Status of Long-Term Services and Supports

Adult Mental Health
Aging and Adult Services
Children's Mental Health
Disability Services
Nursing Facility Rates and Policy

October 2013

Legislative Report

Minnesota Department of **Human Services**

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I. Executive Summary

This report summarizes the status of long-term services and supports for older adults, people with disabilities, children and youth with mental health conditions, and adults living with mental illnesses through calendar year 2012. It was developed in response to a legislative mandate (M.S. 144A.351) to biennially update the legislature on the effects of legislative initiatives to "rebalance" the state's long-term services and supports system.

As required by statute, this report includes demographic trends; estimates of the need for long-term services and supports; summary of statewide trends in the availability of long-term services and supports; and recommendations regarding the goals for the future of long-term services and supports.

Counties contributed data and comments on the changes that have occurred in the availability of services over the past two years. Health plans and county-based purchasing entities provided input on the availability of services for older adults. The most frequently identified gaps in service availability across these groups were chore service, companion service, respite care, transportation and adult day care. In addition, gaps were identified by the counties in the availability of a range of mental health services to support children and youth with mental health conditions and adults living with mental illnesses.

DHS contracted with The Improve Group to provide data and comments from stakeholders including persons who need or are using long-term services and supports; older adult, disability, and mental health organization representatives; service providers; and community members. Area Agencies on Aging assisted in the overall implementation process and provided logistical assistance to organize the focus groups conducted by The Improve Group. The top gaps identified by The Improve Group as a result of the input process confirmed many of the same gaps as in the county Gaps Analysis surveys and included services to help people maintain their own homes, transportation, employment, housing, respite care and mental health services.

II. Legislation

Minnesota Statutes 2012, section 144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS: REPORT REQUIRED.

The commissioners of health and human services, with the cooperation of counties and in consultation with stakeholders, including persons who need or are using long-term care services and supports, lead agencies, regional entities, senior, disability, and mental health organization representatives, service providers, and community members shall prepare a report to the legislature by August 15, 2013, and biennially thereafter, regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities and mental illnesses in Minnesota. The report shall address:

(1) demographics and need for long-term care services and supports in Minnesota;

(2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;

(3) status of long-term care services and related mental health services, housing options, and supports by county and region including:

(i) changes in availability of the range of long-term care services and housing options;

(ii) access problems, including access to the least restrictive and most integrated services and settings, regarding long-term care services; and

(iii) comparative measures of long-term care services availability, including serving people in their home areas near family, and changes over time; and

(4) recommendations regarding goals for the future of long-term care services and supports, policy and fiscal changes, and resource development and transition needs.

III. Introduction

Beginning in 2001 and every two years after, the Minnesota Department of Human Services (DHS) has reported on the current capacity and gaps in long-term services and supports and housing to support older adults in Minnesota. The primary source of this report was a survey completed by the counties to describe the capacity for these services in their local areas. Input was also gathered from health plans, county-based purchasing entities and the Area Agencies on Aging regarding the service capacity across the state. In 2012, the Legislature amended state statute to expand the scope of the survey and resulting report to include people with disabilities, children and youth with mental health conditions and adults living with mental illnesses.

DHS welcomed this opportunity to build on the successful Gaps Analysis Surveys on services for older adults to look across populations and systems to gauge the availability of services. Efforts to conduct a combined Gaps Analysis Survey for older adults and people with disabilities in 2007 had limited success. The results indicated a need for more training and financial support to incorporate disabilities into the existing survey process. In light of available resources, the Gaps Analysis returned to a solely aging-centered survey in 2009.

For this second attempt to conduct an expanded Gaps Analysis survey, DHS developed a separate survey to focus on services for each of the four populations. The surveys focusing on services for older adults and people with disabilities primarily asked about the availability of long-term services and supports. The surveys focusing on services for children and youth with mental health conditions and adults living with mental illnesses primarily asked about the availability of mental health treatment services. The Department recognizes that people will come to the system and may utilize any combination of services. This Gaps Analysis process will help us evaluate how to consolidate or analyze findings in the future to enhance the ability of Minnesotans to access the right service at the right time.

The term *long-term services and supports* refers to on-going supports that an individual needs due to a chronic health condition or disability. These services can be delivered in a person's home, in another community setting, or in an institutional setting. Currently, long-term services and supports is the nationally recognized term for this range of services and is used by the federal government. The term *home and community-based services* refers to long-term services and supports that are delivered in homes or other community-based settings, not in institutional settings. Home and community-based services are a subset of long-term services and supports.

A relatively small proportion of children and youth with mental health conditions and adults living with mental illnesses also use one or more long-term service or support. Most people with mental health conditions access other services, including mental health treatment services.

This report includes state-level summary data on the availability of mental health services; however, the primary focus of the report is on the status of long-term services and supports. To

that end, additional information is provided regarding current expenditures, utilization and availability of these services which includes home and community-based services and nursing home services. In total this information will be used by DHS, the Minnesota Board on Aging, Area Agencies on Aging and other regional and local entities to inform development efforts to fill gaps in service availability and enhance access to services.

The information contained in this report complements the data analysis completed for Reform 2020, which identified the scope and characteristics of individuals who would be impacted by the different reform elements, and the Service Access Study, which seeks to evaluate the impact of Medical Assistance rate reductions on participant access to long-term services and supports. As a whole, this data has and will continue to inform the work of the Olmstead Sub-Cabinet created through Executive Order by Governor Dayton in January 2013. The Olmstead Plan will outline measurable goals to increase the number of people with disabilities receiving services that best meet their needs in the most integrated setting. The Olmstead Plan is consistent and in accord with the United States Supreme Court's decision in Olmstead v. L.C., 527U.S.582 (1999).

This report is a culmination of the findings from several distinct but related projects, all of which are documented in more detail in separate stand-alone reports. These reports include separate Gaps Analysis Reports for each of the four populations included, county-level profiles of the Gaps Analysis results for each population (all of which can be found at www.dhs.state.mn.us/gapsanalysis), the full report from The Improve Group on the Community Services Input Project and the full report on the status of nursing home services.

IV. Demographic Trends and Need for Long-Term Services and Supports

The information below provides estimates of the total number of individuals in Minnesota who are living with a disability. A number of federal agencies use information on disability to distribute funds and develop programs for people with disabilities. For example, data about the size, distribution, and needs of people with disabilities are essential for developing disability employment policy. For the Americans with Disabilities Act, data about functional limitations are important to ensure that comparable public transportation services are available for all segments of the population. Federal grants are awarded, under the Older Americans Act, based on the number of elderly people with physical disabilities and cognitive difficulties.

The United States Census Bureau's American Community Survey estimates that Minnesota has had a lower disability rate than the national average in each of the last four surveys (2008-2011). Minnesota's disability rate has hovered around 10 percent while the national average is 12 percent. These estimates are based on self-reported disability and do not necessarily align with the number of individuals who would be certified as disabled.

The survey has six questions related to a disability. Two questions are asked regardless of age:
• "Is this person deaf or does he/she have serious difficulty hearing?"
• "Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?"

In addition to the first two questions, people five years of age and older (or their parent or legal guardian) are asked:
• "Because of a physical, mental, or emotional condition, does this person have serious difficulty concentrating, remembering, or making decisions?"
• "Does this person have serious difficulty walking or climbing stairs?"
• "Does this person have difficulty dressing or bathing?"

People age 15 and older are asked one additional question:
• "Because of a physical, mental, or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?"

Exhibit 1 shows the most recent Minnesota estimates of the number and percent of individuals with a disability in the community, by age. The United States Census Bureau did not include individuals living in group quarters in these estimates. In the 2011 American Community Survey group quarters was defined as a place where people live or stay, in a group living arrangement that is owned or managed by an entity or organization providing housing and/or services for the residents. This is not a typical household-type living arrangement. These services may include custodial or medical care as well as other types of assistance, and residency is commonly restricted to those receiving these services. People living in group quarters are usually not related to each other. Group quarters include such places as college residence halls, residential treatment

centers, skilled nursing facilities, group homes, military barracks, correctional facilities and workers' dormitories.[1]

Exhibit 1 - Number and percent of total population with a disability in the community, by age

Age Group	Total Minnesota Population	Number of individuals in Minnesota with a disability	Percent of Minnesota population with a disability
Under 5 years	352,449	2,750	1.0%
5 to 17 years	923,586	45,812	5.0%
18 to 34 years	1,219,414	62,051	5.0%
35 to 64 years	2,120,919	207,999	10.0%
65 to 74 years	363,348	77,800	21.0%
75 years and over	307,012	136,490	44.0%
Total	**5,286,728**	**532,902**	**10.0%**

Source: United States Census Bureau, American Community Survey, 2011

Approximately 30,000 individuals were living in nursing facilities in Minnesota on an average day in 2011. This includes short-term rehabilitation stays as well as long-term care, for all payer sources including Medical Assistance, private pay, Medicare, and private insurance. Approximately ninety percent of these individuals were age 65 or older while ten percent were under the age of 65.[2]

The state demographer projects that between 2005 and 2035, the number of Minnesotans age 65+ will double, from 600,000 to 1.3 million. The number of persons 85+ (who tend to need long-term care) will nearly double, growing to 163,000 and then double again by 2050, rising to 324,000 persons. By 2020, there will be more people 65 years or older than school-aged children in Minnesota.[3]

An increasing proportion of Minnesotans have a disability, mental illness or chronic condition. People with disabilities generally need support throughout their lives and due to medical advances people with disabilities are able to live longer, healthier lives than previous generations.

Supplemental Security Income is a federal income supplement program designed to help older adults and people with disabilities who have little to no income. Tracking enrollment in Supplemental Security Income is one way to gauge the proportion of Minnesotans with a

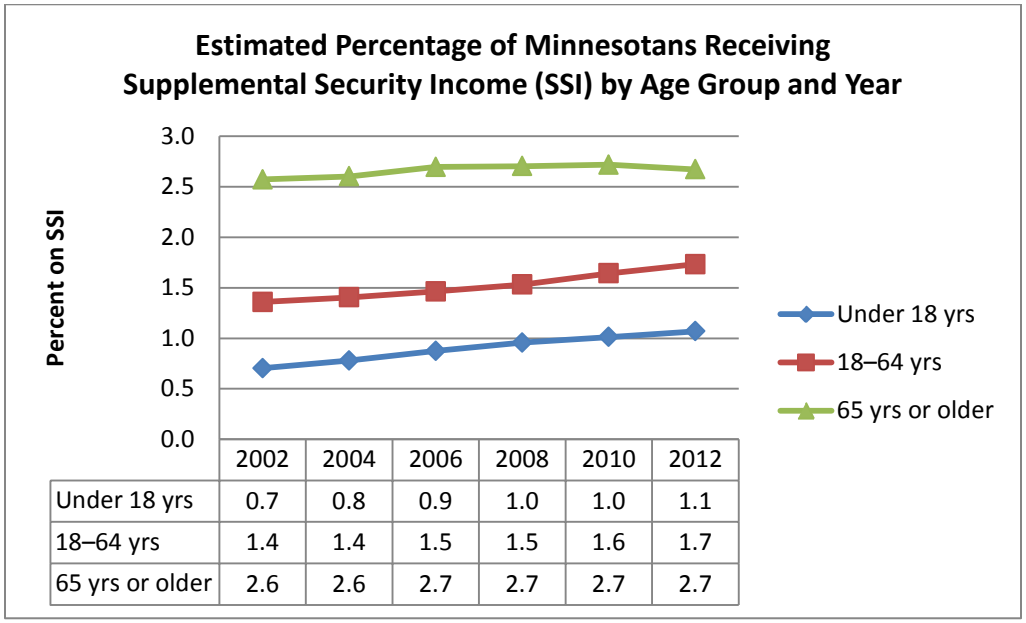
[1] United States Census Bureau, 2011 American Community Survey and Puerto Rico Community Survey: Group Quarters Definitions
[2] Minnesota Department of Human Services, Continuing Care Administration, Nursing Facility Rates and Policy Division, September 30, 2011.
[3] Minnesota State Demographer, March 2013.

disability. As seen in the exhibits below enrollment in Minnesota has grown over the past ten years with the highest rate of growth occurring in people under age 65.

Exhibit 2 - Number of Supplemental Security Income (SSI) Recipients in Minnesota by Age Group over Time

Year	Under 18	18–64	65 or older
2002	9,064	42,506	15,497
2004	9,996	44,813	15,979
2006	11,214	47,558	16,987
2008	12,282	50,564	17,799
2010	12,974	54,886	18,646
2012	13,633	58,437	19,489

Exhibit 3: Estimated Percentage of Minnesotans Receiving Supplemental Security Income by Age over Time



	2002	2004	2006	2008	2010	2012
Under 18 yrs	0.7	0.8	0.9	1.0	1.0	1.1
18–64 yrs	1.4	1.4	1.5	1.5	1.6	1.7
65 yrs or older	2.6	2.6	2.7	2.7	2.7	2.7

DHS publicly reports the number of working-age people served by the medical assistance disability waivers with monthly earnings, and those earning $250 or more per month. In 2012 about 71% of working-age people on the developmental disabilities waiver had monthly earnings, 22% earned $250 or more per month. In 2012 about 26% of working-age people on the other three disabilities waivers had monthly earnings, 11% earned $250 or more per month.

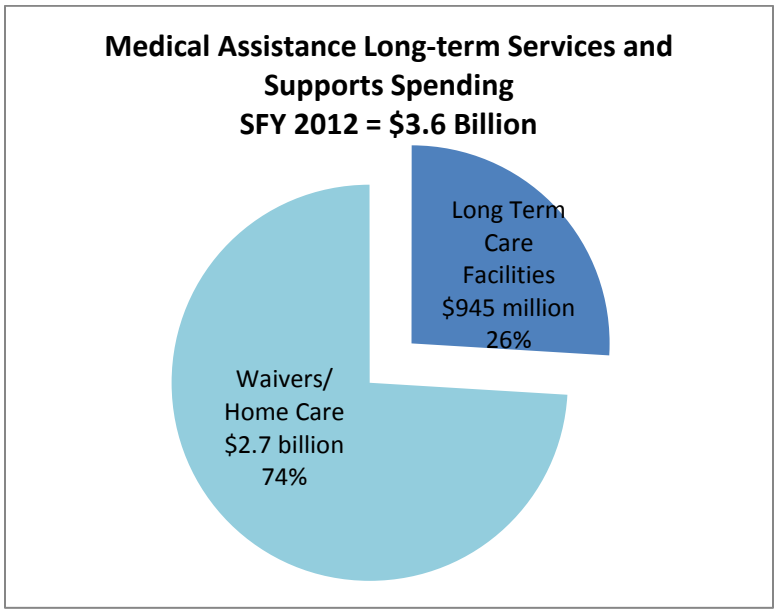
V. Long-Term Services and Supports Utilization and Expenditures

A subset of older adults, people with disabilities, children and youth with mental health conditions and adults living with mental illnesses receive services and supports funded through public programs. Currently, more than 350,000 people receive publicly funded long-term services and supports administered through the Minnesota Board on Aging and the Minnesota Department of Human Services each year, including older Minnesotans, people with disabilities of all ages and families. Many people need only a little help from public programs, for example, a home-delivered meal once a day, a phone consultation for information and assistance, or occasional respite from caregiving that they receive through the Older Americans Act programs. Others require extensive care, such as children who would otherwise live in a hospital (at greater cost) who can instead live at home with care provided by nurses, trained staff, and family members. The following pages highlight the public expenditures for long-term services and supports administered through DHS and include Medical Assistance expenditures as well as expenditures from other state and federal sources.

A. Long-Term Services and Supports Expenditures

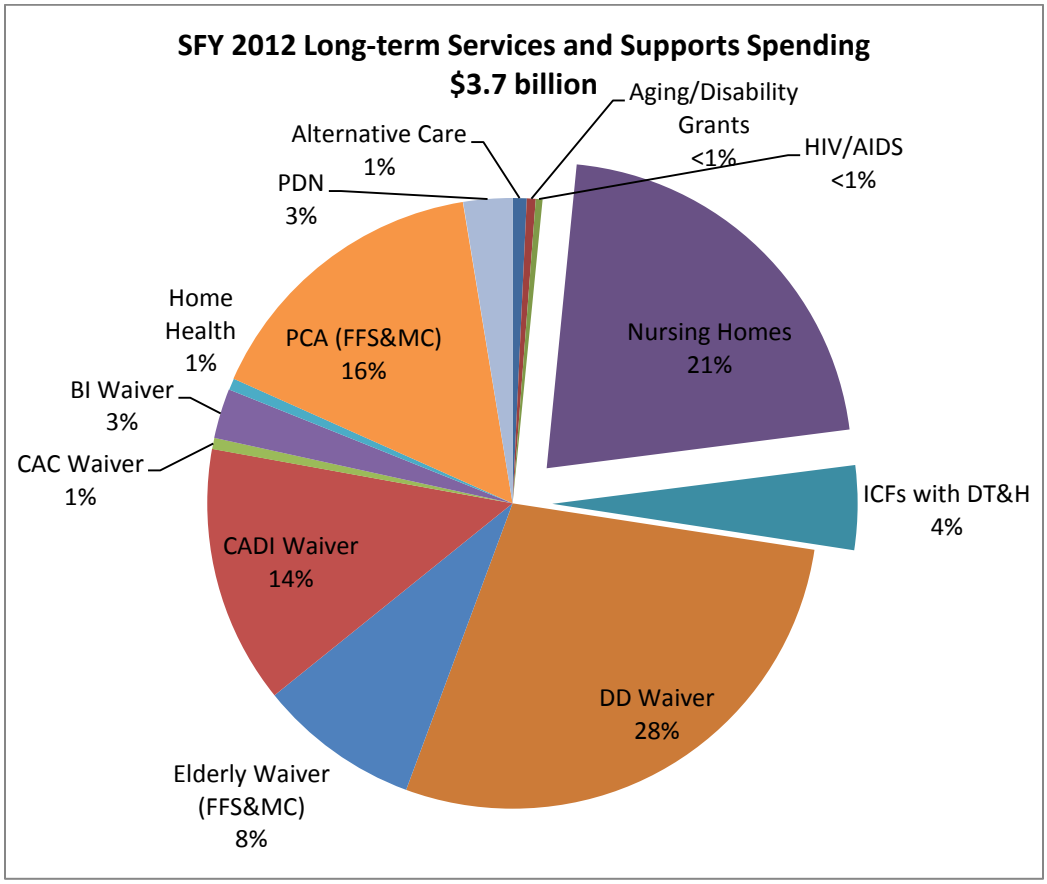
Minnesota spent over $3.6 billion on long-term services and supports in state fiscal year 2012 through Medical Assistance programs. Seventy-five percent (75%) of those expenditures were supporting older adults and people with disabilities through home and community-based services.

Exhibit 4: Medical Assistance Long-term Services and Supports Spending



Source: November 2012 DHS Forecast

Exhibit 5: Long-Term Services and Supports Expenditures by Program



Source: November 2012 DHS Forecast[4]

Medical Assistance home and community-based waiver and state plan services comprise over $2.7 billion annually in state and federal spending. Medical assistance state plan services include Home Health, Personal Care Assistance (fee for service), and Private Duty Nursing which support more than 23,700 people per month. The five home and community-based waiver programs[5] support more than 54,000 people per month who are at risk of placement in an institution. State and federal grants, which comprise 3% of total long-term care program spending, serve more than 250,000 people each year. The largest of these is the Older Americans Act funding which provides that little bit of assistance people need to keep them otherwise living independently.

[4] ICFs with DT&H are Intermediate Care Facilities with Day Training and Habilitation. FFS & MC refers to fee for service and managed care. For more information on individual programs visit the Disability Services or Aging Services sections of the DHS public website.

[5] The five waiver programs include: Brain Injury (BI) waiver, Community Alternative Care (CAC) waiver, Community Alternatives for Disabled Individuals (CADI) waiver, Developmental Disability waiver (DD) and Elderly Waiver (EW).

Medical Assistance expenditures for long-term care facilities comprise about $945 million a year. Nursing facilities serve about 28,000 people per month through medical assistance. Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD) serve 1,720 residents per month. Day Training and Habilitation providers (DT&Hs) serve more than 10,000 people per year.

B. Medical Assistance Expenditure Trends for Long-Term Services and Supports

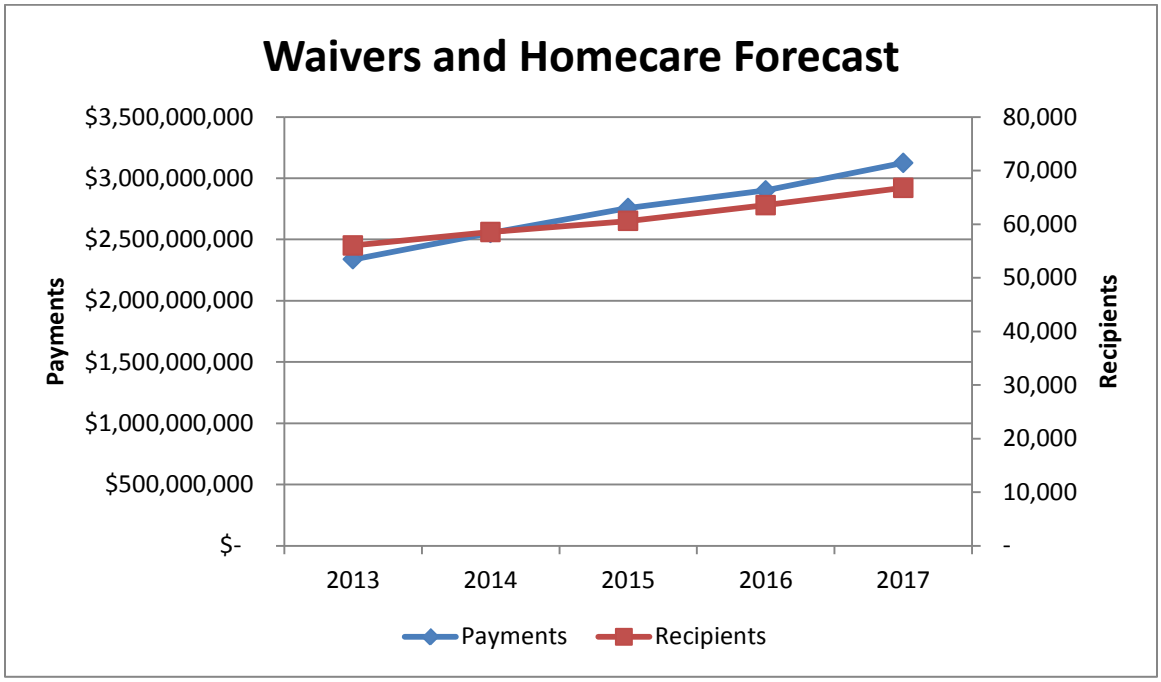
Since 1995, Minnesota has spent an increasing proportion of its Medical Assistance long-term services and supports dollars on home and community-based services and less on institutional services. Currently, 74 percent of all medical assistance long-term services and supports expenditures support home and community-based services.

Most people with disabilities who receive long-term services and supports receive them in community-based settings instead of nursing facilities, intermediate care facilities, or state-operated facilities. In 2007, about 90 percent of people with disabilities receiving medical-assistance funded long-term services and supports received home and community-based services. By 2011, the overall percent increased to approximately 93 percent. DHS is tracking the trend of Funding by Type of Long-Term Care Service for People with Disabilities in a one-page report on the public website .

Increasingly, older adults who receive long-term services and supports receive them in their homes instead of going to institutions. In 2007, almost 58 percent of older adults receiving medical-assistance funded long-term services and supports received home and community-based services. By 2011, the overall percent increased to 64.3 percent. DHS is tracking the trend of Funding by Type of Long-Term Care Service – Seniors in a one-page report on the DHS public website.

The Department of Human Services prepares a forecast of expenditures in its major programs twice each year. It aims to forecast caseloads and expenditures given current state and federal law at the time of publication. Expenditures for long-term care facilities are projected to continue to decrease through state fiscal year 2017. Meanwhile the number of recipients and dollar payments for waivers and home care services are projected to increase over the next five years.

Exhibit 6 - DHS Medical Assistance Waivers and Homecare Forecast (November 2012)



Projected Medical Assistance payments for waivers and homecare (fee for service only) services are increasing at an average annual rate of 7.5%. The average monthly number of recipients is expected to increase by 4.5%.

VI. Local Capacity for Long-Term Services and Supports

Beginning in 2001 and every two years afterward the Minnesota Department of Human Services (DHS) has gathered information about the current capacity and gaps in long-term services and supports needed by older persons in Minnesota. The primary source of this report is a survey completed by the counties to describe the capacity for these services in their local areas.

In 2012, the Legislature amended state statute to expand the scope of the survey and resulting report to include people with disabilities, children and youth with mental health conditions and adults living with mental illnesses. The corresponding divisions created separate surveys to focus on services for each of the four populations. The surveys focusing on services for older adults and people with disabilities primarily asked about the availability of long-term services and supports. The surveys focusing on services for children and youth with mental health conditions and adults living with mental illnesses primarily asked about the availability of mental health treatment services. People may simultaneously access long-term services and supports and mental health treatment services, with the goal to provide the right service at the right time.

DHS received approximately 80 responses for each of the four surveys. The following two groups of counties submitted a single response because they operate as multi-county human service agencies: Faribault and Martin counties; Lincoln, Lyon, Murray, Pipestone, Redwood and Rock counties. These responses constitute a single county response in all calculations. The resulting response rate for each of the four surveys was at least 95 percent. The following pages highlight key findings from the four surveys. Additional information on the statewide results, including results specific to each of the populations, and county-level profiles are available on the DHS website.

A. Gaps Analysis Survey Results

Improvements in Service Availability

When considering the availability of services to support older adults all but one county reported an increase in at least one home and community-based service since 2011. Services most commonly reported as more available were: health promotion activities (with 42% of counties reporting this service as more available), customized living (35%), technology (34%), end-of-life/hospice/palliative care (31%), personal care assistance (23%) and insurance counseling/forms assistance (23%).

When considering the availability of services to support people with disabilities over three-fourths of counties reported an increase in at least one home and community-based service. Services most commonly reported as new or expanded include: assistive technology (28%), consumer directed community supports (23%), customized living services 24 hour (21%), adult day care (21%), and 24 hour emergency assistance (21%).

The adult mental health services most commonly reported by counties as expanded or improved since 2011 were: diagnostic assessment (27% of counties), dialectical behavior therapy (24%), adult rehabilitative mental health services (24%), certified peer specialist services (22%), and crisis assessment and intervention (22%). The services most often described as added or new were: certified peer specialist services (8%), integrated dual diagnosis treatment (4%), crisis stabilization – nonresidential (4%), dialectical behavior therapy (4%), crisis assessment and intervention (4%), and mental health services in jail (4%).

The children's mental health services reported as meeting or exceeding demand by counties include: outpatient individual psychotherapy (68%) diagnostic assessment (66%); rehabilitative individual psychotherapy (65%), early childhood (pre-school) mental health services (62%), and referral to a mental health professional (from primary care physicians) (60%).

Most Common Service Gaps

The survey asked counties to compare the demand for home and community-based services that support older adults and people with disabilities with the availability of these services. Gaps in service availability combined the number of counties who reported a service as *not available* with those that reported the service as *available but limited*.

When considering the availability of services to support older adults, counties most frequently reported a gap in chore service, with 65% of counties reporting as such. Gaps in companion service (64%), non-medical transportation (60%), medical transportation (58%), and adult day care (57%) were subsequently most frequent. In a review of the county aging gaps analysis results, health plan representatives noted strong agreement with these gaps and added homemaker, personal care assistance and forms assistance.

When considering the availability of services to support people with disabilities, counties reported gaps in transportation (67%); crisis respite (62%); specialist services, chore services, respite (tied - 54%); night supervision, housing access coordination, behavioral programming (tied – 53%); adult day care, bath (52%); and adult day care (51%).

Counties identified gaps in the availability of services to support adults living with mental illnesses and children and youth with mental health conditions. The top ten adult mental health services for which the responding counties identified as gaps were: mental health court (97% of counties), Bridges temporary housing subsidies (90%), permanent supportive housing (87%), mental health services in jail (82%), intensive community recovery services (81%), certified peer specialist services (78%), consumer-run services (77%), federally funded Projects for Assistance in Transition from Homelessness (75%), assertive community treatment (74%), and neuropsychological assessment (73%). In addition, several other services were reported as totally unavailable: partial hospitalization (50%), problem gambling services (47%), drop-in centers (43%), and adult day treatment (40%).

The top ten children's mental health services identified as gaps include attachment bio-behavior catch up (95%), mental health behavioral aide (93%), young < 13 with aggressive/sexual acting-out issues (93%), neuropsychological services (92%), parent child interaction therapy (92%), complex needs, multiple diagnosis and chronicity (92%), trauma informed child-parent psychotherapy (91%), inpatient child/youth psychiatry beds (91%), psychiatric consult to primary care providers (91%) and brain injuries (89%).

Barriers and Strategies to Increase Service Availability

The surveys asked counties to identify and discuss any issues or barriers they believe are currently most critical to overcome in their county in order to ensure people with disabilities and older adults have access to home and community-based services options. The barriers most frequently identified by counties through both surveys include transportation for non-medical needs, recruiting and maintaining staff, distance/isolation and affordable housing with service options. In a review of the county aging gaps analysis results, health plan representatives noted strong agreement with these barriers and added low reimbursement rates, uncompensated travel time and paperwork/training requirements as barriers experienced by providers.

Counties identified local strategies for ensuring that adults with mental illnesses can have recovery-oriented service and support options. Some of the most commonly mentioned strategies included training and hiring more certified peer specialists; working to eliminate cultural barriers; increasing the supply of decent, affordable housing, together with rental subsidies for those who need them; increasing the supply of appropriate, consumer-chosen housing supports; and creating better integration across the various service delivery "silos" including mental health, chemical health, primary care, and public health, among others. Another strategy is to address shortages in key service categories, such as: psychiatric care, mental health services in jail, integrated treatment for co-occurring mental illnesses and substance use disorders, assertive community treatment, and supported employment using the individual placement and support model.

Counties reported a variety of issues and barriers as critical to overcome in order to ensure that children have the necessary home and community-based mental health services. These barriers include workforce shortages, lack of transportation, low reimbursement rates, lack of specialized services, lack of slots in the Community Alternatives for Disabled Individuals (CADI) waiver program, and lack of mental health treatment parity.

Cultural Competence

Counties were asked, from their perspective, how prepared providers in their area are to work with different types of cultural communities. A small percentage of counties believe that the providers who support older adults in their communities are "very prepared" to deliver care that is culturally competent to racial and ethnic minority communities (16%), new American,

immigrant and refugee communities (7%) and gay, lesbian, bisexual and transgender (GLBT) communities (12%). Most notably, 22% of counties report their provider network is not at all prepared to deliver care that is culturally competent to new American, immigrant and refugee communities.

A small percentage of counties believe that the providers who support people with disabilities are "very prepared" to deliver care that is culturally competent to racial and ethnic minority communities (1%), new American, immigrant and refugee communities (14%) and gay, lesbian, bisexual and transgender (GLBT) communities (12%). Nearly one in seven (14%) counties report their provider network is "not at all prepared" to deliver care that is culturally competent to new American, immigrant and refugee communities, and 12% report the same for GLBT communities. Approximately eighty percent (80%) of counties report that providers are "somewhat prepared".

A small percentage of counties believe that the providers who support adults with mental illnesses are "very prepared" to deliver care that is culturally competent to *racial and ethnic* minority communities (14%), new American, immigrant and refugee communities (6%) and gay, lesbian, bisexual and transgender (GLBT) communities (18%). Most notably, 25% of counties report their provider network is "not at all prepared" to deliver care that is culturally competent to new American, immigrant and refugee communities.

A small percentage of counties believe that the providers supporting children and youth with mental health conditions are "very prepared" to deliver care that is culturally competent to racial and ethnic minority communities (9%), new American, immigrant and refugee communities (4%) and gay, lesbian, bisexual and transgender (GLBT) communities (21%). Most notably, 30% of counties report their provider network is "not at all prepared" to deliver care that is culturally competent to new American, immigrant and refugee communities.

Housing Options

The surveys asked counties to report on the availability of affordable and accessible housing for people with disabilities and older adults. The most frequently identified gaps through both surveys were subsidized rental apartments with supervision and/or health care services and subsidized rental apartments with support services only. Additional gaps identified by counties when considering the availability of housing options for people with disabilities included subsidized adult family foster care and other subsidized housing options. When considering the availability of housing options for older adults, fewer counties reported gaps in the availability of market rate housing, with 2% of counties even reporting a surplus of both market rate apartments with no services and with supervision and/or health care services.

The most frequently identified gaps in housing options for adults living with mental illnesses are rental apartments with either support services only (94%) or supervision/health care services

(94%). Market-rate corporate adult foster care, still viewed as a gap for more than six of every ten counties, was the most available option.

Moving Home

Over half of counties reported that there are people with disabilities who could move to a home of their own if supports were available, an additional 32% were unsure. Forty-two percent (42%) of respondents knew of a systematic strategy in their county to help relocate people to homes of their choice.

Barriers cited as the most critical to overcome to relocate people with disabilities into homes of their choice include: limited resources (77%), access to transportation (75%), and lack of housing (72%). Counties that provided additional explanation through an open-ended response indicated that lack of resources to develop alternatives to develop new housing and service options was a challenge. Counties report resistance to moving from participants and their family members. Families in particular have concerns with risks and vulnerabilities to the person with disabilities outside of provider-controlled housing.

Just over 40% of counties reported that there are older adults in nursing homes in their county who could move to the community if supports were available. Nearly three of every eight counties indicated they did not know if they had persons who fit this description. Over 75% of counties reported that most often the older adult or their family chooses to have the older adult remain in a nursing facility. Additional reasons provided include that the family worries about the older adult's health and safety; the person providing care might be exhausted and unable to continue to provide the necessary level of support; and other informal caregivers are not available. Counties report that a lack of assisted living prevents some consumers from leaving the nursing home. A handful of counties mentioned that it is often difficult to move consumers out of the nursing home because they have given up or sold their home and other affordable housing may not be available. Over 60% of counties reported that they have a systematic strategy in place for relocating older adults to the community from nursing facility settings.

Nearly 20% of counties reported that there are adults living with mental illnesses in nursing facilities in their county who could move to the community if supports were available, with 42% reporting there were not. Over 40% of counties indicated they did not know if they had persons who fit this description. The same proportion of counties reported that they have a systematic strategy in place for relocating adults living with mental illnesses to the community from nursing facility settings, with over a quarter reporting they did not.

Over 20% of counties reported that there are children and youth with mental health conditions in their county who could move to the community if supports were available. Three-fifths of counties indicated they did not know if they had persons who fit this description. Counties reported the following barriers to relocating individuals receiving mental health services from

residential services into the community: caregiver issues (34%), access to transportation (27%), caregiver exhaustion (27%), and services not available (25%). Barriers to return to the community weigh heavily on two general deficiencies in local children's mental health systems: first, lack of community based resources and, second, lack of supports for families struggling with the extraordinary demands of raising children with severe and complex mental illnesses.

B. Statewide Stakeholder Input Results

The Improve Group conducted the Community Service Input Project under contract with the Minnesota Department of Human Services. The study augments the information gathered through the Gaps Analysis Surveys to Minnesota's counties. The Community Service Input Project gathered insights about long-term services and supports directly from people with disabilities, adults living with mental illnesses, older people, and their families and caregivers (including those supporting children and youth with mental health conditions).

The contractor collected in-depth data through structured, interactive focus groups held in 16 communities across Minnesota. Focus groups consisted of three primary groups including persons with disabilities and/or mental illness, older persons, and family members or other informal support caregivers. The recruitment process focused on people who had not had prior opportunities to give feedback on services, and who would normally face barriers to participation. All eligible participants were offered an incentive, a light meal, and supports such as transportation, to help them attend the focus group.

The Improve Group held twelve group interviews with county government staff to learn more about the types of services and supports available in their community, as well as any gaps that exist in their county or region. The contractor identified interviewees in each community through contacts provided by DHS. The Improve group held two group interviews with elected and appointed officials and service providers in the Mille Lacs Band of Ojibwe tribal community. In addition, 24 key stakeholders from a variety of organizations and backgrounds participated in phone interviews. Of those interviewed, 33% represent consumer, family and advocacy organizations, 29% service provider collaboratives, 17% government advisory groups and councils, 13% government division, 4% regional development organizations, and 4% health plans.

This study used a website as a data collection strategy to reach people across the state. The website created for this project, Minnesota Service Story, included a link to a 10-minute survey with questions focusing on the availability of services in each respondent's community. In total, the online survey had 110 total respondents.

Care coordinators who work with persons with disabilities of all ages as well as older adults who need services and supports participated in an online focus group. A total of 23 care coordinators participated in a one-hour, online, chat-based focus group and shared feedback about current gaps in services, barriers to serving clients, and what they feel most needs to change.

The following pages provide a summary of the input that was collected through this study. More in-depth information on the findings is available in the full report.

Service gap: Services to help people maintain their own homes

In focus groups, many older adults indicated a greater need for services to maintain their home, including chore services, major repairs, and homemaking. In particular, widowed older adults who used to rely on their spouse for these tasks expressed frustration at their own inability to do these things themselves. Other older adults shared that they would love to do their own chores and home maintenance, they simply cannot physically do it anymore. They also indicated that they are not always aware that there may be chore services available to them. In focus groups, some younger individuals with disabilities expressed a similar need as well.

County staff across the state shared that there is a shortage of services to keep people in their own homes, such as chore, homemaking, home delivered meals, personal care attendants, home health aides, and skilled nurse visits. In some areas, one provider offers these services. If a participant has a conflict with their provider, there may be no one left in the community to offer this service; counties spoke of this being a particular issue for participants with mental illness. Another concern is that providers may not serve rural, remote locations due to the relatively low reimbursement rates for these services and the lack of reimbursement for mileage and travel time.

Service gap: Transportation

In every community outside of the urban centers, a shortage of affordable and reliable transportation options was identified as a problem. In particular, people in rural and tribal communities reported that transportation was the area they most wanted to improve. Older people across the state reported that transportation is the most important factor in being able to live independently and participate more fully in the community. People with disabilities and caregivers also rated transportation as one of the top five factors in being able to live independently.

Focus group participants shared that transportation is a key issue that greatly affects the quality of their lives. Participants indicated that they do not drive because of functional limitations or income level and therefore rely on public transportation services or transportation provided by friends or family. Older people in particular mentioned that without transportation, they are unable to get to appointments and may feel isolated. Many have moved into a larger town nearby specifically because they have not been able to access transportation close to their homes; older people reported great sadness in having to leave their homes due to a lack of nearby transportation.

Focus group participants identified several modes of transportation including walking, public transit, cabs, specialized transportation, and private transportation such as owning a vehicle or having access to rides from family, friends, and volunteers. Whether for medical appointments,

errands such as grocery shopping, or social activities – people with disabilities, older people, their caregivers, and county staff reported that having access to affordable and reliable transportation that is easily accessible greatly supports independence. Focus group participants who reported that they were able to live independently attributed this, in part, to their available transportation options.

Public transportation may be more readily available in urban areas as compared to rural locations. For participants in urban areas, the majority utilized public transit and public specialized transit, such as Metro Mobility, as their primary method of transportation. Some people with disabilities and especially older people shared that the bus stops and warming stations are not always fully accessible, particularly in inclement weather. Additionally, many participants with disabilities expressed that they spend many hours each week commuting when they would prefer to spend that time working.

While some hub[6] and rural communities have public transportation options, participants noted that most of these services have significant limitations. For example, most public transportation options are open during standard business hours and then close down by 4:00 P.M. on weekdays; oftentimes services do not run at all on the weekends. These hours may limit work opportunities as people have a way of getting to work but do not have a way home at the end of the day. Additionally, attending late afternoon medical appointments is not an option for someone relying on public transportation in many rural communities. People who would otherwise be able to attend a community event over the weekend or during the evenings may be unable to do so as public transportation does not operate during those hours.

Where specialized transit is available, many participants reported barriers which make it a limited option. In the Twin Cities, where the services are more readily available, the high cost is a barrier for many participants who are struggling financially. In the Duluth area, participants felt specialized transit availability is inadequate. There are such limited spaces available that participants with disabilities said that often, even when they called a week in advance at 8:00 A.M. when the office first opens, they have been unable to secure a ride because so many other people were calling as well.

Outstate public transportation often has limited routes that do not reach every place people with disabilities, people with mental illness, and older people would like to go. In particular, several participants discussed how limited transportation options impact where and when they can work or volunteer. In some small communities, focus group participants explained that they need to have four or more additional people along for the ride in order to be able to utilize the available transportation services. In very remote areas, there are no public transportation options at all. In

[6] Hub communities are defined as areas in greater Minnesota with concentrations of disability services.

some places taxi services are an option, although they are too expensive for most community members to use on a regular basis.

Many participants with access to private transportation spoke of the large financial burden of maintaining a private vehicle. Some people shared that they have a driver's license but are unable to use their vehicle because of the high cost of insurance. Others have medical conditions that prevent them from driving periodically, which makes it challenging to hold a regular job. Many participants spoke of relying on a friend or family member for private transportation, and going without transportation when their usual rides were unavailable and they had no other options. Asking others for rides felt burdensome to many participants and older people in particular experienced decreased feelings of independence. The older adults that participated in the focus groups do not want to have to rely on their adult children for transportation for errands, volunteering, and social engagements. As a result, many people utilize rides for medical appointments and forgo opportunities for community engagement; they very much want to participate with accessible transportation that allows them to do so independently.

Service gap: Employment

Employment was the top priority area that participants want to improve in both urban and hub locations. Additionally, it was in the top five areas that participants wanted to improve in rural and tribal communities. As a whole, participants in urban communities and people with disabilities and people with mental illness across the state felt employment is the most important factor in being able to live independently and participate more fully in the community. Family members or other people providing informal supports to people with disabilities and people with mental illness also felt very strongly that employment opportunities and supports need to improve.

Overall, many participants expressed a deep desire for meaningful employment and volunteer opportunities. Thirty percent of focus group participants shared that employment or volunteering was going poorly in their lives. This finding was most pronounced in rural and hub communities, as well as with people with disabilities and people with mental illness. Participants reported experiencing multiple barriers to employment, including discrimination. This was especially true for people with disabilities or mental illness. Some participants felt like they had a strike against them when seeking employment because employers show reluctance to make accommodations for their disability, even when they are required to do so by law. Participants shared their perceptions regarding systemic barriers that prevent some people who receive public assistance from working. Transportation was frequently cited as a barrier to employment; in fact, participants who said employment, volunteering, and school were going well for them frequently shared that reliable and affordable transportation was available to them.

County staff reported that communities are aware of the need to develop more employment options; however, they described multiple barriers to employment. Many employment opportunities currently available for people with disabilities are center-based day programs; there is a shortage of community based programs, jobs, and market rate positions available, especially in non-urban areas. Sufficient supportive employment options are lacking, especially for the transition age population and people with mental illness. The jobs available do not necessarily fit a person's strengths, needs, and interests. Staff reported that there is not sufficient funding to sustain ongoing supports like job coaching and supervision, described as being especially lacking in rural areas. Where coaching, supervision, and training opportunities do exist for people with disabilities, focus group participants explained that they are mostly targeted at adolescents and those with specific disabilities; older adults and some people with disabilities feel that there are not as many opportunities available for them.

Young people have unique challenges of their own when it comes to employment. As one advocate articulated, young people with disabilities are different than the previous generation in that they have been raised to believe they have a right to be included. They have been completely integrated in school and expect to be able to access their communities as independently as possible. When they leave school and hope to work, maintain relationships, and participate in their communities, they find it difficult to get from place to place and gain the support they need.

County staff shared that it is important to provide transition-aged young adults with opportunities to work in the community. Many young adults with disabilities have skills for working that are incompatible with center-based employment facilities. Sometimes young adults with disabilities miss opportunities for community-based employment as the employment providers do not have the staff to coach young people as employees. In the case of one focus group participant, her son's school offered transition services to prepare him for the workforce, but she felt that they were so oversimplified that they would not have real-world applicability.

Service gap: Housing

All of the populations reached through the study - people with disabilities, people with mental illness and older adults reported a lack of affordable, quality housing options. Many people from across the state shared that they could not afford some of the housing options available to them. There is a shortage of housing particularly in places with convenient access to services. Multiple focus group participants reported long waiting lists for HUD-subsidized housing in their regions, as well.

While a need for better quality housing options was identified across rural and urban settings, there are some unique challenges in each setting. Urban residents and older adult focus group participants in particular, shared concerns about high crime rates in the public housing neighborhoods. Additionally, some participants expressed problems with bug infestations that

can be particularly difficult for people with disabilities and older adults, as they may exacerbate existing health issues. Rural communities were seen as having too few options and a lack of availability for housing, especially housing for older people.

Many participants expressed a desire to live in a housing situation that allows them to be as independent as possible. Participants shared a need for more flexible options for housing and support services, where people can live self-sufficiently with the right amounts and kinds of support. Older adults are looking to access assisted or maintenance-free housing where the physical demand for upkeep and maintenance is not required. Focus group participants indicated that people living with serious mental illness need affordable housing options where they can receive some minimal supports. Young people with disabilities who are looking to leave their parents' homes could do well living in an apartment with a roommate and with supports for a few hours each week. Family members indicated that level of service and support is not currently available in every community; instead, family members see that their loved ones have the choice of either remaining at home or moving into a congregate setting.

County staff reported the need for housing for transition age young adults and in particular, the need for more apartment-style housing with services and monitoring which would appeal to these individuals. County staff also reported additional challenges in finding housing for people with a criminal background, especially people convicted of sex offenses and felonies. It is always a challenge to find housing to serve people with high behavioral or mental health needs. They often mentioned Minnesota's moratorium on developing corporate foster care homes as a barrier to finding appropriate housing for young adults.

Service gap: Respite Care

Caring for a person with a disability, a person with mental illness, or an older adult with chronic health conditions is a commitment that can take a physical and emotional toll on the caregiver. Many participants and county staff reported a need for more respite care, out-of-home respite services, and respite care providers with more skills, for family members and other people providing informal support. Additionally, many groups of people need respite care, including people caring for older family members and for those with mental illness. Family members and others who provide informal supports use respite service as a time to get groceries, to attend a religious service, to volunteer, and to participate in other activities that give their lives meaning and purpose. Caregivers reported that when they are rested and have time to recharge, they are better able to meet their loved ones' needs.

Focus group participants from all parts of the state shared that respite care services are especially needed for overnight care and on the weekends. Some adults and children that need long-term supports have sleep disturbances; caring for them overnight results in sleep deprivation for the

people providing those supports. Participants noted that despite the great need for these particular services, providers at these times are rarely available.

Service gap: Mental Health Services

The lack of mental health services is a major issue for rural and hub communities. Participants expressed frustrations about the limited access they have to both psychiatrists and psychologists. In some situations there are no mental health services available at all. Or there may be one psychiatrist available but no psychologists or support groups within their geographic area. Other concerns are about the difficulty in accessing someone to prescribe the necessary medication within a reasonable timeframe. County staff described a particular lack of specialist services for people on the autism spectrum including a lack of children's mental health supports such as behavioral health aides and therapeutic foster care. Participants from rural communities shared that they would like to see more education and awareness services for family members and loved ones of those affected with mental illnesses.

For parents of children with disabilities or mental health conditions, the lack of mental health and behavior support services were the biggest barriers to living the life they wanted to live. Parents of children with disabilities and children with mental health conditions in our focus groups were overwhelmed, sad, exhausted and frustrated. There were many examples shared of significant struggles due to not having enough mental health providers available. Especially in rural areas, it is particularly difficult to recruit psychologists and psychiatrists, which has led to this service deficit. In areas without crisis services some people must rely on police assistance when children need hospital services. Too often, if hospitals decide to admit the child, there are no beds available. Children can be taken to hospitals far from homes, sometimes even across state lines.

Many people make significant sacrifices in order to raise their children and access services. One woman described how a lack of reliable, high-quality services led her to decide to quit her job and stay home with her young child with autism. Although the family is eligible for in-home services, none of the providers have had the skills to deal with the child's behavioral and communication challenges.

Focus group participants indicated that, in addition to many regions not having enough mental health services, there is not enough adequate supportive, affordable housing for people with mental illness; accordingly, people are oftentimes placed in regional treatment facilities, costly hospitals and crisis units. When people with mental illness have a legal incident, they often spend extended periods in jail and detention facilities or are released into homelessness because there is no appropriate housing setting available. County personnel who were interviewed are especially challenged in trying to find housing for people with a disability or mental illness and who are convicted felons and/or convicted sex offenders. Without housing it is very difficult to get other supports or employment in place.

Status of Long-Term Services and Supports

Participants from the rural communities in particular shared their concern for the lack of crisis services. Considering that there is already a problem with the limited access to psychologists and psychiatrists, people with mental illnesses could be at a greater risk for experiencing a crisis. County staff shared that when crisis beds for children or adults with mental illness are unavailable; the options to safely manage some situations require arrests or hospitalizations.

VII. Recommendations Related to Home and Community-Based Services

The results of the Gaps Analysis surveys highlight areas for improvement in terms of specific service availability as well as dimensions of service quality such as cultural competence and system responsiveness. It is worth noting that many of these needs are consistent with other contexts, beyond the focus of supports for older adults, people with disabilities, and people with mental illness. Affordable housing and reliable, convenient transportation are concerns for those in poverty. Cultural competency is a goal across many populations and services.

In moving forward this information will guide the development of programs and services that provide meaningful support to people in need of long-term services and supports. The broader stakeholder input process provides insights gleaned from some of those people. This is a positive step in the process to increasingly focus on people not programs. In the future, based on the experience of this first iteration of the expanded Gaps Analysis, DHS plans to consolidate the surveys as much as possible in order to gauge the impact of service availability *across systems* on the people that we serve. There will also be an increased focus on gathering and analyzing more local, community-level data to shed light on the factors that impact availability of services and supports in different types of communities and in different regions around the state.

In the near term, the DHS Continuing Care Administration commits to addressing the areas highlighted for improvement. This work will be consistent with the Continuing Care Administration Strategic Plan, the goals of Reform 2020 and aligned with Minnesota's Olmstead Plan.

Better Individual Outcomes

- Increased flexibility to better meet the needs of each individual
- Increased stability in the community
- Better-informed individual decision-making about long-term services and supports options
- Promotion of person-centered planning and self-determination – life-long planning as well as to mitigate a crisis situation.
- Improved transitions between settings and programs, preventing avoidable health crises
- Recognize and address the social determinants of health care need and cost

Right Service at the Right Time

- Low-cost, high-impact services reach people earlier
- Decreased reliance on more costly services
- Access to home and community-based services, not institutional care, is the entitlement

Status of Long-Term Services and Supports

Ensuring the Future of Long-Term Services and Supports

- Increased sustainability of the long-term services and supports system
- Increased efficiency in the use of public long-term services and supports resources

Minnesota's Olmstead Plan is under development by the Olmstead Sub-Cabinet created through Executive Order by Governor Dayton in January 2013. The Olmstead Plan will outline measurable goals to increase the number of people with disabilities receiving services that best meet their needs in the most integrated setting and is consistent and in accord with the United States Supreme Court's decision in Olmstead v. L.C., 527U.S.582 (1999). Progress will be evaluated, in part, by the findings from future Gaps Analyses. DHS will consider reframing some of the questions to better support this effort in future surveys.

VIII. Nursing Homes

Minnesota's strategy for long-term services and supports (LTSS) has been to "rebalance" the locus of care from institution-based to home- and community based models. However successful this strategy, there continues to be a need for nursing homes, and several policy issues related to the future of nursing homes are of interest, namely quality, cost and industry size.

A. Quality

Goal: Quality of LTSS is an ongoing concern, both in institutional settings and in home- and community-based settings. This concern is especially important in nursing homes where quality affects all aspects of a resident's life and where the burden of changing providers may be quite high. DHS is interested in the quality of nursing home care for several reasons. As the State Medical Assistance Agency, DHS is responsible for certifying nursing facilities for participation in the program, a function that is delegated via contract to the Minnesota Department of Health (MDH), the state agency that licenses nursing homes and boarding care homes. The licensure and certification processes involve strenuous inspections that take place annually. As a purchaser, spending hundreds of millions of dollars of state funds each year for nursing home care, DHS believes that it has an obligation to nursing home residents and to the public to go beyond inspection and use the purchasing activity to leverage quality.

Design of Quality Measures

DHS has worked with MDH and stakeholders for many years to develop quality measures. Several criteria must be met for a quality measure to be useful:

- The measure should be relevant, meaning that it is important to residents, providers and purchasers, it makes sense to them, it relates to guidelines, it can lead to improvement and it measures performance related to provider actions. Measures of outcomes are most desirable.
- The measure should be scientifically sound, meaning it has validity, it can be measured reliably, it can be aggregated.
- It is feasible to implement the measure, meaning the data is available, preferably electronically or can be acquired economically.
- It doesn't encourage providers to take actions that lead to unintended and possibly harmful outcomes.

Seven quality measures have been developed and are currently in use:

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

- Inspection findings from certification and complaint surveys

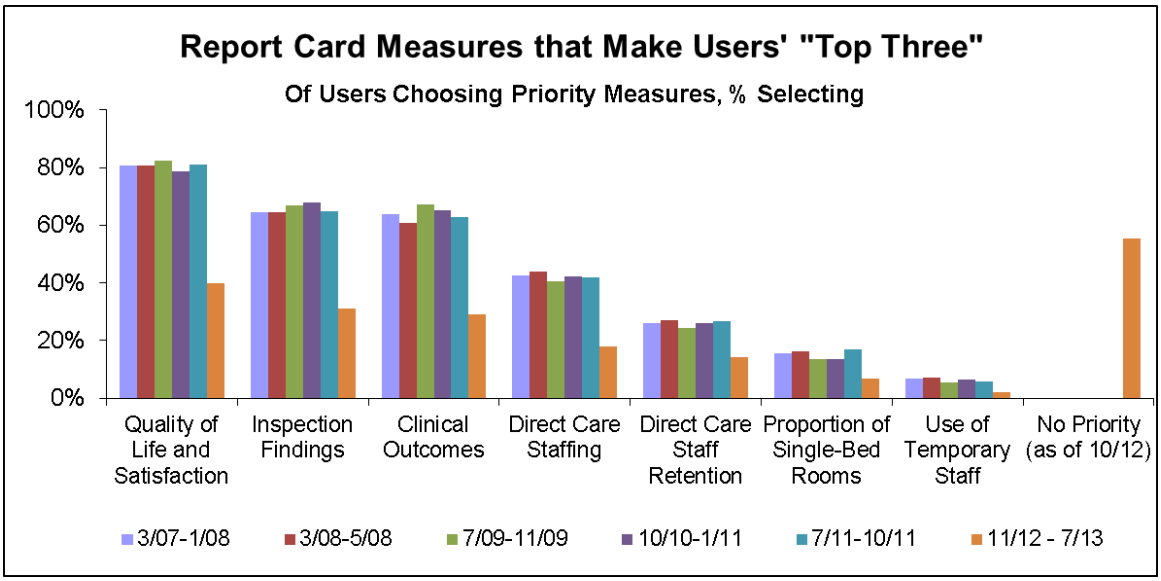
Public Disclosure of Quality Measures, the Nursing Home Report Card

Beginning in January 2006 MDH and DHS published the web-based Minnesota Nursing Home Report Card. It is interactive in that it allows users to view results for a specific facility, or, alternatively, to specify a location they are interested in and to select the quality measures they consider most important. The report card then provides a list of all facilities that meet the geographic criteria and it sorts the list according to the scores of those facilities on the seven quality measures with emphasis placed on the measures prioritized by the user. The user can then select a facility from the list and see its scores on the seven quality measures, using five-star ratings.

In October 2012 these agencies introduced a new and improved version of the report card (http://nhreportcard.dhs.mn.gov/). The most notable changes include side-by-side facility displays to allow comparisons of quality; almost two years of performance history shown for each facility; more detailed information including the exact scores that underlie the star ratings; daily cost information for each facility, including private pay charges for private rooms; and new features to make the site more convenient for users such as the ability to map facilities and print or save spreadsheets of any page.

When selecting the measures most important to them, Report Card users increasingly and overwhelmingly prioritize resident outcomes (quality of life and satisfaction, inspection findings, and clinical outcomes) over process or structural measures, as shown in Exhibit 7.

Exhibit 7: Report Card Measures that Make Users' "Top Three"



A concern with any form of measuring and publicly disclosing of quality information is that the measures are never perfect. It is always a judgment call as to whether or not the quality

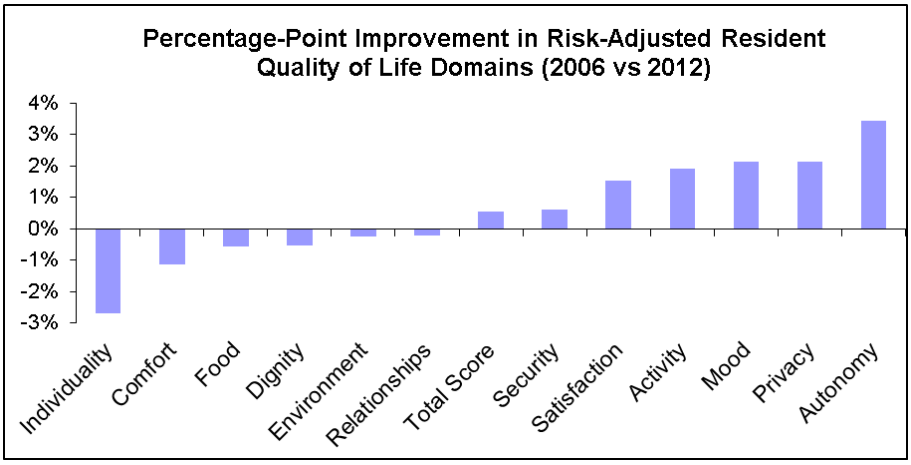
measures are ready. It is then important to seek ways to improve the measures over time, guided in part by research and user feedback. Two changes that have been made to the quality measures since it went live in 2006 were dropping direct care staff turnover as a quality measure and revamping the scoring methodology used on the inspection findings from certification surveys.

Trends in Quality Outcomes

DHS and MDH have calculated Report Card quality measures for multiple years; trends are presented in the following graphs.

Resident quality of life and satisfaction is measured by annual face-to-face interviews with a representative sample of residents in all Medical-Assistance-certified nursing facilities, and results are risk-adjusted to allow a fair comparison of facilities. Exhibit 8 shows improved scores on six quality of life domains and the residents' overall quality of life score since the survey's first full fielding in 2006 (though the survey was first used in 2005, subsequent improvements to the tool and the interview process for the following year require the use of 2006 as a baseline), with autonomy, or resident choices, showing the most improvement. Four domains declined slightly, while two others declined significantly: individuality, which dropped as residents felt staff were less interested in their lives; and comfort, which dropped largely because residents reported more physical pain. These declines could be related to the increasing use of nursing facilities for short-term stays after hospitalizations, which we will discuss in a later section. DHS is concerned about the changes and is taking steps to help facilities improve, mainly through the Performance-based Incentive Payment Program, discussed below, in which DHS cosponsors a quality of life-themed fellowship, and shares provider innovations via annual conference, resource website, and by facilitating provider connections.

Exhibit 8: Percentage-Point Improvement in Risk-Adjusted Resident Quality of Life Domains (2006 vs. 2012)



Exhibits 9 and 10 show clinical processes and outcomes, or quality indicators, that are calculated using Minimum Data Set (MDS) resident assessment information and risk-adjusted to allow fair

comparison of facilities. DHS, MDH and the University of Minnesota first calculated them in 2004, and updated them when the Federal government revised the MDS in October 2010. The new set uses resident interviews for several indicators and adds three new short-stay indicators, marked "SS" (versus "LS" for long-stay).

Exhibit 9 shows improvement since 2004 for indicators that were unchanged by the MDS revision. Scores on 12 of 15 indicators improved during this time, with inappropriate use of antipsychotic drugs and ADL improvement the best areas of positive change, and continence care an area for concern.

Exhibit 9: Percentage-Point Improvement in MN Risk-Adjusted Clinical Quality Indicators (2004 vs. 2012)

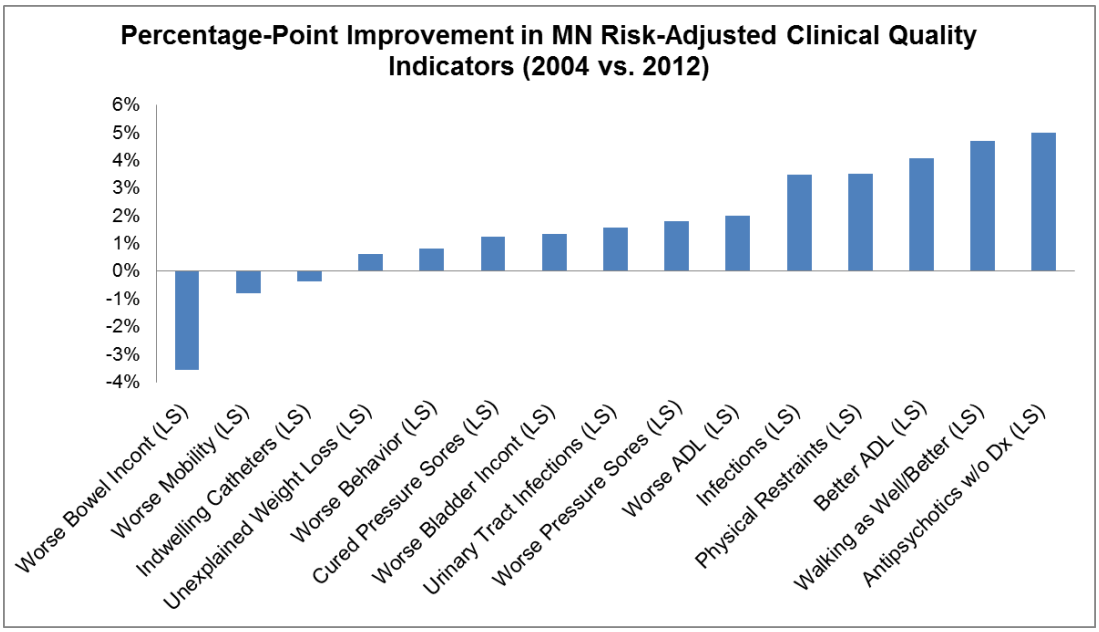
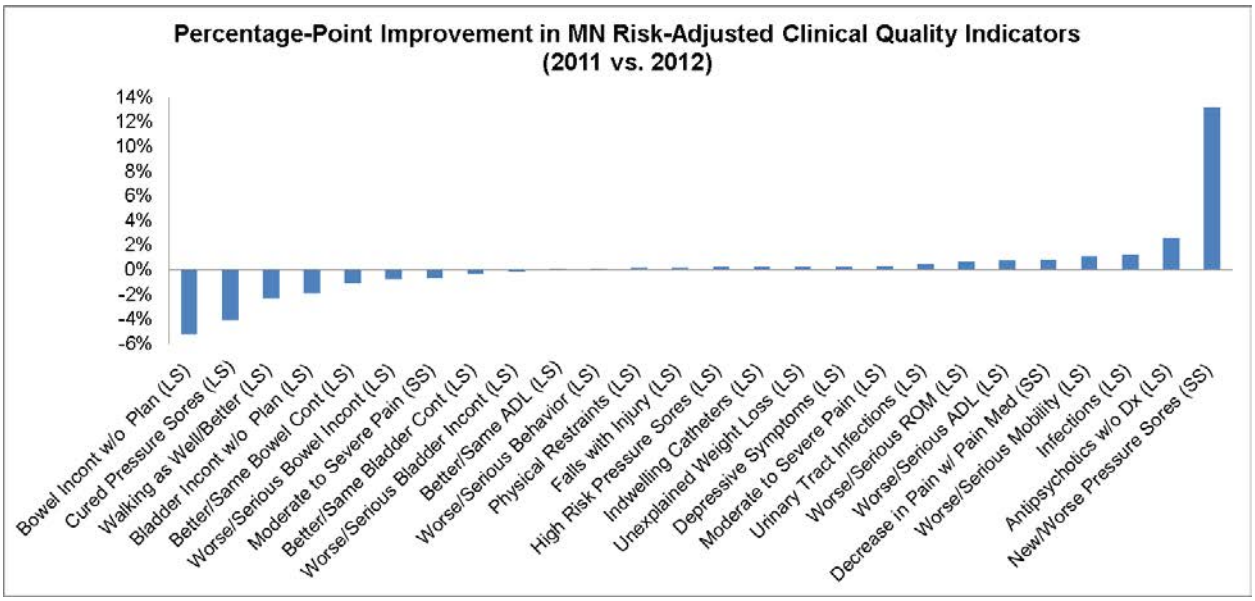


Exhibit 10 shows improvement since 2011 for these plus 11 that were changed or newly created after the MDS revision. Scores on 17 of 26 measures have improved, with particular positive change in the areas of short-stay pressure ulcers and inappropriate use of antipsychotic drugs. However, nine have worsened during this time, especially continence care and long-stay pressure ulcers.

Exhibit 10: Percentage-Point Improvement in MN Risk-Adjusted Clinical Quality Indicators (2011 vs. 2012)



Additional measure trends can be found in graphs located in the full report.

Pay for Performance

In 2005 the Minnesota Legislature enacted a first step in adopting Pay for Performance for nursing facilities. This initiative was in the form of a quality add-on to payment rates. Based on quality scores, facilities received operating payment rate increases up to 2.4% of their operating payment rates effective October 1, 2006. Similar quality add-on payments were funded in 2007 and 2013. More information regarding quality add-ons can be found in the full report.

In 2007 DHS initiated the Performance-based Incentive Payment Program (PIPP). PIPP is a voluntary competitive program designed to reward innovative projects that improve quality or efficiency or contribute to rebalancing long-term services and supports (LTSS). Selected projects will receive temporary operating payment rate adjustments of up to 5%, under amendments to the Alternative Payment System contracts. Of the money rewarded, 80% is contingent upon implementing the program described in the amendment. The remaining 20% is contingent upon achieving specified outcomes. At the time of this writing, 223 nursing facilities have participated in the program, representing 119 different quality improvement projects.

B. Nursing Home Costs/Expenditures

In State Fiscal Year 2012, $782.5 million was spent by the Medicaid Program for nursing home care in Minnesota, of which the state share was $382.1 million. For the year ending September 30, 2012, nursing facilities reported total revenues of $2.286 billion as shown in Exhibit 11

below with an estimate of revenues for non-MA certified nursing homes of $63 million, yielding a total estimated revenue of $2.349 billion.

Exhibit 11: Estimated Total Nursing Home Revenues in Minnesota (2012) by Source of Payment

Estimated Total Nursing Home Revenues in Minnesota (2012) by Source of Payment	
Source	**Amount ($s in millions)**
MA payments, including recipient resources and managed care	$1002
Private pay	476
Medicare Part A and Part B	434
Other	374
Estimated revenues of non-MA nursing homes	63
Estimated **Total** Nursing Home Revenues	$2,349

C. Nursing Facility Financial Status Analysis

The Department of Human Services collects extensive data on nursing facility related costs and revenues in its Nursing Facility Annual Statistical and Cost Report. The department has worked on analyzing this data to better understand the relationship between actual costs, revenues, payment rates, gains and losses, various facility characteristics and quality. This section of the report is the first public disclosure of the findings of this analysis.

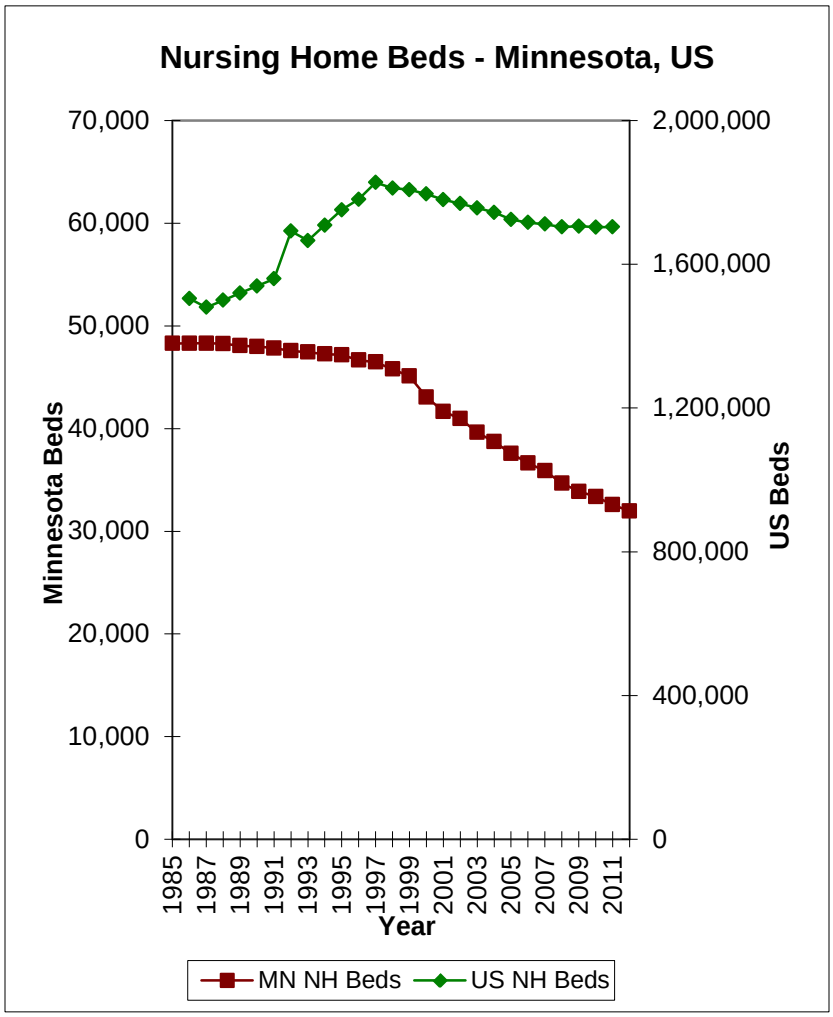
The data in the Nursing Facility Annual Statistical and Cost Report is self-reported. As data is being submitted through a secure web-based portal, the program applies numerous edits and queries, comparing data elements and ratios with prior reported data, and with other facilities. Extensive manual audit activities are then undertaken, with a focus primarily on data elements that affect the Nursing Home Report Card quality measures, or various elements of payment rates. These edits and audit activities provide confidence in the accuracy of the data.

In conducting this analysis, data on all nursing facilities was compiled and several breakouts were prepared to produce a clear picture of the actual financial status of Minnesota nursing facilities. Data is provided covering the four report years ending September 30, 2008, through September 30, 2011. The actual number of facilities included in these reports varies slightly due to facility closures, the opening of new facilities, and the exclusion of a small number of facilities for whom data was deemed unreliable. The analyses of the financial status of nursing facilities and observations may be found in the full report.

D. Industry Size

Rightsizing the nursing home industry has been a major policy theme for Minnesota for over 30 years.[7] This section of the report will examine the trends in bed availability and need, and specifically, will address the question: "Will Minnesota soon experience a shortage of nursing home beds?"

Exhibit 12: Nursing Home Beds – Minnesota, U.S.



Number of Nursing Facilities and Number of Beds

As of September 30, 2012, Minnesota had 392 licensed nursing homes and licensed and certified boarding care homes with a total of 31,996 beds in active service, with 375 facilities and 30,351 beds certified to participate in the Medicaid Program.

The number of nursing homes and licensed beds has been declining since 1987, when Minnesota had 468 facilities with 48,307 beds. By September 2012, 76 facilities had closed altogether (net of new facilities opened) and 15,213 beds had been completely delicensed. An additional 1,205 beds were out of active service, in layaway status. The supply of active beds has declined by 34% over the 25

[7] Programs and strategies that have been enacted (and modified) during this period to assist in rebalancing LTSS: (a) Moratorium on new licensure and MA certification of nursing home beds; (b) Pre-admission screening, now LTC Consultation; (c) Funding for HCBS, through Elderly Waiver and Alternative Care; (d) Local and regional long-term care planning and service "gaps" analysis, (e) Community Services and Service Development grants; (f) Nursing home bed layaway program; (g) Planned closure incentive payments; (h) the Single bed incentive; (i) Nursing facility consolidation; (j) Return to Community Program; (k) Moving Home Minnesota Program; and Olmstead planning.

years since the 1987 peak. In the last three years, the bed supply has declined by 1,989 beds or 5.9%.

Beds per 1,000 Elderly

Historically, Minnesota has been one of the most highly bedded states in the U.S., and in terms of beds/1000, Minnesota continues to have more nursing home bed availability than the national average when measured as beds per 1000 age 65+. However, in 2011, for the first time, Minnesota had fewer beds than the national average when measured as beds per 1000 age 85+. In 1995, Minnesota had 58% more beds per 1000 age 65+ and 28% more beds per 1000 age 85+ than the national average. By 2008 these numbers had decreased to 22% and 9% respectively. And in 2011, the most recent year with national data available, Minnesota had only 13% more beds per 1000 age 65+ and had 0.4% fewer for the 85+ population than the national average. Between 1995 and 2011 Minnesota reduced its bed capacity by 27.92%, more than any other state. During this time period, 23 states increased their bed capacity while the U.S., overall, reduced its bed capacity by 2.73%.

Bed Distribution within Minnesota

Before examining the distribution of beds in Minnesota, it is necessary to describe a relatively new method of measurement – Age Intensity Adjusted (AIA) Beds per Thousand. Comparing the availability of beds over time or between regions is a somewhat inexact science. The two measures that are commonly used, beds per 1000 age 65+ and beds per 1000 age 85+, are inadequate, because of variations in the age composition of the elderly, and the differing utilization rates associated with different age groups. The solution to this problem is risk adjustment – adjusting for differences in age composition. A detailed explanation of this method and the state distribution of age intensity adjusted beds per 1,000 rates can be found in the full report.

Occupancy

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

Occupancy in Minnesota's nursing homes has ranged between a high of 95.4% in 1993 and a low of 90.1% in 2012. This rather narrow range of occupancy has been maintained in recent years largely by taking beds out of service. Occupancy is important to monitor for two reasons. If occupancy were too high, consumers would have difficulty accessing nursing home care and would have limited choice. Low occupancy would likely put a financial strain on facilities, and perhaps, reduce the overall efficiency of the industry.

Hardship Areas

As noted earlier, the distribution of nursing home beds is not uniform across the state. The ratio of beds per thousand between the county with the most beds per thousand and the county with the fewest is 7.3 for the 65+ measure, 4.3 for the 85+ measure and 5.0 for the age intensity adjusted measure. All three measures indicate significant unevenness of distribution of beds.

An amendment to Minnesota Statute 144A.071, Subdivision 3 enacted in 2011 may help to address the uneven distribution of beds by allowing new beds to be added in hardship areas. Criteria to be considered in designating hardship areas are age-intensity adjusted beds per thousand, out migration, availability of non-institutional long-term supports and service, and declarations of hardship due to insufficient access by local county agencies and area agencies on aging. Out migration is defined as a situation in which an individual resides in a nursing facility in a county other than the county of financial responsibility. (See the table at the end of Part 5 of the full report for data on these criteria.) MDH, in consultation with DHS, began a process in August 2013, including a request for information about possible hardship areas and a request for proposals for adding beds in designated areas. MDH may approve up to 200 beds per biennium until 2020, after which up to 300 beds per biennium may be added.

Nursing Facility Utilization

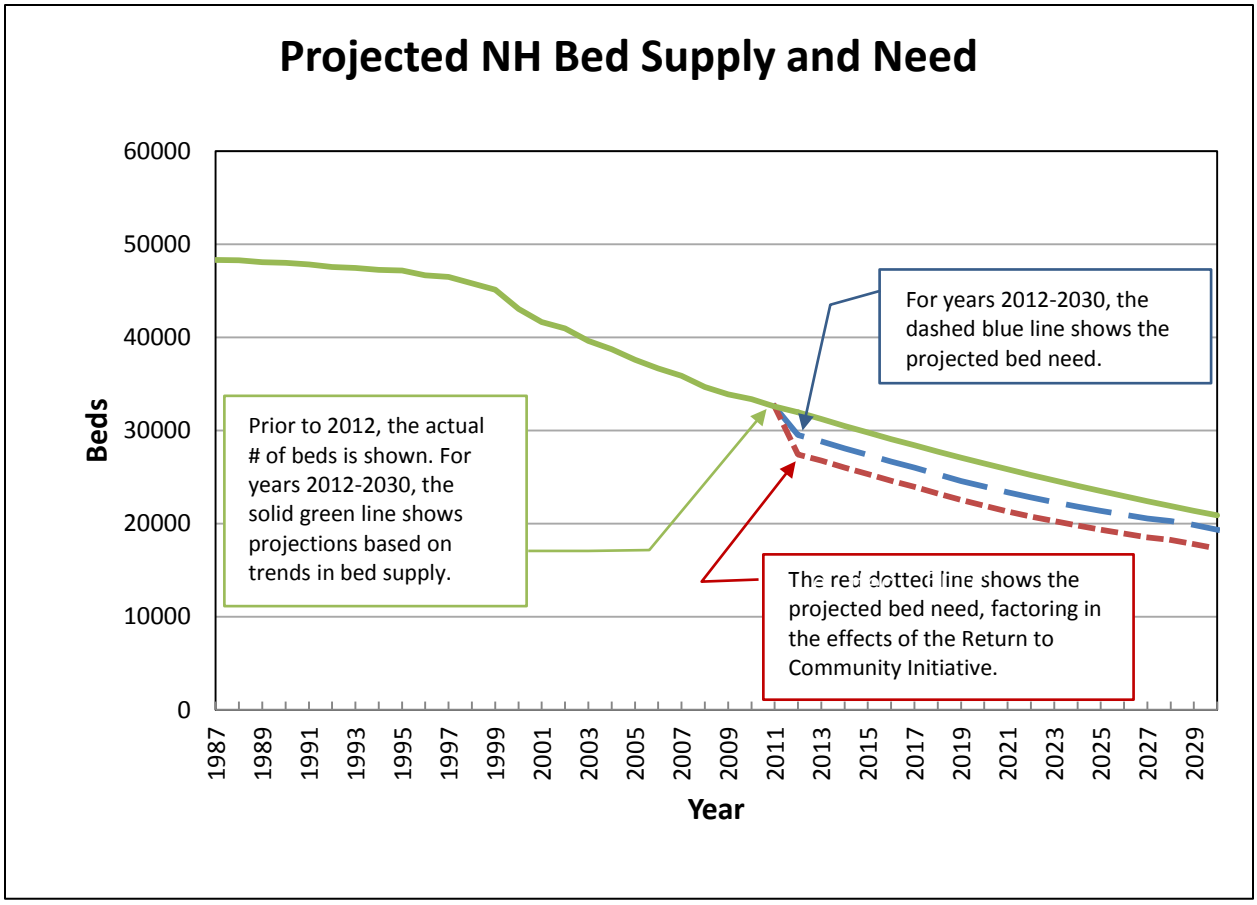
With increasing numbers of elderly and declining numbers of nursing home beds, why is it that occupancy rates have remained relatively stable and even declined? The market is shifting away from institutional care, encouraged by state policies as noted earlier and seen most dramatically in declining utilization rates. Nursing home utilization is a measure of how likely it is that a person will be in a nursing home—namely the percent of people within an age group who are in a nursing home on a given day. The nursing home utilization rate for older people in Minnesota has been declining for at least the past 27 years. In 1984, the utilization rate for persons aged 65+ was 8.4%, and by 2011, it had declined to 3.7%—a 56% reduction. The utilization rate for people age 85+ declined even more dramatically, from 36.4% in 1984 to 14.1% in 2011, a 61% reduction. The reduced utilization of nursing home services has been accompanied by increased numbers of people receiving LTSS in their own homes and in assisted living settings. Additional data on utilization can be found in the full report.

Future Industry Size—Projections

One of the questions this report is intended to address is whether the state continues to be over-bedded, has an adequate supply of nursing home beds for the foreseeable future or if additional beds will be needed, and specifically, is the moratorium still needed. To answer this question we will first look at projected bed availability based upon the downward trend in the number of beds, then projected bed need based upon the downward trend in the rate of utilization of nursing home services and the upward trend in the elderly population.

Exhibit 13 compares the bed availability projection with the bed need projection. The red dotted line shows the additional projected effect of the Return to Community Initiative. Minnesota starts with a projected surplus, in 2012, of 2,434 beds. That surplus falls to about 1,424 beds in 2030, without considering Return to Community. However, with the expected effect of Return to Community, Minnesota is projected to have a surplus of over 3000 beds in 2030. The projections do not include the possible addition of new beds under the hardship provision described earlier because the state does not yet have experience implementing those provisions.

Exhibit 13: Projected Nursing Home Bed Supply and Need



In conclusion, we suggest that we are at a point where the moratorium on new nursing home beds is still useful, but Minnesota should:

- Watch for local and regional access problems,
- Encourage the use of existing mechanisms that allow beds to be relocated from high bedded areas to low bedded areas, perhaps by creating an incentive for nursing facilities in high bedded areas to reduce capacity by making beds available to be relocated to low-bedded areas,
- Monitor the results of the new hardship provision,
- Continue to monitor Minnesota's beds per 1000 in comparison with the U.S., and

- Continue to monitor occupancy rates and, in the event they show a significant rise, consider more timely reporting and analysis of occupancy data, and modifications to policies that address bed closures, bed relocations and hardship areas.

As stated above, the purpose of this section of the report is to examine trends in nursing home bed availability and need, and specifically, to address the question: "Will Minnesota soon experience a shortage of nursing home beds?" The number of nursing facility beds available in Minnesota has been declining steadily for many years, and the need for beds has declined along with their availability. Occupancy of beds is at an all-time low; rates of utilization of beds by the elderly are declining; and the new hardship provision should address hardship in areas where it may begin to present itself. The evidence that Minnesota will not experience a shortage of nursing facility beds during the next several years is very strong.