STRATEGY ON AGING TASK FORCE

EXECUTIVE SUMMARY

INTRODUCTION

The state of Minnesota must have a strategy for assisting its elderly population. A strategy that encourages a variety of independent or semi-independent living arrangements rather than a reliance on nursing homes. A strategy that would: 1) enable the community based care system to take a larger role in caring for the elderly; 2) reduce the rate of increase in public expenditures for long term care; 3) reduce the rate of institutionalization; and 4) increase the capacity of families and communities to care for their elderly.

The Strategy on Aging Task Force has completed its work. The task force reviewed: 1) demographic data; 2) income support programs; 3) housing programs ; 4) social service programs ; and 5) long term health care insurance.

The task force recommends the following Strategy on Aging:

- the development of an income support program for the elderly which encourages independent living.

- the provision of incentives for better planning, coordination and delivery of social services to the elderly;

- the provision of incentives to encourage the development of independent or semi-independent living arrangements;

- the designation of county social service agencies as lead agencies for planning, coordinating and delivering services to the elderly.

BACKGROUND

Between 1980 and 2000, Minnesota's population over the age of 65 will increase by 25 percent, according to the State Demographer's Office. Population between the ages of 75 and 84 will increase by 38 percent and population aged 85 and older will increase by 72 percent. These facts have obvious importance for the planning and development of human service programs for the elderly.

POPULATION GROWTH BY AGE GROUP 1980-2000

AGE GROUP	1980	1990	2000
Under 65	3,596,407	3,822,046	4,000,438
65 to 84	426,775	480,391	509,178
Over 85	52,789	68,521	90,781
TOTAL	4,128,760	4,439,521	4,691,178

PERCENT CHANGE

AGE GROUP	1980-1990	1980-2000
Under 65	6.3%	11.2%
65 to 84	12.6%	19.3%
Over 85	29.8%	72.0%

In 1983, 9.2 percent of all elderly people in Minnesota resided in nursing homes, one of the highest occupancy rates in the nation. In the past, public assistance for the elderly in Minnnesota has been channeled into nursing home care, with the result that few alternative care systems have been developed. Nursing homes are a relatively expensive form of care, without being the most effective means of delivering human services to a population with a wide range of needs.

With the costs of public assistance for the elderly increasing faster than the inflation rate, it is imperative to develop alternative services for an ever expanding population.

In 1983, the state legislature placed a moratorium on the construction of nursing homes, and the state fully implemented a preadmission screening program to encourage the development of community based services for those elderly at risk of nursing home placement if community services were not provided. The Strategy on Aging Task force was established to study public programs for the elderly and to develop recommendations concerning long term care, i.e., housing and social services, which would be more effective and less costly than current institutional programs.

SUMMARY STATISTICS ON THE ELDERLY

- Minnesota's elderly population will grow nearly three times as fast as the nonelderly population.

- The number of persons age 85+ will grow ten times as fast as the nonelderly population; these elderly are most likely to need long term care services, or to be placed in nursing homes.

- In 1980 there were 245,180 elderly households in Minnesota:
  - Sixty-eight percent were homeowners; 32 percent rented;
  - Forty-two percent were married couples; 40 percent were women living alone.

- Eighty-eight percent of all elderly homeowners owned their housing unit free and clear.

- In 1979, 16 percent of the state's elderly had incomes below federal poverty thresholds, less than $3,479 for a one-person household or less than $4,385 for a two-person household.

- Eighty-two percent of the public funds spent for the elderly are for the 9.2 percent residing in nursing homes.

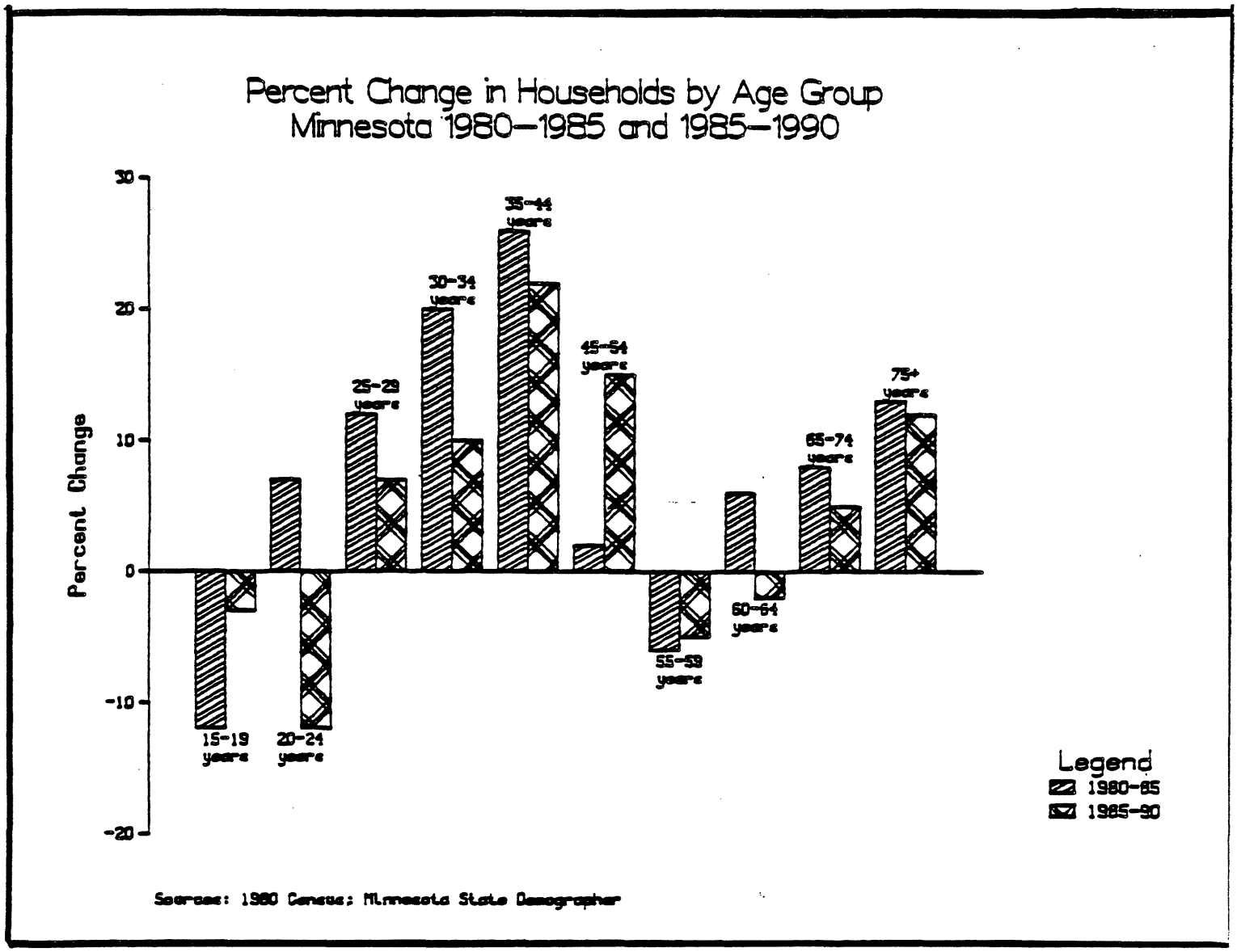
- Minnesota ranked first in the United States in 1979 in Medicaid reimbursed days of nursing home care.

- Sixty percent of the state's Medical Assistance budget is spent on institutional care.

- One percent of the state's Medical Assistance budget is spent on community based care.

The current delivery system for services for the elderly offers primarily nursing home care, which is supported through the Medical Assistance Program (9.8 percent of the state budget). On a national level, nursing home expendiures increased by 82 percent between 1976 and 1980. To the extent that Minnesota does not contain its Medical Assistance costs by developing alternative service systems for its elderly population, budget resources for other high priorities diminish.

Minnesota needs to ensure that a continuum of services is available to the elderly. With the continuation of the nursing home moratorium, as well as increasing demographics, the state needs to insure that there are a range of options to help the elderly remain living in their community.


Percent Change in Households by Age Group
Minnesota 1980–1985 and 1985–1990
Percent Change
30
20
10
0
-10
-20
15-19 years
20-24 years
25-29 years
30-34 years
35-44 years
45-54 years
55-59 years
60-64 years
65-74 years
75+ years
Legend
1980-85
1985-90
Sources: 1980 Census; Minnesota State Demographer

MAJOR PROGRAMS PROVIDING FOR THE ELDERLY FOR FISCAL YEAR 1984

MEDICAL ASSISTANCE (MA)

Medical Assistance pays for medical services for low income persons. Counties pay 10 percent of the nonfederal share.

	Federal	State	Total*
Elderly - All Services	$229.3M	$201.9M	$431.2M
Nursing Home Services	212.2M	186.9M	399.1M
Noninstitutional Services	17.1M	15.0M	32.1M

PREADMISSION SCREENING/ALTERNATIVE CARE GRANTS (PAS/ACG)

PAS/ACG screens people aged 65+ considered at risk of entering a nursing home, and pays providers of long term home care services to prevent or postpone nursing home placement. Counties pay 10% of the nonfederal share.

	Federal	State	Total*
All Services	$ 0.8M	$ 3.9M	$ 4.7M
MA Eligible	0.8M	0.7M	1.5M
Non-MA Eligible	--	2.8M	2.8M

COMMUNITY SOCIAL SERVICES ACT (CSSA)

CSSA pays for a variety of community services delivered by county social services agencies. Counties allocate $133M for the program in addition to the figures shown below.

	Federal	State	Total*
All Services	$ 42.2M	$ 57.7M	$ 99.9M
Elderly - All Services			9.3M

COMMUNITY HEALTH SERVICES (CHS)

CHS pays for a variety of health services delivered by local health boards. Counties allocate $64M for this program in addition to the fitures shown below.

	Federal	State	Total*
All Services	$ 6.6M	$ 11.2M	$ 17.8M

OLDER AMERICANS ACT - TITLE III

Title III pays for a variety of social, health and nutrition programs for persons aged 60+, delivered by regional Area Agencies on Aging.

	Federal	State	Total
All Services	$ 11.6M	$ 3.5M	$ 15.1M

* Total excludes county funds

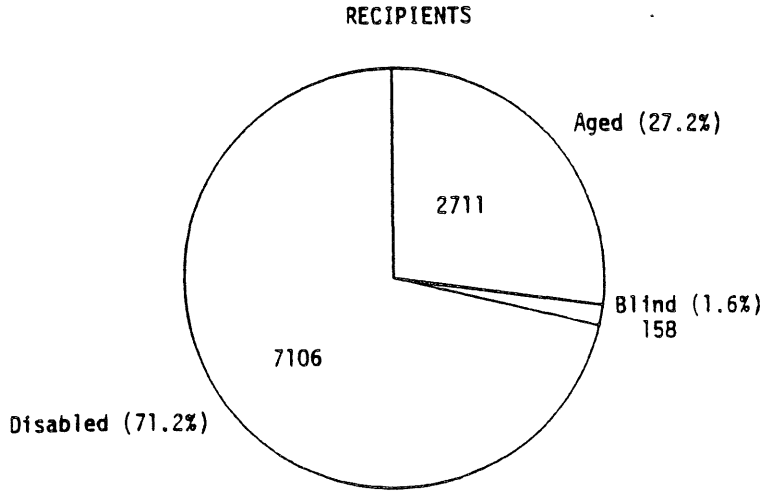
INCOME SUPPORT PROGRAMS FOR THE AGED

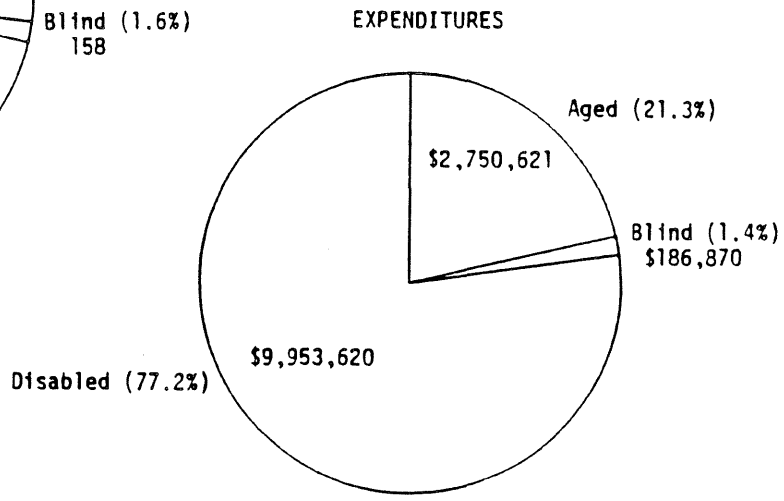
A. Programs Descriptions: These two programs meet the basic maintenance needs for the aged, blind and disabled.

PROGRAM NAME	SOURCE OF FUNDS	FUNDING LEVELS	NUMBER OF RECIPIENTS
Supplemental Security Income (SSI)	100% federal	$ 48.3M	29,002
Minesota Supplemental Aid (MSA)	85% state 15% county	$ 12.9M	9,975

B. Program Data

MSA Recipients and Expenditures: SFY 1983





RECOMMENDATIONS

The Strategy on Aging Task Force, consisting of representatives from seven state agencies (see Appendix A), was funded through a cooperative arrangement with Center for Urban and Regional Affairs (CURA), the Humphrey Institute and the Minnesota Housing Finance Agency. The task force did not simply identify alternatives to the present care system, it looked to those alternatives that would offer quality care, a system of coordinated services that preserve the dignity and freedom of choice of the elderly person according to the following continuum.

CONTINUUM OF CARE

Residence of Older Person	Older Persons Own Home or Apartment	Subsidized Housing	Congregate or Shared Housing	Board and Care Facility	Nursing Homes
	(Independence				Dependence)

Recommendations are divided into four basic areas:[1]

1) Income Support

2) Housing

3) Community Services

4) Long Term Care Insurance

The total 1986-87 fiscal impact of the recommendations is $15.8 M in state funds.

[1] More detailed information on each of these areas may be obtained in technical reports available upon request. Contact Nellie Johnson, Department of Finance, 309 Administration Building, St. Paul, Minnesota 55155.

INCOME SUPPORT

RECOMMENDATION:

Establish a minimum monthly Minnesota Supplemental Aid (MSA) payment of $400 for all individuals not residing in negotiated rate facilities.

RATIONALE:

Income Maintenance programs are an integral part of a community based system. An adequate income provides the means for an individual to live independently by providing resources to meet basic maintenance needs such as food and shelter.

A minimum payment standard should be established that does not discriminate against a person based on living arrangement. A $400 payment would be available regardless of whether the person lived independently, or in the home of another. MSA is the only income maintenance program that does not have a uniform payment. Rather, the payment standard is determined by each county and varies significantly by living arrangement. Further, the federal Supplemental Social Income (SSI) program reduces payment if an individual shares a home with another, a factor which tends to deter alternative living arrangements.

CURRENT SSI AND MSA PAYMENT STANDARDS

BY LIVING ARRANGEMENTS

Living Arrangement	SSI Payment	MSA Payment	Total SSI/MSA Payment
Independent Living	$ 314	$ 35	$ 349
Home of Another	$ 209	$ 45	$ 254
Room/Board - Negotiated Rate	$ 314	$21-$821	$340-$1,140

The task force recommendation would encourage individuals on SSI and MSA to live independently or in alternative housing arrangements.

RECOMMENDATION:

Establish a maximum monthly MSA payment of $500 for all individuals residing in negotiated rate facilities.

RATIONALE:

MSA payments range from $335 to $1,035 a month for individuals residing in room and board facilities. Currently, payment is intended to cover only room and board; however, it is questionable whether the funding is actually being used in this manner. Counties have total flexibility in negotiating rates, for which the state pays 85 percent. It would appear that some counties are funding more than room and board out of this program, because of the fiscal incentives. State funds for social services are limited and counties pay a higher match on social services than on income support; therefore, there is an incentive for counties to shift as many costs as possible to the income support programs. Counties would be free to negotiate higher rates, but they would not be reimbursed by the state.

RECOMMENDATION:

Change the resource limits of the MSA program so that these limits are the same as those of the federal Supplemental Security Income (SSI) program.

RATIONALE

The resource limits for these two programs differ. The MSA program is the only income maintenance program that recognizes the value of a home as a criterion for eligibility. Since the state is attempting to encourage people to remain within the community, the state should not have more restrictive standards for MSA than does SSI. The current MSA resource standards restrict eligibility for people who might otherwise seek nursing home placement.

SSI AND MSA RESOURCE LIMITS

Cash Resources	SSI	MSA
Individual		
Aged	$ 1,500	$ 300
Blind	1,500	2,000
Disabled	1,500	300
Couple		
Aged	$ 2,250	$ 450
Blind	2,250	4,000
Disabled	2,250	450
Home Equity	no limit	$ 47,032

Total Fiscal Impact of Above Recommendations for 1986-87 (new funds only) $10.5 million.

HOUSING

RECOMMENDATION:

Establish an accessibility pilot program.

RATIONALE:

Funds in the form of a grant, deferred loan, or low interest loan would be available for accessibility improvements. At times, elderly persons need only small renovations such as a construction of a wheel chair ramp for bathroom on the first floor in order to remain in their homes. These items are far less costly than having the person move to a nursing home. Elderly households would be referred by the local social services agency to ensure the selection of households that would benefit the most from an accessibility improvement to their residence. This program can reduce the cost of Medical Assistance for the state and add to the quality of life of the elderly person. The fiscal impact for this item is $500,000 in 1986-87.

RECOMMENDATION:

Establish a Home Sharing/Shared Residence Program.

RATIONALE:

Funds would be available as seed money for sponsors of home sharing programs. Home sharing programs match existing homeowners with tenants. The homeowner is generally an elderly person and the tenant is generally not as old. The tenant may either pay rent or provide services to the homeowner. Funds would also be available for the conversion of existing buildings into structures with three to twelve private rooms with shared kitchens and common space. The monthly charge per resident would depend upon the services provided to the residents.

The fiscal impact for this item is $1.5 million in 1986-87.

RECOMMENDATION:

A Home Equity Demonstration Program.

RATIONALE:

Funds would be available for a sponsor to demonstrate the potential for home equity conversion in Minnesota. Many elderly are house rich, but cash poor. Other areas in the country have established programs to assist the elderly in becoming more economically independent through the use of the equity in their homes. The demonstration program would examine how equity conversion programs would work in rural areas with lower real estate values. This demonstration program would examine the market for the program and the need for consumer safeguards.

The fiscal impact for this item is $225,000 in 1986-87.

COMMUNITY SERVICES

RECOMMENDATION:

Designate the county social service agency as the lead agency for planning, coordinating and delivering services to the elderly.

RATIONALE:

Ensuring that appropriate and effective community services are available for the elderly is the final, crucial, link in the strategy on aging. Income support and housing options alone will not be successful in meeting the needs of Minnesota's elderly population. The elderly must have the access to appropriate community support programs in two ways: needed programs must be available statewide, and the elderly must know about those programs and how to utilize them as necessary. Community services must enhance, not support, the informal network of family and friends which currently provides an estimated 90% of the elderly's service needs. Such services must also cover the gaps in the continuum of care so that needed services are available to the range of elderly, from those who require minimum support to those who require full medical care in a nursing home. In addition, state direction on community services delivery must recognize the crucial role of the counties in the planning, development, and delivery of services.

County social services agencies already have responsibility for the provision of the majority of community services for the elderly, as well as for the one state program aimed at preventing inappropriate institutional care. This recommendation would reinforce and strenghten the county's responsibility for providing services for the elderly and would provide additional funding for the expanded coordination and case management activities. County social services agencies would be the one place where

the elderly in need of services would go. The county would assess the elderly individual's needs and would link the individual with the required services, whether they were housing, income support, public health, or other social services. County staff would need to be aware of services available through all agencies and would control the matching of individual needs with available services so that only needed services would be provided. Coordination of program planning cycles and state technical assistance with plan preparation would assist the counties in this role as lead agency for aging services.

The fiscal impact for this item is $3.5 million in 1986-87 for case management services.

RECOMMENDATION:

Study the relationship between the area agencies on aging and county social service agencies in the delivery of direct services to the elderly.

RATIONALE:

All state administered, locally delivered social and health services, except for Title III, are under the jurisdiction of county boards. In order to strenghten the role of the county as lead agency for aging services, it appears reasonable to assess whether area agencies should also be providing direct services to the elderly. A potential for greater coordination and efficiency exists by bringing all direct services for the elderly, including Title III services, under the control of county boards. Such control could enable counties to plan and control the provision of services in a more comprehensive manner.

Administrative/program development costs were 14 percent of the Title III program in Minnesota in F.Y. 1983.

The role of the area agencies in relation to the elderly is unique, and since this would be a major change for both counties and area agencies, the task force felt that more study was needed before a final recommendation could be made.

RECOMMENDATION:

Change the state/county match for institutional care under the Medical Assistance Program from 90/10 to 75/25 of the nonfederal share. Allocate the state savings directly back to the counties to meet the increased match requirement or to fund community services.

RATIONALE:

Fiscal incentives which favor institutional placement over independent living with supportive services have existed for years in both federal and state policies. In reaction to these incentives, counties have also favored institutional placements over the provision of community services. Counties pay only 5% of the costs for an individual in a nursing home who is on medical assistance, but must pay approximately 60% of the costs of community services such as homemaker or adult foster care for an elderly person in the community.

Under this recommendation, the fiscal incentives would be changed and counties would have greater responsibility for the full array of services. A base year nursing home utilization rate would be determined for each county. The value of the state match change from 90% to 75% would be determined and these funds would be transferred to the counties. Counties would have discretion in how the transfer fund was used, as long as it paid for either nursing home or community services for the elderly. If the county's

nursing home utilization rate did not change the county would break even. In otherwords, the county would receive, in reimbursement from the state, exactly the same amount as it was paying in increased match; however, if the county's nursing home utilization dropped in the second year, the county would have additional money available to fund community services. If the county's nursing home placements increased, the county would fund only the increased utilization over the base year. The current moratorium places a cap on any new nursing home beds so increased use of nursing homes is not anticipated. This transfer fund would be adjusted for inflation annually so that counties would only be at risk for increases in nursing home utilization beyond the base year.

This recommendation will give counties more incentive to be aware of their nursing home utilization rates and the flexibility to provide services in the community.

RECOMMENDATION:

Change the Preadmission Screening/Alternative Care Grants (PAS/ACG) Program so that counties have more flexibility in providing alternative services and provide a funding increase which anticipates increases in the elderly population.

RATIONALE:

The Preadmission Screening/Alternative Care Grants Program, which is administered by county social services agencies, is the current statewide program which is specifically targeted at providing services to the elderly who are at a risk of institutional placement. Other county programs such as CSSA and CHS are block grants aimed more generally at the population in need of either social or health services. PAS/ACG has a strong case management focus, as well as the proven ability to assess individuals' service needs and to provide for those needs outside of an institutional setting. In its current form, the PAS/ACG Program cannot provide for the array of the elderly's

service needs because of its limitation to people who are at imminent risk of institutional placement and who either are currently eligible for medical assistance or who would be eligible for M.A. within 180 days of institutional placement.

The screening requirements of the current program and the alternative care grants for MA-eligibles would remain unchanged: however, the alternative care grants program for the current 180-day eligibles would be replaced with a direct allocation of funds to counties, based on the current formula. These dollars would be placed in a community care incentive fund which counties could use to fund services for the elderly without the current program restrictions. Counties could define services to be funded and eligibility for services as they chose, as long as they met the service needs of elderly in the county and performed the lead agency role defined above. The allocation amount would be based on projections of the increased numbers of elderly needing long term care services and would be a fixed amount for each county. The community care incentive fund would also be combined with the MA reallocation fund and the additional case management allocation to give each county flexible control over a substantial amount of funding for community services for the elderly.

The Department of Human Services has requested $ 29.0 million in new funds for 1986-87 to allocate for preadmission/alternative care grants. While the Strategy on Aging recognizes that additional dollars are needed for this area, it did not recommend a specific dollar level. Rather, it recommended that the method of allocating any additional dollars be changed according to the process outlined above.

An example of these community service recommendations follows.

MEDICAL ASSISTANCE FUND TRANSFER

MA Expenditures (in millions) Fiscal Year 1986

	State	Percent	County	Percent
Current Law	$208.2	90%	$ 23.1	10%
Proposed	173.5	75%	57.8	25%
Change	$(34.7)		+$ 34.7	

COMMUNITY CARE INCENTIVE FUND

Funds Available to Counties In Fiscal Year 1986

MA Transfer - Fiscal Year 1986		$34.7
Non-MA PAS/ACG		$17.8
Fiscal Year 1986 Base	$ 5.0	
Department, Human Services Change Request	$11.0	
County Match	$ 1.8	
Case Management (new state funds)		$ 2.0
TOTAL		$54.5*

*54.5 million available to counties.

LONG TERM CARE INSURANCE

RECOMMENDATIONS:

1. Monitor the long-term care insurance market for increased interest by insurance companies.
2. Study and evaluate the outcomes of alternative delivery system experiments in long-term care insurance.

RATIONALE:

Long-term care insurance has been viewed as a potential source of private financing for nursing home, and potentially community long-term care, services.

Only 25 insurance companies currently have long-term care insurance packages. These packages are quite limited in amounts actually covered for nursing home care, and none of the companies covers services which are alternatives to nursing home care. Insurance companies are reluctant to enter the market for a variety of barriers to accurate estimations; employers and employees do not demand such coverage; government regulations impede the development of packages, while government-funded programs such as Medicare and Medicaid are available as a last resort for individuals in nursing homes who cannot afford the cost.

It is not clear at this time whether publicly-funded incentives which expand long-term care insurance but which do not change the delivery system will actually decrease overall public costs. Low income individuals would have to receive subsidies to help pay the premiums and public funds would be needed to pay for the nursing home costs not covered by insurance. In addition, administration, overhead and operating costs of insurance companies would be included in the premiums, costs over which the state would

have little control. A number of researchers have concluded that cost-effective long-term care insurance will not develop until comprehensive and integrated delivery systems are developed. The Long-Term Care Insurance Project of the Twin Cities Community Coalition for Affordable Health Care is on example of a demonstration project in this area.

Total Fiscal Impact of Task Force Recommendations: (in thousands)

	F.Y. 1986	F.Y. 1987	Biennium
Income Support	$ 1,699	$ 8,851	$ 10,550
Housing	1,125	1,125	2,250
Case Management	1,000	2,000	3,000
TOTALS	$ 4,824	$ 11,976	$ 15,800

Aging Strategy

Director:	Nellie Johnson
Team Leaders:	Monte Aaker Nancy Feldman
Co-Workers: (Areas of Responsibility)	Carol Anderson (Income Maintenance Review Long Term Health Care Insurance)
	Bob Mayer (Demographic Profile; Community and Health Services)
	David Siburg (Housing, Home Equity Conversion)
Members:	Dean Honetschlager State Planning
	Richard Nelson MN Board on Aging
	James Parker Department of Health
	Allan Schenkelberg Department of Transportation
	James Solem Housing Finance Agency
	Betsy Walton Department of Human Services