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Status of Long-Term Care in Minnesota 2005

A Report to the Minnesota Legislature

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Minnesota Department of Human Services
Aging Initiative

June 2006

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I. Purpose of This Report

This document summarizes the status of long-term care[1] for older persons in Minnesota in 2005. It was developed in response to a legislative mandate (M.S. 144A.351) to biennially update the legislature on the effects of legislative initiatives to "rebalance" the state's long-term care system. In 2001, the Minnesota Legislature enacted a comprehensive set of historic long-term care reform provisions prepared by the state's long-term care task force[2]. Several key provisions were enacted to reduce reliance on the institutional model and expand the availability of home and community-based options for older persons. This report provides information on progress toward achieving the reforms initiated at that time.

As required by statute, this report includes demographic trends; estimates of the need for long-term care among older persons in the state; and the status of home and community-based services, senior housing and nursing homes serving older persons at the state, regional and county levels. Also discussed are the activities and roles of the Minnesota Department of Health in regulation and quality assurance, changes in the state's strategies to provide information to consumers for long-term care decision-making, and other issues that will affect long-term care in the future. The report concludes with four long-term care benchmarks that measure the progress made on key elements of long-term care reform in Minnesota and a brief summary of the current status of long-term care in Minnesota as well as some policy and resource implications.

The Minnesota Department of Health contributed data and other information necessary for the completion of this report. Counties and Area Agencies on Aging/Eldercare Development Partnerships also contributed data and comments on the changes that have occurred in the availability of services over the past two years. The cost to prepare this report was approximately $5,000.

[1] Long-term care is defined as ". . . assistance given over a sustained period of time to people who are experiencing long-term care inabilities in functioning because of a disability" *(Ladd, Kane, Kane, 2000).* For purposes of this report, long-term care refers to care provided in all settings, including homes, apartments, residential settings and nursing homes.

[2] That report is available at www.dhs.state.mn.us/agingint/ltctaskforce/reports.

II. Demographic Trends and Need for Long-Term Care

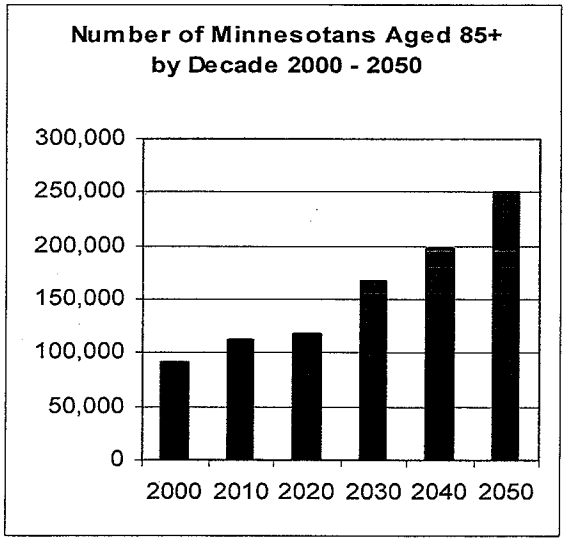
Earlier reports to the Legislature on this topic (2001 and 2004) reported on the demographic trends that are expected to have a profound impact on the need and demand for long-term care in Minnesota. This section summarizes those trends and reflects Minnesota's experience over the past two years in interpreting the impact of these forecasts.

A. Demographic Changes

One of the basic drivers of the initiatives now underway is the aging of Minnesota's population—namely the gradual increase in both the number and proportion of older persons in the state's population. Compared to the growth in the overall state's population, the older population (i.e., age 65+) has had relatively *slow* growth over the past 25 years. For example, between 1990 and 2000, Minnesota's overall population increased 12.4 % while the population 65+ increased only 8.7 %. The current slow growth in numbers of elderly is due to the lower birth rates in the years around the Depression, when today's older persons were born.

Looking ahead, the population 65+ is expected to grow by about 14 % between now and 2010, while the under 65 population will grow about 10 %. Then, beginning in 2011, the first wave of boomers, born between 1946 and 1964, begins to turn 65. From then and for the next 30 years, this cohort dominates the state's growth. Between 2010 and 2020, the population 65+ will grow by 40 % while the under-65 population will increase by about 4 %. Between 2020 and 2030, the comparable figures are 36 % growth in the older group and less than one percent for the younger group.

Today's elderly are, in general, healthier than their age peers just a generation ago. However, among persons age 85 and older the prevalence of chronic illness (and rates of disability) rise significantly.[3] Between 1990 and 2000, this group grew by about 25 %, from 69,000 to 86,000. The number of persons over age 90 grew even faster, increasing by 28 %. The 85+ group will have increased by another 25 % by 2010; another 14 % between 2010 and 2020; 34 % between 2020 and 2030; and 58 % between 2030 and 2040.



[3] He *et al* (2005) *65+ in the United States: Current Population Reports,* National Institute on Aging.

By 2060, the overall numbers decline slightly because nearly all the baby boom generation will have died, and the next generation will not be as large. However, an older society will be a permanent fixture of the state's demographic profile into the foreseeable future.

This next generation of older Minnesotans also has significantly fewer children than previous cohorts, and is more likely to live alone in older age—thus reducing the availability of "informal," i.e., unpaid, family care for future elderly. In addition, the projected labor force supply for long-term care is also likely to be inadequate without significant changes in labor deployment, recruiting and maintenance.

B. Need for Long-Term Care

The current and forecast demand for long-term care in Minnesota is tied to both the demographic projections and disability rates. As noted above, the older, at–risk population is projected to continue to increase, more slowly through 2020, and then quite rapidly for the next two decades. At the same time, age-specific disability rates in the United States have been decreasing at he rate of 1% or more per year for the past several decades, partly due to generally improved public health standards during this cohort's early years (1920s and 30s), and partly due to advances in health and medical care widely utilized by older people, e.g., hip or knee replacements, prescription drugs that increase the ability to function and be independent.

Whether the gradual reduction in disability rates among elderly will continue into the future is unknown, given the strong effect of lifestyle choices. Certainly, reduced rates of cigarette smoking will positively affect future health status and some reduced disability. However, the rising rates of obesity and adult-onset diabetes, which are tied to eating and exercise habits, could even offset this positive trend. For the purposes of this report, however, we will use national estimates[4] of the need for community vs. institutional care among the elderly, and apply those factors to our population.

It should be noted at this point that nursing home utilization in Minnesota has historically been somewhat higher than the national rates. However, by 2003, based on national estimates about 24,000 persons would have needed long-term *residential* care in a nursing home setting in Minnesota. That same year (2003) Minnesota's average monthly caseload of publicly funded persons aged 65+ in institutional settings was only 21,500. In addition, by the same national estimates another 95,000 would have needed some kind of long-term assistance to remain in their own homes and apartments in the community while slightly more than 41,000 persons received publicly supported long-term care in their own homes and apartments.

The sections that follow track the significant changes in the past 5 years to "rebalance" Minnesota's long-term care system—further reducing reliance on an institutional model of care and expanding the supply of home- and community based options.

[4] Manton, Kenneth and XiLiang Gu (1999) *Changes in the prevalence of chronic disability in the United States black and nonblack population above age 65 from 1982 to 1999.* Center for Demographic Studies, Duke University Durham, NC.

III. Home and Community-Based Services

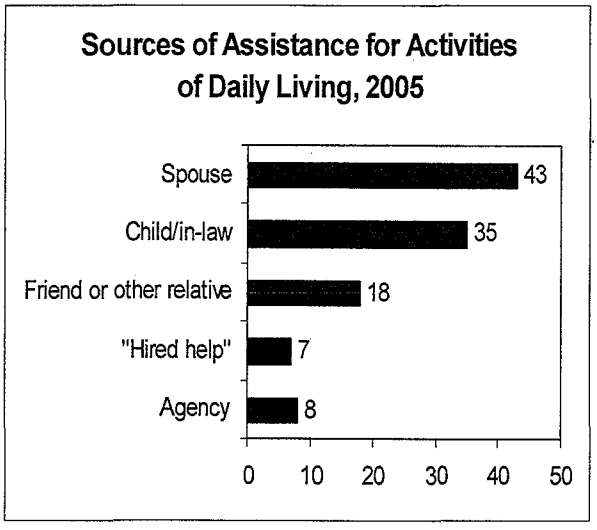
Most older persons today want to stay in their own homes and apartments as long as possible, either with no help, with help from family or with hired help. In 2005, one of the greatest expressed concerns of older Minnesotans is that they might one day have to live in a nursing home. Fully 67% of persons aged 65 and older voiced this as a major concern for their future.[5] Surveys also show that subsequent cohorts of older Minnesotans have higher levels of education and higher per capita and household incomes, and they are expecting and demanding more choice and control over their long-term care. This trend is expected to accelerate as baby boomers, the first real "consumer" generation, grow old and need care. The beginnings of this trend are already evident in the changing market for long-term care services and supports.

A. Family and "Informal" Care

Family members—mostly spouses and daughters and daughters-in-law—continue to provide the vast majority of help to older persons who need assistance with daily activities, although there have been some significant changes in the patterns of family help over the past 20 years.

Through the Survey of Older Minnesotans, the state has been able to monitor the sources of help provided to older persons who require assistance on a daily basis. A standardized set of questions used to identify need for long-term care (the Activities of Daily Living [ADL]) which includes eating, bathing, dressing, transferring (i.e., from bed to chair) and using the toilet. Among persons aged 60 and older who are living in their own homes and apartments in the community, about 2% need help from another persons with one or more of these activities.

As the table to the right shows, the primary sources of personal assistance–for those who need daily assistance with basic activities—continue to be family (spouse and /or child) and friends or other relatives. While the role of family members in providing basic long-term care is becoming more widely recognized, the significant role of neighbors and friends has been largely overlooked.



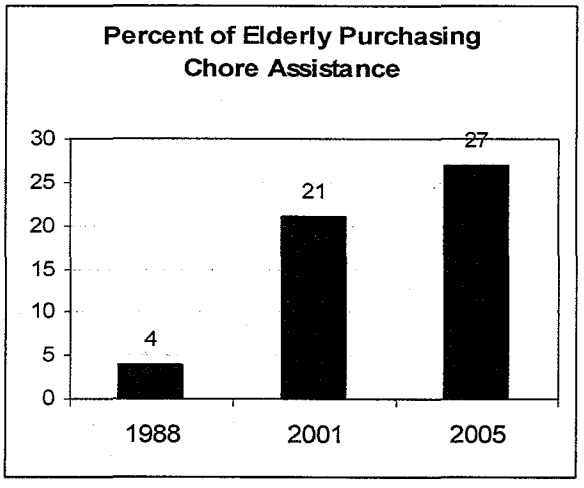
[5] Survey of Older Minnesotans, 2005 -- http://www.mnaging.org/advisor/survey.htm.

Over the past 10 years there has been a significant increase in the purchase of "hired help" -- whether hired by the older person or their family member -- to supplement the family's ability to meet care needs. At the same time, there has been a decrease in the role of children and children-in-law (primarily daughters and daughters-in-law). In 1995, over 50% of persons receiving personal assistance for ADLs mentioned help from a child or child-in-law. That percentage had declined to 35% in 2005.

In the future, the number of older persons who live alone is projected to increase. Given current trends, there will be fewer elderly persons living with a spouse who can provide needed care, and the number of "children" available to help future cohorts of elderly will also decrease because of the trend toward fewer children per household – down from 3.2 children per household for today's elderly to 1.9 children for the Boomer cohort (18% of whom are childless).

The role of "friends and neighbors" in providing long-term care supports has been an area of interest to the state and to local communities that have expanded church-sponsored and volunteer-based programs. Examples include ecumenical groups of churches that provide home delivered meals, local agencies that provide volunteer drivers' services, and civic- and faith-based programs that provide health and social support services to older residents in the community. The following section provides an overview of state efforts in this area. While there is no comprehensive inventory of such community- and faith-based programs across the state, it is estimated that there are now between 500 and 700 such groups, operating in virtually all of Minnesota's 87 counties.

While this report is focused on *long-term care* needs, many older Minnesotans who need this kind of help also need help with regular household chores such as home maintenance, snow shoveling/yard care and other activities that are also necessary to maintain one's independence in the community. Based on the Survey of Older Minnesotans, the proportion of older persons (and their caregivers) who purchased these services has increased over the past two decades—from about 4 % in 1988 to 27 % in 2005—partly to meet long-term care needs and partly attributable to lifestyle changes in this "new" elderly cohort.



B. Local/Community Long-Term Care Capacity

As noted above, a significant proportion of older people do require some assistance to live in non-institutional settings, and the majority of this support is provided by family or is purchased from non-agency sources. However, when an older person's family can no longer handle their relative's needs (or there is no family to depend on), a more "formal" agency intervention is called in, or the family begins considering either assisted living or a move to a nursing home.

In order to rebalance Minnesota's long-term care system, these formal components of the home and community-based services need to be greatly expanded. First, an increasing proportion of frail persons are now choosing to live in their own homes and apartments, and need these services on a regular basis. In addition, they are an important adjunct to family supports which are likely to be ever more stretched in the future due to smaller families and the increasing proportion of elderly who live alone.

The number of licensed and Medicare certified home care agencies in Minnesota peaked at 252 agencies in 1998 and has remained relatively constant since that time. This is despite occasional media coverage and concern when an agency ceases operation in a rural part of the state. Labor shortages, however, are a concern for nearly all long-term care services.

Home health agencies usually accept both Medicare and Medicaid reimbursement, and these dollars comprise the majority of their budgets, although about 25 % of home health agency budgets are private dollars. In assisted living, this is reversed, with the majority of the costs paid privately, and with Medicaid or insurance reimbursement a smaller proportion of overall budgets. Medicare does not reimburse assisted living costs.

Responding to a legislative requirement in 2001, all counties and Area Agencies on Aging (AAAs) in Minnesota reviewed the local capacity to meet the long-term care needs of current residents, and to report on any significant "gaps" in services or supports. Subsequent surveys in 2003 and 2005 followed roughly the same format. The table below shows the types of services that were ranked as significantly not available to meet the needs of frail elderly in 2001, 2003 and 2005.

2001 Survey 87 counties responding			**2003 Survey** 72 counties responding			**2005 Survey** 76 counties responding		
Type of service	**Rank**	**% of counties**	**Type of service**	**Rank**	**% of counties**	**Type of Service**	**Rank**	**% of counties**
Transportation	1	66	Transportation	1	42	Transportation	1	55
Respite/ Companion	2	57	Respite/ Companion	3	22	Respite/ Companion	5	42
Chore Service	3	48	Chore Service	2	28	Chore Service	3.5	47
LTCC for Relocation	4	39			**			**
Information and Assistance	5	25			**			**
			Adult Day Service	4.5	21	Adult Day Service	3.5	47
			Home Delivered Meals	4.5	21			
						Evening and Week-end Care	2	50

* Long-Term Care Consulting is provided by counties to persons who are anticipating relocation to a nursing home.
**Between 2001 and 2003 Senior LinkAge Line® was expanded and Minnesotahelp.info™ was developed and promoted by the state in partnership with the Area Agencies on Aging.

The highest priority "service gap" in the three successive surveys was **Transportation** for frail, at-risk elderly. The next two are also consistent across all three surveys: **Chore Service**, such as snow shoveling and the kinds of physical chores most needed by persons who live alone in their own homes, and **Respite/Companionship,** to step in when family caregivers are not available or companion service for persons who live alone or have no available family.

It should also be noted that over the past five years there has been a significant increase in counties' ranking of the need for support services for families and informal caregivers. In 2005, the need for **Respite/Companion**, **Adult Day Service** and **Evening/Week-end Care** all ranked among the top five, and all three are services that support an older person's family caregivers. This highlights a growing need for effective strategies to sustain and strengthen the family and informal supports.

The table below shows the number of counties that reported new services developed in the last two years—in comparison to the highest priority needs identified in 2003.

In 2005, about 90% of responding counties had developed new home and community-based services since 2003.[6] In some cases, service developments directly addressed gaps identified in the 2003 survey, such as transportation and in-home respite and caregiver support. In other cases, service development was driven by changes in federal policies and market trends. By far the most significant increase in service options was in **Assisted Living**: 9 out of 10 counties in Minnesota reported that new Assisted Living options had been developed in their area between 2003 and 2005. It is also important to note that new *supports for family caregivers* were developed in over two-thirds of the counties responding. The service called Fiscal Intermediary was expanded in 37 counties, partly in response to a 2004 Medicaid waiver that was went into effect in all counties in April 2005. This waiver allows eligible persons on all MA waivers to directly employ and manage the people who help them with their home and community-based service needs, and the Fiscal Intermediary service assists them in doing this. These changes are described in a later section of this report entitled **Consumer Direction**.

New Services 2003-2005		
Type of Service	**Rank as Gap in 2003**	**% of Counties Adding**
Assisted Living	NA	87
In-Home Respite and Caregiver Support	3.5	52
Fiscal Intermediary	NA	37
Transportation	1	28
Chore services	2	27
Companion services	3.5	27
Adult day service4	5.5	21
Home delivered meals	5.5	11

C. Targeted Strategies to Increase Home- and Community-Based Services

One of the reasons that there has been significant growth in local service capacity is because of the state programs put in place to promote this development. The Community Service/Services Development (CS/SD) state grant program was established in 2001 as part of long-term care

[6] In 2005 76 counties responded to the LTC Gaps Survey. Eight of the responding counties reported no new services developed between 2003 and 2005.

reform. It provides funds to develop new capacity within the home and community-based service system, and to help existing services redesign themselves to make them more cost-effective and fiscally sustainable into the future. To date, about $22.4 million[7] in grant funds have been awarded to 181 CS/SD projects in 82 counties across Minnesota. These projects have served more than 62,000 persons and increased the number of volunteers providing services by more than 14,000. The table below provides a summary of the types of projects funded, and the numbers of frail older persons who have been supported in community settings through this program. Note significant growth in the number and capacity of programs that have a volunteer component: specifically volunteer-based community support, transportation and caregiver support services. Note also that these new services directly reflect the service area priorities identified in the statewide gaps analysis.

Community Service/Services Development Projects Funded 2001 – 2005*

Type of CS/SD Project	Number projects	People Served
Converting nursing home units to apartments	37	800+ units
Creating new "assisted living" by making a service package available in low-income senior housing	75	2,218
New models of adult day care	8	622
New volunteer-based community support services: additional Living at Home/Block Nurse sites, faith-in-action programs, new services provided by existing volunteer programs	69	41,519
New transportation projects using volunteers or implementing more efficient methods of operation	17	14,723
Tele-home care in rural areas to support family caregivers and reduce emergency medical trips	9	556
Home modification services, e.g., accessibility, air conditioning, safety	16	1,884
Chore/ Home maintenance	10	4,617
Caregiver support, caregiver coach, caregiver respite services	27	6,778
Grocery/pharmacy delivery	12	2,355

* The data in this table cover the period from September 1, 2002 through June 2005.

The state's Eldercare Development Partnership program (EDPs, previously known as SAIL) provides targeted technical assistance to counties, local communities and service providers. Through EDP technical assistance new services are created and existing services are redesigned to improve quality and sustainability. The local communities generally need assistance in two areas:

- Best practices for most effective use of *existing public(and private) resources* to meet emerging needs and priorities in a changing market, and

[7] This amount is the approximate equivalent of the cost of serving approximately 425 persons in a nursing home setting for one year.

- Assistance in making needed changes—whether "business planning" expertise, convening and developing new partnerships, or direction toward state CS/SD or other grant sources.

Many of the agencies that provide these services are funded through the Minnesota Board on Aging and its network of Area Agencies on Aging (AAAs)[8] using the federal Older Americans Act and related state funds. Minnesota's AAA network is organized and charged to develop home and community services, including senior nutrition programs, senior centers, transportation, chore, respite, information and advocacy, and health promotion programs. AAAs are currently focused on developing local "linkages" between acute care providers and community-based supports—to reduce health crises by improving chronic care management. In addition, AAAs continue to focus the targeting of nutrition services (Senior Dining) to low-income, at-risk persons, and especially to the population of low-income elderly currently residing in public housing across the state. In 2005, more than a third of all Senior Dining sites were located in public and low-income housing. Nearly 81,000 older persons (unduplicated count) were served through AAA-funded programs in 2005. And while these services are targeted to persons who are not eligible for other public programs, 16% of recipients (12,504) had incomes below federal poverty level guidelines. In addition, the AAAs use Older Americans Act funds (specifically, the National Family Caregiver Support Program) to expand resources for family caregivers statewide.

D. Publicly Funded Entitlement (and Low-Income) Programs

As the preference of older people for home and community-based services (HCBS) has grown, so too has the utilization of home and community-based services within publicly funded programs. These services include those provided through the Elderly Waiver (EW), Alternative Care (AC) and Medical Assistance (MA) home care programs.

In the past five years (2001 – 2005), the overall number of persons 65+ served through the EW, AC and MA home care programs has grown from 23,000 to about 28,000, a 22 % increase. The expenditures for HCBS have grown from $130 million to $224 million, a 73 % increase. It is important to note that while these figures have increased for the EW/AC and MA programs, the number of older persons served and dollars expended for nursing home care for the same target population have declined. This is *consistent with the goals of long-term care rebalancing*: to reduce the proportion of long-term care provided in nursing homes or other institutional facilities and to increase the proportion of care that is provided to older persons in their own homes or apartments.

The table on the next page shows the changes from 2001 through 2005 in the number of clients and the total expenditures for each of these three programs.

[8] Area Agencies on Aging are regional entities designated by the Minnesota Board on Aging under the federal Older Americans Act that provide information and assistance services, work with local providers and funders to improve aging services, and administer grants to agencies that provide nutrition or supportive services to older persons in their areas.

Total Annual Utilization and Expenditures for Publicly Funded HCBS for Persons 65+ Minnesota - 2001 – 2005

SF Year	Alternative Care		Elderly Waiver		MA Home Care		Total HCBS	
	Clients	Cost	Clients	Cost	Clients	Cost	Clients*	Cost
2001	11,787	$56,346,000	10,978	$69,112,000	695	$4,057,000	23,460	$129,515,000
2002	12,233	$66,969,000	12,050	$84,024,000	1,847	$5,471,000	26,130	$156,464,000
2003	11,709	$76,445,000	13,561	$104,267,000	4,129	$14,483,000	29,399	$195,195,000
2004	9,106	$59,294,000	16,249	$133,378,000	3,633	$13,982,000	28,988	$206,653,000
2005	7,557	$55,807,000	17,124	$152,476,000	3,380	$15,783,000	28,061	$224,066,000

*Numbers may include duplicated count, since some clients use more than one program over a year's time.
Source: Minnesota Department of Human Services Data Warehouse , and Hennepin County Social Services for Hennepin County AC figures. For MA and EW, figures do not include some services paid for under managed care; MSHO program not included 2001-2003. EW State Plan Home Care costs included in Elderly Waiver costs.

Twice a year, DHS prepares a five-year forecast of the expected utilization (based on monthly caseload) and expenditures for persons served by publicly funded health programs. The February 2006 forecast for long-term care services for persons 65+ estimates that community care will continue to grow, increasing from approximately 20,000 persons served monthly in 2001 to 27,000 in 2007.

Impact of Recent Changes in Alternative Care Program. In 2003 the Legislature enacted several major changes in the Alternative Care (AC) program, and in 2005 new policy changes were enacted, eliminating the previously imposed state recovery provisions (liens) while further tightening eligibility criteria, and eliminating coverage for AC recipients in "assisted living" and adult foster care services (namely AC-funded packages of services provided in a non-private home or apartment). The goal of these changes was to reduce overall program expenditures, and to refocus this state-funded program on services and supports in people's own homes.

As expected, these changes have had an impact on the program's current clients as well as potential clients. As of June 2005, approximately one third of the recipients were affected by the 2005 changes in the benefit set. Of these, most (about 75%) used their own funds to pay privately in order to continue receiving services. But because they are very low income, these persons quickly "spent down" and became eligible for the Elderly Waiver (EW) program. Another 12% substituted ala carte services from the remaining benefit set in order to stay in "assisted living" settings. Of the remaining group (about 12% of those affected), most were admitted to nursing facilities.

In terms of numbers, *average monthly* participation in the AC program dropped from 7,100 in June 2003 to 3,400 by January 2006. DHS will continue to monitor these changes, especially the use of institutional care by those who would otherwise have been served by the AC program.

Impact of Recent Changes in the MA Home Care and Elderly Waiver Programs. Historically, elderly with very low incomes (i.e., eligible for Medicaid) were automatically enrolled in Minnesota's Prepaid Medical Assistance Program (PMAP). In 2003 the State Legislature added a set of "long-term care" services to the basic Medicaid managed care package. This new product is called Minnesota Senior Care Plus and includes basic Medicaid services plus the home- and community-based services included in the Elderly Waiver package

(see below), and 180 days of Nursing Facility care. This change was implemented in the 20 County Based Purchasing counties effective June 2005. Three health plans are participating.

Also effective June 2005, all PMAP-enrolled seniors statewide were transferred to a new managed care waiver under 1915(b) for basic care services called Minnesota Senior Care. This is now available in 83 counties.

Very low income elderly who need *nursing home level* care may be eligible for Minnesota's Elderly Waiver (EW) program (.i.e., they meet the *income eligibility* criteria for Medicaid and the *functional criteria* for institutional care). The intent of the EW program is to provide the necessary supports to keep these persons in their own homes or apartments, and to prevent or delay institutionalization. The EW "service package" includes an array of home- and community services and may be provided in one of two ways: (1) via a Fee For Services (FFS) arrangement through their county, or (2) via a Managed Care arrangement through a health plan.

In 2004 the federal Centers for Medicare and Medicaid Services (CMS) approved statewide expansion of Minnesota Senior Health Options (MSHO). MSHO is a voluntary alternative for "dual-eligible" persons aged 65 and older, that has been operating in Minnesota since 1997, assuming full risk for both Medicare and Medicaid services: primary, acute, and long-term care (including 180 days of nursing home and waivered community services). MSHO is now available in 83 counties and is provided through nine health plans. Further, the Medicare Modernization Act of 2003 includes a new Medicare Advantage option that allows health plans that serve dual-eligibles to become Special Needs Plans (SNPs). All MSHO plans transitioned into this "Special Needs Plan" status for Medicare services on January 1, 2006. This allows the MSHO model to provide Medicare Part D drug benefits to enrollees, and has accelerated the enrollment of dual eligible seniors into MSHO.

Currently 61% of all Elderly Waiver clients are receiving their EW services through Managed Care contracts (either through MSHO or the Minnesota Senior Care Plus managed health plans) and 39% are receiving EW services through fee-for-service models managed by the counties.

Consumer-Directed Service Options. Future cohorts of older Minnesotans are expected to want more options and more flexibility in services than previous generations. A *consumer-directed* model of services became available to Minnesota's elderly (and all waiver population in the state) in April 2005 via a federal CMS waiver. The *Consumer-Directed Community Supports* (CDCS) model, originally piloted in three states, allows maximum consumer input into selecting the supports that will be most effective for them. The CDCS model allows eligible clients to use an "allowance" based on their service needs that they may use to hire the worker of their choice to provide needed personal care services, including hiring family members, friends, neighbors or others. Developing and implementing this model requires significant shifts in organization and management of long-term care, first promoting more choice and responsibility on the part of consumers and second creating new ways to monitor outcomes and ensure accountability. Because the consumer-directed approach offers the opportunity to "customize" services, it also has the potential to make long-term care expenditures more cost-effective.

A 3-year grant from the Robert Wood Johnson Foundation (through 2007) has enabled the state to promote the CDCS model for older persons, and to identify best practices throughout the state. As of February 2006, 13 counties had implemented CDCS for one or more older clients, and had enrolled a cumulative total of 32 older persons.

In a parallel development, the Minnesota Board on Aging and Area Agencies on Aging are implementing pilot CDCS programs (at least one in each planning and service area in the state) for caregiver respite and for nutrition interventions targeted to individuals at high nutritional risk.

New Quality Assurance Initiatives. Most of our collective experience in quality assurance in long-term care has been in the institutional area, where formal regulations and rules dominate. As the state reshapes long-term care and encourages older consumers to "age in place" in their current home and community, we need to develop a quality assurance system that is responsive to the unique challenges of services provided in non-regulated environments.

A framework of quality assurance for community-based long-term care was developed by a work group of the long-term care task force in 2002. It included seven essential elements.

- Accurate and timely consumer information about options in a variety of formats.
- Supports to help consumers and families use consumer-directed services.
- Building a community presence in local both facility-based and community-based long-term care venues through volunteers, community integration, and improved communication between the community and providers.
- Continuous quality improvement, including regular use of consumer feedback.
- Consumers that understand their rights and have access to the means to exercise their rights.
- Consumer protection and access to complaint offices and ombudsman services.
- Rules and regulations that are responsive to the consumer and to the special program integrity issues faced by home and community-based options.

DHS has incorporated these seven elements into Phase 5 of its Quality Management Strategy, the federal quality framework mandated by CMS. In addition, DHS and MBA have a number of additional efforts underway to address elements of a quality assurance, including expansion of consumer information, development of ways to integrate consumer satisfaction and other feedback loops into programs, provision of easy-to-understand booklets on consumer rights and how to exercise those rights, and expansion of the use of ombudsman volunteer advocates to more residential long-term care settings.

In 2003 DHS received a federal grant to improve quality assurance in its home and community-based waiver services. The project will expand the department's capacity to manage, assess and make improvements in home and community-based services and programs; incorporate client definitions of quality of care and quality of life into quality improvement strategies; and enhance the capacity of the state and counties to address the health and safety of clients by improving the Vulnerable Adults report tracking system.

In 2005, this federal grant funding was used to complete a statewide in-person survey of Elderly Waiver consumers, using volunteers recruited and trained through Ombudsman for Older

Minnesotans program as interviewers. A final report on this survey is available on the Minnesota Board on Aging website: www.mnaging.org. In addition, technology developments are being implemented to integrate quality assessment data from across divisions and agencies.

The Continuing Care Administration (within a larger Department of Human Services initiative) is implementing business process analysis related to all home and community-based services. The goal is to identify how well the design and implementation of programs is meeting quality goals. In addition, the lead agencies responsible for implementing HCBS programs (i.e., the counties, tribes and health plans) will participate in reviews to identify best practices and ensure compliance. Developing and implementing all the components of a community-based quality assurance system will continue to be a key component of long-term care reform as increasing numbers of long-term care consumers are served in their homes and community settings.

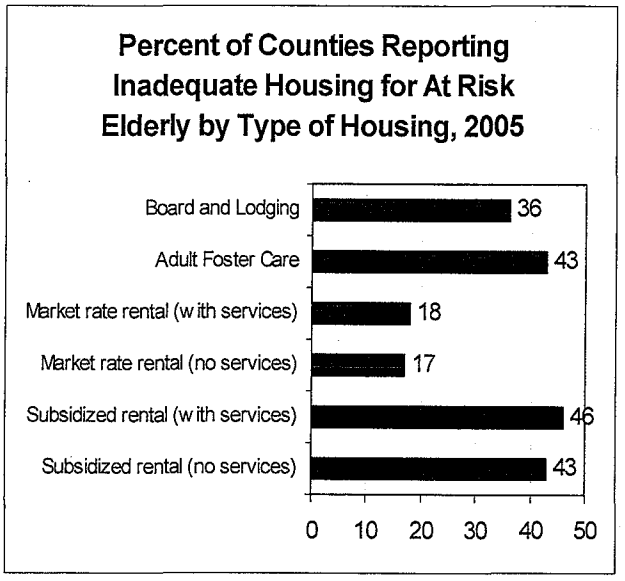
IV. Senior Housing

There has been significant expansion in new housing options marketed to older persons during the past five years. While the general term *senior housing* includes everything from active adult communities to memory care facilities, for purposes of this report, the most significant trend has been the increase (and variety) in *assisted living* options and its impact on meeting the current and future long-term care needs in Minnesota.

A. Locally Identified Need for Senior Housing

Over the past five years there have been significant increases in the availability of housing choices for older persons in Minnesota, particularly market rate options. In 2001, more than half of Minnesota counties (50 of 87) reported that affordable senior housing was not adequately available in their counties. By 2003, counties reported that much additional housing had been developed: 27 counties reported new subsidized or affordable housing units, 17 reported new adult foster care, and 16 reported new assisted living options. In 2005, 66 counties reported new senior housing options: a total of 211 buildings and a total of 5,142 new units. It should be noted that the survey did not distinguish between new construction or remodeling or re-development of existing units, so the latter figure includes a significant number of conversions—from nursing home to apartment use. Most counties with new housing development also reported that CS/SD or other state grants were instrumental in their development.

In 2005 about half of Minnesota counties reported that the overall supply of senior housing was "adequate." However, there are still some parts of the state where specific housing options are in short supply. Nearly half of all counties report that there is an insufficient supply of *subsidized* (i.e., below market rate) housing—whether with or without service packages included. Counties also reported a substantial need for additional Adult Foster Care and Board and Care facilities—both of which provide a higher level of care/supervision than a traditional housing with services facility. It should also be noted that despite the growth in market rate housing (especially assisted living options), there are still some areas in the state where even this option is inadequately available.



B. Assisted Living / Housing With Services

Any Senior Housing provider in Minnesota and offers some type of service package is considered to be a type of "housing with service establishment"[9] and must be registered as such with the Minnesota Department of Health (MDH). The housing (building) must comply with applicable housing and safety codes, and the services must be provided by appropriately licensed providers. Residents usually pay a fixed monthly fee that includes the rent and a "package" of services. The combination of an apartment type of living unit with services available as needed offers an attractive package to both older persons and their families, promising both independence/privacy and supports/services as needed.

Until 2006, all registered "housing with services" establishments were considered to be "assisted living" for purposes of insurance reimbursement. As of May 2006 there were 1,081 housing with services establishments registered in Minnesota. Between 1997 and 2006, the numbers of residences increased 150% (from 426 to 1,081) and currently serve an estimated 46,000 older residents.

However, as the number of popularity of this type of arrangement increased, issues that were originally identified early on became clearer, e.g., need for more clarification on the definition of assisted living, what services are included, continuing stay criteria, definition of "supervision," and locus of liability. During most of 2005 an *ad hoc* group of stakeholders, including both providers and consumer advocates, met together to identify solutions to these issues. They jointly developed a legislative proposal to define minimum standards for the services. The 2006 Legislature established a common working definition of assisted living and a set of standards and regulations which entities using the terminology to describe their services must abide by. The new law prohibits persons or entities from using the term "assisted living" unless they are "housing with services" establishments and provide some or all of the components of assisted living as specified in chapter 144G. The law also establishes consumer protection and consumer information requirements (see *Laws of Minnesota 2006,* chapter 282, article 19, sec.1 – 20).

[9] The Minnesota housing with service establishment definition: *. . .an establishment providing sleeping accommodations to one or more adult residents, at least 80 % of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment* (MN Statutes Chap. 144D.01, subd.4).

V. NURSING HOMES

The state strategy for long-term care has been to "rebalance" the locus of care from institution-based to home- and community based models. However successful this strategy, there is and will be a need for nursing homes, although several policy issues related to the future of nursing homes are of increasing interest, namely quality, cost and industry size.

A. Quality

Quality of long-term care services is an ongoing concern, both in institutional settings and in home- and community-based settings. This concern is especially important in nursing homes where quality affects all aspects of a consumer's life and where the burden of changing providers may be extreme. DHS is interested in quality of nursing home care for several reasons. As the State Medicaid Agency, DHS is responsible for certifying nursing facilities for participation in the program, a function that is delegated via contract to the Minnesota Department of Health (MDH), the state agency that licenses nursing homes and boarding care homes. As a purchaser, spending hundreds of millions of dollars of state funds each year, DHS believes that it has an obligation to the public to use that purchasing role to leverage quality.

Nursing Home Report Card. MDH and DHS have collaboratively undertaken several initiatives to improve the quality of nursing home care. In early 2006 the department published a nursing home report card in cooperation with MDH. Hosted on the MDH website (www.health.state.mn.us/nhreportcard) the Minnesota Nursing Home Report Card is believed to be the most comprehensive nursing home report card in the nation. It is interactive in that it allows the user to select the quality measures that s/he considers most important. The Report Card then provides scores on eight quality measures, using a five star rating. The quality measures are:

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

MDH and DHS are now entering into a planning phase to implement enhancements to the Report Card, guided in part by user feedback.

Pay for Performance. In 2005 the Minnesota Legislature enacted a first step in adopting Pay For Performance for nursing facilities. This initiative is in the form of a quality add-on to payment rates. Based on quality scores, facilities will receive increases as large as 2.4% of their operating payment rates effective October 1, 2006. The quality score is developed from five of the eight measures on the Report Card:

- Clinical outcomes, accounting for 40% of the total score
- Direct care staff retention, accounting for 25% of the total score

- Direct care staff turnover, accounting for 15% of the total score
- Use of temporary staff from outside pool agencies, accounting for 10% of the total score
- Inspection findings from certification surveys, accounting for 10% of the total score

It appears that the Report Card and the quality add-on are already having an effect on nursing facilities. A great deal of attention is being paid to improving quality, as seen in attendance at training offered by the department and others.

Study on Staffing Standards. The department recently concluded a study of the effects of direct care staffing level on quality of care. This study was conducted at the request of the legislature to determine if the state should establish a new direct care staffing standard. Two factors precipitated the need for this study. Before October 2002 the Minnesota Case Mix system, used as an "acuity adjustor" for nursing home payments, was also used to set a minimum staffing requirement that varied with overall resident acuity in a given setting. This staffing standard was eliminated because the required resident assessment duplicated the federally required Minimum Data Set (MDS) system as a method for monitoring resident status. In addition, many people felt that Minnesota needed to *increase* staffing levels as a quality improvement strategy. Because this would be an enormously expensive proposition, it was proposed that Minnesota first examine the relationship between staffing and quality to ensure that an optimal and efficient standard could be identified and that this would be the best way to improve quality.

Four separate but related analyses were undertaken to address issues surrounding the relationship between nursing home staffing and quality:

- Critical review of research studies examining the relationship between nurse staffing and quality in long-term care facilities;
- Examination of other states' nurse staffing standards and an analysis of state staffing standards and actual nurse staffing;
- Group interviews with stakeholders in Minnesota regarding their perspectives on nurse staffing standards for Minnesota nursing facilities ; and
- An analysis of the relationship between the time spent by various nursing home staff caring for individual residents and the evidence of those residents' quality of care.

Critical Review of Literature. The literature review examined over 30 studies related to nurse staffing and quality in nursing homes. The pattern of findings from the studies reviewed favored some positive relationships between staffing and quality, but the pattern was not consistent and the amount of variance in quality explained by the various measures of staffing was small. The studies demonstrated a number of design weaknesses, including multiple operational definitions of the two critical measures of staffing and quality, which made summarization difficult. The entirety of this literature showed some common problems. The majority of the studies used staffing and quality data that were assessed at the facility level. Facility level analysis has a high likelihood of leaving unexplained much of the important variation in care quality. It also increases the possibility of specification error due to the different time periods in which the staffing and quality variables were measured. When staffing and quality data are aggregated to the facility level, endogeneity (i.e., the situation where the acuity of residents, a factor related to quality of care, affects the level of staffing) is particularly problematic. Higher staffing may

contribute to better resident health outcomes; however poor outcomes, perhaps as the result of poor care, may occasion the need for higher staffing.

State Staffing Standard Analysis. The analysis of state standards for staffing levels and the effects of those standards found that 33 (65%) of the states had specific standards for the number of hours of nursing care residents were to receive. Thirty-three (65%) states had additional licensed nurse staffing requirements that were above the minimum federal requirements. Minnesota currently requires a minimum of 2.00 hours of nursing care per day for each resident with no further requirements regarding licensed nursing staff.

The states' staffing standards were examined in relationship to the actual staffing in all the states' nursing homes. Higher state staffing standards were associated with higher nursing staff levels. However, setting standards may come at a risk because those minimum standards could become ceilings. The analysis revealed that states with lower nurse staffing standards had, on average, lower levels of nurse staffing than states with no state staffing standards.

Stakeholder Interviews. Although the literature review suggests a mixed level of support for staffing as a vehicle for achieving quality, Minnesota respondents were very consistent in their assertions that more staffing would lead to better quality. To that end, they believed that there should be required staffing standards and that such standards should be based on and associated with the acuity/care needs of residents. The stakeholders included families, residents, ombudsmen, nursing home administrators and directors of nursing, direct care nursing staff (RNs, LPNs, CNAs), union leaders, and nurse practitioners.

Staff Time and Quality Analysis. A Minnesota-specific analysis of the relationship between staff time devoted to specific residents and their quality of care was undertaken. This analysis was possible because of work also being done to re-norm the RUGS case mix indices (CMIs). This study design addressed one of the limitations of its predecessors, namely that the prior work had all been done at the facility level, allowing more room for various associations. Using a statistical technique called Hierarchical Linear Modeling (HLM), the analysis of nurse staff time and risk adjusted process and quality measures was simultaneously performed at the resident level and the unit level. Because resident and unit acuity and unit type could influence the relationship between nursing resource use and quality outcomes, the analysis controlled for them statistically.

The analyses found predominately weak or non-significant relationships between the amount of care received by residents from different types of staff (RN, LPN, nursing assistants and other) and quality-related care processes and outcomes for those residents. Further, unit staffing level (average amount of care available per resident) had little relationship to resident-level care processes or outcomes. In both instances, the direction of the relationship was as often negative as positive. These findings offer little evidence that more staff time is associated with better quality care. The identification of nurse staffing time/quality thresholds was not possible based on the findings from this study.

Study Conclusions. Two data sources (review of literature and analysis of nurse staff time and quality) offer very weak evidence that the amount of care received by residents is associated with process and outcomes quality indicators. The examination of state staffing standards found that

facilities in states with low staffing standards tended to have even lower nurse staffing levels than states which had no state staffing standard at all. This finding suggests that, if legislating standards, it is critical that they be sufficient to lead to good quality outcomes. The perspective of the nursing home stakeholders differs substantially from the findings of the empirical analyses. There was consensus among the stakeholders that nurse staffing levels were associated with quality of care and that the current Minnesota staffing standard is too low to ensure quality care. Further, the stakeholders were supportive of having a staffing standard that would ensure quality of care for nursing home residents.

In light of these mixed findings, the department has chosen not to propose any specific requirement for level of direct care staffing. Quality of care for nursing home residents may have more to do with the qualifications and expertise of the direct care staff, staff morale and teamwork, facility or unit management, care delivery practices, leadership, supervision, and the use of care-related technologies than on any specific staffing standard. Simply requiring increased amounts of staff may accomplish little to improve quality.

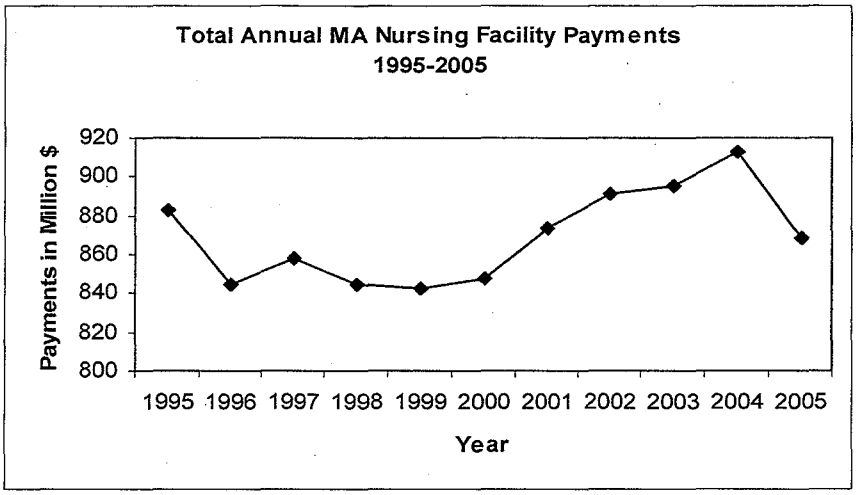
B. Nursing Home Costs/Expenditures

In State Fiscal Year 2005, $868 million was spent through the Medicaid Program for nursing home care in Minnesota, of which the state share was $425 million. In that same year nursing home industry total revenues are estimated at nearly $2 billion. The table below shows the funding sources and amounts for nursing home care in Minnesota in 2005.

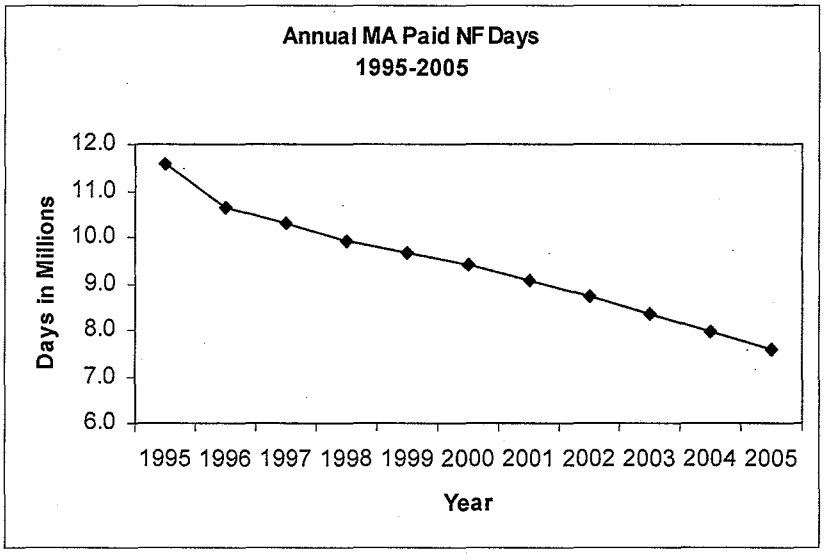
Estimated Total Nursing Home Costs in Minnesota (2005) by Source of Payment

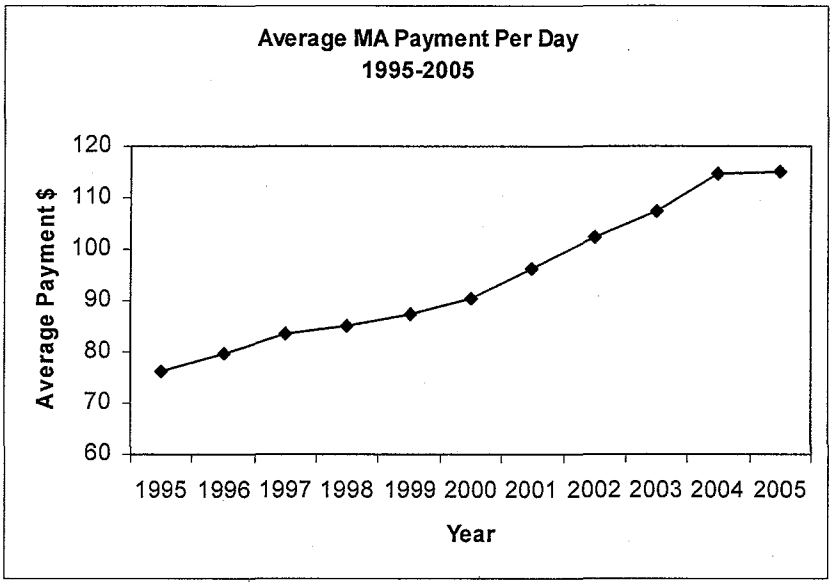
Source	Amount (in millions)
MA payments	$868
Federal share	*434*
State share	*425*
County share	*9*
Payments by MA recipients	217
Private pay	475
Medicare	291
Other	57
Estimated revenues of non-MA nursing homes	38
Estimated **Total** Nursing Home Revenues	$1,946

The line graph on the next page shows the changes in total MA spending on nursing homes in Minnesota from 1995 through 2005. This expenditure has been remarkably stable over the past ten years, fluctuating between a low of $842 million in 1999 to a high of $912 in 2004.



The next two charts show the very different trends in state caseload and unit costs. Caseload has declined as an increasing proportion of persons needing LTC services are now being supported in non-institutional home- and community-based settings. Caseload, the number of resident days paid for by MA, has decreased from 11,571,518 in 1995 to 7,554,540 in 2005. At the same time, the average daily payment rate (MA payment not counting recipient resources) has increased from $76.25/day in 1995 to $114.93/day in 2005.





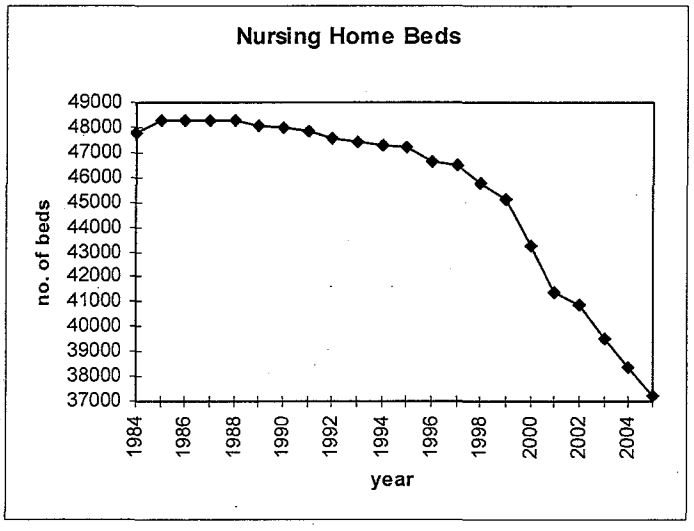
C. Industry Size

Rightsizing the nursing home industry has been a dominant policy theme for the state for over 25 years.[10] This section of the report will address the question of how big the nursing home industry in Minnesota should be.

Number of Beds and Beds per 1,000 Elderly. At the end of 2005 Minnesota had 411 licensed nursing homes and licensed and certified boarding care homes with a total of 37,182 beds in active service with the availability of beds varying substantially across counties. One of the easiest ways to describe this variability is in terms of the ratio of nursing home beds per 1,000 elderly persons, and in this case we will examine this ratio under two definitions of "elderly": age 65 and older, and age 85 and older. While the former measure is most commonly used nationally, the generally longer life expectancy in Minnesota results in a higher than national rate of very old persons in this state. The table below shows the state averages for these measures as well as the variance across counties and across "groups" of counties. This latter measure takes into account the use of nursing homes by persons in adjacent counties.

[10] Programs and strategies that have been enacted (and modified) during this period to assist in right-sizing the nursing home industry include: (a) Moratorium on construction of new nursing home beds; (b) Pre-admission screening, now LTC Consultation; (c) Funding for HCBS, through EW and AC; (d) Local and regional long-term care planning and service "gaps" analysis, (e) Community Services and Service Development grants; (f) Nursing home bed layaway program; (g) Planned closure incentive payments; and (h) Single bed incentive.

Average Nursing Home Beds per Thousand Persons Age 65+ and 85+ (and Range) -- Minnesota 2005		
VARIABLE	AGE 65+	AGE 85+
Statewide beds per 1000	60.4	378.6
County median beds per 1000	65.9	373.7
County mean beds per 1000	67.8	395.0
County standard deviation of beds per 1000	22.1	119.9
County range of beds per 1000	Low is 20.7 in Anoka High is 127.2 in Norman	Low is 180.2 in Hubbard High is 775.9 in Norman
Contiguous county groups median beds per 1000	62.8	377.8
Contiguous county groups mean beds per 1000	64.6	380.3
Contiguous county groups standard deviation of beds per 1000	11.3	43.0
Contiguous county groups range of beds per 1000	Low is 32.4 in Chisago High is 89.4 in Traverse	Low is 282.1 in Chisago High is 549.4 in Cook

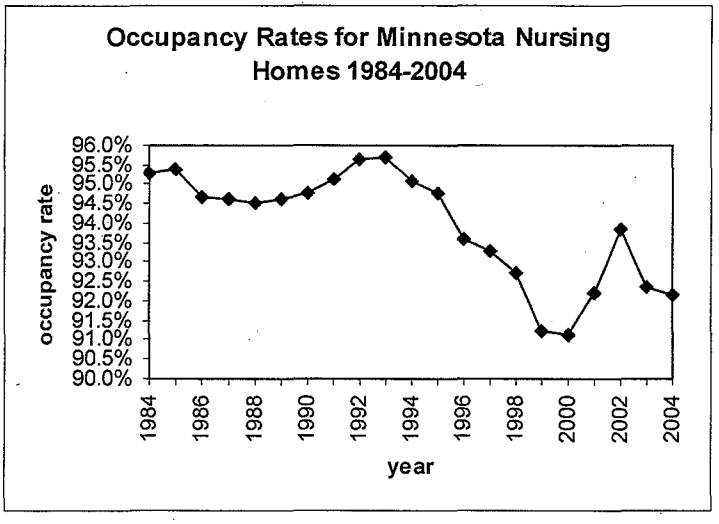


The number of nursing homes and licensed beds has been declining since 1987, when Minnesota had 468 facilities with 48,307 beds. Since that time 57 facilities have closed altogether and 9,538 beds have been completely delicensed. An additional 1,587 beds have been taken out of active service and put in "layaway" status. The supply of active beds has declined by 23% over the 18 years since the 1987 peak. In the two years since the last Legislative Report, the bed supply has declined by an additional 2,348 beds or 6%.

For many years policy makers have considered Minnesota to be over-bedded, based on its comparison with the U.S. as a whole. Nationally (as well as in Minnesota) rates of beds per capita have been declining over the past several years. As recently as 2003, Minnesota still had comparatively more bed capacity that the rest of the nation (31% more for persons aged 65+ and 10% more for persons age 85+). However, the rate of reduction in Minnesota has exceeded the national average (see table below), raising the question of the degree to which Minnesota may

still have an "over-supply" of nursing home beds in the near future. The following table compares Minnesota data on nursing home supply with comparable national data.

Comparison of Minnesota and U.S. Data on Nursing Home Supply			
	Minnesota	**U.S.**	**MN as % of U.S.**
Historic number of beds	1987 – 48,307		
	1995 – 47,181	1995 – 1,751,302	2.69%
Current number of beds	2003 – 39,530	2003 – 1,756,699	2.25%
	2005 – 37,182		
Average annual % change in number of beds, 1995 to 2003	-1.37%	0.03%	
Peak beds per 1000 age 65+	1987 – 91.2		
	1995 – 82.0	1995 – 51.9	158%
Current beds per 1000 age 65+	2003 – 64.2	2003 – 48.9	131%
	2005 – 59.3		
Average annual % change in beds per 1000 age 65+, 1995 to 2003	-2.24%	-0.66%	
Peak beds per 1000 age 85+	1987 – 745.3		
	1995 – 611.4	1995 – 475.8	128%
Current beds per 1000 age 85+	2003 – 407.7	2003 – 372.3	110%
	2005 – 365.4		
Average annual % change in beds per 1000 age 85+, 1995 to 2003	-3.68%	-2.69%	



Occupancy. Occupancy is defined as the percentage of days a nursing home bed is occupied during the year. It is calculated as the actual number of resident days of nursing home care provided during a year divided by the maximum capacity for that year, that is, the number of resident days that would have been provided if all beds in active service were occupied every day.

Occupancy in Minnesota's nursing homes has ranged between a high of almost 96% in 1993 and a low of 91% in 2000. This rather narrow range of occupancy over many years has been maintained largely by taking beds out of service. The statewide occupancy rate for the fiscal year ending 9/30/04 was 92.2%. Occupancy is an important statistic to monitor for two reasons. First, it is important that nursing home beds be available when needed. People should be able to access this service when needed—sometimes on very short notice. If occupancy is too high, access may be constrained. The Department of Human Service would be concerned about access if occupancy rates exceeded the historic (20-year) range. Above about 97% occupancy, access problems will likely

become common. Second, low occupancy is likely to exacerbate the financial strain on facilities, and perhaps, reduce the overall efficiency of the industry.

Extreme Hardship Counties. The general distribution of nursing home beds is certainly not uniform across the state. As noted earlier in this chapter, the range in number of beds per thousand persons aged 65+ is over 6-fold (e.g., low of 20.7 in Anoka County and high of 127.2 in Norman County). Further declines in bed supply may trigger an "extreme hardship" situation in specific areas of the state. By definition in statute, two criteria must be met for such an extreme hardship situation to be recognized:

1. A county must have fewer beds per 1,000 for people age 65+ (in that county and contiguous counties) than the national average plus 10% (110% of 48.9 beds/1000 [in 2003, the most recent year for which the data is available] is 53.8), and
2. An extreme hardship situation can only be found after the county documents the existence of unmet medical needs that cannot be addressed by any other alternatives.

In 2005 there were 11 counties—Chisago, Isanti, Sherburne, Washington, Goodhue, Cass, Morrison, Pine, Pope, Meeker, Rice, and Kanabec—where an exception to the moratorium on nursing home beds might be considered due to the potential for the "extreme hardship" criteria defined above. In 2003, only five counties met this test.

The statutory definition of "extreme hardship county" produces some peculiar results, best exemplified by Anoka and its contiguous counties. Chisago, Isanti, Washington, and Sherburne Counties all border Anoka County, which has the state's lowest ratio of beds per 1000 age 65+ with 20.7. Even though Isanti and Sherburne counties have high beds per 1000 (ranking 28th and 33rd respectively in bed capacity), they are potential extreme hardship counties, while Anoka (ranking 87th—lowest capacity in the state) is not. A similar phenomenon occurs with Goodhue and its contiguous counties. The status of a county may be driven more by the availability of beds in a more populous neighboring county than by its own bed availability. So low-bedded Anoka, adjacent to larger high-bedded Hennepin and Ramsey Counties will not meet the hardship test, while high-bedded Chisago, Isanti and Sherburne Counties, adjacent to a larger low-bedded county, Anoka, will meet the test.

The objective of identifying potential hardship counties may be better met by using criteria that recognize either low beds per 1,000 rates for both a county and its contiguous county group, or very low beds per 1,000 for a county regardless of contiguous counties.

Nursing Facility Utilization. With increasing numbers of elderly and declining numbers of nursing home beds, why is it that occupancy rates have remained relatively stable if not perhaps a bit soft? The answer lies in declining utilization. Nursing home utilization is a measure of how likely it is that a person will enter and stay (for any length of time) in a nursing home—namely the percent of people within an age group who are in a nursing home on a given day. The nursing home utilization rate for older persons in Minnesota has been declining for the past 20 years, and has continued to decline over the past two years. In 1984, the utilization rate for persons aged 65+ was 8.4 %, and by 2005, it had declined to 4.9 %—a 42 % drop. The utilization rate for people age 85+ dropped even more dramatically, by 52%.

Nursing Home Utilization Rates in Selected Years from 1984 - 2002 for Persons 65+ and 85+ in Minnesota								
			(Restated)*					(Restated)*
Year	65+ Utilization	Annual Rate of Change	65+ Utilization	Annual Rate of Change	85+ Utilization	Annual Rate of Change	85+ Utilization	Annual Rate of Change
1984	8.4%				36.4%			
1987	8.1%	-1.2%			35.1%	-1.2%		
1989	7.8%	-1.9%			33.4%	-2.4%		
1993	7.6%	-0.6%			30.8%	-1.9%		
1994	7.1%	-6.6%			28.7%	-6.8%		
1996	6.9%	-1.4%			28.2%	-0.9%		
1998	6.1%	-5.8%			24.3%	-6.9%		
2000	6.1%	0.0%	5.84%		22.3%	-4.1%	22.8%	
2001	5.8%	-2.5%	5.59%	-2.2%	22.0%	-0.6%	21.3%	-3.3%
2002			5.52%	-0.6%			20.6%	-1.6%
2005			4.92%	-2.8%			17.4%	-4.2%

Source: Residents – MDH and DHS; Population – US Census Bureau
*Beginning in 2002, it was necessary to restate the utilization rate because the data source used to compute this rate was no longer available when the Minnesota case mix system was replaced with the RUGS system.

D. Future Industry Size--Projections

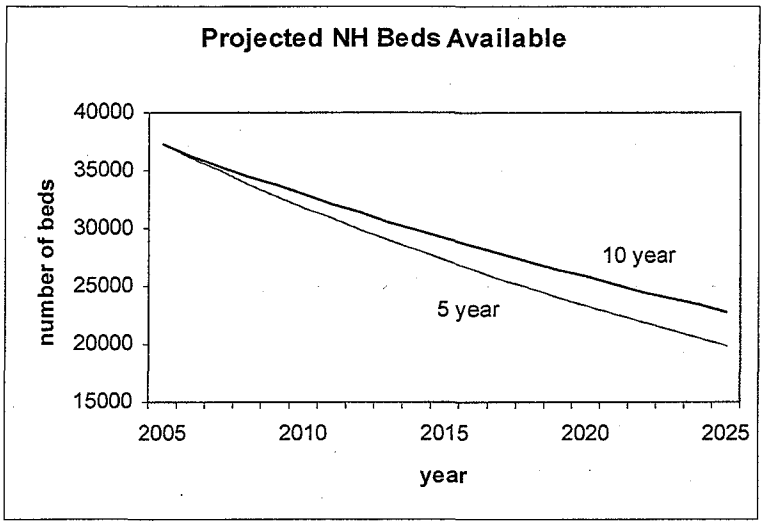
One of the questions that must be addressed in this report is whether the state continues to be over-bedded, has an adequate supply of nursing home beds for the foreseeable future or if additional beds will be needed. DHS first looked at projected bed availability based upon changes in the number of beds, then projected bed need based upon changes in the rate of utilization of nursing home services and of population, and then combined these two projections.

Projected availability based on changes in the number of beds. As we have seen, the number of nursing home beds in Minnesota has been decreasing at an accelerating rate. To project the number of beds needed in the future, staff developed two different scenarios. These scenarios chart future bed supply based on the average change in the number of beds over the last ten years and the last five years. The five-year trend is steeper, because of the accelerating rate of bed delicensure.

Projecting Number of Nursing Home Beds Available in Minnesota 2005-2025

	10-Year Trend	5-Year Trend
2005*	37,182	37,182
2010	32,912	31,808
2015	29,133	27,210
2020	25,788	23,278
2025	22,826	19,913

*2005 = actual number of beds



Using the ten-year trend line, we project delicensure or layaway of 2.41% of nursing home beds per year, resulting in about 33,000 beds in 2010 and 23,000 beds in 2025. Using the five-year line, we project delicensure or layaway of 3.07% of nursing home beds per year, resulting in about 32,000 beds in 2010 and 20,000 in 2025.

Projected need based on the changing utilization rate of nursing home services and population estimates. Utilization rates have been falling for many years. Nonetheless, if we were to assume that the rate of nursing home bed utilization would level off at the 2005 rate of 4.9% for the 65+ age group, the need for beds would increase steadily due to growth in the elderly population and would surpass current supply as soon as 2007, assuming occupancy does not exceed the record high of 95.68% in 1993.

But, because of the decline in disability rates, shorter nursing home stays, and increasing utilization of alternatives to nursing home services, we expect that the nursing home utilization rate will continue to exhibit the trend we have seen for many years.

Assuming then, that utilization rates will continue to decline, the question is, will the pattern of recent declines continue or will a longer-term average be more likely? And then, what does that mean for the number of nursing home beds that will be needed?

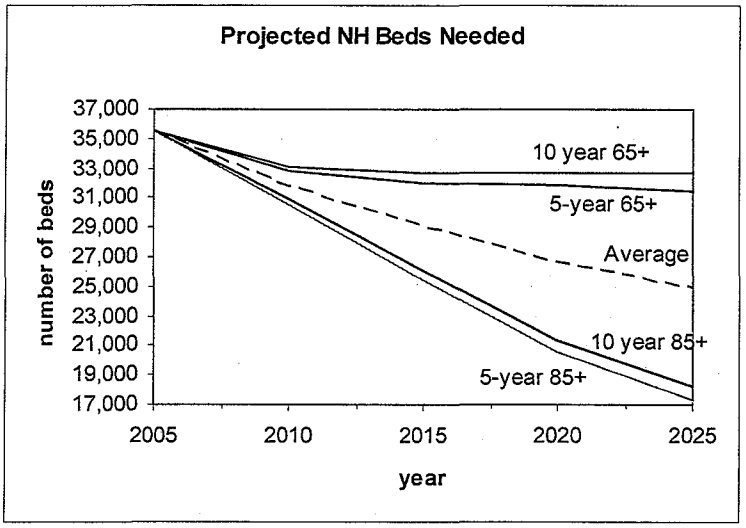
To answer these questions, DHS projected nursing home utilization rates for persons 65+ and 85+ out to 2025 using trends in the utilization rate from the most recent five years and the most recent ten years, and then applying population estimates to the utilization estimates[11] to project future nursing home bed need.

The table on the next page shows these projections—from 2005 to 2025—based on both 5- and 10-year averages, and on both 65+ and 85+ population projections.

[11] Because of the necessity to re-state utilization rates in 2002, the 10-year trend line was calculated using both data sources and the older data points are adjusted based on a comparison of overlapping reporting periods. DHS uses U.S. Census population projections, and the assumptions that 91% of all nursing home residents will continue to be 65+, 52% will continue to be 85+, and that there is a maximum occupancy rate of 95.68 %.

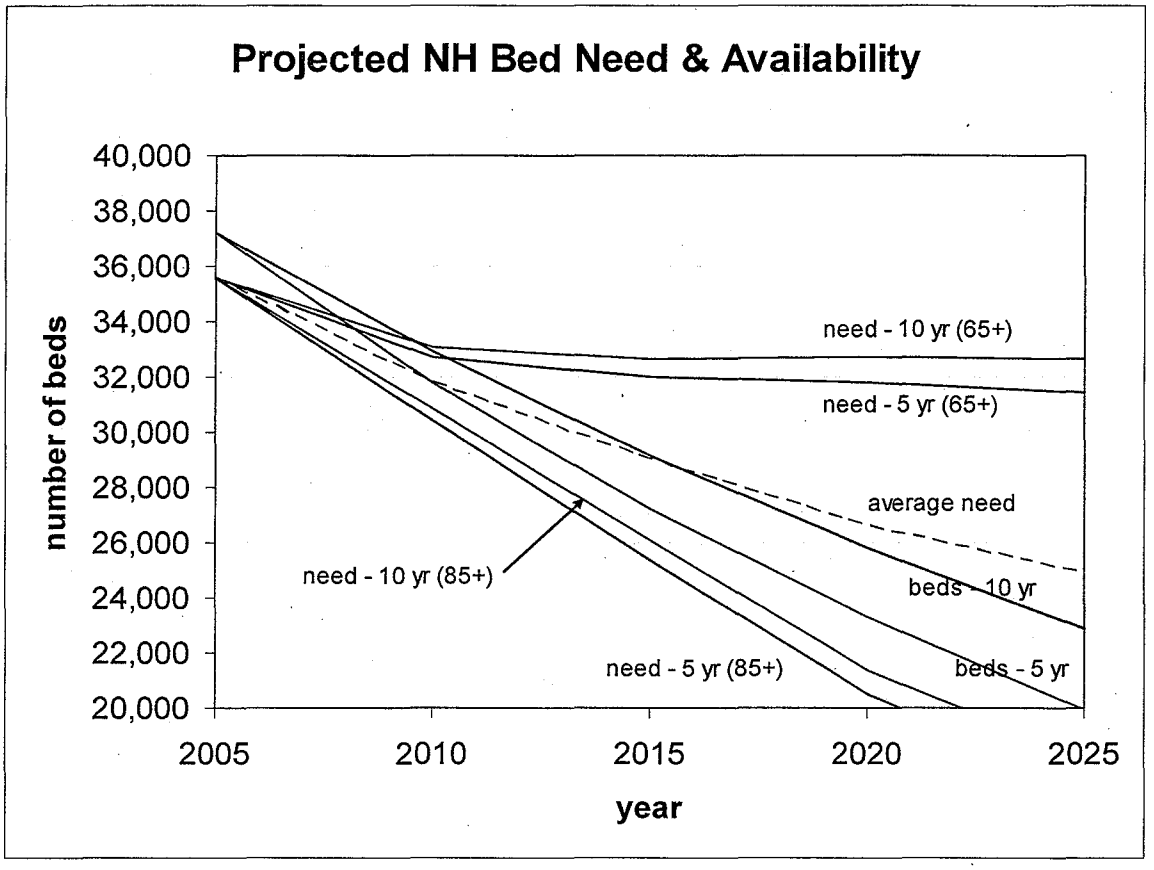
Projecting Number of Nursing Home Beds Needed
Minnesota: 2005-2025

	10-year trend (65+)	5-year trend (65+)	10-year trend (85+)	5-year trend (85+)
2005	35,538	35,538	35,538	35,538
2010	33,066	32,750	30,881	30,462
2015	32,613	31,992	26,053	25,350
2020	32,733	31,802	21,332	20,474
2025	32,629	31,398	18,243	17,272



For both the 65+ and the 85+ populations, the five year trend line is steeper, but the difference between them is slight. However the difference between the trend line for the 65+ and 85+ populations is quite large. Therefore, we also present a line called "Average Need" projection, which represents the average of all four Projected Nursing Home Bed Need lines.

The final step of this analysis is to lay the bed availability projection on top of the bed need projection. The chart on the following page shows all four "need" projections (and the "average need" composite) overlaid on the projected number of beds based on the historic rate of bed reductions in Minnesota.



We start with a surplus, as of 2005, of 1644 beds. Given long standing trends in bed availability and bed need, do we see a greater likelihood of continuing to have a surplus of beds? Will we have a shortfall? or will supply and need decline in parallel with each other? The answer appears to depend on which set of bed need projections are better. When we use the bed need projections for the 85+ population, our bed surplus will actually grow somewhat. However, when we use the bed need projections for the 65+ population we encounter a bed shortage in about 2009.

A cautious conclusion would be that the likely bed need will in reality be between the 65+ and 85+ projections and that a shortage of beds is unlikely to be seen, except in isolated regions of the state, before about 2015. It would be wise to closely watch the status of availability and need for nursing home beds and be prepared to intervene before a shortage occurs. The rate of bed closure is likely influenced by the three incentive programs the state has to encourage nursing homes to take beds out of service (layaway, planned closure and single bed incentive), and could be slowed by suspending those programs. We may also be approaching a time where the addition of limited numbers of new beds in the regions of the state with the lowest bed availability needs to be considered.

VI. Minnesota Department of Health

The Minnesota Department of Health (MDH) is primarily responsible for many elements of the state's overall long-term care strategy. These are described in the individual sections of this report. However this section summarizes major activities that have been the MDH focus since the last LTC Report.

A. Long-Term Care Quality Assurance

The Minnesota Department of Health strengthened supervisory and internal communication processes to promote consistent administration and application of the nursing home licensing and certification survey process. During 2005, MDH made progress in narrowing variation across districts in the average and median number of deficiencies issued per nursing home survey. MDH is working to understand factors that contribute to variations in deficiencies, and is collaborating with Stratis Health, providers, and advocates, to promote improvements in long term care regulatory compliance and quality of care. MDH and members of the Long Term Care Issues Ad Hoc Committee are preparing an educational video to promote understanding of the nursing home survey process. A regional stakeholders group in the Northeast region of the state met monthly and developed educational presentations on the survey process that have been presented regionally and to statewide meetings. MDH participated in joint training for MDH staff, provider staff, consumers, and advocates, on new surveyor guidance for pressure ulcer prevention, and for urinary incontinence and catheter care.

The federal government has adopted National Fire Protection Association Standard 101 (Life Safety Code, 2000 Edition) as the minimum standard for fire and life safety in all certified health care facilities. Life Safety Code (LSC) surveys are conducted by the State Fire Marshall Division under contract with the Minnesota Department of Health. All states experienced an increase in Federal Monitoring Surveys in 2005. These monitoring surveys resulted in a significant number of LSC deficiencies. The state fire marshal and MDH have adjusted their approach to more closely follow the approach used by CMS. This has resulted in a significant increase in the number of LSC deficiencies issued to long-term care facilities. The state fire marshal and MDH have communicated these changes to the provider community by letter, and in five training seminars presented to providers and surveyors by a national fire safety expert. The training sessions were funded by Civil Money Penalty (CMP) funds collected from nursing homes that have been found to be out of compliance with federal requirements.

Case Mix Review began licensing surveys of Assisted Living Home Care Providers (ALHCP) in June, 2004 and began licensing surveys of Class A Home Care Agencies on June 1, 2005. Licensing and Certification continues to perform federal certification surveys for Medicare certified home care agencies. As of January 11, 2006, 311 of the state's 471 licensed ALHCP agencies have been surveyed, and 146 have had a follow-up survey. As of January 11, 2006, 51 of the state's 400 Class A Home Care agencies have been surveyed. Both types of agencies will be re-surveyed every 18 to 24 months.

B. Nursing Home Capacity

A winter 2006 moratorium exception round was opened November 21, 2005 with applications due February 17, 2006, for nursing homes and certified boarding care homes. Priority for projects was to complete building replacement in conjunction with reductions in the number of beds in a county (with greater weight given to projects in counties with a greater than average number of beds per 1,000 elderly); technology improvements; improvements in life safety; construction of nursing facilities that are part of senior services campuses; and improvements in the work environment. There was $1.5 million in MA funding available for this round.

C. Consumer Information

Minnesota's Nursing Home Report Card,[12] developed in collaboration with DHS, with input from long term care researcher Dr. Robert Kane, and provider and advocacy representatives, became operational on the MDH website on January 20, 2006. The Report Card uses multiple measures of quality, and incorporates sophisticated risk adjustments to compare facilities fairly. Consumers can compare nursing homes on eight quality measures. (These are described on page 16 of this Report).

Each nursing home can receive from one to five stars on each measure. The report card Web site also contains a number of links to other sources of information consumers may find helpful in choosing a home. The Web address for the Report Card is:
www.health.state.mn.us/nhreportcard

[12] More information on the methodology behind this instrument is available in an earlier section of this report, Nursing Home Quality issues, pages 16-19.

VII. Reducing Future Need for Long-Term Care

A. Health Promotion and Disability Prevention

In terms of preventing future disability, new initiatives are underway to provide evidence-based disability-reduction programs across the state. The Minnesota Department of Health is funded by the Center for Disease Control to spearhead a project to reduce the negative effects of arthritis among elderly, and the Minnesota Board on Aging received a grant from the Administration on Aging to promote a statewide falls prevention program. Numerous health plans are also exploring new evidence-based programs to improve health and reduce disability rates among enrolled persons. While it is too early to project the outcome of these programs, it is clear that there is momentum across several sectors to reduce future long-term care needs and costs.

As noted in earlier reports, Minnesota has a long track record of innovation in integrating long-term care and acute care. This integration is increasingly important because persons with multiple chronic conditions consume over 90% of all Medicare and Medicaid expenditures. It is assumed that better chronic care management will result in improved quality of life for persons with chronic illnesses and cost savings to the health care budget.

Service delivery models that promise better chronic care management include managed care plans such as Minnesota Senior Health Options (MSHO), because they deliver all Medicare and Medicaid benefits to persons who are both Medicare and Medicaid eligible. As noted earlier, there has been a significant increase in the number and proportion of publicly-funded older persons enrolled in managed care models in Minnesota, in 2005 because of the passive enrollment of Elderly Waiver clients into Pre-Paid Medical Assistance Programs (PMAP) and changes in Medicare Part D which allow provision of prescription drug benefits through a managed care model.

VIII. Access to Information and Assistance

The expectations of older persons and their families regarding "aging" and the kinds of help and support that *should be available* are changing. Increasingly, people are seeking more home and community-based services instead of institutional models of care. They want to remain in their homes and choose the services they need to maintain independence. Because consumers generally do not seek out information about "long-term care" until a crisis occurs, the 2001 long-term care reform legislation included a multi-pronged approach to improve consumer information and assistance so that it can respond in real time to the need for information.

A. Information and Assistance Improvements

The Minnesota Board on Aging has provided information and assistance through the AAAs for several years. In response to the 2001 legislation, the MBA developed an easy-to-use website called MinnesotaHelp.info. It also improved the quality of service provided through its Senior LinkAge Line®, expanded a toll-free telephone information and assistance service available throughout the state, and improved linkages between the Senior LinkAge Line® and the assessment, screening and eligibility determination functions of the counties.

B. Long-Term Care Consultation Services

In Minnesota, the counties' Long-Term Care Consultation (LTCC) programs are designed to provide an objective assessment as well as options for the person and her/his family to consider—including home health agency services. Recent legislative changes include expanding the counties' responsibilities to provide broader "consultation" services to older persons of all income levels faced with long-term care issues.

County LTCC staff provided screenings to about 65,000 people 65+ and 22,000 persons under 65 in 2002. About 89% of the screenings and about 60% of the community visits were provided to persons 65+. About 70% of the persons visited in institutions were under age 65, in part because of legislation that required early follow-up visits for people under 65 admitted to nursing facilities.

C. One-Stop Aging and Disability Resource Centers

A consortium of agencies including DHS, Hennepin County, the Metropolitan Center for Independent Living, the Metropolitan Area Agency on Aging, and the University of Minnesota Center for Aging received a federal grant in late 2003 to improve consumer access to services. Among other things, it included the creation of four resource centers in Hennepin County, additional professional and consumer linkages with www.minnesotahelp.info, a management information system that links to county billing systems, and expanded access to screening options for caregivers and professional helpers.

These efforts will more closely coordinate the many components of Minnesota's highly regarded information and assistance system, improve consumer access to information about long-term

care services and offer this information in a wide variety of formats. This work will move us closer to achieving Minnesota's goal of "no wrong door" for consumers desiring to find out about their options, obtain information about specific providers, and make their own decisions about long-term care services.

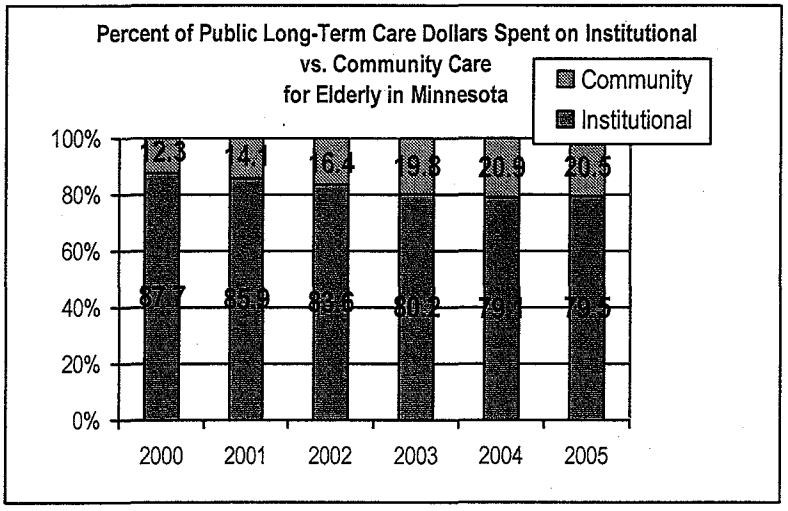
In May 2006, a new web-based tool was launched to help consumers navigate the complex array of long-term care choices. *Long-term Care Choices* is a step-by-step tool created to help individuals, in particular older adults, figure out what they need to live well and age well. The site also guides older adults and caregivers to resources in their community, as well as creates a personalized plan for individuals in need of extra help. The Long-term Care Choices tool is online at longtermcarechoices.minnesotahelp.info.

IX. Long-Term Care Benchmarks

In 2001, five benchmarks were identified to measure the state's progress toward rebalancing the long-term care system as called for in the state's long-term care reform. These benchmarks are described below, with the most recent measures included.

Benchmark #1

Percent of public long-term care dollars spent on institutional vs. community care for persons 65+.



What does this benchmark measure? It measures the relative proportion of the state's and each county's total long-term care budget spent for nursing home care and community care for persons 65+. Community care includes expenditures in the Elderly Waiver, Alternative Care and the Medical Assistance home care programs, and institutional care includes MA expenditures for nursing facility care.

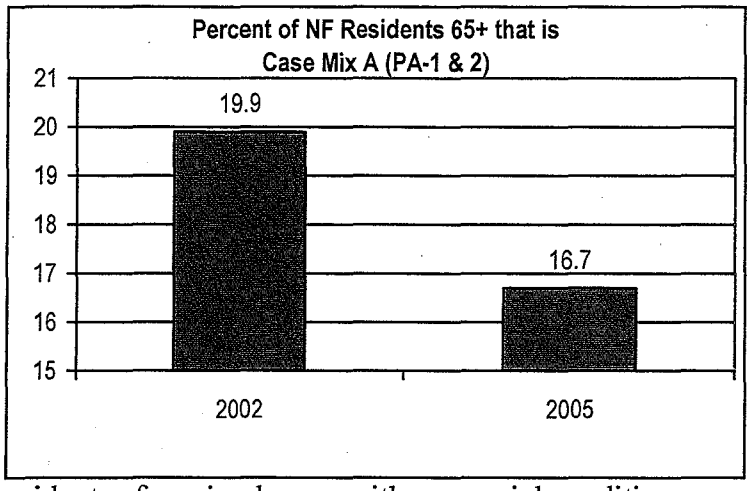
Why is this important? Minnesota's use of nursing home care is higher than the national average, and as we reduce our reliance on nursing homes, we will reduce the proportion of public long-term care dollars spent on nursing home care and increase the proportion spent on community care. This benchmark allows us to compare each county with statewide averages, and compare Minnesota to other states in the country.

Where do we stand? In 2004, our statewide proportion of total long-term care expenditures for the elderly was 79/21of expenditures on nursing home care vs. community care. The ratio has continued to shift since 2001, when it stood at 86/14. There is wide variation among the state's 87 counties in the ratio of institutional to community care expenditures, ranging from 69.9/30.1 in Itasca County to 95.7/04.3 in Cook County. This compares to a 70/30 ratio for the United States as a whole.[13]

[13] Williams, C.G . (2005) *Introduction to Health Care Policy: A Seminar for State Legislators,* AHRQ.

Benchmark #2

Percent of nursing home residents 65+ that is *low acuity.*



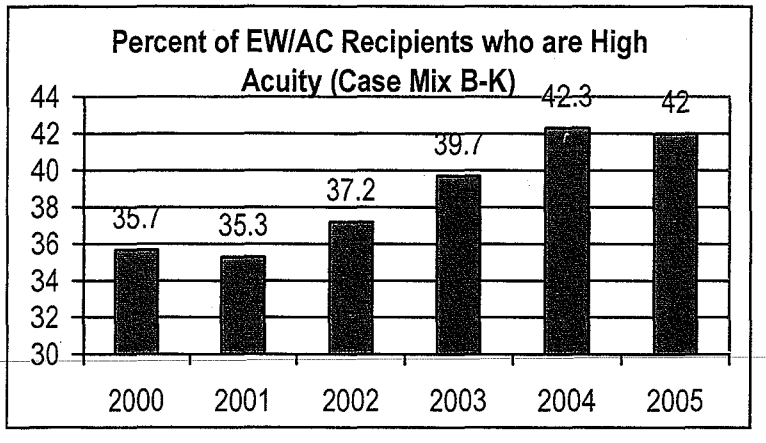
What does this benchmark measure? It measures the percent of the less disabled older people being served in nursing homes, i.e., those elderly with "case mix A" level of ADLs. Because the state's case mix system was replaced with the RUGS system in October 2002, this benchmark has been redefined using measures in the new system. Beginning in 2002, this measure is now called "PA-1 & PA-2" instead of "case mix A." It is defined as residents of nursing homes with no special conditions, no nursing rehab needs, and an ADL count of 4 – 5.

Why is this important? In order to reduce our reliance on nursing homes, we need to examine the way we use nursing homes, especially for older people with fewer needs who could be maintained in the community if proper support services were available.

Where do we stand? In 2002, the overall state proportion of nursing home residents that was *low acuity* was 19.8%. By 2005, this percent has gone down to 16.7%, indicating that a smaller proportion of those served in nursing facilities are light care individuals. This indicates that more disabled older people are being served in our nursing facilities, and that less disabled individuals are able to receive needed assistance in other settings.

Benchmark #3

Percent of Elderly Waiver and Alternative Care recipients that is *high acuity*

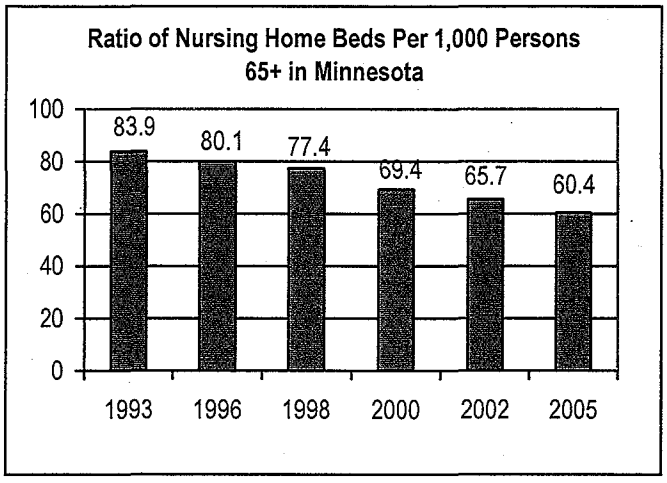


What does this benchmark measure? It measures the percent of the elderly served in Elderly Waiver and Alternative Care programs who are more disabled and need more intensive services because of greater difficulties with ADLs.

Why is this important? In order to reduce our reliance on nursing homes, we need home and community care options that can support more disabled frail elderly in their homes or apartments.

Where do we stand? In 2004 and 2005, the statewide proportion of elderly served in the community care programs that had case mix scores of B - K was 42 %. This is an increase from 2003 when 39 % of clients was at higher case mix levels. Again, there is wide variation among counties in this measure, ranging from 5.2 % in Kittson County to 75.2 % in Scott County.

Benchmark #4
Ratio of nursing home beds per 1000 persons 65+.



What does this benchmark measure? It measures the current number of nursing home beds and computes the ratio of nursing home beds to the current population 65+. It allows a consistent comparison of the relative supply of nursing home beds in a particular geographical area.

Why is this important? Minnesota's ratio of nursing home beds per 1000 has been higher than the national average, and we are trying to reduce our reliance on nursing homes. This measure helps us compare the supply of beds to the population, and monitor how this changes over time, as more community options are put in place.

Where do we stand? In 2005, our statewide ratio of beds was 60.4 beds per 1000 persons 65+. The rate has been steadily declining since 1987, and has reached an historic low. However, there is wide variation among counties, with the ratio ranging from 127.2 in Norman County to 20.7 in Anoka County.

X. Conclusions and Future Challenges

A. Progress in Long-Term Care Reform

There has been significant progress toward long-term care "rebalancing," a strategy initiated by the Legislative Long-Term Care Task Force and set in motion by the State Legislature in 2001. The data in Benchmark #1 show a gradual but steady increase in the proportion of state LTC dollars spent on community-based services and supports—from a ratio of 88/12 (nursing home to home care expenditures) in 2000, to 79/21 in 2004. Part of this has been accomplished through efforts to help the less frail to support themselves in their own homes and apartments. The proportion of the "less frail" residing in nursing homes (Benchmark #2) shows a slight decrease—from about 20% of nursing home residents in 2002 to under 17% in 2005.

In order to provide realistic alternatives to nursing home care, the new community options must be able to truly support frail persons. Minnesota has seen a significant increase in the proportion of public LTC clients who are "more frail" and yet supported in their own homes and apartments (Benchmark #3), from about 36% of home- and community-based elderly in 2000 to 42% in 2995.

Finally, Minnesota continues to make progress in reducing its nursing home capacity as measured by number of beds per 1,000 persons age 65+—once among the highest rates in the country. The number of nursing home beds per1,000 persons age 65+ in the state has decreased from 84 in 1993 to 60 in 2005, and the beds per 1,000 persons 85+ in the state is actually lower than the national average.

B. Non-Institutional Long-Term Care Capacity

The basic challenge to supporting persons in non-institutional settings is having local service and support "capacity" to do so. Minnesota's targeted strategies to develop and strengthen these resources have been an unqualified success. State surveys of service "gaps" show that in each successive year, there are fewer counties reporting significant gaps. New services and approaches to supporting older people and their families have been developed in virtually every county in the state. Even the previously "intractable" service needs, such as transportation, have seen improvement in availability and accessibility. This is not to say that these resources are equitably distributed across the state, but there has been significant progress on almost all fronts. Some of the significant issues for the next few years in this area include:

- New emphasis on supporting family caregivers to be able to continue to provide the support needed by their parents and spouses, but also to improve the care that they are able to provide.
- New service models that capitalize on the increasing ability (and willingness) of older persons and their families to pay for the services they need.
- New, *sustainable* service models that use technologies to maximize the effectiveness of limited staff and to reduce administrative costs.
- Acknowledged role of faith-based and civic-based models for a wider range of supportive services.

C. Quality Assurance and Adult Protection

As a larger proportion of older people are able to live more independently in their own homes and apartments, the *locus* of long-term care has become decentralized throughout the entire community. Most current mechanisms for ensuring quality and accountability were not designed for this new reality. New mechanisms must be developed that are effective in this service-diffuse environment, where the care team is likely to include family members. It is already apparent that the ability of counties to meet the requirements for protection of vulnerable adults are strained. New or redesigned Adult Protection functions will be necessary.

D. Managed Care

Elderly MA recipients are in managed care in all but four counties in Minnesota. In addition, approximately 10,000 Elderly Waiver clients (61%) are currently receiving EW services through managed care (either through MSHO or the Minnesota Senior Care Plus managed health plans). The strategy of increasing the service integration for these "dual eligibles"(i.e., eligible for both for Medicare and Medicaid) promises improved chronic care management, better integrated health and social support services, fewer health care crises, and consequently lower costs. It will be increasingly important for the state to monitor the resulting improvements in service quality (care management and crisis reduction) as well as the cost. Following up a 2004 Legislative Study on evidence-based practice, the state should continue to ensure that state health care practices increasingly reflect the latest evidence-based care protocols, not only in hospital and acute care, but also in chronic care management and long-term care.

E. Assisted Living (and Other Housing Options)

There are now over 1,000 senior housing projects in Minnesota that offer some services to older persons who live there. We now have more than twice as many of these new "housing with service" facilities than we have nursing homes in the state. Legislation in 2006 set standards for use of the phrase "Assisted Living" when marketing to older persons and their families. At this time, there is still no agreed-upon uniform disclosure mechanism to help consumers compare among providers, although this is a high priority issue among consumers.

F. Changing Role of the Nursing Home

The number of Nursing Home facilities and number of beds in Minnesota nursing homes is continuing to decrease. Both the Minnesota Department of Health and the Department of Human Services have focused on three issues:

- Improved consumer information—the Minnesota Nursing Home Report Card allows consumers to compare among nursing homes on the basis of several standard measures of quality.
- Reimbursement strategies that provide incentives for quality care.
- Strategies to continue to "right-size" the nursing home industry, and to objectively forecast future need.

Future challenges will be to "refine" the strategies used to control nursing home growth to accommodate distributional inequities and to ensure that payment mechanisms provide

incentives for both effective as well as efficient care. The following recommendations address nursing home "bed supply" capacity:

1. Permit the Commissioner to suspend one or more of the bed closure incentive programs on a regional or statewide basis, if and when the *supply* of beds approaches the *projected need* for nursing home beds, and to re-activate those incentive programs in the event that the surplus of beds begins to grow.
2. Revise the hardship county exception to the moratorium to allow construction of new beds in counties with the lowest beds/1,000 persons age 65+ ratios.
3. Develop refinements to the Minnesota Nursing Home Report Card to include an environmental assessment or a measure of family satisfaction.
4. Extend the quality add-on payment.
5. Implement the Performance Incentive Payment Program.

G. Larger, Demographic and Cultural Issues

Project *Transform 2010* is a statewide effort to begin to anticipate the significant challenges of changing population dynamics, namely, the aging of the Boomer cohort. It is abundantly clear that if we do nothing to change current trends, the magnitude of potential demand for long-term care far exceeds the future ability of the state to provide it. The Department of Human Services has identified nine strategic actions that are specifically related to long-term care:

1. Encourage Minnesotans to lead healthy lives and prepare for their retirement.
2. Support families as they care for their older relatives.
3. Create livable communities that are supportive for a lifetime.
4. Transform the fragmented and separate systems of health and long-term care into an integrated model that improves quality, access and chronic care management.
5. Transform the long-term care system from a paternalistic model to one that is consumer-centered and family-centered.
6. Strengthen our consumer protection systems to support the growing numbers of older persons that receive services in their homes.
7. Make these changes in ways that respect cultural and ethnic differences and that improve access for older persons with communication, hearing, visual, physical or mental disabilities.
8. Recruit and retain a stable work force for aging services, with the geriatric training and competence to provide high quality care to older persons.
9. Maximize the use of technology to redesign systems, provide efficient services and make best use of limited resources.

As noted in this Report, the State is already moving forward on many of these fronts. The challenge will be to maintain the momentum and Keep the Vision.

Minnesota Department of Human Services
7-06