# State Long-Term Services and Supports Scorecard
# What Distinguishes High- from Low-Ranking States?
# Case Study: Minnesota

**Robert Mollica and Leslie Hendrickson**
**May 2012**

## Introduction

The *State Long-Term Services and Supports Scorecard* found wide variation in how states perform across the 25 indicators that comprise four key dimensions of a high-performing system.[1] The *Scorecard* is designed to help states improve the performance of their long-term services and supports (LTSS) systems by targeting opportunities for improvement. Looking to other states that performed better in specific areas can inform potential paths for improvement. Leading states do well on multiple indicators, but even states with a low ranking scored in the top quartile for at least one indicator. A series of case studies provide a deeper context for understanding how high-, medium-, and low-ranking states performed for the baseline *Scorecard*, and how they are already striving to improve LTSS for older people and adults with physical disabilities. This case study focuses on Minnesota.

## Highlights for Minnesota

Minnesota was selected because it ranked first overall in the nation. Its solid top ranking reflects 15 of 25 indicators in the top quartile and fully 11 among the top five—a level of performance unmatched even by other high-ranking states. It is the only state that achieved a first quartile rank across all four dimensions. Appendix A provides a complete summary of Minnesota's ranking on each of the 25 indicators that comprise the four dimensions and yield the overall ranking.

- Minnesota has a mature LTSS system with an array of Medicaid and state-funded home and community-based services (HCBS) that balances the majority of spending toward HCBS.

[1] S. Reinhard, E. Kassner, A. Houser, and R. Mollica, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (Washington, DC: AARP Public Policy Institute, September 2011).

- A well-established statewide managed care program includes both health and LTSS. Health plans have an incentive to use HCBS rather than nursing homes. Individuals seeking admission to a nursing home or other LTSS receive an assessment and information about all service options.

- State officials collaborate with consumers and other stakeholders in the development of public policy and programs.

- Minnesota's quality measurement activities, public disclosure of quality measures on its Nursing Home Report Card, and performance-based incentive payment program have improved the quality of care in nursing homes.

- Minnesota's low scores were all clustered in the area of home health services. Not only is home health affordability a challenge; home health quality measures lag, especially in comparison to other areas of performance.

- Minnesota has submitted a §1115 waiver demonstration proposal to the Centers for Medicare & Medicaid Services (CMS) that would raise the nursing home level of care threshold, create a lower-cost "Essential Community Service" package for people with lower needs, and receive federal reimbursement for a state-funded HCBS program.

**Table 1: Minnesota's *Scorecard* Ranking**

| Scorecard Dimensions | Ranking where 1 = highest | Quartile Ranking (First Quartile is the highest) |
|---|---|---|
| Overall Ranking | 1 | First Quartile |
| Affordability and Access | 4 | First Quartile |
| Choice of Setting and Provider | 3 | First Quartile |
| Quality of Life and Quality of Care | 4 | First Quartile |
| Support for Family Caregivers | 4 | First Quartile |

## Background

The *Scorecard* is the first attempt to use a multidimensional approach to comprehensively measure state LTSS system performance overall and across diverse areas of performance. It describes the goals to aim for when considering both public policies and private sector actions that affect how a state organizes, finances, and delivers service and supports for people who need ongoing help with activities of living (ADLs), instrumental activities of living (IADLs), health maintenance tasks, service coordination, and supports to their family caregivers. The *Scorecard* examines state performance across four key dimensions of LTSS system performance: (1)

*Affordability and Access*; (2) *Choice of Setting and Provider*; (3) *Quality of Life and Quality of Care*; and (4) *Support for Family Caregivers*.[2]

Minnesota is a Midwestern state with a population of 5.3 million and a landmass of 79,626 square miles.[3] Its population density of 66.6 people per square mile is below the national average of 87.4.[4] Some 12.9 percent of the population was age 65 or older in 2010, near the national average of 13.0 percent.[5] The median household income was $55,616 in 2009, above the national average of $50,221, and higher than all its neighboring states (Iowa, North Dakota, South Dakota, and Wisconsin).[6] Disability rates are below the national average among people age 18 to 64 with an ADL disability (1.4 percent compared to 1.8 percent). Among older people with an ADL disability, Minnesota's rate of 6.0 percent is the third lowest in the nation, and substantially below the national average of 8.8 percent. Only the neighboring states of North and South Dakota have lower disability rates among people age 65 or older.

Administrative responsibilities for LTSS are located in the Department of Human Services (DHS) and the Department of Health. Administrative units within DHS whose activities directly touch on LTSS include the Continuing Care Administration, the Health Care Administration, and the Health Policy and Reform Administration.

The Continuing Care Administration is responsible for all LTSS for older people and people with disabilities. The Continuing Care Administration includes the Aging and Adult Services Division, the Disability Services Division, and the Nursing Facility Rules and Policy Division, as well as Aging 2030. It also houses the Deaf and Hard of Hearing Division.

The Aging and Adult Services Division develops community services and resources for older people and manages the Alternative Care and Elderly Waiver programs that help older people remain in their communities. It also manages the Long-Term Care Consultation function, which provides options counseling to LTSS applicants. The division provides staff support to the Minnesota Board on Aging.

The Nursing Facility Rates and Policy Division is responsible for Medicaid policy development and program administration of nursing facility-based services. The division conducts the rate setting for nursing homes and the Performance-Based Incentive Payment Program (PIPP).

The Disability Services Division (DSD) manages programs that support people with developmental disabilities, chronic medical conditions, acquired or traumatic brain injuries, and physical disabilities. DSD manages the Community Alternatives for Disabled Individuals waiver, the Brain Injury waiver, the Community Alternative Care waiver for chronically ill and medically fragile people who need the level of care provided in a hospital, and the Developmental Disabilities waiver.

---

[2] Adequate state-level data were not available to assess states' performance on a fifth dimension, *Effective Transitions and Organization of Care.*

[3] U.S. Census Bureau, *State and County Quick Facts,* http://quickfacts.census.gov/qfd/states/27000.html.

[4] Ibid.

[5] Ibid.

[6] AARP Public Policy Institute analysis of 2009 American Community Survey, Public Use Microdata Sample.

Aging 2030, also part of the Continuing Care Administration, models the expected impact of the aging of Minnesota's population and helps state agencies develop policy options that prepare for the demographic shifts that will peak in 2030 when baby boomers turn 85.[7]

DHS also includes the Health Care Administration, which oversees purchasing, service delivery, eligibility, and benefit policies for Medicaid Programs. The Purchasing and Service Delivery Division, Special Needs Purchasing area is responsible for purchasing and management of the managed LTSS programs.

The Department of Health is responsible for licensing nursing homes, home health and home care agencies, and registering Housing with Services Establishments (assisted living).

## Methodology

To better understand the context for Minnesota's current *Scorecard* ranking and the state's plans for improvement, the authors reviewed relevant documents, and conducted a site visit and phone interviews in March 2012.

Interviews with multiple stakeholders included the following:

- State officials in the Aging and Adult Services Division, the Disability Services Division, and the Department of Human Services, Purchasing and Service Delivery Division
- LTSS providers
- Consumer advocates

We focused on factors that affect Minnesota's performance in the *Scorecard*'s four dimensions, with an emphasis on selected indicators in the top and bottom quartiles. We also explored current or planned activities that might lead to improvement.

## Current Status and Future Potential for Progress

As the top-ranking state in the nation, Minnesota has many areas of high performance. Notable findings include a strong and long-standing commitment to HCBS, a long history of managed care that includes both health and LTSS, development of housing alternatives that help keep people out of nursing homes, and a focus on quality improvement. Those interviewed also described a complex collaborative relationship in which state officials and stakeholders work together on policy and legislative proposals. Stakeholders are asked for feedback on concepts and ideas for change before they are proposed. One state official suggested that the tradition of collaboration could be rooted in the Scandinavian culture that is prevalent among Minnesotans.

A policy focus on future planning also characterizes Minnesota. Aging 2030 is designed to prepare Minnesota for the coming "age wave." The project surveyed baby boomers about work, housing, and the impact of health, finances, and caregiving responsibilities on these choices. It

[7] For a description of Aging 2030, see http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006833.

then issued a framework to help policymakers and the public understand the challenges of the imminent demographic trends.[8,9] Planning of this nature is not new in Minnesota. Groundwork was laid in a 2007 report, *Blueprint for 2010: Preparing for the Age Wave*.

Affordability and Access

The *Affordability and Access* dimension measures the extent to which individuals and their families can easily navigate their state's LTSS system, finding readily available, timely, and clear information to make decisions about LTSS. In a high-performing system, services are affordable for those with moderate and higher incomes, and a safety net is available for those who cannot afford services. Eligibility is determined easily and quickly, and the costs of LTSS do not impoverish the spouse of the person needing LTSS.

Minnesota scored well on this dimension, with four of the six indicators in the top quartile. A key factor in Minnesota's overall rank in this dimension is its first place performance on two indicators: the reach of its Medicaid LTSS program to low-income people with disabilities and the high functionality of its Aging and Disability Resource Center (ADRC) and Single Entry Point system. The median annual cost of private-pay home care as a percentage of median household income of people aged 65 or older was the state's lone indicator that ranked in the fourth quartile.

*Eligibility Rules and Access*

Minnesota adopted eligibility options that support access to LTSS. Medicaid covers older adults with income below 100 percent of the federal poverty level (FPL) and is one of 34 states that offers a "medically needy" option whereby individuals who are over income for Medicaid can use recurring medical expenses to lower their income and thus qualify for Medicaid. The state's medically needy income standard is 75 percent of the FPL, which is more generous than 23 of the other states with a medically needy program. Minnesota is also one of 38 states that covers nursing home-eligible beneficiaries with income up to 300 percent of the federal Supplemental Security Income benefit rate and allows single individuals to have up to $3,000 in assets, whereas a majority of states use a $2,000 asset limit.[10]

Another factor is Minnesota's unique adoption of a "rate equalization" policy that prevents nursing homes from charging private-pay residents more than the home receives from Medicaid for residents living in a shared room. Only one other state, North Dakota, has a similar policy. Enacted in 1976, this policy has played a role in both improving affordability for private-paying individuals and ensuring adequate Medicaid payments.[11] However, Medicaid reimbursement for LTSS has been cut over the last three to four years, increasing provider resistance to the state's rate equalization policies.

---

[8] Further information is available at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_005435.

[9] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_138737.

[10] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities* (Washington, DC, February 2010), https://www.kff.org/medicaid/upload/8048.pdf.

[11] The policy does not apply to private rooms, which comprise nearly a third of all nursing home beds.

*Long-term Care Insurance*

Minnesota ranked 9th on the number of private long-term care policies in effect per 1,000 people aged 40 or older. Private long-term care insurance is an important option for covering LTSS in Minnesota.

One insurance industry official attributed the state's ranking to a series of factors. In 1988, the state published county-based estimates of the aging of the population by 2030. The data stimulated extensive discussion of the need to prepare for a dramatic increase in demand for LTSS, a demand that could not be covered by public resources alone. Other factors are as follows:

- In addition to the federal tax incentives, in 1997, the Minnesota legislature passed a bill allowing a tax credit of 25 percent of the premium up to $100 per year for policy owners.
- Minnesota sponsored a group plan for state employees in 2002.
- Minnesota's larger employers offer long-term care insurance as a voluntary benefit.
- State officials promote discussion of the risks of requiring LTSS and the need to prepare for the future.
- The state is working with the federal program, Own Your Future, and is contemplating a mailing of as many as a million and a half letters to households of older Minnesotans suggesting that they consider ways of building resources to pay for their future LTSS needs. Such a mailing will likely stimulate some interest in long-term care insurance.

*Access to Medicaid Services*

Minnesota ranked 12th on the percentage of adults with an ADL disability and limited income who receive Medicaid. Minnesota ranked first on the percentage of adults with an ADL disability and limited income who receive Medicaid LTSS, either nursing home or HCBS services.

In addition to financial eligibility rules, a review of Minnesota program operations shows that access is aided by the provision of information about LTSS and one-on-one consultation about LTSS options.

Minnesota's ADRC, the Minnesota Help Network, provides information and assistance about LTSS through four channels—direct assistance from call centers in Area Agencies on Aging, through Centers for Independent Living, via the Internet (e-mail messages, instant messaging), and from LTCC staff. Printed materials are available in health clinics, physicians' offices, hospitals, and discharge planners. Videoconferencing (webcam) is also available but is seldom used. Documents needed to determine eligibility can be transmitted securely to expedite decision making.

Minnesota provides extensive information to the public about LTSS. Long-term care consultation service (LTCC), formerly known as preadmission screening, includes services to help people make decisions about long-term care. In this form of options counseling, consultants help people and their families choose services based on their needs and preferences. LTCC is

provided by county teams consisting of a social worker and a public health nurse. The team is supposed to provide information and education about local long-term care options, complete a visit to assess needs and help plan services, offer information about public programs that cover LTSS, and provide transition assistance for people who want to move to a community setting from a nursing home. While most people requesting LTCC are older adults, LTCC is available to people of all ages with long-term or chronic care needs. All older adults receive a health risk screen that includes LTSS needs shortly after they enroll in a managed LTSS plan. Prior to the managed LTSS program expansion, new Medicaid beneficiaries had to seek additional information about waiver services on their own. The risk screening streamlines access to LTSS for everyone who needs them.

Members of the team must conduct a visit within 15 days from the date of a request for an assessment. The LTCC effort is an effective method to support efficient access services, and in fiscal year (FY) 2010, information about admission to a nursing home was provided to 57,000 people. Minnesota also has an active website, www.minnesotahelp.info, and a telephone access line, the Senior LinkAge Line to provide information about LTSS options.

Several factors may contribute to the relative unaffordability of home care in Minnesota. Higher wages among nurses and home health aides may be a contributing factor. Bureau of Labor Statistics data for May 2010 show that Minnesota ranked 12th among states in terms of annual salaries for registered nurses[12] and 19th in terms of annual wages for home health aides.[13] One informant commented that Minnesota has a long history of union activity, which might contribute to its high home care costs.

Choice of Setting and Provider

The dimension in which Minnesota scored highest was *Choice of Setting and Provider*. A major factor is the state's effectiveness in serving people in HCBS settings. Ranked 3rd on Medicaid "balancing," Minnesota spends 60 percent of its LTSS dollars on HCBS. It ranked first on another measure of balance—its ability to serve new LTSS users in HCBS settings. At 83.3 percent, Minnesota's effectiveness on this indicator is far above the national median of 49.9 percent. Minnesota also ranked first on the availability of assisted living and residential care alternatives.

Below are seven factors that may account for Minnesota's high ranking on these indicators:

- Vision
- Effective transition programs
- HCBS spending
- Waiver programs
- Use of managed care to support home and community-based care

[12] See Bureau of Labor, http://data.bls.gov/oes/search.jsp?data_tool=OES.
[13] Ibid.

- Residential alternatives
- Reduction in the excess supply of nursing home beds

*Vision*

These high rankings reflect significant policy decisions emphasizing LTSS that have been in place for almost two decades. Minnesota's commitment to HCBS evolved under strong leadership from a series of state officials in the DHS and the Aging and Adult Services and Disability Services Divisions.

The current DHS vision is articulated in the "Framework for the Future: 2012"[14] and is based on four core values:

- A focus on people, not programs
- Providing ladders up and safety nets for the people served
- Working in partnership with others
- Accountability for results

A primary imperative of the "people" focus is to increase the number of Minnesotans served in their homes and communities rather than in institutions. Other features include the integration of primary care, behavioral health, and long-term care and a campaign to encourage people to plan for future LTSS needs. The Framework calls for implementation of MnCHOICES, an automated web-based "assessment tool to better align services to individual needs."[15]

Minnesota's emphasis on care coordination is a tangible expression of this vision, since it helps ensure that people are afforded the opportunity to use HCBS services. Under the fee-for-service system, state agencies contracted with counties for HCBS waiver case management services. The emergence of a statewide managed LTSS system has changed the contracting arrangements. Health plans are responsible for care coordination. Some health plans are county sponsored and continue to contract with a county agency for care coordination. A few health plans do not contract with counties. Care coordination is broader than waiver case management; it includes access to primary care, follow-up of health conditions, implementation of quality improvement initiatives, and health monitoring. Care coordination is provided to all members, not just those receiving waiver services. The development of the health care home model is also focusing attention on the most efficient ways to coordinate care across programs and payer sources.

[14] Department of Human Services, "Framework for the Future: 2012," https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464-ENG.

[15] MnCHOICES is a single assessment tool that will replace assessment tools that are used for specific programs. The tool will be used to determine eligibility for the elderly waiver, the state-funded alternative care program, the Community Alternatives for Disabled Individuals waiver, state plan personal care and home health services, other state plan services, waivers serving individuals with intellectual/developmental disabilities, and admission to a nursing home.

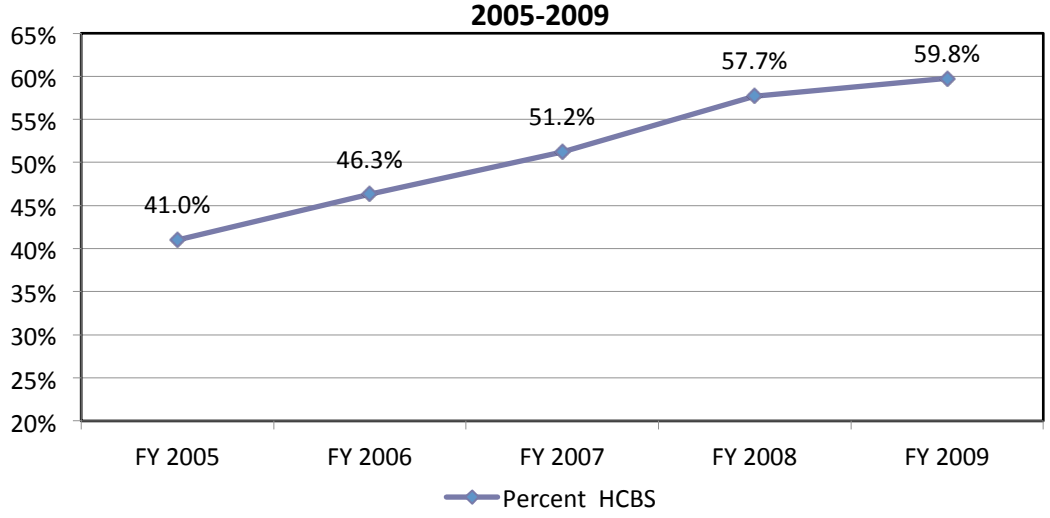
*Effective Transition Programs*

Minnesota has two programs that help people move from nursing homes to the community. The Return to the Community program was implemented in 2010. It offers support to residents who have a nursing home stay of 90 days or less from the date of admission; have the desire and/or support to return to the community; have a high probability of community discharge; and are at risk of a lengthy stay. Since April 2010, 372 individuals have moved from a nursing home to a community setting under this program. The Money Follows the Person demonstration program began in 2011 and is projected to transition 741 older adults and 179 adults with physical disabilities by the end of 2016.

*HCBS Spending*

Until the 2008 recession, Minnesota had steadily expanded its HCBS funding as a percentage of all LTSS spending[16] (see figure 1).

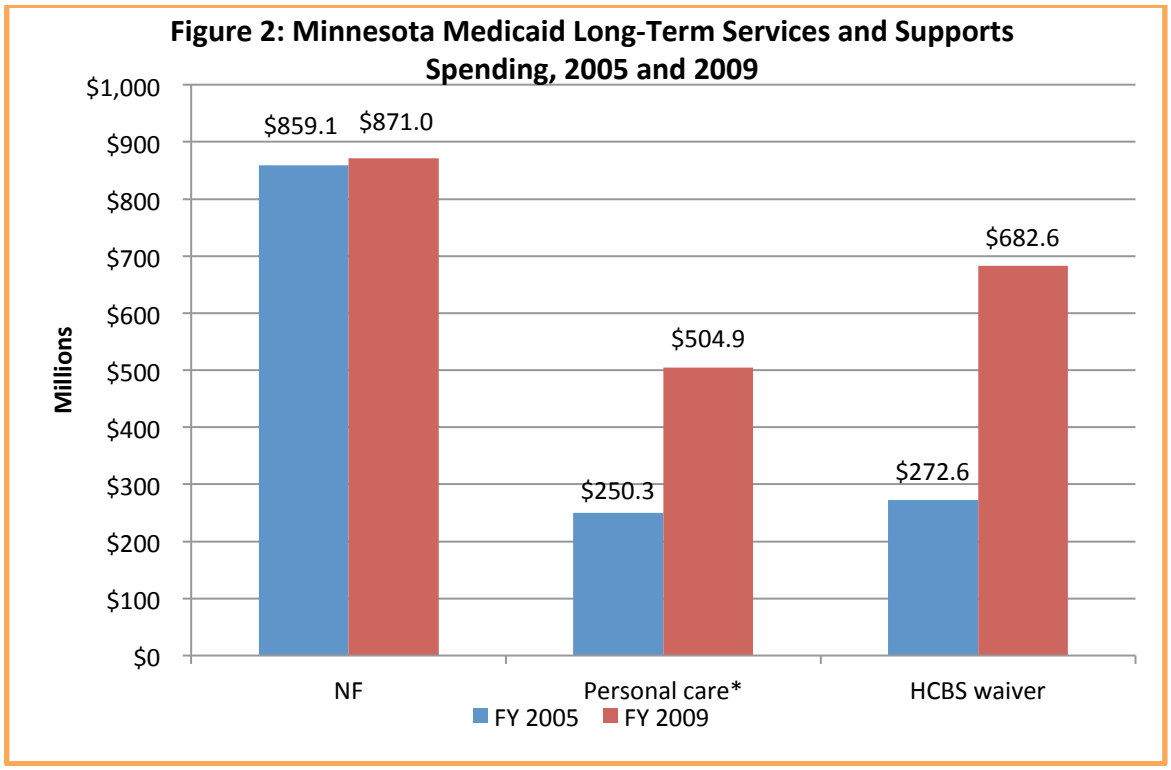
**Figure 1: Percent of HCBS Spending in Minnesota Medicaid Program, 2005-2009**




Data source: Thomson Reuters.
Note: FY 2005 to 2007 percentages do not include HCBS spending through managed care programs.

[16] S. Eiken, K. Sredl, B. Burwell, and L. Gold, *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update* (Thomson Reuters, 2011), p. 49, http://www.hcbs.org/files/208/10395/2011LTSSExpenditures-final.pdf.

Figure 2 illustrates Medicaid spending trends by type of service.[17]



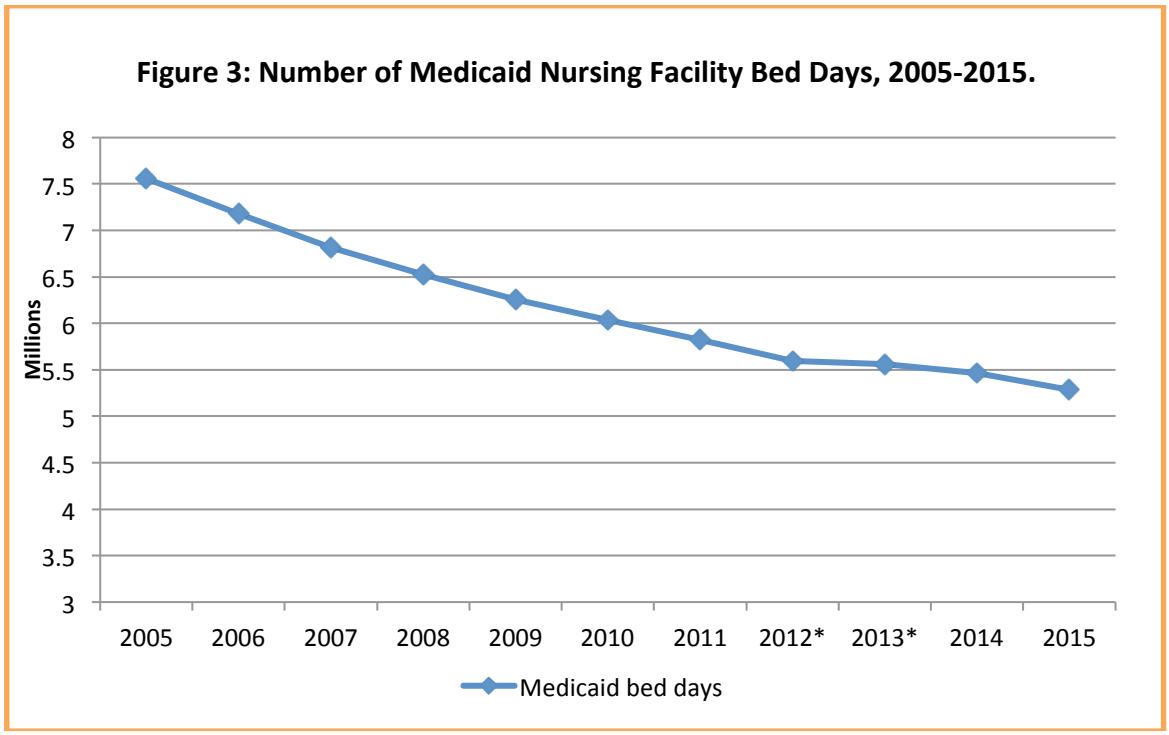

Data source: Thomson Reuters.
Note: Personal care spending includes spending for all Medicaid beneficiaries.

The February 2012 budget forecast projects a decline in nursing home spending from $795.9 million in FY 2011 to $769.9 million by FY 2015. The number of Medicaid beneficiaries in nursing homes is projected to drop from 17,535 in FY 2011 to 16,225 by FY 2015.[18]

Paralleling the funding changes, the emphasis on providing a broad range of LTSS reduced Medicaid nursing home utilization over the past decade. In December 2005, 19,774 residents, or 59.1 percent of all residents, were Medicaid beneficiaries. In December 2011, 15,753, or 55.5 percent, were Medicaid beneficiaries, a drop of more than 4,000 residents.[19]

The number of Medicaid "bed days" is a good indicator of nursing home utilization, since it reflects both the length of stay and the number of days that Medicaid actually pays for. Over a 10-year period from FY 2005 to FY 2015, the number of Medicaid bed days is projected to decline by 30 percent (see figure 3).[20]

[17] Ibid.
[18] See background tables for 2012 February forecast provided by the Aging and Adults Services Division, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_016358.
[19] Online Survey and Certification and Reporting data compiled by the American Health Care Association.
[20] See background tables for 2012 February forecast provided by the Aging and Adults Services Division.




Data source: Minnesota DHS Budget Forecast, February 2012.

*Home and Community-Based Services Programs*

While Medicaid bed days have declined, the number of HCBS participants has grown steadily, from 23,000 in 2001 to 34,000 in 2009.[21] DHS provides services through five HCBS programs for older adults and adults with physical disabilities—the Elderly Waiver Program, the Community Alternatives for Disabled Individuals, the Brain Injury waiver, the Community Alternative Care waiver, and a state-funded Alternative Care Program.

The Alternative Care and Elderly Waiver programs fund HCBS for people age 65 and older who require the level of care provided in a nursing home. County financial workers determine financial eligibility for payment of Alternative Care and Elderly Waiver services.[22]

Alternative Care services are available to people whose income and assets would not cover a nursing home admission for more than 135 days. The monthly cost of services must be less than 75 percent of the average Medicaid payment limit for older people with a comparable case mix classification. Participants pay a portion of the costs (not to exceed 30 percent of service costs) based on a sliding scale.

[21] Long Term Care Realignment Section 1115 waiver request, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_167144.

[22] Information about the Elderly Waiver and the Alternative Care Programs are from the program manual, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_056766.

The Alternative Care program is for people who are not financially eligible for Medicaid. It provides limited HCBS for people age 65 or older. For FY 2011, the Alternative Care program served 4,812 people and spent a total of $28.6 million in state revenues. The average monthly cost per enrollee was $496, and the program served an average of 3,086 participants a month.[23]

In FY 2011, the Elderly Waiver program served 28,158 unduplicated individuals through two managed care options. The Minnesota Senior Health Options (MSHO) is an integrated Medicaid/Medicare health care and long-term care option that began in 1997. The Minnesota Senior Care Plus (MSC+) program is a mandatory Medicaid health care program that began in 1983 and added a long-term care component between 2005 and 2008. About 1,700 Elderly Waiver participants are exempt from enrolling in managed care and remain in the fee-for-service system. At the end of FY 2011, 93 percent of the Elderly Waiver clients received services through a managed care organization.

Total spending for the Elderly Waiver program in FY 2011 was $310.8 million in state and federal funds.[24] The average monthly number of Elderly Waiver participants for FY 2011 was 21,783, with an average monthly cost of $1,577 per fee-for-service participant and $1,155 per managed care participant.

DHS also manages a separate waiver for children and adults with physical disabilities and individuals with mental illness. The Community Alternatives for Disabled Individuals (CADI) Waiver provides funding for HCBS for children and adults who would otherwise require the level of care provided in a nursing home. CADI Waiver services may be provided in a person's own home, his/her biological or adoptive family's home, a relative's home, a family foster care home or corporate foster care home, a board and lodging home, or an assisted living facility. In FY 2011, spending for the CADI Waiver was $468.1 million. The waiver served an average of 15,695 participants a month at an average monthly cost of $2,515.14.[25]

The Community Alternative Care (CAC) waiver serves individuals under age 65 who require the level of care provided in a hospital. The waiver served an average of 314 people a month in FY 2011. The average monthly cost was $5,283 per participant. The Brain Injury waiver serves individuals who require the level of care provided in a hospital or a neuro-behavioral hospital. This waiver served an average of 1,349 people a month in FY 2011. The average monthly cost was $5,969 per participant.[26]

As shown in table 2, Minnesota's waiver services are extensive and provide access to multiple HCBS services.

[23] See background tables for 2012 February forecast provided by the Aging and Adults Services Division.
[24] Ibid.
[25] Ibid.
[26] Ibid.

**Table 2: HCBS Service Array for Older Adults and Adults with Physical Disabilities**

| Home and Community-Based Services | Coverage by Program | | | | |
|---|---|---|---|---|---|
| | Elderly waiver | CADI waiver | Brain injury waiver | CAC waiver | Alternative care |
| 24-hour customized living | ● | ● | ● | | |
| 24-hour emergency assistance | | ● | ● | | |
| Adult day services | ● | ● | ● | | ● |
| Adult day services bath | ● | ● | | | ● |
| Behavior programming | | | ● | | |
| Caregiver assessment | | | | | ● |
| Caregiver living expenses | | ● | ● | | ● |
| Case management | ● | ● | ● | ● | ● |
| Chore services | ● | ● | ● | | ● |
| Companion services | ● | ● | ● | | ● |
| Consumer-directed community supports | ● | ● | ● | ● | ● |
| Customized living services | ● | ● | ● | | |
| Environmental accessibility adaptations | ● | ● | ● | ● | ● |
| Extended home care services | ● | ● | | ● | ● |
| Family counseling and training | | ● | ● | ● | |
| Foster care | ● | ● | ● | ● | |
| Home-delivered meals | ● | ● | ● | ● | ● |
| Homemaker services | ● | ● | ● | | ● |
| Housing access coordination | | ● | ● | | |
| Independent living skills (ILS) | | ● | ● | | |
| ILS therapies | | | ● | | |
| Night supervision services | | | ● | | |
| Nutrition services | | | | | ● |
| Personal Emergency Response System | | | | | ● |
| Prevocational services | | ● | ● | | |
| Personal care assistant | ● | | | | |

| Home and Community-Based Services | Coverage by Program | | | | |
|---|---|---|---|---|---|
| | Elderly waiver | CADI waiver | Brain injury waiver | CAC waiver | Alternative care |
| Residential care | ● | ● | ● | | |
| Respite care | ● | ● | ● | ● | ● |
| Skilled nursing | | | | | |
| Specialized equipment and supplies | ● | ● | ● | ● | ● |
| Supported employment services | | ● | ● | | |
| Tele-home care | ● | | | | ● |
| Training for informal caregivers | ● | | | | |
| Transitional supports | ● | ● | ● | ● | |
| Transportation | | ● | ● | ● | |

Data source: Compiled by AARP from Minnesota CMS 372 Elderly Waiver report, Program Fact Sheets, and Program Manuals.

*Use of Managed Care to Support Home and Community-based Care*

Older adults (65+) have been required to enroll in Medicaid managed care for primary and acute care services since 1983. DHS contracts with eight health plans statewide. Enrollment in a health plan is mandatory for the vast majority of the state's 56,000 Medicaid beneficiaries. About 10 percent are exempt for a variety of reasons. Health plans provide additional member services, transportation, primary care/care system/medical homes, interpreter services, enhanced care coordination, monitoring, and facilitation of access to services above what is normally provided in fee-for-service.

MSHO integrates Medicare and Medicaid primary care, acute care, prescription drugs, home care, and other long-term care services, as well as Elderly Waiver services and nursing home care. MSHO plans provide all Medicare services, including Part D prescription drugs. Enrollment is voluntary and free of charge. MSHO serves about 37,000 dually eligible older adults through contracts with eight Medicare Advantage Special Needs Plans.

The MSC+ program serves eligible beneficiaries age 65 and older. The program, which expanded to managed LTSS statewide starting in 2005, covers primary care, acute care, Medicaid state plan home care, Elderly Waiver services, and nursing home care for enrollees who enter a nursing home after enrollment. MSC+ does not include Medicare services or Medicare Part D prescription drugs. MSC+ members must obtain their Medicare Part D drugs through a separate Medicare prescription drug plan. Enrollment in MSC+ is mandatory. MSC+ currently serves 11,500 people, both those who are dually eligible for both Medicaid and Medicare and people who are not dually eligible.

Minnesota capitates two community rate cells and makes a nursing home "add-on" to each rate cell. The first cell is a community rate for people who are well and need basic state plan primary and acute care services. The second rate is for people who are receiving or who will probably need HCBS. When a person is admitted to a nursing home, the plan no longer receives the well community or HCBS rate, but receives a much lower payment for basic state plan services and is responsible for paying for the first 180 days in the nursing home. The member remains enrolled even when the per diem payment reverts to fee-for-service after the 180 days. The 180 days are counted cumulatively over time, so it could take years before the benefit is exhausted. Once completed, the 180-day period may recur if a person leaves the nursing home and returns to the community.

The average length of stay for a person in a Minnesota nursing home in the first year is 150 days. These capitation arrangements create a financial incentive for the plans to minimize nursing home utilization, since the plans are at risk for significant amounts of nursing home utilization.

Moreover, the capitation payments also discourage hospital admissions. Plans are not at risk for LTSS for new beneficiaries who are already in a nursing home when they enter the plan. The state would continue to pay for their nursing home days. However, should the beneficiary leave the home and be admitted to the hospital, then the MSHO plan is at risk for the cost of the hospitalization and any postacute care that may be required.

*Residential Alternatives*

Minnesota reported the most assisted living and residential care units (ranked first in the *Scorecard*). In July 2010, it had 954 establishments registered as housing with services, with a capacity to serve 36,310 individuals. The term "housing with services" is similar to assisted living in other states. Minnesota also reported 4,814 adult foster homes, with a capacity to serve 17,393 individuals. Adult foster home care is defined as the provision of food, lodging, protection, supervision, and household services to a functionally impaired adult in a residence; it may include the provision of personal care, household and living skills assistance or training, medication assistance, and assistance safeguarding cash resources. Adult foster homes provide 24-hour care to no more than four functionally impaired residents.

State officials expressed concerns about the impact of the growth of assisted living on Medicaid spending and the pace of spend-down to Medicaid eligibility by private-pay residents with low care needs. While Medicaid beneficiaries account for 8 to 12 percent of assisted living residents, 35 percent of all Elderly Waiver participants live in assisted living settings, and they account for 65 percent of Elderly Waiver spending. Among private-pay residents, 60 percent have low care needs. State officials noted that private-pay residents with low care needs spend their assets and resources to Medicaid eligibility levels more quickly, and they could be served at home.

In 2011 the legislature passed a law requiring that all establishments registered as housing with services inform all prospective residents that they need to call the Senior LinkAge line for information about long-term services and supports. Prospective residents may decline to receive the information, but they must document that they made the call by obtaining a verification number. The establishments must verify that the prospective resident has a verification number

before he or she signs a lease or contract. Prior to instituting the mandatory screening program, the state had a voluntary program and found that 50 percent of the people who called the Senior LinkAge line who planned to enter a housing with services establishment remained at home after learning about their home care service alternatives.

State agencies worked with the health plans to develop a tool that is used for assessment and rate setting for all Elderly Waiver participants who live in housing with services establishments. State officials are considering two initiatives that will promote alternatives to living in housing with services establishments. First, the state is discussing raising the medical necessity criteria for "customized living" services under the Elderly Waiver. Second, policymakers are considering expanding an "in-home support" service to include a package of services that enable individuals with lower care needs to stay in their own homes and prevent or delay admission to housing with services establishments.

Quality of Life and Quality of Care

Minnesota scored in the top quartile on six of the nine indicators in the dimension of *Quality of Life and Quality of Care*.

Minnesota funded significant efforts to improve quality in nursing homes through a pay-for-performance program called PIPP. Funded at $18 million annually, PIPP is a project-based incentive program that solicits applications from nursing homes, selects projects, and funds homes to improve the quality of care and/or quality of life.[27] The state has published data showing that homes that participate in this program have higher rates of improvement in both quality of life and quality of care compared with homes that have not participated.[28]

Pressure sores and the use of restraints have been frequent targets for improvement over the past 20 years at both the national and state levels. In Minnesota, Stratis Health, the state's quality improvement organization, has made recent efforts to reduce the prevalence of pressure sores and the use of physical restraints in nursing homes. Stratis targeted homes that have lower quality of care rates and provided free consultation to them. Provider associations also sponsor periodic educational sessions on pressure sores and the use of restraints and fall prevention. Additionally, the state sponsored projects that affect the use of restraints. For example, PIPP funded homes to reduce the amount of psychotropic medication used and to prevent falls. Homes that use more psychotropic medication also tend to use more restraints, and fall prevention programs reduce the use of physical restraints to prevent falls.

Minnesota ranked first for the low percentage of nursing home residents with a hospital admission.[29] Minnesota's health care providers are interlinked through years of working together. Admissions from nursing homes to hospitals and hospital readmissions have been identified as issues that should be addressed. At least two significant efforts are currently underway in Minnesota. Reducing Avoidable Readmissions Effectively (RARE) is a campaign

[27] See Minnesota's 2012 request for proposals, http://www.agingservicesmn.org/inc/data/idcplg.doc.
[28] For example, see http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_166684.
[29] Minnesota had the lowest percentage of hospital readmissions nationally.

led by the Institute for Clinical Systems Improvement, the Minnesota Hospital Association, and Stratis Health. RARE sponsors three collaboratives, each focusing on a particular model for reducing admissions: Coleman's Care Transition model, Project Red, and the Safe Transitions model.[30] All of the MSHO and MSC+ health plans participate in this initiative. PIPP has also funded nursing homes to study Interventions to Reduce Acute Care Transfers (INTERACT II), a quality improvement model focused on nursing home residents with acute conditions.[31]

Despite its generally high quality rankings, Minnesota scored in the third quartile on the two quality indicators related to home health: the percentage of at-risk home health patients whose plan of care documented intervention to reduce pressure sores; and the percentage of home health patients with a hospital admission. Although the percentage differences between Minnesota and national averages were small, these findings stand out in contrast to otherwise high ranks. Interviewees could not explain these differences. Yet what is notable is the state's quick response to the *Scorecard* findings. Rather than simply congratulating itself on its first place rank, a supplemental budget request includes funds to examine the quality of home care services to address the rate of home health clients with a hospital admission. A health care task force was appointed in November 2011 that could also examine this area. One of the working principles of the task force is "Minnesotans must prepare for decisions and needs they will face as they age, and we must ensure that our systems of care and financing— acute and long-term care, health care and community-based services—are prepared to meet these needs."[32]

The task force includes work groups on access, care integration/payment reform, prevention/public health, and the health workforce. The purpose of the work groups is to gather information on key health care issues and provide the full task force with policy recommendations on specific topics. The task force will submit its report to the Governor and the legislature by November 30, 2012.

The AARP state office is considering developing approaches that are similar to PIPP, which has been successful in nursing facilities.

Minnesota scored in the top quartile on the relative rate of employment of adults with physical disabilities compared with all adult employment. Minnesota state staffs described a decade of sustained work. In 1999, Minnesota implemented a Medicaid buy-in program called Medical Assistance for Employed Persons with Disabilities. In addition, Minnesota was awarded a Medicaid Infrastructure Grant in 2000 and created the Pathways to Employment program. Over the decade, the state developed an array of improvements in services to increase employment of people with disabilities. For example, the state has—

- Created a support center focusing on employment called Minnesota Employment Training and Technical Assistance Support Center[33]
- Started Annual Disability and Employment Conferences

[30] For more information about RARE, see http://www.rarereadmissions.org/about/index.html.
[31] For more information about INTERCT II, see http://interact2.net/index.aspx.
[32] Minnesota Health Care Task Force Summary, http://mn.gov/health-reform/images/Task-Force-and-Work-Groups-Summary-2012-01-31.pdf.
[33] See http://www.mntat.org/main/index.asp.

- Set up a Disability Linkage Line, which is a free, statewide information and referral resource that includes information about work
- Conducted periodic consumer satisfaction surveys
- Included a range of employment-related services through HCBS waivers and other authorities
- Established a monitoring system that tracks the employment and wages of each person receiving services from counties and their contractors

Regardless of their program responsibilities, Minnesota staffs always describe their vision for ensuring that program efforts increase employment opportunities and policy and program initiatives that lead to fulfilling the vision.

What is also noteworthy about Minnesota's employment efforts for people with disabilities efforts is a clearly articulated vision that people with disabilities must have real jobs in the community and live in their own homes. The emphasis on real jobs is accomplished through the local programs that develop real employment opportunities and the use of data systems that track employment income by county and contractor. Counties and contractors that lag behind others are monitored and required to develop corrective action plans. State staffs said that "make-work" roles in contractor workshops are not acceptable. The emphasis on living at home is tied to planning for the future that seeks to build sustainable programs.

A decade of sustained employment efforts and a determined vision contribute to Minnesota's high ranking on employment of people with disabilities.

Support for Family Caregivers

Minnesota ranked 4th on the *Support for Family Caregivers* dimension. Its 3rd place rank on the percentage of caregivers who felt they were getting needed support is not surprising, given the high level of state performance nearly across the board. In particular, Minnesota has worked intensively on caregiver consultation and care coordination and provides services that accommodate individual care needs. Minnesota allows a range of nurse delegation for most tasks except for insulin use and the intramuscular injection of medications.

*Reform Initiatives*

Two initiatives over which state policymakers have direct control may have an impact on the *Scorecard* indicators. First, a Long-Term Care Realignment §1115 Demonstration waiver proposal was submitted to CMS in February 2012. The initiative is based on legislation passed in 2009 that Minnesota was unable to implement due to federal maintenance-of-effort requirements. The proposal is intended to increase program stability by ensuring that higher-intensity, higher-cost services are used only when necessary. The proposed changes in Medicaid eligibility and coverage are a response to demographic and budgetary pressures that pose risks to the state's capacity to maintain its leadership status. Absent this change, the state would direct DHS to

"implement a 1.67 percent rate reduction for long-term care providers, excluding nursing homes, from July 1, 2012, to December 31, 2013."[34]
The Realignment §1115 waiver proposal would raise the level of care for admission to a nursing home and offer a limited benefit package of "low-cost, high-impact" Essential Community Supports of up to $400 a month to Medicaid beneficiaries who would no longer meet the nursing home level of care criteria.[35] This change in eligibility is estimated to affect approximately 4,500 people.[36]

The §1115 proposal will also provide Medicaid coverage for a "more robust package of services" through the Alternative Care program for individuals who meet the nursing home level of care standards but whose income and resources exceed current Medicaid standards.[37]

Minnesota's current nursing home level of care criteria require periodic or ongoing physical assistance, supervision or cuing with one ADL impairment or periodic or ongoing assistance, or supervision or cuing with IADLs.[38] Under the proposed criteria, Medicaid beneficiaries would have to require daily clinical monitoring; or need assistance or constant supervision in four or more ADLs (bathing, dressing, eating, grooming, and walking); or need assistance or constant supervision that cannot be scheduled in one critical ADL (toileting, transferring, or positioning); or have significant difficulty with memory or behavior; or live alone and be at risk (have experienced a fall resulting in a fracture, be at risk of neglect or abuse, or have a sensory impairment that affects functional ability and maintenance of a community residence).

The proposal was developed because "despite past success, continuing reform is needed to ensure the viability of the state's public programs for our most vulnerable citizens." The proposal cited the pressures on the growth of public long-term care spending due to the increase in the proportion of the population over age 65, which will increase 40 percent between 2010 and 2020. Changes to the level of care criteria will save a projected $18 million in the first year, $44 million in the second year, and $54 million in the third year.

The state proposes to continue Medicaid payments for individuals who are financially eligible for Medicaid in a nursing home who do not meet the revised level of care criteria. The proposed level of care changes will also apply to §1915(c) HCBS waiver programs. A review of waiver participants determined that 13 percent of the current Elderly Waiver participants would lose eligibility for waiver services. However, 84 percent of this group would be eligible for Alternative Care and Essential Community Support services. Individuals who are no longer

[34] Department of Human Services, Long Term Care Realignment Section 1115 waiver request, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_167144.
[35] Essential Community Supports will include service coordination, personal emergency response, homemaker services, chore services, caregiver support and education, home-delivered meals, and community living assistance (assistance and support for basic living and social skills, household management, medication education and assistance, monitoring of well-being and problem solving).
[36] Interviewees provided estimates that the following numbers of people would lose their eligibility for Medicaid LTSS services: 3 percent of the CADI waiver (500 people), 3 percent of the Elderly Waiver (3,049), 8.6 percent of the Alternative Care program (269), and 2 percent of the people in nursing homes (700).
[37] Department of Human Services, Long Term Care Realignment Section 1115 waiver request.
[38] Ibid.

eligible for Elderly Waiver services will be eligible to receive Medicaid state plan personal care and home health services, depending on their financial eligibility.

The AARP state office and other stakeholders submitted letters to DHS describing concerns about the proposal. The letters raised questions about the needs of Medicaid beneficiaries who will lose eligibility for services, whether the services available to beneficiaries who will not meet the revised level of care criteria will be adequate, and other issues.[39]

In addition to the Realignment initiative, DHS is pursuing further integration of the Medicare and Medicaid programs for people who are dually eligible for both programs. Minnesota was one of 15 states to receive a grant from CMS to plan and design a new delivery and payment system model that integrates health care for dual eligibles.[40] Under the grant, the state plans to "improve performance of primary care and care coordination models for dual eligibles served in integrated Medicare and Medicaid Special Needs Plans and fee for service delivery systems by building on current State initiatives."[41]

## Summary and Conclusions

Minnesota has a mature, well-established LTSS system that provides alternatives to nursing homes for people seeking publicly supported service. The state funds both Medicaid and non-Medicaid HCBS programs, and is a national leader in operating integrated health and LTSS managed care programs. The state achieved its success because of the strong leadership from a series of DHS commissioners and division directors over a 20-year period. The state also attempts to offer cost-effective programs and encourages Minnesotans to plan for their future LTSS needs (e.g., through promoting the purchase of private long-term care insurance).

The realignment proposal to increase nursing home eligibility requirements is another example of the state's philosophy of offering cost-effective programs. The state supports HCBS services because policymakers believe they are cost-effective, a belief expressed in Minnesota's budget forecasting models. For example, the models assume that reductions in HCBS spending will lead to an increase in Medicaid nursing home utilization.

Like other states, Minnesota faces budgetary and demographic challenges that threaten its ability to meet the needs of people with health and functional limitations. Despite these financial challenges, Minnesota health policymakers are developing the next generation of policies that link housing, employment, livable community concepts, long-term care insurance products, caregiver support policies, technology changes, and managed care innovations.

---

[39] For further information about stakeholder comments, see Public Comments. Long Term Care Realignment Section 1115 waiver request, appendix 5, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_167144.

[40] Department of Human Services, Proposal for State Demonstration to Integrate Care for Dually Eligible Individuals (2011), http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_163568

[41] For a summary of the Minnesota proposal, see http://www.cms.gov/medicare-medicaid-coordination/05_StateDesignContractSummaries.asp#TopOfPage.



*Support for this research was provided, in part, by The Commonwealth Fund and The SCAN Foundation.*

Appendix A

Minnesota's Ranking on Each of the 25 indicators

| Dimension and Indicator | Year | State Rate | All States Median | Top 5 States Average | Best State Rate | Rank |
|---|---|---|---|---|---|---|
| **Affordability and Access** | | | | | | **4** |
| Median annual cost for private-pay nursing home resident, as percentage of median household income, age 65 | 2010 | 219 | 224 | 171 | 166 | 21 |
| Median annual cost for private-pay home care, as percentage of median household income, age 65 | 2010 | 110 | 89 | 69 | 55 | 48 |
| Private long-term care insurance policies in effect per 1,000 population, age 40 | 2009 | 71 | 41 | 150 | 300 | 9 |
| Percentage of low-income adults at or below 250% of poverty level with ADL disability and enrolled in Medicaid or other public health insurance, age 21 | 2008-09 | 53.9 | 49.9 | 62.2 | 63.6 | 12 |
| Medicaid LTSS participant years per 100 adults with ADL disability in nursing homes or living in the community at or below 250% of poverty level, age 21 | 2007 | 74.6 | 36.1 | 63.4 | 74.6 | 1 |
| Ability to access LTSS system through ADRC or other single entry point (composite indicator, rated on 0–12 scale) | 2010 | 11 | 7.7 | 10.5 | 11 | 1 |

| Dimension and Indicator | Year | State Rate | All States | Top 5 States | Best State Rate | Rank |
|---|---|---|---|---|---|---|
| | | | Median | Average | | |
| **Choice of Setting and Provider** | | | | | | **3** |
| Percentage of Medicaid and state-funded LTSS spending going to home- and community-based services for older people and adults with physical disabilities | 2009 | 60 | 29.7 | 59.9 | 63.9 | 3 |
| Percentage of new Medicaid LTSS users first receiving services in the community | 2007 | 83.3 | 49.9 | 77.1 | 83.3 | 1 |
| Number of people with disabilities directing own services, per 1,000 adults age 18 | 2010 | 12.2 | 8 | 69.4 | 142.7 | 20 |
| Tools and programs to facilitate consumer choice (composite indicator, rated on 0–4 scale) | 2010 | 2.9 | 2.75 | 3.79 | 4 | 16 |
| Home health and personal care aides per 1,000 population age 65 | 2009 | 108 | 34 | 88 | 108 | 1 |
| Assisted living and residential care units per 1,000 population age 65 | 2010 | 80 | 29 | 64 | 80 | 1 |
| Percentage of nursing home residents with low care needs | 2007 | 14.5 | 11.9 | 5.4 | 1.3 | 32 |

| Dimension and Indicator | Year | State Rate | All States | Top 5 States | Best State Rate | Rank |
|---|---|---|---|---|---|---|
| | | | Median | Average | | |
| **Quality of Life and Quality of Care** | | | | | | **4** |
| Percentage of adults age 18 with disabilities living in the community who usually or always get needed support | 2009 | 73.9 | 68.5 | 75.5 | 78.2 | 5 |
| Percentage of adults age 18 with disabilities living in the community who are satisfied or very satisfied with life | 2009 | 86.3 | 85 | 90.9 | 92.4 | 18 |
| Rate of employment for adults with ADL disability relative to rate of employment for adults without ADL disability, ages 18–64 | 2008-2009 | 36 | 24.2 | 42.4 | 56.6 | 5 |
| Percentage of high-risk nursing home residents with pressure sores | 2008 | 6.6 | 11.1 | 7.2 | 6.6 | 1 |
| Percentage of long-stay nursing home residents who were physically restrained | 2008 | 1.9 | 3.3 | 1.3 | 0.9 | 11 |
| Nursing home staffing turnover: ratio of employee terminations to average number of active employees | 2008 | 36.8 | 46.9 | 27.2 | 18.7 | 12 |
| Percentage of long-stay nursing home residents with hospital admission | 2008 | 8.3 | 18.9 | 10.4 | 8.3 | 1 |
| Percentage of home health episodes of care in which interventions to prevent pressure sores were included in care plan for at-risk patients | 2010 | 88 | 90 | 95 | 97 | 35 |
| Percentage of home health patients with hospital admission | 2008 | 31.3 | 29 | 23.2 | 21.8 | 37 |

| Dimension and Indicator | Year | State Rate | All States | Top 5 States | Best State Rate | Rank |
|---|---|---|---|---|---|---|
| | | | Median | Average | | |
| **Support for Family Caregivers** | | | | | | **4** |
| Percentage of caregivers who usually or always get needed support | 2009 | 81.7 | 78.2 | 82.2 | 84 | 3 |
| Legal and system supports for caregivers (composite indicator, rated on 0–12 scale) | 2010 | 3.7 | 3.17 | 5.9 | 6.43 | 17 |
| Number of health maintenance tasks able to be delegated to LTSS workers | 2011 | 13 | 7.5 | 16 | 16 | 13 |

See *Scorecard* website for Minnesota at http://www.longtermscorecard.org/DataByState/State.aspx?state=MN.