INFORMATION BRIEF
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Long-Term Care Services for the Elderly

Elderly people in Minnesota can receive services from Medical Assistance and other state programs. This information brief summarizes Medical Assistance eligibility for persons who are elderly (age 65 and over) and describes home care, elderly waiver, nursing facility, and other MA services commonly used by persons who are elderly. The information brief also describes the following state programs for the elderly—Long-Term Care Consultation Services, Alternative Care, Group Residential Housing, and programs administered by the Minnesota Board on Aging.

Contents

Overview of Medical Assistance

Medical Assistance (MA), the state's Medicaid program, provides payment for health care services provided to low-income persons who belong to an eligible group, and who meet income and asset limits and other eligibility requirements.

Eligible groups include the elderly, persons with disabilities or who are blind, families and children, and pregnant women. MA income and asset limits vary across the different eligibility groups.

The federal government pays a share of the cost of state MA expenditures. This is referred to as the federal medical assistance percentage (FMAP). Minnesota's FMAP for covered services is 50 percent. Minnesota pays the remaining 50 percent for most services (some services have a county share).[1]

Eligibility for the Elderly

In order to be eligible for full coverage of MA services as elderly, an individual must:

- Be age 65 or older;
- Have net income that does not exceed the program income limit for the elderly of 100 percent of FPG ($851/month for one-person households and $1,141/month for two-person households);[2]
- Meet the program asset limit of $3,000 for an individual and $6,000 for two persons in a household, with $200 added for each additional dependent[3] (The homestead, household goods, and other specified items are not considered assets when determining eligibility); and
- Meet requirements related to citizenship and residency.

Individuals who do not meet the MA income limit may qualify through a spenddown. An individual who is elderly can qualify under a spenddown by incurring medical bills in an amount that is greater than the amount by which his or her income exceeds the MA spenddown limit for the elderly of 75 percent of FPG ($639/month for one-person households and $857/month for two-person households).

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[1] For example, counties are responsible for 20 percent of the cost of nursing facility placements of persons with disabilities under age 65 that exceed 90 days. For this and other required county shares, see Minnesota Statutes, section 256B.19, subdivision 1.

[2] The federal poverty guidelines are updated every year, usually in February. New DHS income standards based on the updated guidelines are effective July 1 of each year.

[3] In addition, if an applicant for MA payment of long-term care services has exhausted benefits under a private sector long-term care insurance policy issued on or after July 1, 2006, that qualifies under the state's long-term care partnership program, an amount of assets equal to the dollar amount of benefits paid out under the qualifying policy is disregarded for purposes of determining eligibility for MA payment of long-term care services. These assets are also protected against estate recovery and are not subject to asset transfer penalties.

Spousal Asset Division

When one spouse of a married couple seeks MA coverage for care in a nursing facility or other long-term care facility, or services under the Elderly Waiver, for a continuous period expected to last at least 30 consecutive days, the MA program divides the total assets of the married couple and calculates a protected spousal share for the spouse remaining in the community. The protected spousal share is equal to one-half of all nonexempt assets owned by either spouse, subject to a minimum and maximum amount set by law.[4]

The spouse remaining in the community can retain the protected spousal share. The spouse receiving long-term care services must reduce his or her assets to the MA asset limit of $3,000, but may in some cases transfer assets to the community spouse, either to bring the assets of the community spouse up to the spousal share minimum or to raise the income of the community spouse and dependent family members to specified minimum levels.

Eligibility for Medicare Cost-Sharing

Certain Medicare enrollees who do not meet the income and asset standards for full coverage of MA services are eligible for MA coverage of Medicare cost-sharing only. The table below summarizes MA coverage for these groups of Medicare enrollees.

Eligibility Category	Income Limit	Asset Limit	Medicare Cost-Sharing Coverage
Qualified Medicare Beneficiaries (QMBs)	≤ 100% FPG	$10,000 for households of one and $18,000 for households of two or more	Premiums, coinsurance, and deductibles for Medicare Parts A and B
Service Limited Medicare Beneficiaries (SLMBs)	> 100% but < 120% of FPG	Same as above	Medicare Part B premium only
Qualifying Individuals (QI) Group 1[5]	≥ 120% but < 135% of FPG	Same as above	Medicare Part B premium only
Qualified Working Disabled Adults	≤ 200% of FPG	Must not exceed twice the SSI asset limit	Medicare Part A premium only

Medicare enrollees who qualify for full coverage of MA services also qualify for coverage of Medicare cost-sharing as QMBs.

[4] For more information on the division of spousal assets, see the DHS brochure "Medical Assistance Program Information for People: Living in a Nursing Home or Getting Elderly Waiver Services," available on the DHS web site at http://edocs2.dhs.state.mn.us/lfserver/Legacy/DHS-2908-ENG.

[5] Eligibility for persons in this group is contingent on federal funding. Federal funding is scheduled to expire on December 31, 2007, unless re-authorized by the U.S. Congress.

MA Cost-Sharing

Federal law requires Medicaid cost-sharing to be "nominal." Cost-sharing does not apply to pregnant women and children, and other exceptions apply. Minnesota requires nonpregnant adults to pay the following copayments:

- $3 for nonpreventive visits
- $3 for eyeglasses
- $6 for nonemergency visits to a hospital ER
- $3 per brand name drug/$1 per generic ($12/month limit)

In Minnesota, the MA payment rate is reduced by the amount of the copayment. A recent district court ruling held that providers cannot deny services to enrollees who do not pay the copayment.[6]

MA Health Care Services for the Elderly

This section provides information on MA covered services and the managed care system under which most elderly MA enrollees receive services. This section also describes home care, personal care assistant services, Elderly Waiver, and nursing facility services in more detail.

MA Covered Services

MA enrollees who are elderly receive coverage for the standard MA covered services available to all other MA eligibility groups. MA benefits include federally mandated services and services provided at state option. In addition to covering standard medical services such as physician, inpatient hospital, dental, and therapy services, MA also covers many services used heavily by elderly persons. These include the following:

- Nursing facility services
- Home health care
- Personal care assistant services
- Private duty nursing
- Prescription drugs

Medicare serves as the primary payor and MA as the secondary payor, for elderly (and disabled) MA enrollees who are also enrolled in Medicare. As secondary payor, MA pays only for those services not covered by Medicare and also for any Medicare cost-sharing obligations.

[6] Minnesota Statutes, section 256B.0631, subdivision 4, allowed providers who routinely refused services to individuals with uncollected bad debt to include uncollected copayments as bad debt and deny services to enrollees. On September 15, 2005, the Ramsey County District Court ruled that this provision was preempted by federal law (*Dahl et. al. v. Goodno*, court file number C9-04-7537). This provision will be repealed January 1, 2009.

Service Delivery Through Managed Care

MA enrollees who are elderly are required to receive health care services from prepaid health plans through Minnesota Senior Care or Minnesota Senior Care Plus, depending on their county of residence,[7] and have the option of receiving services through Minnesota Senior Health Options (MSHO).

Minnesota Senior Care replaced PMAP for elderly enrollees effective June 1, 2005. Minnesota Senior Care covers all the same services as PMAP, except that prescription drugs for MA enrollees also eligible for Medicare are covered by Medicare Part D.[8] In addition, Minnesota Senior Care covers 90 days of nursing home services for enrollees not residing in a nursing facility at the time of enrollment.

Minnesota Senior Care Plus has provided services to elderly enrollees enrolled in county-based purchasing initiatives since June 1, 2005. In addition to covering all Minnesota Senior Care services, Minnesota Senior Care Plus also covers elderly waiver services and an additional 90 days of nursing home services (for a total of 180 days) for enrollees not residing in a nursing facility at the time of enrollment. Minnesota Senior Care Plus is being expanded to all counties and participating health plans, except the seven-county metropolitan area, effective January 2008.

Elderly enrollees in Minnesota Senior Care and Minnesota Senior Care Plus must enroll in a separate Medicare plan to obtain their prescription drug coverage under Medicare Part D. However, elderly enrollees also have the option of receiving managed care services through the Minnesota Senior Health Options (MSHO), rather than Minnesota Senior Care or Minnesota Senior Care Plus. MSHO includes all Medicare and MA prescription drug coverage under one plan. Since 1997, MSHO provided a combined Medicare and MA benefit as part of a federal demonstration project; the program now operates under federal Medicare Special Needs Plan (SNP) authority.[9] DHS also contracts with SNPs to provide MA services. Enrollment in MSHO is voluntary. As is the case with Minnesota Senior Care Plus, MSHO also covers elderly waiver services and 180 days of nursing home services. MSHO expanded statewide to 83 counties in 2005. Most elderly MA enrollees are enrolled in MSHO rather than Minnesota Senior Care or Minnesota Senior Care Plus because of the integrated Medicare and MA prescription drug coverage. As of August 1, 2007, MSHO enrollment was 35,500, compared to a combined enrollment in Minnesota Senior Care and Minnesota Senior Care Plus of 10,700.

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[7] The use of prepaid health plans to deliver MA services to enrollees who are elderly or in families with children has been phased in by county. As of September 2007, only four counties have not converted to prepaid health care delivery.

[8] Since January 1, 2006, MA has not covered prescription drugs covered under the Medicare Part D prescription drug benefit for individuals enrolled in both MA and Medicare (referred to as "dual eligibilities"). These individuals are instead eligible for prescription drug coverage under Medicare Part D. MA continues to cover certain drug types not covered under the Medicare prescription drug benefit, such as over-the-counter drugs for coughs and colds and certain vitamin and mineral products.

[9] A Medicare Special Needs Plan is a Medicare managed care plan that is allowed to serve only certain Medicare populations, such as institutionalized enrollees, dually eligible enrollees, and enrollees who are severely chronically ill and disabled. SNPs must provide all Medicare services, including prescription drug coverage.

Health Care Services

Home care provides medical and health-related services and assistance with day-to-day activities to people in their homes. Home care can also be used to provide short-term care for people moving from a hospital or nursing home back to their home and can also be used to provide continuing care to people with ongoing needs. Home care services may be provided outside a person's home when normal life activities take the individual away from home.

Home care services provided to MA enrollees must be:

- medically necessary;
- ordered by a licensed physician;
- documented in a written service plan;
- provided at a recipient's residence (not a hospital or long-term care facility); and
- provided by a Medicare-certified agency.

A registered nurse from a Medicare-certified home health agency completes an assessment to determine the need for service. The assessment identifies the needs of the person, determines the outcomes for a visit, is documented, and includes a plan. Most home care services must be prior authorized. The maximum benefit level is one visit per day for home health aide services, one visit per discipline per day for therapies (except respiratory therapy), and two visits per day for skilled nurse visits.

Home care services include the following:

- Intermittent home health aide visits provided by a certified home health aide
- Medically oriented tasks to maintain health or to facilitate treatment of an illness or injury provided in a person's place of residence
- Personal care assistant (PCA) services
- Private duty nursing (PDN)
- Therapies (occupational, physical, respiratory, speech)
- Intermittent skilled nurse visits provided by a licensed nurse
- Equipment and supplies

Sixty percent of home care, PCA, PDN, and home health agency recipients are MA nonwaiver recipients receiving home health and PCA/PDN services through a local public health agency; 40 percent are MA waiver recipients (mostly CAC and CADI waivers[10]) whose care is coordinated by counties in service plans.

Recent home care policy changes include allowing a recipient whose spouse is a licensed nurse to be paid to provide private duty nursing services in certain circumstances; allowing self-

[10] The Community Alternative Care (CAC) waiver provides community-based care to chronically ill persons under age 65 who are residing in a hospital or at risk of inpatient hospital care. The Community Alternatives for Disabled Individuals (CADI) waiver provides community-based care to disabled individuals under age 65 who are residing in, or at risk of placement in, a nursing facility.

employed PDNs to receive the same reimbursement rate as PDN agencies; defining complex and regular PDN; increasing skilled nurse visits from five to nine visits before a prior authorization is needed; increasing skilled nurse visit limit from one to two visits per day; reimbursing telehomecare skilled nurse visits;[11] allowing assistant therapists to be paid for home care services; and increasing the fiscal year 2006 reimbursement rate.

Home care program statistics (does not include managed care enrollees) for fiscal year 2006:

- Total expenditures: $28.4 million
- Monthly average recipients: 5,705
- Average monthly cost per recipient: $415

Personal Care Assistant (PCA) Services

Personal Care Assistants provide assistance and support to the elderly, persons with disabilities, and others with special health care needs living independently in the community.

In order for a person to receive PCA services, the services must be:

- medically necessary;
- authorized by a licensed physician;
- documented in a written service plan; and
- provided at the recipient's place of residence or other location (not a hospital or health care facility).

In addition, recipients of PCA services must be in stable medical condition and be able to direct their own care or have a responsible party who provides support.

The determination of the amount of service available to a person is based on the PCA assessment and a PCA decision tree that classifies individuals based on care needs. PCA services provided include the following:

- Assistance with activities of daily living (e.g., eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning)
- Assistance with instrumental activities of daily living (e.g., meal planning and preparation, managing finances, shopping for essential items, performing essential chores, communication, and participating in the community)
- Assistance with health-related functions
- Redirection and intervention for behavior including observation and monitoring

[11] Telehomecare allows a nurse to assess and communicate with a consumer using audiovisual technology and computer equipment, without being physically present in the consumer's home.

Recent PCA policy changes include adding choice of supervision for PCA services, removing the PCA hardship waiver, adding social workers as qualified professionals who can supervise a PCA, and making PCA hours available as flexible use. The 2005 Legislature adopted several provisions intended to tighten administration of the program. These included requiring a physician's statement of need in order to receive payment, requiring personal care provider organizations to meet certain standards, and requiring prior authorization of flexible use of hours.

PCA program statistics (includes private duty nursing, does not include managed care enrollees) for fiscal year 2006:

- Total expenditures: $323.6 million
- Monthly average recipients: 10,799
- Average monthly cost per recipient: $2,497

Elderly Waiver Services

The Elderly Waiver (EW) provides home and community-based services not normally covered under MA to MA enrollees who are at risk of nursing facility placement. In addition, EW recipients are eligible for all standard MA covered services.

In order to receive EW services, an enrollee must:

- be age 65 or older;
- have been screened by a long-term care consultation team, be determined by the team to need nursing facility level care, and choose community care; and
- meet the EW income standard.

In addition, the cost of EW services cannot exceed the estimated cost of nursing facility services.

The EW uses an income standard that is higher than the income standard used by the regular MA program. Individuals with incomes that do not exceed a special income standard of 300 percent of the Supplemental Security Income (SSI) level ($1,869/month[12]) are able to qualify for EW and regular MA services. These individuals must contribute any income above a maintenance needs allowance ($839/month[13]) towards the cost of EW services. This is referred to as the individual's waiver obligation. If the amount of income above the maintenance needs allowance is greater than the cost of EW services, individuals can retain any excess income that remains after the waiver obligation is met. No contribution is required towards the cost of regular MA services.

Individuals with incomes that do not exceed the maintenance needs allowance are eligible for EW and MA services without meeting a waiver obligation. Individuals with incomes that exceed

[12] The special income standard is adjusted each January 1. The dollar amount specified is effective for calendar year 2007.

[13] The maintenance needs allowance is adjusted each July 1. The dollar amount specified is effective for the period July 1, 2007, through June 30, 2008.

the special income standard must spenddown to the regular MA spenddown standard for the elderly of 75 percent of FPG ($639/month) to qualify for EW and MA services.

Services available through the EW include the following:

- Adult day care
- Assisted living
- Caregiver training and education
- Case management
- Chore, companion, and homemaker services
- Foster care
- Extended home care services
- Home-delivered meals
- Home modifications
- Nonmedical transportation
- Residential care
- Respite care
- Supplies and equipment
- Telehomecare
- Transitional supports

Consumer Directed Community Supports (CDCS) is an option available under the EW (and other home and community-based waivers and the Alternative Care program) that gives enrollees greater flexibility and control in developing a service plan, managing a budget, paying for services, and hiring and managing direct care staff. The service was made available in certain counties beginning in October 2004, and since April 1, 2005, has been available statewide.

As discussed in the section on managed care, EW services are increasingly being provided through the managed care system. As of March 2006, 61 percent of EW enrollees received services through the managed care system (either through MSHO or Minnesota Senior Care Plus) and 39 percent through the fee-for-service system.[14]

EW program statistics for fee-for-service enrollees for fiscal year 2006:

- Total expenditures: $111.7 million
- Monthly average recipients: 8,301
- Average monthly cost per recipient: $1,090

EW program statistics for managed care enrollees for fiscal year 2006:

- Total expenditures: $60.0 million
- Monthly average recipients: 5,934
- Average monthly cost per recipient: $961

[14] As reported in DHS, *Status of Long-Term Care in Minnesota 2005*, June 2006, p. 11.

Nursing Facility Services

Nursing facility services under MA are a package of room and board and nursing services. Acute care services such as hospitalization are paid for separately under MA; this is also usually the case for therapy and other ancillary services.

In order to be eligible for nursing facility care, an MA enrollee must:

- be screened by a long-term care consultation team; and
- be determined by the team to need nursing facility level care.

The screening team assigns each nursing facility resident one of 34 case-mix classifications under the Resource Utilization Groups (RUGs) case-mix system.[15] Each classification is assigned a weight that represents the amount of care needed. This weight is used in calculating reimbursement rates for nursing services.

MA recipients receiving care in nursing facilities are required to contribute most of their income towards the cost of care, except for a personal needs allowance of $82 as of January 1, 2007, and other allowed exclusions.

Nursing facilities are reimbursed by MA on a resident-per-day basis. The nursing home reimbursement levels are adjusted under the RUGS case-mix system to reflect the varying care needs of residents.

MA rates and private pay rates do not vary within a facility. This is due to Minnesota's equalization law, which prohibits nursing facilities from charging private pay residents more than residents whose care is paid for by MA.

Since October 1, 2006, all nursing facilities participating in MA have been reimbursed under the alternative payment system (APS), sometimes referred to as the contract system. APS was developed as an alternative to an existing cost-based system (sometimes referred to as Rule 50). Under the cost-based system, reimbursement to facilities was based upon their reported costs, and at times, certain limits applied to the rate of increase in operating costs. Under APS, facilities are exempt from certain requirements of the cost-based system and are reimbursed at the level of their payment rate in effect just prior to entering into an APS contract with the commissioner. These payment rates are adjusted annually for inflation, subject to limitations specified in law. Effective July 1, 1999, through September 30, 2011, the automatic inflation adjustment has been or will be applied only to the property-related rate; inflation adjustments for operating costs must be authorized by the legislature.

The 2007 Legislature required DHS to rebase nursing facility rates. Rebasing will allow nursing facilities to have new or currently unreimbursed expenditures recognized in the facility payment

[15] RUGS classifies nursing facility residents into 34 groups based on information collected using the federally required minimum data set. RUGS replaced the Minnesota-specific 11-group case-mix system on October 1, 2002. The RUGS case-mix reimbursement system for nursing homes is described in Minnesota Statutes, sections 144.0724 and 256B.438.

rate, subject to certain limits. The rebased operating cost payment rates will take effect October 1, 2008, and will be phased in over eight years, through the rate year beginning October 1, 2015. Property rates will be rebased beginning October 1, 2014. During the phase-in period, facilities will be held harmless— a facility cannot receive an operating cost payment rate that is less than what the facility would have received without rebasing.

The 2007 Legislature also eliminated the requirement that DHS establish and phase in a value-based nursing facility reimbursement system and provided nursing facilities with an operating payment rate increase of 1.87 percent for the rate year beginning October 1, 2007. Nursing facilities are also eligible to receive a quality add-on payment of up to .3 percent for the rate year beginning October 1, 2007. Whether a facility receives a quality add-on payment, and the amount of any payment, will depend on the facility's score on various quality measures.

MA nursing facility statistics for fiscal year 2006:

- Total expenditures: $841.9 million
- Monthly average recipients: 20,991
- Average monthly payment per recipient: $3,342
- Average payment per day: $117.26

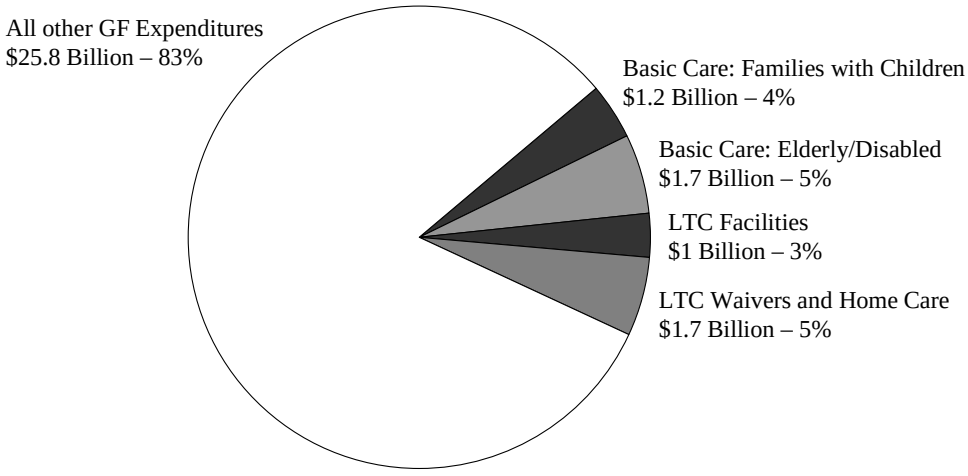
MA Long-Term Care Expenditures and Recipients

This section contains pie charts and bar graphs that highlight various aspects of MA long-term care spending. In figures 1 and 5 to 7, the long-term care facilities and long-term care waivers home care categories include both elderly and disabled MA enrollees.

Figure 1 shows state MA general fund expenditures by category and as a percentage of total general fund spending. During the 2006-2007 biennium, state MA general fund expenditures are projected to be $5.6 billion—17 percent of total state general fund expenditures. Spending on long-term care services for the elderly and disabled (both facility and community-based), will account for just under one-half of state general fund MA spending ($2.7 billion).

Figure 1

Medical Assistance General Fund Expenditures and Percent of Total General Fund Expenditures
FY 2006-07 Total GF Expenditures: $31.4 billion
FY 2006-07 Total State Share MA Expenditures: $5.6 billion

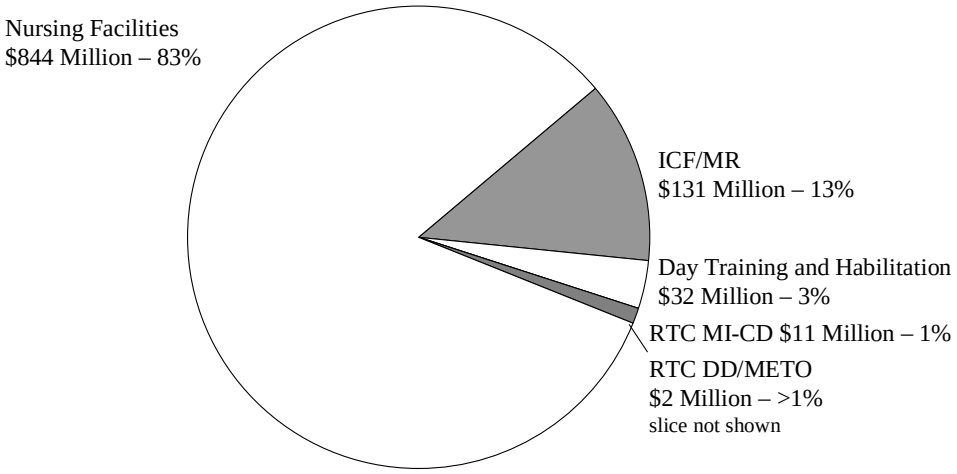


Source: House Fiscal Analysis Department

Figure 2 shows MA long-term care (LTC) facility spending by category. Spending for nursing facility services is projected to account for over three-quarters of total state MA spending for LTC facility services of $1 billion for the 2006-2007 biennium.

Figure 2

Medical Assistance Long-Term Care Facilities
FY 2006-07
Total LTC Facilities State Share: $1 billion

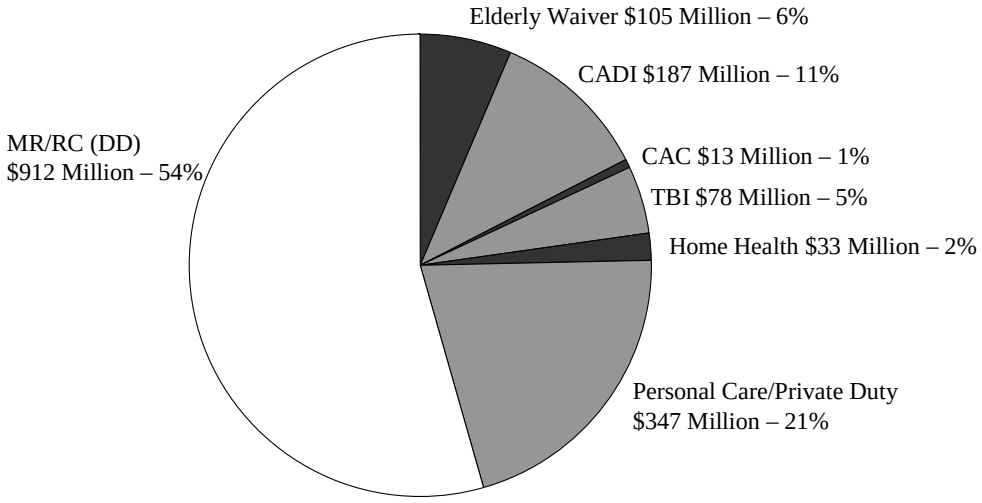


Source: House Fiscal Analysis Department

Figure 3 shows MA LTC waiver and home care spending by category. Services provided through the home and community-based waiver for persons with mental retardation and related conditions (MR/RC waiver) are projected to account for just over one-half of LTC waiver and home care spending for the 2006-2007 biennium. Services provided through the Elderly Waiver are projected to account for just 6 percent of spending for this category.

Figure 3

Medical Assistance Long-Term Care Waivers/Home Care
FY 2006-07
Total LTC Waivers State Share: $1.675 billion

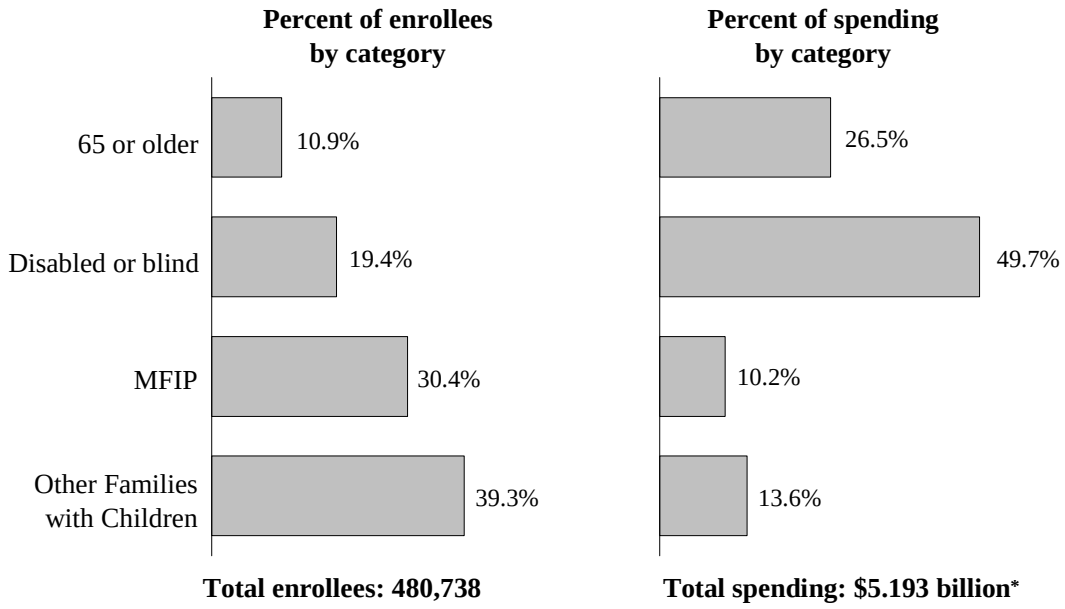


Source: House Fiscal Analysis Department

Figure 4 compares the percentage of MA enrollees in each major eligibility category to the percentage of MA spending for that eligibility category for fiscal year 2005. Families with children (both those on the Minnesota Family Investment Program and others) made up about 70 percent of MA enrollees but accounted for 24 percent of MA spending. In contrast, elderly enrollees made up about 11 percent of MA enrollees but accounted for just over one-quarter of MA spending, while disabled or blind enrollees made up just under 20 percent of MA enrollees, but accounted for about one-half of MA spending.

Figure 4

Minnesota Medical Assistance Eligibles – SFY 2005

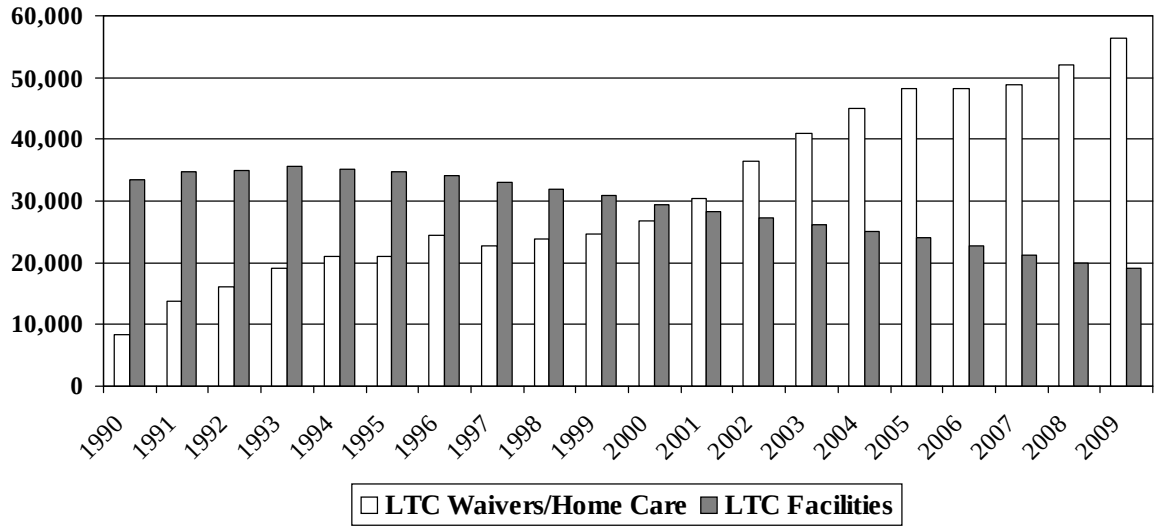


* Does not include special funding items and adjustments

Figure 5 compares the number of MA enrollees (measured on an average monthly basis) receiving services in a long-term care facility[16] with the number receiving waiver/home care services over time. The number of enrollees receiving services in LTC facilities has declined over time, while the number of MA enrollees receiving home and community-based waiver or home care services has increased over the same period. For example, the average number of enrollees per month receiving long-term care services declined from 33,328 in fiscal year 1990 to 24,024 in fiscal year 2005. During the same period, the average number of enrollees per month receiving waiver or home care services increased from 8,452 to 48,157.

Figure 5

Medical Assistance Long-Term Care Facilities and Waivers/Home Care
Monthly Average Recipients, FY 1990-2009



Source: House Fiscal Analysis Department

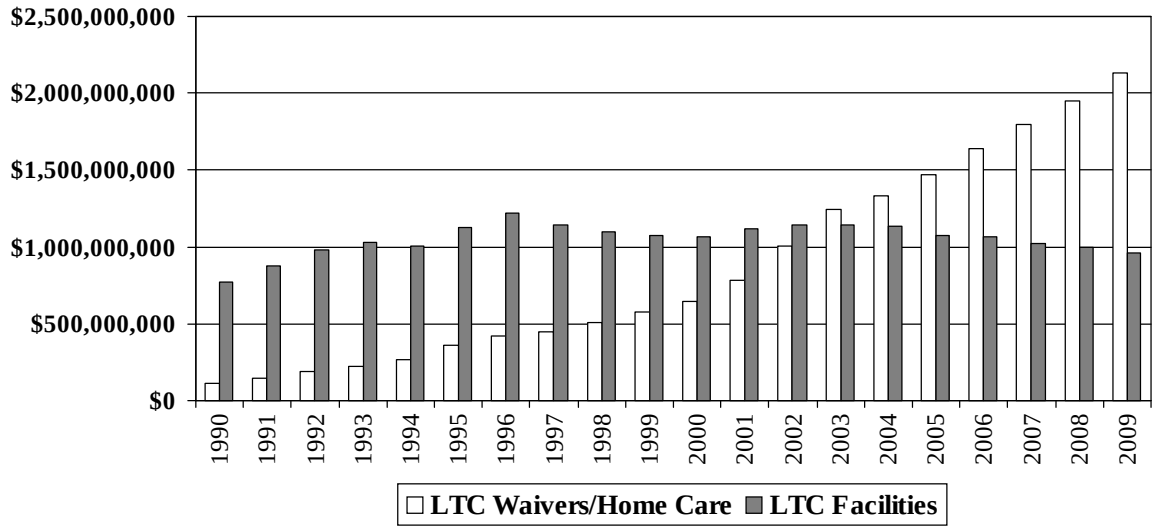
Note: Figures for FY 2006 and beyond are projections based on the February 2006 Forecast.

[16] For this figure and figure 6, long-term care facility means a nursing facility, intermediate care facility for persons with mental retardation and related conditions (ICF/MR), or regional treatment center (excluding state-operated community services).

Figure 6 compares expenditures for MA long-term care facilities and waiver/home care services over time. MA long-term care facility expenditures decreased from a high of $1.224 billion in fiscal year 1996 to $1.074 billion in fiscal year 2005. During that same period, MA expenditures for waivers and home care increased from $420.4 million to $1.469 billion.

Figure 6

Medical Assistance Long-Term Care Facilities and Waivers/Home Care
Total Expenditures, FY 1990-2009



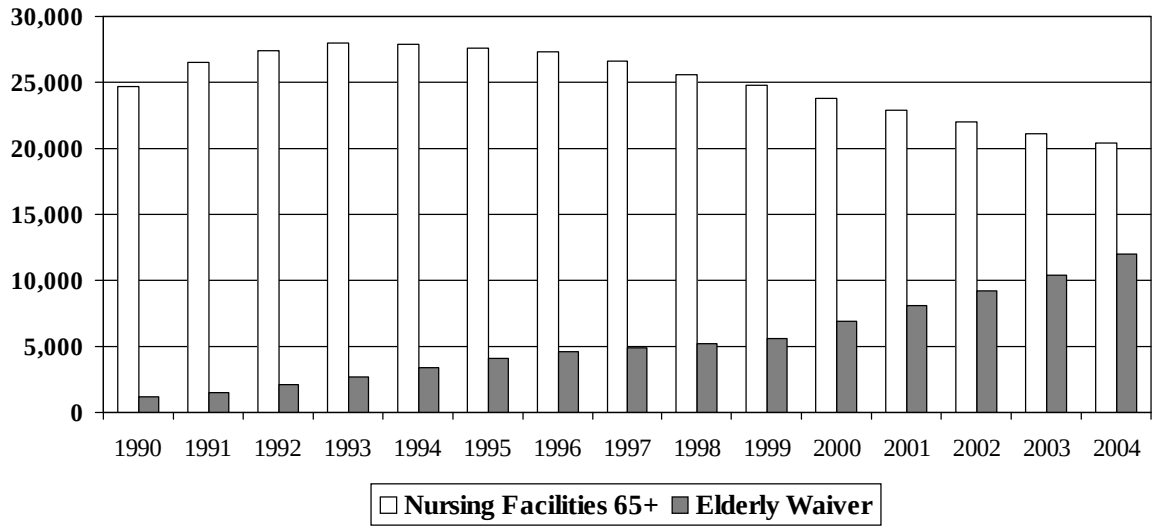
Source: House Fiscal Analysis Department

Note: Figures for FY 2006 and beyond are projections based on the February 2006 Forecast.

Figure 7 compares average monthly enrollees age 65 and over in nursing facilities to average monthly enrollees receiving services under the Elderly Waiver over time. In recent years, average monthly enrollees receiving nursing facility services declined from a high of 28,000 in fiscal year 1993 to 20,390 in fiscal year 2004. During that same period, average monthly enrollees receiving services through the Elderly Waiver increased from 2,677 to 11,995.[17]

Figure 7

MA Nursing Facilities and Elderly Waiver
Average Monthly Recipients FY 1990-2004



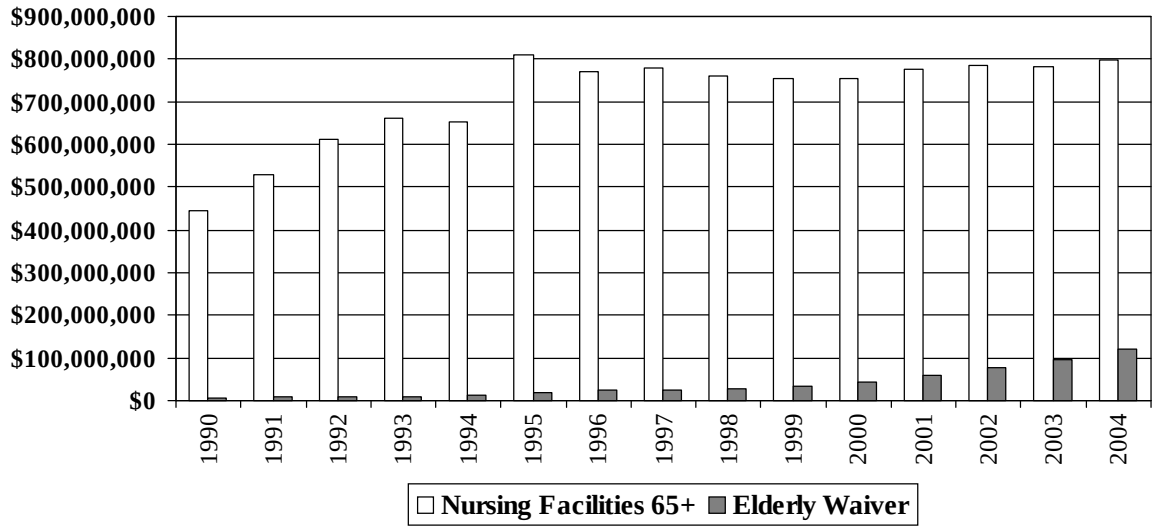
Source: House Fiscal Analysis Department

[17] Elderly waiver recipients include both persons receiving the service through fee-for-service and those receiving the service under managed care. The number of elderly waiver recipients receiving the service under managed care has increased from 10 in fiscal year 1997 to 1,327 in fiscal year 2005.

Figure 8 compares total MA expenditures for nursing facilities (for persons age 65 and over) and Elderly Waiver services over time. Nursing facility expenditures were $809.9 million in fiscal year 1995 and decreased to a low of $754.1 million in fiscal year 2000, before increasing to $797.9 million in fiscal year 2004. During that period, total expenditures for elderly waiver services increased from $17.5 million in fiscal year 1995 to $120.5 million in fiscal year 2004.

Figure 8

MA Nursing Facilities and Elderly Waiver
Total Payments FY 1990-2004



Source: House Fiscal Analysis Department

State Programs for the Elderly

This section provides information on the following state programs for the elderly—Long-Term Care Consultation Services, the Alternative Care program, Group Residential Housing, and programs administered by the Minnesota Board on Aging.

Long-Term Care Consultation Services

Long-term care consultation services provide screening, assessment, and information and education services to help individuals access and decide on the appropriate level of long-term care services.

State law requires all applicants to MA-certified nursing facilities to be screened prior to admission to determine if they need a nursing facility level of care. This preadmission screening is done by a long-term care consultation team, which consists of at least one social worker and one public health nurse.

Counties are also required, as part of preadmission screening, to assess individuals to determine whether alternatives to nursing facility care, such as alternative care services and elderly waiver services, are appropriate.

The cost of preadmission screening in each county is built into the nursing facility rates of nursing facilities within the county. This allows the state to receive federal matching funds through MA for the cost of screening.

During fiscal year 2005, counties conducted 22,513 preadmission screenings and 11,389 assessments for individuals age 65 and older. In addition, counties conducted 1,208 assessments of individuals age 65 and over residing in nursing facilities and 2,893 preadmission screenings for individuals under age 65. The total allocation in fiscal year 2005 for long-term care consultation services was about $6 million, with the federal government, state government, and private-paying individuals each paying about one-third of the total cost.

Alternative Care Program

The Alternative Care Program is a state-funded program that provides home and community-based services to individuals who are not MA enrollees, but who are at-risk of nursing facility placement.

In order to qualify for AC services, individuals must:

- be age 65 or over;
- screened by a long-term care consultation team, be determined by the team to need nursing facility level care, and choose community care; and

- have a gross monthly income that is greater than 120 percent of FPG, or have gross assets greater than the standard MA asset limit, and have combined assets and income no greater than the cost of 135 days of nursing facility care.[18]

In addition, the monthly cost of alternative care services must not exceed 75 percent of the average state MA payment for nursing care for the person's case-mix classification.

Services available through the Alternative Care Program include the following:

- Adult day care
- Caregiver training and education
- Case management
- Chore, companion, and homemaker services
- Extended home care services
- Home-delivered meals
- Home modifications
- Nonmedical transportation
- Nutrition service
- Respite care
- R.N. supervision of personal care assistants
- Supplies and equipment
- Telehomecare

Effective September 1, 2005, AC coverage of adult foster care, assisted living and assisted living plus services, and residential care services was eliminated.

Enrollees meeting certain income and asset criteria are required to pay a monthly fee to help offset the cost to the state of providing AC services. Fees are determined based on the following table.[19]

Adjusted income	Assets	Monthly fee
<100% FPG and	< $10,000	None
≥ 100% FPG but < 150% FPG and	< $10,000	5%
≥ 150% FPG but < 200% FPG and	< $10,000	15%
> 200% FPG **or**	≥ $10,000	30%

[18] The requirement that combined assets and income not exceed the cost of 135 days of nursing facility care took effect September 1, 2005, (for new EW clients) and was phased in by January 1, 2006, for existing EW clients. Prior to these dates, the limit on combined assets and income was the cost of 180 days of nursing facility care

[19] Generally, adjusted income is total income minus recurring medical expenses, with additional deductions allowed for married individuals. Generally, assets are total assets minus most assets excluded under MA, with additional exclusions allowed for married individuals. See Minn. Stat. § 256B.0913, subd. 12.

AC program statistics for fiscal year 2006:

- Total expenditures: $42.6 million
- Monthly average recipients: 3,949
- Average monthly cost per recipient: $834

Group Residential Housing

GRH is a state-funded income supplement program that pays for room-and-board costs for low income adults residing in a licensed or registered setting with which a county human services agency has negotiated a monthly rate.

In order to be eligible for GRH payments, a person must have county approval for residence in a GRH setting and must: (1) be aged, blind, or over 18 years old and disabled, and meet specified income and asset standards; or (2) belong to a category of individuals potentially eligible for General Assistance and meet specified income and asset standards.

Beginning July 1, 2007, the GRH basic room and board rate is $757 per month. Recipients in certain GRH settings may also qualify for a supplemental payment that is in addition to the GRH basic room and board rate. GRH pays for room and board in a number of licensed or registered settings, including:

- adult foster care;
- board and lodging establishments;
- supervised living facilities;
- noncertified boarding care homes; and
- various forms of assisted living settings registered under the Housing with Services Act.

Persons residing in a setting with a GRH rate are usually considered to be living in the community in their own home. As such, these persons can receive services from most community sources, such as home care and home and community-based waiver programs.

Recent GRH policy changes include obtaining home and community-based waiver funding to pay for the extra cost of providing residential services to waiver recipients residing in adult foster care homes (this allowed the GRH payment to be reduced) and allowing congregate settings for the elderly to register with the Minnesota Department of Health as housing with services facilities, making them eligible for GRH.

GRH program statistics for fiscal year 2006:

- Total expenditures: $78.0 million (general fund)
- Average monthly recipients: 14,466
- Average monthly payment per recipient: $449

Programs Administered by the Board on Aging

The Minnesota Board on Aging is a 25-member board whose members are appointed by the governor. Board staff are provided by DHS and the board is housed within that agency. One of the duties of the board is to administer programs funded through the federal Older Americans Act (OAA). The board is the agency designated by the state to receive OAA funds for distribution to Area Agencies on Aging.

In fiscal year 2007, the board received about $22.5 million in federal funds and $6.4 million in state funds for programs that it administers. Some of these programs are described below.

- ***Senior LinkAge Line and related information and assistance services.*** A free telephone service that provides elderly persons with information on and assistance in accessing a range of community services, such as transportation, housing, home care, chore help, caregiver support, meal delivery and nutrition, access to prescription drugs (through RxConnect) and health insurance counseling. The Senior LinkAge Line recently provided callers with assistance in signing up for Medicare Part D prescription drug coverage. In calendar year 2006, the Senior LinkAge Line received 155,493 contacts. The Senior LinkAge Line phone number is 1-800-333-2433.

- ***MinnesotaHelp.*** Provides individuals with information and guidance on long-term care planning, decision-making, and resources. Individuals can access a directory of long-term care, health care, housing, disability, and human services providers and organizations at www.MinnesotaHelp.info. The information provided can be tailored to the location and needs of the individual. In calendar year 2006, the web site was visited by 42,235 individuals.

- ***Senior Nutrition Services.*** Senior dining services (also referred to as congregate meals) provide nutritionally balanced meals to individuals age 60 and over, and their spouses, at various sites in the community. Home-delivered meals provide meals to homebound individuals age 60 and over in their place of residence. There is no charge for these services, but donations are requested to pay for the cost. In fiscal year 2006, 67,800 individuals were served congregate meals and 15,400 were served home-delivered meals.

- ***Caregiver Grants.*** Grants provided to Area Agencies on Aging and service providers to fund respite care, education and training in caregiving, and support groups for family caregivers. In fiscal year 2006, an estimated 1,400 caregivers were served by these grants.

- ***Minnesota Senior Corps.*** A network of programs that provide elderly persons with volunteer opportunities. The Retired and Senior Volunteer Program (RSVP) assists persons age 55 and over in volunteering at hospitals, youth recreation centers, and other community organizations. The Senior Companion Program (SCP) allows seniors age 60 and over to assist at-risk, frail elderly in daily living tasks. The Foster Grandparent Program (FPG) allows seniors age 60 and over to serve as mentors, tutors, and caregivers for children and youth with special needs. In fiscal year 2006, more than 18,000 volunteers provided over two million hours of service.

- ***Ombudsman for Older Minnesotans.*** This office serves as an advocate for and investigates and resolves complaints brought by residents of long-term care facilities, persons receiving home care, and Medicare beneficiaries with concerns about hospital admissions and discharges. This office is primarily state funded, but also receives some OAA funding.

For more information about public assistance programs, visit the health and human services area of our web site, www.house.mn/hrd/issinfo/hlt_hum.htm.