility.¹⁶⁰ The follow-up assessments provide an opportunity to identify appropriate community options once the person is stable and has completed rehabilitation and

¹⁵⁶ Amado, Angela; Roehl, A; Fields, J; Larson, S; Sauer, J; and McBride, M. *Status of Case Management Reform in Minnesota – County-Level Practices and Policies* University of Minnesota Institute on Community Integration: June 30, 2006

¹⁵⁷ Willshire, Joan; Roscoe, Ann; Hansen, Eva; Griffith, Maggie “Options Too Nursing Home Relocation: Survey Results on Successful Relocation” (presentation) Metropolitan Center for Independent Living and Minnesota State Council on Disability: 2009

¹⁵⁸ Minnesota Department of Human Services “Bulletin 09-48-02: 2009 Legislative change to the MSA Supports Options Initiative with extra allowance for Shelter-Needy clients with special needs” August 12, 2009

¹⁵⁹ *Options Too: Acting Together to Promote Community Alternatives for People with Disabilities* February 15, 2007

¹⁶⁰ Minnesota Department of Human Services *Long-Term Care Consultation Services* February 2008

are conducted by county social workers and public health nurses. The follow-up LTCC assessments started as part of the Options Initiative in 2001 to promote community alternatives for nursing facility residents under age 65. It is now part of the Options Too initiative, along with MSA Shelter Needy and relocation service coordination (which is available regardless of age).

Transition Assistance for People of All Ages

Several transition assistance initiatives are available to people regardless of age and are described below. Two services are available to institution residents who receive Medicaid-funded services. A new initiative starting in 2010 will provide assistance to nursing facility residents regardless of payer. Also, two programs provide temporary housing assistance to people with mental illness. Finally, the Ombudsman offices provide information regarding transition options to people seeking transition from a long-term care facility.

Medicaid Transition Assistance

Relocation service coordination helps a person plan the transition to a home or apartment. Relocation service coordination is paid as part of the Medicaid targeted case management service for people whose institutional service is covered by Medicaid.¹⁶¹ State funds pay for relocation service coordination for people who would be eligible for Medicaid but are not because they live in a mental health institution of more than 16 people.

Transitional services can pay for a variety of expenses necessary to set up a community residence, such as security deposits, utility deposits, furniture, and other household items. If the person joins a Medicaid home and community-based services waiver after moving from the facility, the waiver can pay for transitional services.¹⁶²

Return to Community Initiative

In 2009, the Minnesota Legislature created a new Relocation to Community Initiative to help nursing facility residents. For residents who express a preference for living in the community, Senior LinkAge Line® staff located at Area Agencies on Aging will provide intensive support services (assessment, care planning, service coordination, placement and ongoing monitoring) for persons to facilitate a move to a non-institutional setting. This state-funded program will become effective April 1, 2010.

¹⁶¹ Minnesota Department of Human Services “Relocation Service Coordination Targeted Case Management (RSC-TCM)” Updated October 18, 2007

¹⁶² Minnesota Department of Human Services, *Continuing Care Administration Bulletin 08-69-02: 2008 Minnesota Legislature provides rate adjustments for continuing care and other providers* July 15, 2008

Temporary Housing Assistance

The Crisis Housing Assistance Fund allows people who experience a mental health crisis to maintain their home when no other funding is available. The fund pays for rent, utilities and other essential bills while the person is in a hospital and/or a residential treatment facility.¹⁶³

The Bridges program assists people on a waiting list for the U.S. Housing and Urban Development's Section 8 program. It pays a portion of a person's rent or mortgage payments until a Section 8 voucher is available.¹⁶⁴

Ombudsman

The Ombudsman for Long-Term Care and the Ombudsman for Mental Health and Developmental Disabilities provide information about legal options to individuals seeking transition from a long-term care facility, including nursing facilities and housing with services establishments. They also provide independent oversight to protect resident rights and quality of care, as authorized by the Federal Older Americans Act and state statute. On behalf of the resident, the ombudsman monitor the work of the facility, LTCC assessors, and community services care coordinators to ensure that a supportive care plan is developed in the community setting. Their support can be particularly important to work through problems when the facility, family, or guardian wants the person to remain in the facility. In addition to voluntary transitions, both ombudsman offices must be notified when a nursing facility is closing in order to help ensure people know their rights during a transition to another nursing facility or a different setting.

¹⁶³ Minnesota Department of Human Services *Uniform Application FY 2009 – State Plan: Community Mental Health Services Block Grant* Submitted to SAMHSA Center for Mental Health Services October 5, 2008

¹⁶⁴ *Ibid.*

Component 8: Institutional Supply Controls

Minnesota has significantly reduced institutional capacity since the 1970s. The mechanisms used to limit institutional supply have varied by the type of institution, so this section is organized based on types of institutions. As described on page two and in the previous section, institutions are defined as:

- State-operated hospitals and forensic facilities serving people with developmental disabilities or serious mental illness
- Intermediate care facilities for people with mental retardation (ICFs/MR)¹⁶⁵
- Nursing facilities

The roles of many of these institutions have changed in recent years to emphasize short-term placement with a goal of improving function while in the facility. State hospitals for people with mental illness primarily provide short-term acute services, rather than long-term housing and services. The only remaining state institution serving people with developmental disabilities, Minnesota Extended Treatment Options (METO), also is intended for short-term stays. Nursing facilities are increasingly used for short-term, rehabilitative stays of 90 days or less. For example, of the 24,648 people admitted to a nursing facility in State Fiscal Year 2006, 82% were discharged within 90 days.¹⁶⁶

State-Operated Facilities

As in many states, Minnesota's institutional service system began in the last third of the 19th century with state-operated institutions. Several institutions were built in subsequent decades to serve different populations, including:

- People with mental illness
- People with substance abuse
- People with developmental disabilities
- People with tuberculosis
- Children who were neglected
- Children with disabilities¹⁶⁷

Initially, each hospital served a specific population. Later, the institutions for people with mental illness, substance abuse, and developmental disabilities became regionally based with each institution serving all three populations for a particular catchment area. The institutions also began providing community-based services, using smaller residential settings such as adult foster care and psychosocial rehabilitative services. Starting in the 1970s, Minnesota closed some of its state-operated facilities for people with mental

¹⁶⁵ The authors prefer to use the phrase "intellectual disabilities" instead of "mental retardation". When describing ICFs/MR, the authors use "mental retardation" to reflect the name for these facilities in Federal law and regulation.

¹⁶⁶ Arling, Greg; Kane, Robert L.; and Bershadsky, Julie *Targeting Criteria and Quality Indicators for Promoting Resident Transition from Nursing Homes to Community* Minnesota Department of Human Services: Revised January 5, 2009

¹⁶⁷ Minnesota Department of Human Services, State Operated Services *The Evolution of State Operated Services* October 2007

illness, substance abuse, and developmental disabilities. The remaining facilities were renamed Regional Treatment Centers in 1985 to reflect their regional focus and a mission beyond institutional services.

By 2007, almost all large state-operated institutions were closed. The remaining large hospital for people with mental illness, in Anoka, provides short-term services and averaged 71 days per client in 2007. In 2006 and 2007, the state opened nine 16-bed facilities across the state called Community Behavioral Health Hospitals (CBHH) to improve the state's capacity for acute mental health services.¹⁶⁸ CBHH also have a short-term stay focus, and averaged 23 bed days per client in 2007.¹⁶⁹ In addition, a separate Child and Adolescent Behavioral Health Services hospital is located in Willmar and serves approximately 17 children on an average day.¹⁷⁰ While this section is titled "Institutional Supply Controls", there may be a need for more of the acute mental health services provided at these and private hospitals. A recent report expressed concern about inadequate access to acute hospital beds due to a lack of intensive community supports that can help individuals with complex, long-term needs avoid hospitalization.¹⁷¹

Before closing the last state institutions for people with developmental disabilities in 2000, Minnesota developed a new unit in Cambridge for people with developmental disabilities and challenging behaviors that present a public safety risk, called Minnesota Extended Treatment Options (METO). Unlike previous state institutions for people with developmental disabilities, METO is not intended to be a permanent residence. More than half of METO residents in State Fiscal Year 2007 were discharged during that year.¹⁷² In November 2008, METO decertified its remaining ICFs/MR beds and now is state-funded. It serves a small number of people with a developmental disability who are under commitment as mentally ill and dangerous.

In addition, State-Operated Forensics Services serve people who are a public safety risk. These facilities include METO; a Competency Restoration Program in Anoka to treat people committed to that program; and several facilities in Saint Peter for people who have a mental illness including the Minnesota Security Hospital, a forensic nursing facility, a program for young adults and adolescents, and special needs services for people who are cognitively impaired and have sexually dangerous behavior.¹⁷³

ICFs/MR

The closing of state-operated ICFs/MR was described in the previous section on state-operated facilities. Minnesota's private ICFs/MR include a few institutions that serve dozens of people on a campus and several smaller ICFs/MR settings serving four to fifteen individuals (often called community ICFs/MR). Starting in the 1970s, Minnesota was one of the first states to develop community ICFs/MR as an alternative for

¹⁶⁸ Minnesota Department of Human Services, Mental Health Divisions *Minnesota 2007 Implementation Report: Community Mental Health Services Block Grant 2007*

¹⁶⁹ Minnesota Department of Human Services, Mental Health Divisions *Mental Health Management Report: Service Utilization Tables For Adults During Calendar Year 2007* Undated

¹⁷⁰ Minnesota Management And Budget *FY 2010-11 Governor's Budget Recommendation: Agency Level Narratives* January 27, 2009

¹⁷¹ Minnesota Department of Human Services: Children and Adult Mental Health Divisions *Mental Health Acute Care Needs Report* March 2009

¹⁷² Prouty, Robert W.; Alba, Kathryn; Lakin, K. Charlie (eds.) *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007* University of Minnesota Institute for Community Integration: August 2008

¹⁷³ Minnesota Department of Human Services *Forensic Services* August 2008

people leaving large state ICFs/MR institutions. Community ICFs/MR helped Minnesota comply with the Welsch class action lawsuit settlement that required a reduction of state institution census.¹⁷⁴

In 1983, Minnesota established a moratorium on ICFs/MR development and started the Developmental Disabilities (DD) Waiver, which was then called the Mental Retardation or Related Conditions Waiver.¹⁷⁵ Some ICFs/MR residents moved to adult foster care settings with services funded by the DD Waiver. Adult foster care facilities serve up to four people, although a temporary increase to five residents was authorized in 2009 as explained in *Component 3: Variety of Housing Options*. The use of DD Waiver services increased until 2003, when it served over 15,000 individuals.¹⁷⁶ The state further encouraged alternatives to ICFs/MR in 2003 when it required counties to pay 20% of the state share of ICFs/MR expenditures. This percentage was reduced to 10% in 2007.

Some community-based ICFs/MR have downsized and/or closed as demand has decreased.¹⁷⁷ Between 1987 and 2007 the number of Minnesotans living in private ICFs/MR settings declined from 4,868¹⁷⁸ to 1,924.¹⁷⁹ The combination of declining demand, the county share requirement, and other reimbursement changes has led some stakeholders to question the future viability of ICFs/MR.¹⁸⁰

The trend toward fewer ICFs/MR slowed in 2006 and 2007 when only 76 beds were de-certified during these two years combined. In contrast, Minnesota averaged 193 de-certified beds per year from 2001 to 2005, which does not include closures of state facilities (See Component Table 8.1 below).¹⁸¹ As of June 30, 2007, Minnesota had a total of 1,936 ICFs/MR beds with 843 of these beds in facilities with six or fewer people (See Component Chart 8.1 below).¹⁸²

¹⁷⁴ Minnesota Department of Human Services: Disability Services Division *Plan for ICFs/MR in Minnesota* January 2009

¹⁷⁵ Minnesota Department of Human Services *Assessment of the Impact of the ICF/MR Moratorium* January 1988

¹⁷⁶ Minnesota Department of Human Services: Disability Services Division *Home and Community-Based Services Waiver For Persons with Mental Retardation and Related Conditions* January 2005

¹⁷⁷ Minnesota Department of Human Services: Disability Services Division *Plan for ICFs/MR in Minnesota* January 2009

¹⁷⁸ Minnesota Department of Human Services *Assessment of the Impact of the ICF/MR Moratorium* January 1988

¹⁷⁹ Minnesota Department of Human Services: Disability Services Division *Plan for ICFs/MR in Minnesota* January 2009

¹⁸⁰ *Ibid.*

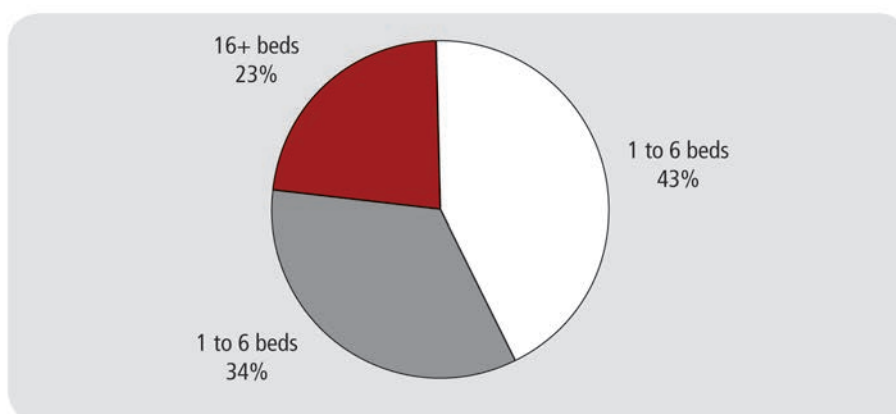
¹⁸¹ *Ibid.*

¹⁸² *Ibid.*

Component Table 8.1 – Number of De-Certified ICFs/MR Beds by State Fiscal Year

	De-Certified Beds
2001	179
2002	244
2003	215
2004	172
2005	158
2006	57
2007	19

Minnesota Department of Human Services:
Disability Services Division *Plan for ICFs/MR
in Minnesota* January 2009

Component Chart 8.1 – Minnesota ICFs/MR Bed Capacity by Facility Size, June 30, 2007

Source:
Minnesota Department of Human Services: Disability Services Division
Plan for ICFs/MR in Minnesota January 2009

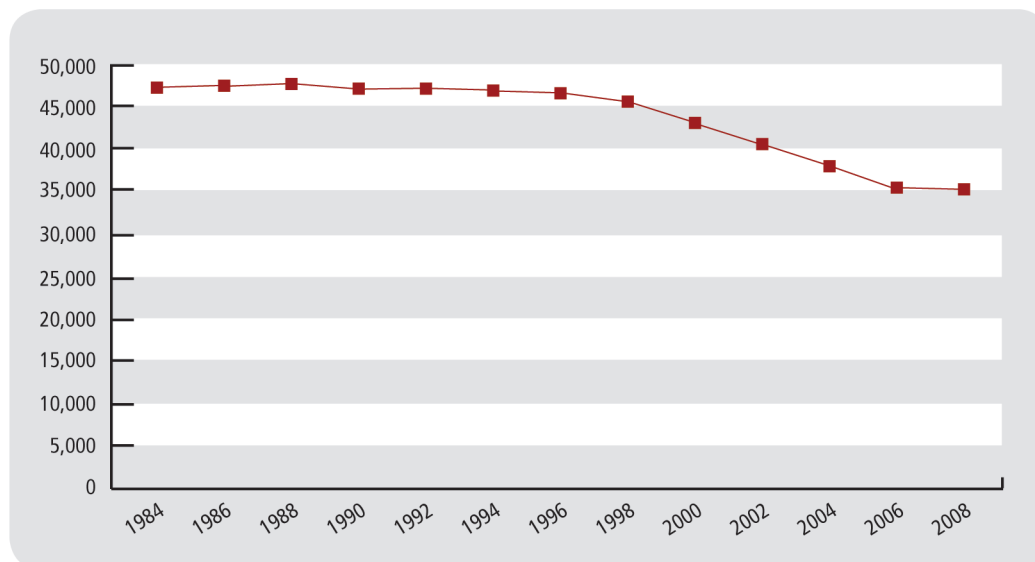
Nursing Facilities

Minnesota's nursing facility supply declined slowly for several years after the state enacted a moratorium on licensure and certification of new nursing home beds and on major nursing facility construction projects in 1983. Starting in 2000, a combination of incentives encouraged nursing facilities to reduce beds and/or close facilities. These incentives coincided with a time in which demand for nursing facility services decreased, including in the private sector. This decreased demand is expected to continue into the future as people exercise their preference for smaller home-like settings and as the nursing facility business increasingly moves toward short-term rehabilitative stays.¹⁸³ Since 2000, the number of nursing

¹⁸³ *Creating the Care Center of the Future: Recommendations and Next Steps* March 5, 2009 and LarsonAllen *The Demand Model* The Long-Term Care Imperative: Undated

facility beds has shrunk by over 9,000 beds (See Component Chart 8.2).¹⁸⁴ As shown in Component Table 8.2, Minnesota has decreased its bed supply more quickly than its neighboring states, except for South Dakota.¹⁸⁵

Component Chart 8.2: Total Nursing Home Beds in Minnesota, 1984 – 2008



Source:

Minnesota Department of Human Services, Continuing Care Administration summary of data from Minnesota Department of Health

Component Table 8.2: Change in Number of Certified Nursing Facility Beds, 2004 to 2008

	2004	2008	Percent Change
Minnesota	38,268	34,211	-10.6%
Iowa	33,345	32,397	-2.8%
North Dakota	6,522	6,396	-1.9%
South Dakota	7,327	6,544	-10.7%
Wisconsin	40,895	37,730	-7.7%
<i>United States</i>	<i>1,685,129</i>	<i>1,672,821</i>	<i>-0.7%</i>

Sources:

American Health Care Association *Nursing Facility Beds by Certification Type: CMS OSCAR Data Current Surveys, June 2008*

American Health Care Association *Nursing Facility Beds by Certification Type: CMS OSCAR Data Current Surveys, June 2004*

¹⁸⁴ Minnesota Department of Human Services, Continuing Care Administration summary of data from Minnesota Department of Health. The number of licensed beds in Component Chart 8.2 is greater than the number of certified beds in Component Table 8.2 because a small percentage of beds licensed by the state are not certified based on Federal Medicare standards.

¹⁸⁵ American Health Care Association *Nursing Facility Beds by Certification Type: CMS OSCAR Data Current Surveys, June 2008* and American Health Care Association *Nursing Facility Beds by Certification Type: CMS OSCAR Data Current Surveys, June 2004*

The first incentive was a 2000 law that allows nursing facilities to temporarily reduce their number of beds, called the bed layaway program. Facilities can take an unoccupied bed out of service for at least one year, and then bring it back into service without being subject to the moratorium. If the bed is on layaway for five years, it is permanently decertified.¹⁸⁶

The bed layaway program takes advantage of several incentives that encourage high occupancy rates in Minnesota nursing facilities. First, Medicaid nursing facility per diem reimbursement is based in part on property costs, where a 95% occupancy rate is assumed. If a facility has a higher occupancy rate, the property reimbursement is greater than its costs. Conversely, a facility loses money in the property rate calculation if occupancy is below 95%. Second, licensing fees and a nursing facility bed tax apply to both occupied and unoccupied beds. Finally, Minnesota law requires nursing facilities that accept Medicaid to charge the same rates to Medicaid and private pay residents, except for people in single bed rooms.¹⁸⁷ This “rate equalization” requirement increases the impact of state policies regarding nursing facility payment.

In 2001, the state began the second incentive, a planned closure program that increases a facility’s Medicaid rate if it permanently removes beds. This payment had been a negotiated rate between the facility and DHS since 2005, but 2009 legislation returned it to a fixed rate of \$2,080 per bed per year.¹⁸⁸ Many beds that were removed were initially on layaway. Planned closures can apply to occupied or unoccupied beds. The facility must work with the county to ensure that bed closures will not lead to access problems and to provide orderly discharge planning to other facilities or to home and community-based services if it closes an occupied bed.¹⁸⁹

The most recent incentive provides rate increases for establishing private rooms and is called the single bed room incentive. Under this 2005 initiative, DHS allows operating payment rate increases when a facility closes beds permanently and creates new single bed rooms in the process. Additional incentives for private rooms include an additional payment from Medicaid for a private room if the private room is medically necessary, and the ability to charge private pay residents more than the Medicaid rate. The number of single bed rooms in nursing facilities has increased from 9,460 in 2006 to 10,167 in 2008, comprising 28% of all facility beds.¹⁹⁰

¹⁸⁶ Minnesota Statutes 144A.071, subd. 4b and Meyer, Lori and Lips, Jonathan “Institutional Supply Controls” presentation to the HCBS Expert Panel, December 19, 2008

¹⁸⁷ Minnesota Statutes 256B.48

¹⁸⁸ Minnesota Department of Human Services, Continuing Care Administration, “2009 Legislative Session Summary,” June 15, 2009. The fixed rate was effective August 1, 2009.

¹⁸⁹ Minnesota Statutes 144A.161

¹⁹⁰ Meyer, Lori and Lips, Jonathan “Institutional Supply Controls” presentation to the HCBS Expert Panel, December 19, 2008, citing Minnesota Department of Health data

Component 9: Coordination with Other Supports

People who need long-term care often need to coordinate many different supports to live actively and independently. The reason a person needs long-term support is just one aspect of that person's life. He or she may have other needs or preferences that require additional supports, such as a chronic health condition or a desire to pursue a job. A person and his or her informal caregivers also may need other assistance such as physical and behavioral health care; special education; transportation; and assistance paying for housing, food, utilities, or child care.

Coordination of supports beyond long-term care is particularly important for people receiving services in their own home or a family home. Residential service providers combine room and board and long-term support, and typically provide transportation and have health care professionals such as physicians on staff or on contract.

Minnesota's managed care experience has enabled the development of multiple models of supports coordination.¹⁹¹ According to interviews with HCBS Expert Panel members and studies commissioned by DHS,¹⁹² the degree to which that person is linked to other health and social services varies based on the type of local administrative agency responsible for supports coordination. This section describes how coordination with health and social services other than long-term support varies among types of organizations that provide most supports coordination for older adults and people with disabilities.

Supports Coordination Organizations

The lead agencies for local administration of Medicaid supports mentioned in *Component 1: Coordinated State Agencies* – primarily counties and managed care organizations (MCOs)¹⁹³ – are responsible for supports coordination, including supports beyond long-term care. Both counties and MCOs can contract with a separate organization for supports coordination and/or other responsibilities.

According to one study of care coordination for older adults, counties tend to use a social model¹⁹⁴ that focuses on non-medical needs such as housing, employment, and independent living. Connection to

¹⁹¹ Johnson, Alison; Ripley, Jeanne; Nwoke, Susan; Malone, Joelyn; Morishita, Lynne; Paone, Deborah A *Study of Care Coordination and Case Management in Minnesota's Publicly-Funded Managed Health Care Programs for Seniors* Hallelund Health Consulting: November 2007.

Minnesota uses several terms for the task of identifying a person's need for supports, assisting the person in obtaining necessary services, and ensuring supports are coordinated. These terms vary between fee-for-service and managed care and each term was selected for a specific meaning. Terms include case management (fee-for-service Medicaid and MSC+), care coordination (MSHO), navigation assistance (SNBC), and service coordination (MnDHO). The authors use the term "supports coordination" when applying this concept regardless of payment methodology or program, because it is used in other states and is not officially used in Minnesota.

¹⁹² The two most recent studies published to date are Johnson, Alison; Ripley, Jeanne; Nwoke, Susan; Malone, Joelyn; Morishita, Lynne; Paone, Deborah A *Study of Care Coordination and Case Management in Minnesota's Publicly-Funded Managed Health Care Programs for Seniors* Hallelund Health Consulting: November 2007 and Palsbo, Susan and Ho, Pei-Shu *Evaluation of the Minnesota Disability Health Options (MnDHO) Program: Start-Up Phase: September 2001 – August 2004* National Rehabilitation Hospital, Center for Health and Disability Research: July 2005

¹⁹³ The White Earth and Leech Lake tribes are also lead agencies, with responsibilities similar to counties for people living on their reservations who choose to receive supports coordination from the tribes.

¹⁹⁴ Johnson, Alison; Ripley, Jeanne; Nwoke, Susan; Malone, Joelyn; Morishita, Lynne; Paone, Deborah A *Study of Care Coordination and Case Management in Minnesota's Publicly-Funded Managed Health Care Programs for Seniors* Hallelund Health Consulting: November 2007

social supports outside the long-term care system is a natural strength of counties, who provide case management for a variety of human services. For example, counties also provide local administration for food assistance, income support, child care subsidies, and child welfare services.

Since MCOs are financially responsible for a person's health care as well as long-term care, it is not surprising that supports coordinators working in managed care tend to be more involved in health care services than county staff.¹⁹⁵ Some organizations contract with case management organizations such as AXIS HealthCare or Evercare that specialize in managing both health and long-term care for people with disabilities or older adults. For example, AXIS HealthCare's supports coordination team includes social workers as well as registered nurses in order to incorporate the strengths of both the medical and social service models.¹⁹⁶

Some MCOs have a contract with health care provider organizations where the provider provides care coordination, called a "care system." According to a 2007 study, supports coordinators in care systems had greater communication with the participant's primary care providers than supports coordinators working for the health plan or a county.¹⁹⁷ A delivery system care coordination arrangement is similar to the health care homes defined in Minnesota's 2008 health care reform legislation, where clinicians, care coordinators, and patients with disabilities or chronic health conditions work together to plan health care services. The reform legislation requires the Minnesota Department of Health and the Department of Human Services to certify health care homes and to develop a per-person care coordination payment methodology to compensate health care homes.¹⁹⁸ Beginning in July 2010, MCOs under contract to provide services for Minnesota Health Care Programs will be required to offer health care homes to their enrollees and to pay certified providers a fee for qualified enrolled patients.

Regarding coordination with supports other than long-term care, counties and MCOs have different strengths that reflect their different responsibilities. Many HCBS Expert Panel members noted the categories of counties and MCOs are not mutually exclusive. Some counties have jointly established managed care organizations, called county-based purchasing. Some MCOs contract with counties to provide supports coordination, which is more common in rural areas than in urban areas. Collaboration between an MCO and a county is required in the Preferred Integrated Networks (PINs) for people with serious mental illness. These county and MCO partnerships have the potential to combine the strengths of both types of organizations to help participants obtain necessary health and social supports.

¹⁹⁵ *Ibid.*

¹⁹⁶ Palsbo, Susan and Ho, Pei-Shu Evaluation of the Minnesota Disability Health Options (MnDHO) Program: Start-Up Phase: September 2001 – August 2004 National Rehabilitation Hospital, Center for Health and Disability Research: July 2005

¹⁹⁷ *Ibid.*

¹⁹⁸ Minnesota Department of Health *Proposed Expedited Permanent Rules Related to Health Care Homes* July 6, 2009

Appendix A: LTC Expenditures Data

Table A.1 – Expenditures for Medicaid-Funded Supports, State Fiscal Year (SFY) 2004 through SFY 2008, in thousands

	2004	2005	2006	2007	2008	Average Annual Percent Change, 2004 - 2008
Institutional Services						
Nursing Facility – fee-for-service (includes county facility payments)	\$934,664	\$890,232	\$836,477	\$841,174	\$829,222	-3%
Nursing Facility – managed care*	\$2,337	\$19,633	\$25,572	\$30,704	\$35,320	97%
<i>Total Nursing Facility</i>	<i>\$937,001</i>	<i>\$909,865</i>	<i>\$899,049</i>	<i>\$871,878</i>	<i>\$864,542</i>	<i>-2%</i>
ICFs/MR (includes day training and habilitation for ICFs/MR residents)	\$185,798	\$171,502	\$172,927	\$173,344	\$176,290	-1%
Total Institutional	\$1,122,799	\$1,081,367	\$1,061,976	\$1,046,263	\$1,040,832	-2%
HCBS Waivers						
Elderly Waiver – fee-for-service	\$124,050	\$139,509	\$121,732	\$97,104	\$82,601	-10%
Elderly Waiver – managed care	\$9,328	\$12,967	\$68,470	\$137,605	\$178,370	109%
<i>Total Elderly Waiver</i>	<i>\$133,378</i>	<i>\$152,476</i>	<i>\$190,202</i>	<i>\$234,709</i>	<i>\$260,971</i>	<i>18%</i>
CADI Waiver – fee-for-service	\$103,244	\$124,448	\$164,326	\$223,405	\$294,032	30%
CADI Waiver – managed care **					\$36,091	n/a
CAC Waiver	\$6,419	\$7,800	\$11,566	\$13,557	\$17,151	28%
TBI Waiver – fee-for-service	\$52,053	\$61,454	\$69,159	\$78,937	\$88,189	14%
TBI Waiver – managed care**					\$2,318	n/a
DD Waiver	\$806,376	\$843,105	\$874,866	\$901,154	\$925,546	4%
Total HCBS Waivers	\$1,101,470	\$1,189,283	\$1,310,119	\$1,451,762	\$1,662,707	11% (10% for services with all years' data)
State Plan Community Services						
Personal Care – fee-for-service	\$190,859	\$240,382	\$275,300	\$305,442	\$343,155	16%
Personal Care – managed care***				\$52,907	\$85,007	n/a
Private Duty Nursing	\$37,973	\$44,599	\$48,263	\$56,983	\$65,317	15%
Home Health – fee-for-service	\$29,520	\$29,521	\$28,392	\$26,784	\$25,247	-4%
Home Health – managed care****				\$17,638	\$22,939	30%
Developmental Disabilities Adult Targeted Case Management	\$4,008	\$8,197	\$11,365	\$9,266	\$9,106	23%
Mental Health Case Management*****	\$58,117	\$67,560	\$64,220	\$62,047	\$61,867	2%
Residential Treatment (Rule 5 for children)*****	\$6,489	\$6,346	\$7,605	\$7,085	\$7,887	5%
Total State Plan Community Services	\$326,966	\$396,605	\$435,145	\$538,152	\$620,525	17% (12% for services with all years' data)
Grand Total	\$2,551,235	\$2,667,255	\$2,807,240	\$3,036,177	\$3,324,064	7% (6% for services with all years' data)

Managed care expenditures increased significantly starting in 2006 when managed care programs were expanded significantly.

See the following page for notes and source information

* Nursing Facility – Managed Care is based on a capitation rate called the Nursing Facility Add-On. This payment is paid for all plan members not in nursing facilities for the risk of future nursing facility admission. The dollar figures here are based on Calendar Year. Data for 2004 – 2007 for people under age 65 was not available at the time this report was written.

** Managed Care data for people under age 65 was not available for 2004 – 2007. The dollar figures here are based on Calendar Year.

*** Personal care data were not available for 2004 – 2006 and only include people age 65 or older for 2007. The dollar figures here are based on a Calendar Year. The percentage increase was not calculated because incomplete data for 2007 means that spending data for 2007 and 2008 are not comparable.

**** Home health data were not available for 2004 – 2006 and only include people age 65 or older for 2007 and 2008. The dollar figures here are based on a Calendar Year.

***** Data for other Medicaid mental health services were not available at the time this report was developed.

Sources for Table A.1:

Managed care data for Nursing Facility, CADI, TBI, and personal care for people under age 65 were received from the Minnesota Department of Human Services in August and September 2009

Data for Personal Care and Home Health managed care data for people age 65 or older were obtained by multiplying data regarding member months of managed care enrollment by per member per month claim costs reported in Wachenheim, Leigh M. Trend & Surplus Adjustments for 2010 Payment Rates – Seniors Milliman, Inc.: September 9, 2009 and Wachenheim, Leigh M. Trend & Surplus Adjustments for 2009 Payment Rates – Seniors – Version3 Milliman, Inc.: October 21, 2008

Data for other services are from Minnesota Department of Human Services, Reports and Forecasts Division February 2009 Forecast March 3, 2009

**Table A.2 – Expenditures for Publicly-Funded, Non-Medicaid Supports,
State Fiscal Year (SFY) 2004 through SFY 2008, in thousands**

	2004	2005	2006	2007	2008	Average Annual Percent Change, 2004 - 2008
Institutional Services						
State-Operated Mental Health Services**			\$131,244	\$147,737	\$124,290	-3%
Total Institutional			\$131,244	\$147,737	\$124,290	-3%
Community Services						
Alternative Care	\$55,073	\$56,843	\$37,930	\$28,131	\$29,740	-14%
Aging Network Services	\$34,466	\$29,284	\$30,885	\$31,626	\$31,430	-2%
Community Mental Health Grants (State Payments)	\$65,798	\$60,243	\$60,248	\$65,667	\$71,601	2%
Community Mental Health (County Payments)***	\$112,352	\$101,377	\$109,828	\$92,719	n/a	-6%
Day Training and Habilitation (Non-Medicaid)	\$10,458	\$11,422	\$13,402	\$14,600	\$14,111	8%
Semi-Independent Living Services	\$10,061	\$10,375	\$10,359	\$10,731	\$10,808	2%
Family Support Grant	\$3,626	\$3,716	\$3,811	\$3,986	\$4,119	3%
Consumer Support Grant	\$5,546	\$6,310	\$7,627	\$10,296	\$11,945	21%
Group Residential Housing	\$88,003	\$80,319	\$78,523	\$84,082	\$90,792	1%
Minnesota Supplemental Aid (state supplement to SSI)	\$28,165	\$29,160	\$29,948	\$30,695	\$30,830	2%
AIDS Drug Program*****	\$2,954	\$2,712	\$2,508	\$3,278	\$3,798	6%
AIDS Insurance Program*****	\$2,792	\$2,747	\$3,271	\$2,896	\$3,792	8%
Independent Living Services	\$2,755	\$2,783	\$3,644	\$3,637	\$5,566	19%
Vocational Rehabilitation	\$46,137	\$47,091	\$42,179	\$46,270	\$48,994	2%
Extended Employment	\$13,302	\$13,369	\$14,378	\$14,123	\$14,876	3%
Total Community Services (excluding education)*****	\$481,488	\$457,751	\$448,541	\$442,737	\$465,121	-1%
Grand Total (excluding education)*****			\$579,785	\$590,474	\$589,411	1%

Special education expenditures are shown separately because many of these expenditures are for educational services rather than long-term support

Special Education and Early Intervention*****		\$1,351,000	\$1,429,000	\$1,503,000		5%
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See the following page for notes and sources and for how a year is defined for each program or service.

** Expenditures data for years before 2006 and for particular mental health services, such as psychiatric hospitalizations, were not available at the time this report was developed.

*** County spending for community mental health is based on a Calendar Year. 2008 data regarding county payments were community mental health services were not available at the time this report was written. These data include people who receive brief therapy or counseling, thus including services that would not usually be considered as long term care.

**** The AIDS Drug Program includes Dental, Nutrition, Mental Health, and Drug services. The AIDS Insurance Program helps people with AIDS purchase health insurance.

***** Total Community Services and Grand Total for 2008 were calculated using 2007 data for Community Mental Health Services (County Funded).

***** 2008 data for Special Education and Early Intervention were not available at the time this report was developed.

Sources for Table A.2:

Data received from the Minnesota Department of Human Services in January and February 2009 for AC and GRH (Data are by State Fiscal Year)

The following sources for Aging Network Services (Data are by Federal Fiscal Year):

Minnesota Board on Aging FY 2004 *Profile of State OAA Programs: Minnesota* June 8, 2006

Minnesota Board on Aging FY 2005 *Profile of State OAA Programs: Minnesota* September 5, 2007

Minnesota Board on Aging FY 2006 *Profile of State OAA Programs: Minnesota* November 7, 2007

Minnesota Board on Aging *State Program Report – 2 Year Comparison: Fiscal Year 2007 vs. 2008* March 9, 2009

Data received from the Minnesota Department of Human Services in September 2009 for county funding of community mental health (Data are by Calendar Year)

The following sources for DT&H, SILS, and FSG (Data are by Calendar Year):

Minnesota Department of Human Services, Financial Operations Division *Social Services Expenditure and Grant Reconciliation Report (SEAGR) Statewide Reports for Calendar Year 2008* March 23 2009

Minnesota Department of Human Services, Financial Operations Division *Social Services Expenditure and Grant Reconciliation Report (SEAGR) Statewide Reports for Calendar Year 2007* April 30, 2008

Minnesota Department of Human Services, Financial Operations Division *Social Services Expenditure and Grant Reconciliation Report (SEAGR) Statewide Reports for Calendar Year 2006* March 6, 2007

Minnesota Department of Human Services, Financial Operations Division *Social Services Expenditure and Grant Reconciliation Report (SEAGR) Statewide Reports for Calendar Year 2005* March 22, 2006

Minnesota Department of Human Services, Financial Operations Division *Social Services Expenditure and Grant Reconciliation Report (SEAGR) Statewide Reports for Calendar Year 2005* March 9, 2005

Minnesota Department of Human Services, Reports and Forecasts Division *February 2009 Forecast* March 3, 2009 for CSG and MSA (Data are by State Fiscal Year)

Minnesota Department of Education *2006-2007 Minnesota Annual Report on Special Education Performance* August 2008 for special education and early intervention (Data are by State Fiscal Year)

Data received from the Minnesota Department of Human Services in June 2009 for AIDS program data (Data are by State Fiscal Year)

The following sources for other services or programs (Data are by State Fiscal Year):

Minnesota Management and Budget *2010-11 Governor's Budget Recommendation: Agency Profiles* January 27, 2009

Minnesota Management and Budget *2008-09 Governor's Budget Recommendation: Agency Profiles* November 30, 2006

Minnesota Management and Budget *2010-11 Governor's Budget Recommendation: Agency Profiles* November 30, 2004