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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
August 2015

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. 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 (LTSS) 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 initial recommendations regarding the goals for the future of long-term services and supports.

This report is a synthesis of information collected and analyzed through four distinct efforts:

- Gaps Analysis Study
- Home and Community-Based Services Critical Access Study
- Corporate Foster Care Needs Determination
- Nursing Facility Status Update

The Gaps Analysis Study is conducted every two years to gather local information about the perceived capacity and gaps of the service delivery system (i.e., the home and community-based services system and the continuum of mental health services and supports). The Minnesota Department of Human Services (DHS) contracted with Wilder Research to conduct the Gaps Analysis Study. Wilder Research collected input from a variety of stakeholders regarding the status of the two systems for the two-year period of January 1, 2013 to December 31, 2014. The Gaps Analysis Study was expanded in scope to collect data to inform a statewide brain injury needs and resources assessment and the Corporate Foster Care Needs Determination process.

The Home and Community-Based Services Critical Access Study was a one-time study conducted to augment the Gaps Analysis Study. DHS contracted with Abt Associates to conduct the study to provide additional detail about the extent to which the LTSS that individuals need and prefer (i.e., home and community-based services) are or are not currently available to state Medical Assistance beneficiaries. In addition, Abt developed measures and analyses to define "critical" access that could be used for tracking over time, in conjunction with the mandated Gaps Analysis Study.

The Foster Care Needs Determination is required of the commissioner each year per Minnesota Statute 245A.03, Subd7(e) to report to the legislature on capacity, management and recommendations for change. The commissioner chose to combine the August 2015 corporate foster care needs determination report with the report on the status of long-term care services and supports. This allowed the collection of data to occur through the same process, thus avoiding duplication of requests for information from counties, tribes and service recipients.

The Nursing Facility Status Update addresses trends in quality, cost, nursing facility financial status and need for and availability of nursing facility beds.

II. Legislation

Minnesota Statutes 2014, section 144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS: REPORT REQUIRED.
Subdivision 1.**Report requirements.**

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.

Subd. 2.**Critical access study.**

The commissioner of human services shall conduct a onetime study to assess local capacity and availability of home and community-based services for older adults, people with disabilities, and people with mental illnesses. The study must assess critical access at the community level and identify potential strategies to build home and community-based service capacity in critical access areas. The report shall be submitted to the legislature no later than August 15, 2015.

Minnesota Statutes 2014, section 245A.03, subd. 7 (e)

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph (c) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change

service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1, 2013, and August 1, 2014, and each following year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

III. Introduction

Beginning in 2001 and every two years after, DHS has reported on the current capacity and gaps in LTSS 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 managed care organizations 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.

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 home and community-based service (HCBS). However, most people with mental health conditions access services primarily through the continuum of mental health services and supports. The continuum of mental health services and supports includes the full range of treatment services and supports that individuals living with a mental illness need. These services and supports may be delivered in homes or other community-based settings, and in institutional settings. The continuum of mental health services and supports is not a subset of long-term services and supports, rather it is a complementary set of services for all individuals of any age living with a mental health condition.

Components of the Gaps Analysis Study and HCBS Critical Access Study sought to determine the degree to which each of the four populations need and are able to access services from both systems and the degree to which the barriers to sufficient service capacity are shared across the two systems. The Gaps Analysis Study also gathered input from lead agencies and stakeholders regarding additional systems components and characteristics including housing, choices and community integration, residential services and foster care, employment, transportation, cultural responsiveness and coordination.

This report is a synthesis of information collected and analyzed through several distinct efforts. The Gaps Analysis Study is conducted every two years to gather local information about the perceived capacity and gaps of the service delivery system (i.e., the home and community-based services system and the continuum of mental health services and supports). The Minnesota Department of Human Services (DHS) contracted with Wilder Research to conduct the Gaps Analysis Study. Wilder Research collected input from a variety of stakeholders regarding the status of the two systems for the two-year period of January 1, 2013 to December 31, 2014.

As a part of the study process, DHS asked Wilder Research to streamline and improve the approach for gathering information. To meet this need, Wilder Research, working in cooperation with DHS subject matter experts, made several significant changes to the study, including:

- Integrating all four populations of interest into a common data collection process.
- Expanding the scope to collect data to inform a statewide brain injury needs and resources assessment and the Foster Care Needs Determination annual report to the legislature.
- Collecting a more robust set of information from stakeholders, including statewide surveys with people who received services and with service providers.

The full data collection effort for the study included: surveys with lead agencies (counties and one tribe, with review and input provided by managed care organizations), service providers, people who receive services and their caregivers as well as in-depth interviews with tribal representatives and other key stakeholders such as advocacy organizations.

The Home and Community-Based Services Critical Access Study was a one-time study conducted to augment the Gaps Analysis Study. DHS contracted with Abt Associates to conduct the study to provide additional detail about the extent to which the LTSS that individuals need and prefer (i.e., home and community-based services) are or are not currently available to state Medical Assistance beneficiaries. In addition, Abt developed measures and analyses to define "critical" access that could be used for tracking over time, in conjunction with the mandated Gaps Analysis Study.

This report contains the high-level summary results from these studies and includes initial recommendations for goals related to home and community-based services for the four populations. This includes areas for improvement related to coordination between HCBS, the continuum of mental health services and supports, housing and transportation. The full reports with findings from each of the studies, as well as the county gaps analysis profiles for each of the four populations, will be made available on the DHS website in August 2015.

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

This section of the report provides estimates of the number of older adults and people with disabilities who may need long-term services and supports. It is important to remember that these estimates are based on the total Minnesota population. Only a subset of people included in these estimates ever access publicly-funded long-term services and supports. Many receive help from family, friends and neighbors and/or purchase services with their own money.

A. Estimates of Minnesotans with a Disability

The information below provides estimates of the total number of individuals in Minnesota who are living with a disability. 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 five surveys (2009-2013). 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.

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. [1] In addition, an estimated 38,079 people with disabilities are living in group quarters or potentially segregated settings.[2]

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	351,338	2,169	0.6
5 to 17 years	926,919	44,795	4.8
18 to 34 years	1,218,401	61,897	5.1
35 to 64 years	2,113,570	210,733	10.0
65 t0 74 years	370,233	76,860	20.8
75 years and older	308,432	139,853	45.3
Total	5,288,893	536,307	10.1

[1] "Group quarters" are 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. 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.

[2] Minnesota Department of Human Services, September 30, 2014, "Minnesota Olmstead Plan: Demographic Analysis, Segregated Settings Counts, Targets and Timelines."

Source: United States Census Bureau, American Community Survey 2009-2013

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 another way to gauge the proportion of Minnesotans with a 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

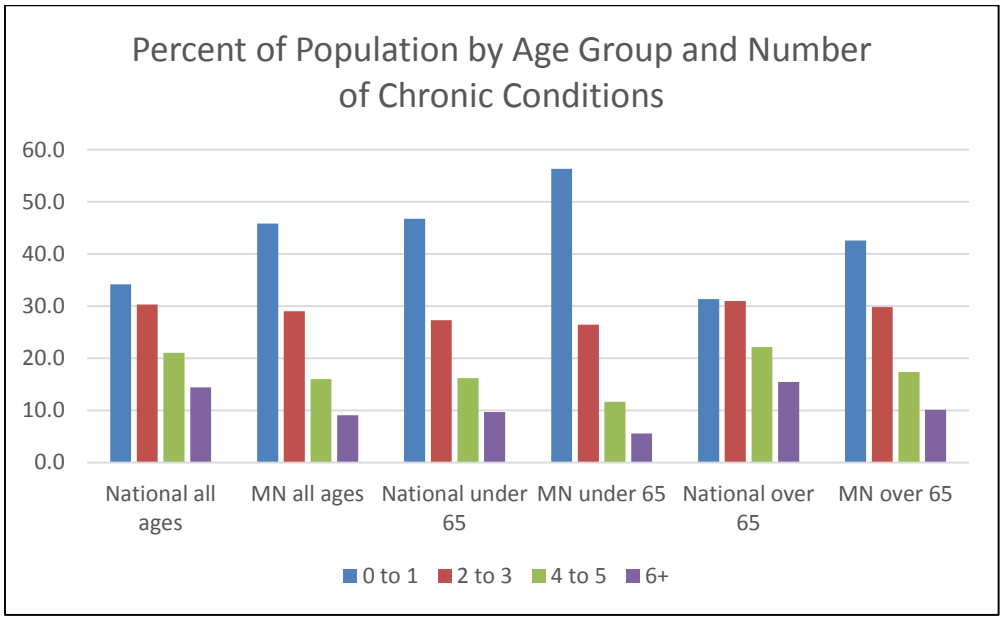
Year	Under 18	18–64	65 or older
2002	9,064	42,506	15,497
2004	9,996	44,813	15,979
2006	11,214	47,558	16,987
2008	12,282	50,564	17,799
2010	12,974	54,886	18,646
2012	13,633	58,437	19,489
2013	13,917	59,840	19,991

Source: Social Security Administration

B. Estimates of Minnesotans with Chronic Conditions

Exhibit 3 compares the percent of the Minnesota Medicare fee-for-service population that has one or more chronic condition with the percent of the total United States population by age group. Chronic conditions are a primary driver behind functional limitations in older adults and need for long-term services and supports. Older adults are more likely to have multiple chronic conditions as compared to younger age groups. The chart shows that, of the 780,000 Minnesotans age 65 and older, 30 percent have 2 to 3 chronic conditions (234,000), 17% have 4 to 5 chronic conditions (132,600) and 10% have 6 or more chronic conditions (78,000). Even though the overall disability rate for the state remains fairly stable at about 10 percent, the increase in the sheer number of older adults will drive an increase in overall demand for long-term services and supports.

Exhibit 3: Percent of U.S. and Minnesota Population by Age Group and Number of Chronic Conditions

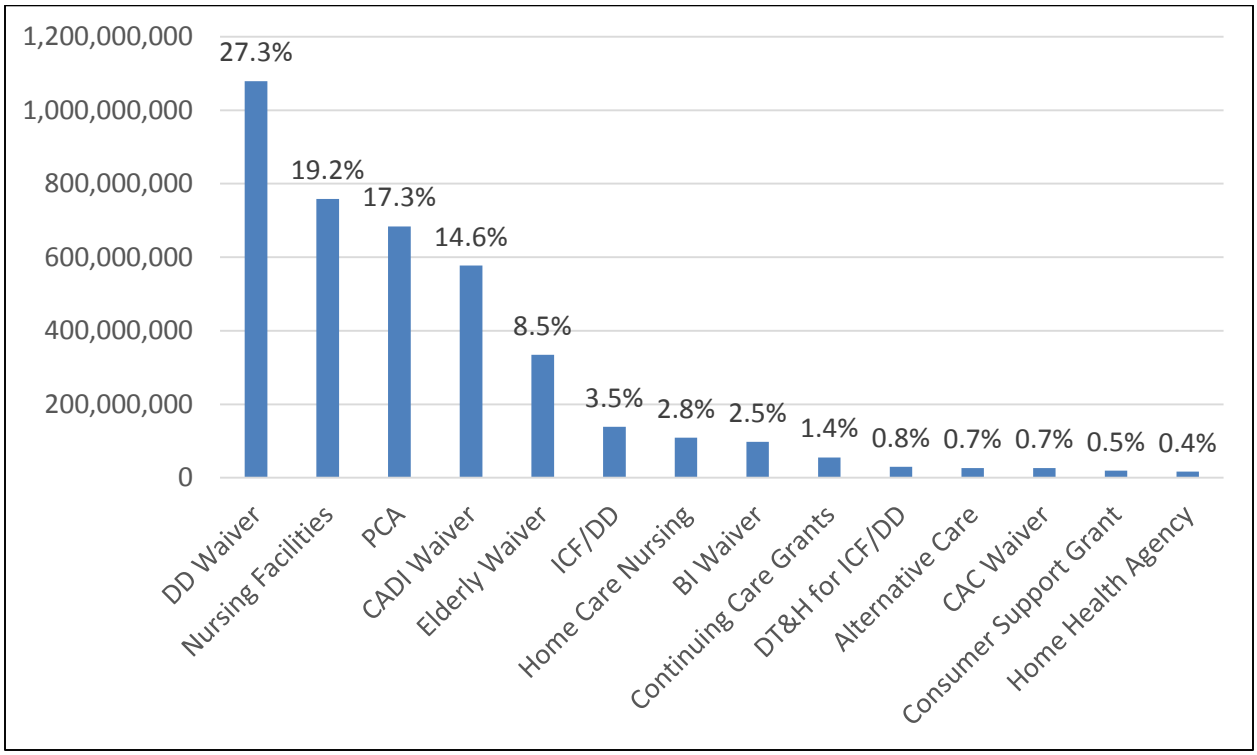


Source: Chronic Conditions Among Medicare Beneficiaries Chartbook, 2012. Data is based upon CMS administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program. These data are available from the CMS Chronic Condition Data Warehouse (CCW), www.ccwdata.org.

V. Long-Term Services and Supports Utilization and Expenditures

A subset of older adults with chronic conditions, people with disabilities, children and youth with mental health conditions and adults living with mental illnesses receive publicly-funded long-term services and supports. Currently, more than 365,000 people receive services administered through the Minnesota Board on Aging and the Minnesota Department of Human Services each year. 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 current and forecasted public expenditures for and utilization of long-term services and supports administered through DHS.

Exhibit 4: SFY 2014 Total Long-Term Services and Supports Spending, $3.9 billion

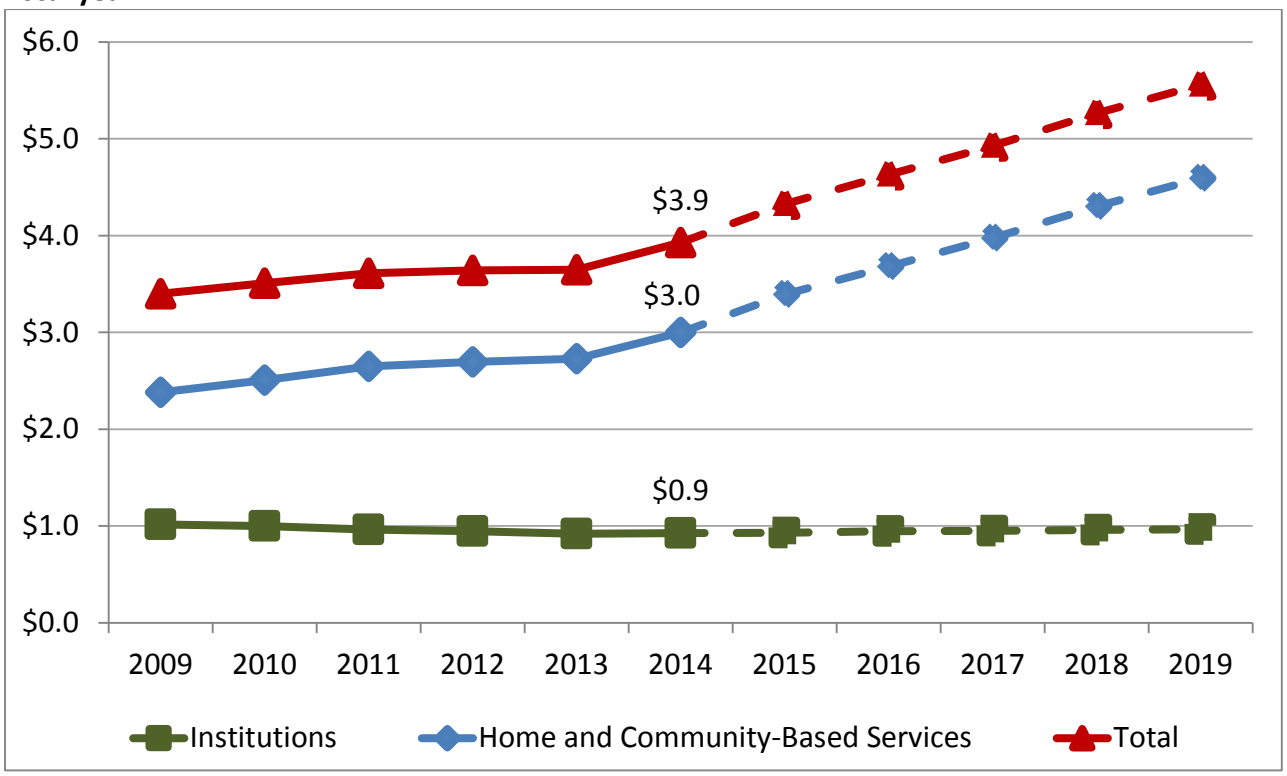


Source: Feb. 2015 DHS Forecast

Home and community-based waiver and state plan services comprise nearly $3.0 billion annually in state and federal spending and accounts for the majority of public spending on LTSS. In SFY 2014, Medical Assistance state plan services, including Home Health, Personal Care Assistance (fee for service), and Home Care Nursing, served more than 35,000 people. In addition, the

Consumer Support Grant, a state funded alternative to Medical Assistance home care services, served about 2,300 people. The six home and community-based waiver programs[2] served more than 47,000 people who are at risk of placement in an institution. State and federal grants, which comprise 1.4 percent of total long-term services and supports program spending, serve more than 225,000 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. Medical Assistance expenditures for nursing facilities comprise about $928 million a year. Nursing facilities serve about 15,600 people per month through Medical Assistance. Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD) serve 1,650 residents per month.

Exhibit 5: Total Forecasted Spending for Long-Term Services and Supports (in billions), by state fiscal year



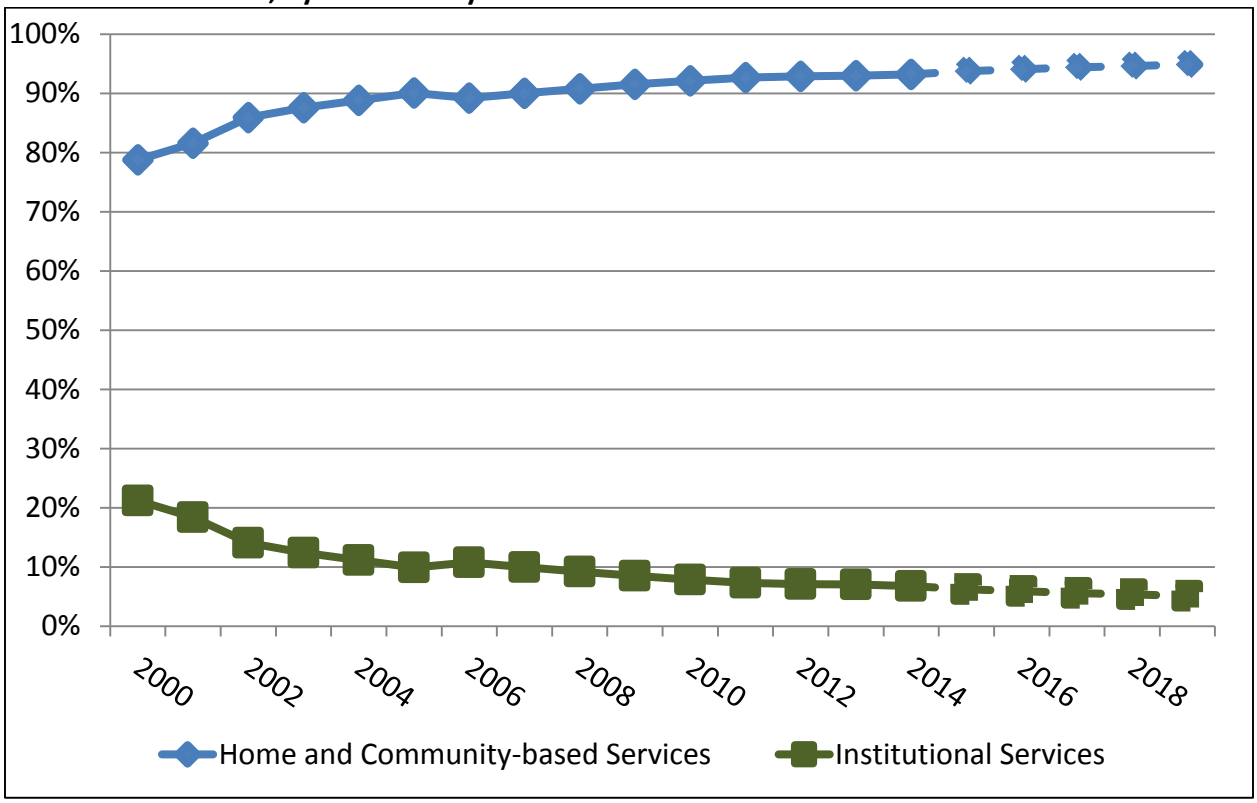
Source: Feb. 2015 DHS Forecast (data does not reflect changes passed during the 2015 legislative session)

Exhibit 5 reflects total (state, federal, and county) spending for long-term services and supports for all populations. The home and community-based services programs include Medical Assistance spending for the disability waivers, Elderly Waiver, State Plan Home Care (Personal Care Assistance, Home Care Nursing, and Home Health Agencies), Alternative Care, Essential

[2] The six waiver programs include: Brain Injury (BI) waiver, Community Alternative Care (CAC) waiver, Community Access for Disability Inclusion (CADI) waiver, Developmental Disability waiver (DD), Alternative Care (AC) and Elderly Waiver (EW).

Community Supports, and the Consumer Support Grant. Institutional programs include Medical Assistance spending for Nursing Facilities, Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD), and Day Training and Habilitation services for ICF/DD residents. This does not include services provided through other grant programs. The exhibit shows that over time proportionally more of the total spending has gone to home and community-based services and less on institutional services. This is projected to continue, however the institutional expenditures trend line will be affected by the changes passed in the 2015 legislative session.

Exhibit 6: Percentage of People with Disabilities using Home and Community-based vs. Institutional services, by state fiscal year

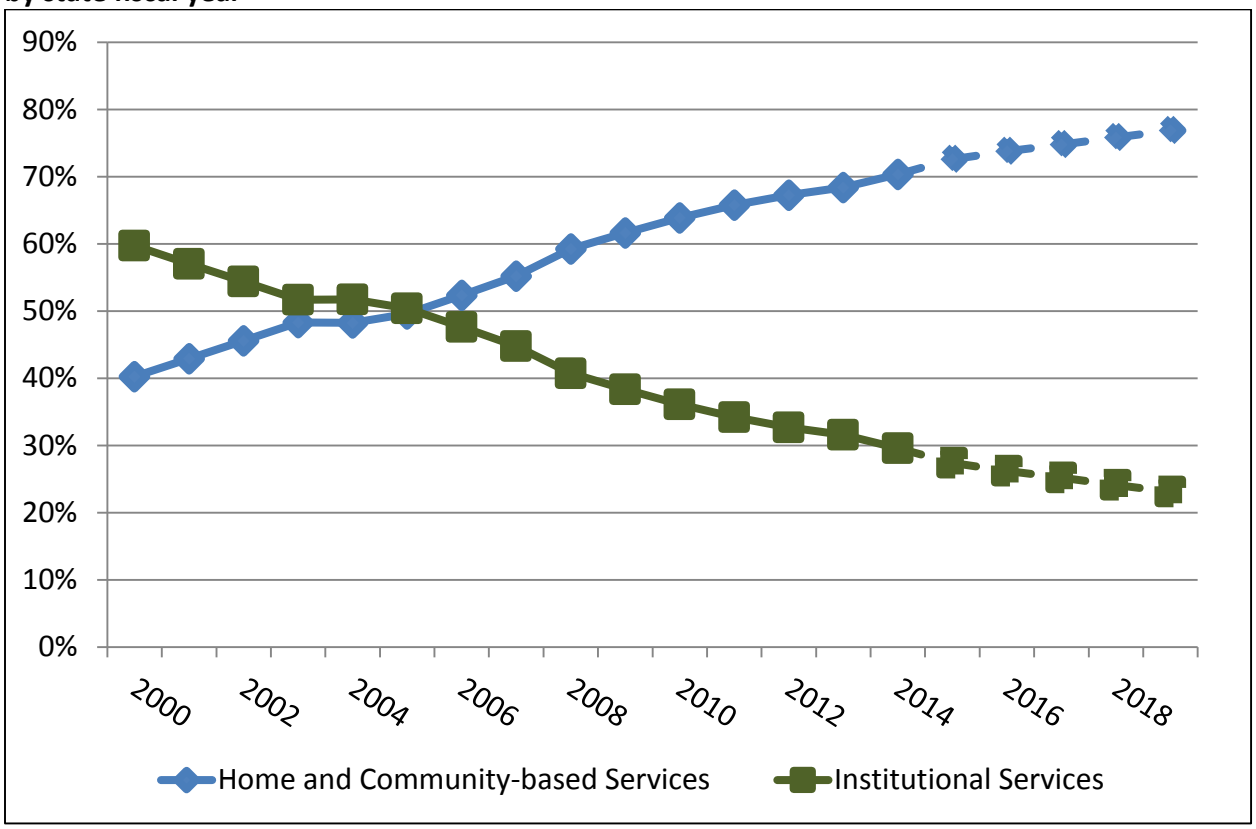


Source: Nov. 2014 DHS Forecast, average monthly caseloads

Exhibit 6 reflects the percentage of people with disabilities using the publicly-funded long-term services and supports programs. The home and community-based services (HCBS) programs include the disability waivers, State Plan Home Care (Personal Care Assistance, Home Care Nursing, and Home Health Agencies), and the Consumer Support Grant. The institutional programs include people under age 65 served in nursing facilities through Medical Assistance and Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD). This does not include services provided through other grant programs. The exhibit shows that over time more people with disabilities receiving publicly-funded LTSS received HCBS rather than institutional services. This measure is important because HCBS are less expensive to provide

when people with disabilities can stay in their homes. HCBS also provides people more control over services, which promotes independence.

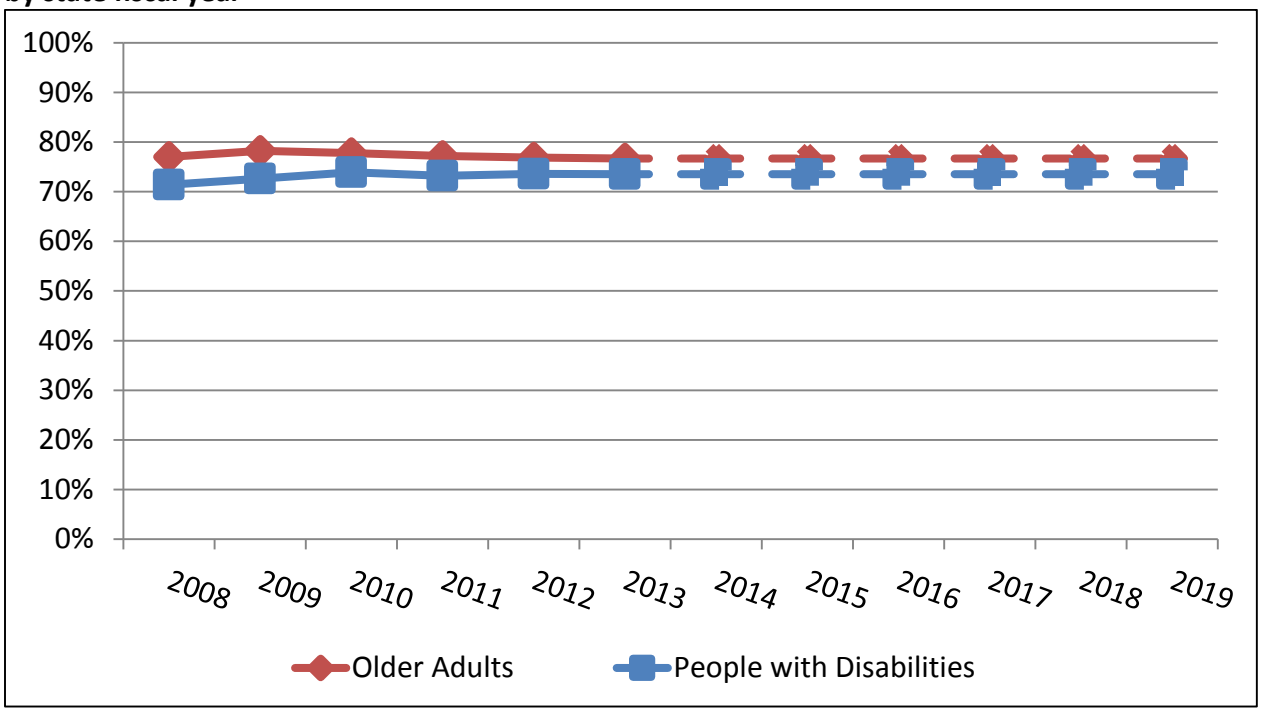
Exhibit 7: Percentage of Older Adults using Home and Community-based vs. Institutional services, by state fiscal year



Source: Nov. 2014 DHS Forecast, average monthly caseloads

Exhibit 7 reflects the percentage of older adults using publicly-funded long-term service and support programs. The home and community-based services programs included in the graph include Elderly Waiver, Alternative Care, State Plan Home Care (Personal Care Assistance, Home Care Nursing, and Home Health Agencies) and Essential Community Supports. The institutional programs include people age 65 and older served in nursing facilities through Medical Assistance. This does not include services provided through the Older Americans Act or other grant programs. Approximately 225,000 older adults and family caregivers receive services through these sources. In state fiscal year 2014, 70 percent of older adults received HCBS as compared to 30 percent living in nursing homes. This is a dramatic improvement from state fiscal year 2000 when only 40 percent of older adults received HCBS and 60 percent lived in nursing homes.

Exhibit 8: Percentage of People using Home and Community-based Services in their Own Homes, by state fiscal year

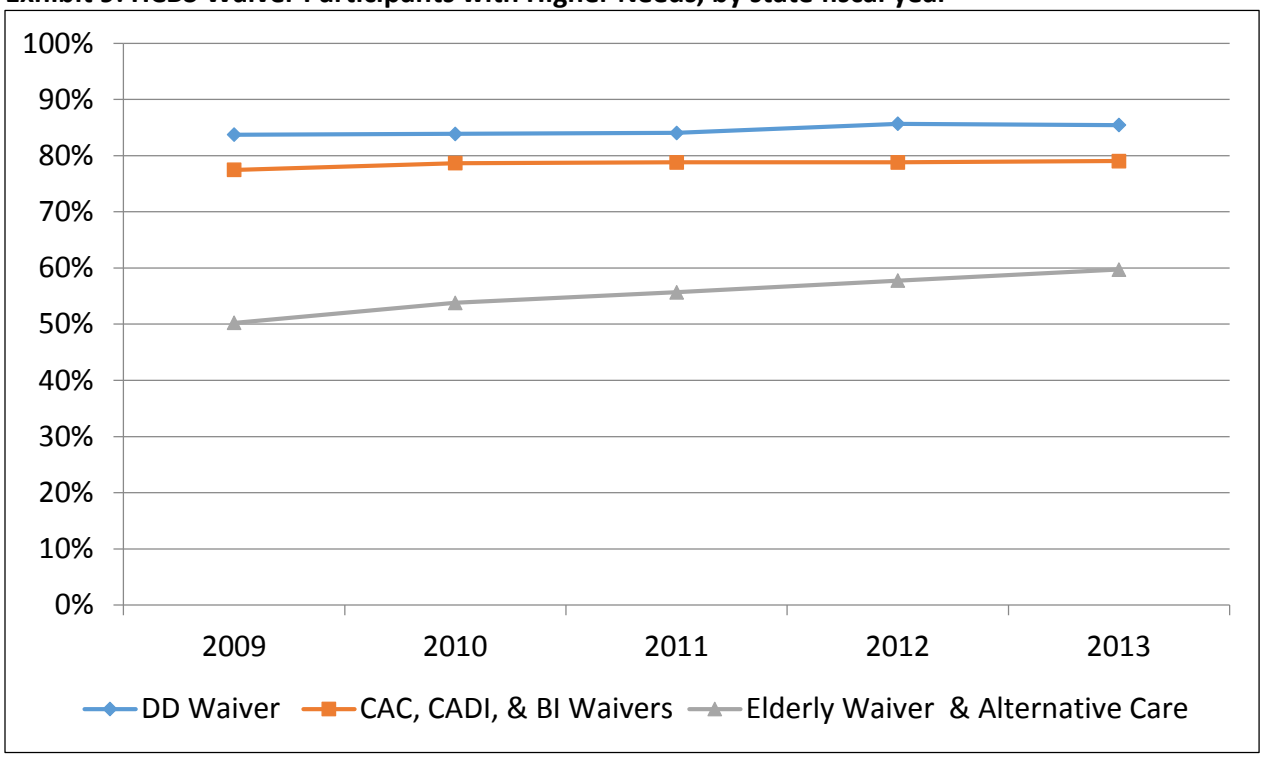


Source: DHS MMIS claims and service agreements

Exhibit 8 represents the percentage of people served in the HCBS programs (the disability waivers, Elderly Waiver, Alternative Care, Essential Community Supports, Personal Care Assistance, Consumer Support Grant, home care nursing, and home health agencies) who receive services in their own home or a family home rather than residential services. Residential services include customized living, foster care, and residential services. This measure includes waiver participants as well as people receiving state plan home care services only. In state fiscal year 2014, 73.5 percent of people with disabilities and 76.7 percent of older adults received HCBS in their own homes. These proportions are expected to remain fairly stable through state fiscal year 2019.

Exhibit 9 shows the proportion of waiver recipients with high needs. This measure shows that people with disabilities and older adults with high needs are staying in their homes or communities. In the past, people with greater needs were not able to stay in their communities because the services they needed were only available in institutions. This measure shows that the long-term services and supports system has been able to develop and offer more intense and specialized services in the community. In the Developmental Disabilities waiver, persons with higher needs are those individuals with a profile 1 through 3. In the other disability waivers, Elderly Waiver and Alternative Care programs, persons with higher needs are those individuals having a case-mix of "B" -"K".

Exhibit 9: HCBS Waiver Participants with Higher Needs, by state fiscal year

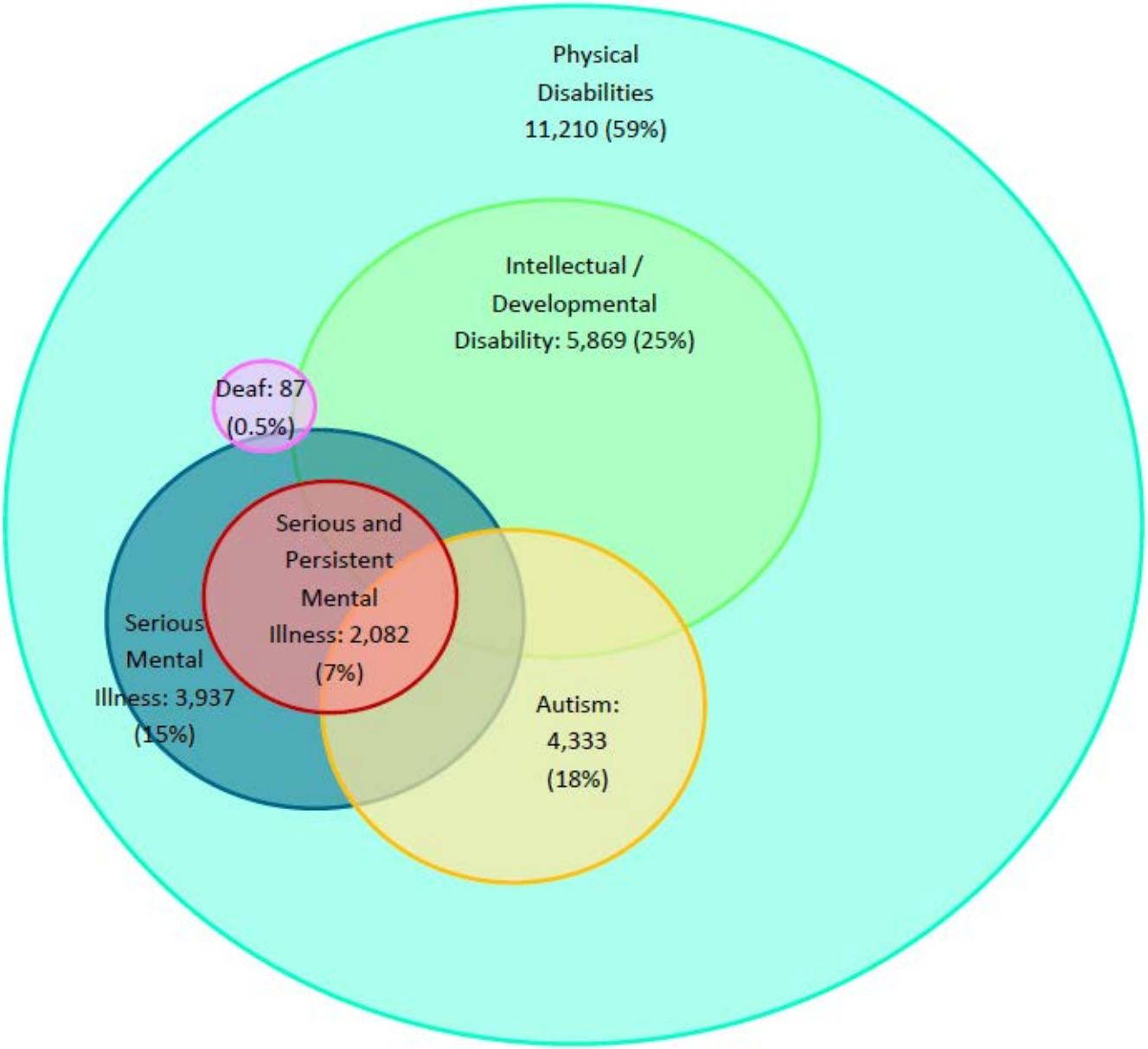


Source: DHS Data Warehouse

Exhibit 10 on the next page, depicts the complexity of the population of individuals who receive fee-for-service home care. Most generally it shows that a subset of the total fee-for-service home care population has a physical disability. Of that sub-group, a number of people have additional diagnoses many of which are mental health conditions. DHS recognizes that people will come to the system and may utilize any combination of services that meet their needs. People do not fit neatly into just one diagnosis or one program. This illustration shows how in just one part of the LTSS system, those receiving fee-for-service home care, individuals fit into multiple groupings and their needs are more complex than what any of the existing LTSS programs can meet alone.

Exhibit 10: Diagnoses among Home Care Fee-For-Service Participants, SFY 2013

Total Home Care Fee-For-Services Participants: 27,518



Source: DHS MMIS

Exhibit 10 includes people receiving state plan fee-for-service home care services only. It does not include people receiving HCBS through the waiver programs. It also does not include people receiving home care services through managed care. Physical disabilities may include cerebral palsy, blindness, medical disabilities, muscular and neurological disabilities, brain injury and other conditions and diagnoses.

VI. Current Capacity of the Home and Community-Based Service System and the Continuum of Mental Health Services and Supports Continuum

A. Gaps Analysis Study

DHS contracted with Wilder Research to conduct the Gaps Analysis Study for this report. The study examined the status of the service systems in 2013-2014. Data was collected through: surveys with 79 lead agencies (all counties and one tribe, with input from the managed care organizations); surveys with 344 service providers; surveys with 437 people who received services or their caregivers; and in-depth interviews with representatives of eight tribes and with 30 other key stakeholders such as advocacy organizations.

The managed care organizations reported a high level of agreement with the assessment of the counties and tribe that completed the lead agency survey.

Service availability and gaps

For each of the Gaps Analysis study populations, home and community-based services were more likely to meet demand than mental health services. The services most likely to be rated by the lead agencies as meeting or exceeding demand for each population are listed below.

Exhibit 11: Services most often rated by lead agencies as meeting or exceeding demand

Older adults Consumer directed community supports (90%) Long-term care consultation/community assessment (89%) End-of-life, hospice, palliative care (89%)	Persons with disabilities Consumer directed community supports (90%) Specialized supplies and equipment (86%) Home delivered meals (81%) Relocation service coordination (81%)
Adults with mental health conditions Adult protection (77%) Targeted case management (76%) Case management (73%)	Children with mental health conditions Specialized supplies and equipment (70%) Case management (67%) Consumer directed community supports (65%)

For many services, availability fell short of demand. This was especially true for children and adults with mental health conditions, where very few services were identified as meeting or exceeding demand. For children with mental health issues, three core gaps emerged from the perspective of lead agencies (counties and tribe) and service providers: inpatient psychiatric hospitalization, psychiatric prescribing, and residential treatment. Results were similar for adults with mental health conditions, with inpatient psychiatric hospitalization, psychiatric prescribing, permanent supportive housing, and medication management for psychotropic drugs identified as core gaps. The managed care organizations agreed overall with the identification of gaps and emphasized the significance of the gaps in mental health and transportation.

For older adults, lead agency representatives from the counties and tribe rated transportation, chore services, personal care assistance, and respite care among the largest or most significant gaps. For people with disabilities, lead agencies most frequently cited out-of-home respite care, services in foster care, and crisis respite care as the areas with the largest or most significant gaps. Managed care organizations agreed overall with the identification of gaps and emphasized the significance of the gap in respite care.

Exhibit 12: Percent of lead agencies (counties and tribe) rating services as one of their three with most significant gaps (N = 79)

Service	Older adults	Persons with disabilities	Adults with mental health concerns	Children with mental health concerns
Adult Intensive Residential Treatment Services (IRTS)	6%	9%	22%	--
Behavioral programming	--	19%	6%	3%
Chore services	28%	9%	--	--
Inpatient adult psychiatric beds	--	--	46%	--
Inpatient child/youth psychiatry beds	--	--	--	38%
Medical transportation	19%	5%	9%	4%
Non-medical transportation	37%	18%	10%	4%
Permanent Supportive Housing	--	--	25%	0%
Personal care assistance	19%	16%	--	--
Psychiatric prescribers	--	--	38%	37%
Respite care – Crisis	5%	23%	3%	1%
Respite care – Out of home	15%	30%	4%	5%
Specific placements for children/youth with aggressive behaviors	--	--	--	37%
Waiver services to older adults and persons with disabilities in foster care	8%	24%	5%	6%

When needed services are not available, lead agencies were likely to say that people received no alternative services. For older adults and persons with disabilities, alternative support was provided through natural or informal supports, such as family and friends. In some cases, people receive more restrictive services than needed, such as through nursing homes or hospitals.

Changes in service availability

Lead agency staff were asked to rate whether specific services for each target population have become more or less available. For most services, lead agencies were most likely to say that availability has *not changed* over the past two years. For older adults and persons with disabilities, lead agencies reported that the greatest *declines* occurred with out-of-home respite care (32 percent), Personal Care Assistance (29 percent), and in-home respite care (27 percent). For children and adults with mental health conditions, the largest declines were seen in psychiatric prescribers (psychiatrists, nurse practitioners, clinical nurse specialists) (35 percent), services in foster care (34 percent), and inpatient adult psychiatry beds (34 percent).

Other services were more likely to have *increased* in availability over the past two years. For older adults and persons with disabilities, lead agencies were most likely to report increased availability of assistive technology (42 percent), health promotion activities (42 percent), and 24-hour emergency assistance (29 percent). For children and adults with mental health conditions, the greatest increases were reported for Trauma-Focused Cognitive Behavioral Therapy (56 percent), mental health services offered in schools (48 percent), and Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Childhood (DC:0-3R) (43 percent).

Barriers and strategies to increase service availability

Across populations, there were some common reasons why services are not more available. Top-ranked reasons for all four populations included provider reimbursement rates, challenges recruiting and retaining mental health and other service providers and front-line staff, a shortage of trained staff, and a lack of funding (other than reimbursement).

For adult and children's mental health, the most significant reason for limited service availability was a shortage of prescribers. A shortage of facility space also limits child/adult mental health services, while inconsistent/insufficient demand for service (primarily in rural areas) limits services for older adults and persons with disabilities especially for chore, adult day service and PCA.

Lead agencies also ranked barriers that prevent people from accessing needed services. Across all populations, geographic distance to service and transportation were significant issues. Long waiting times for services or providers, and a lack of service availability on short notice or during crisis, also posed accessibility barriers.

Lead agencies (counties, tribe and managed care organizations), providers, people who received services or their caregivers, tribal representatives, and other stakeholders all highlighted the particular challenges of providing or receiving services in rural communities. Services are less available, and barriers such as distance and transportation are more significant in more rural areas. When services are not available within the county, people typically need to travel to receive services in other areas. In addition to considering strategies for recruiting providers to work in rural communities, the need for transportation services was also highlighted.

Most often, the county and tribal lead agencies and providers said that no strategies were currently underway to either increase the availability of services or reduce barriers to access. These lead agencies and providers often said that they cannot develop deeper strategies without guidance and additional resources (e.g., funding). They often felt that responsibility for addressing the barriers fell to the state, rather than regional or local groups. Strategies such as increasing reimbursement rates, offering grants or other funding sources, developing training models, or enacting legislative reforms were specifically offered as suggestions for the state.

Managed care organizations frequently identified strategies underway to address a gap in service availability or to address barriers to access. The managed care organizations felt that good work was underway across many of the counties that they serve particularly in children's and adult mental health. They also offered several recommendations to address barriers experienced by these two populations including increased used of telehealth and increased availability of mobile crisis response services.

Additional perspective of people who received services or their caregivers

People who have received services, or their caregivers responding on their behalf, provided additional information regarding their experiences with the service delivery system. It should be noted that only 437 consumers or caregivers completed the survey. Their perspectives may not reflect the full population of people receiving publicly-funded services, especially within some of the specific populations addressed in this study. It should also be noted that many of those surveyed represented more than one target population. Only 158, or 36 percent, identified themselves as belonging to only one of the groups. Forty percent of survey respondents identified themselves with two groups, either personally or as the caregiver for someone in the group. Twenty-four percent identified with three or more populations.

Two-thirds of the people who received services, or their caregivers, found it "very easy" or "somewhat easy" to access the services that they had found most valuable. Some people, especially adults with mental health issues and caregivers of children with mental health issues, described challenges learning about and accessing services. Most people (64 percent) rated their most valuable services to be "very good" (64 percent); another 31 percent felt they were "pretty good, but could be better."

Thirty-five percent of survey respondents felt that the help they received met "all of their needs" while 61 percent said it met "some of their needs." Forty-two percent said that they need help they are unable to get, such as respite care and crisis support. Throughout the consumer survey, ratings varied across populations. Older adults and their family caregivers rated services consistently more positive compared to the other populations while survey respondents rating children's mental health services rated those services consistently less positive compared to the other populations.

Service integration and service systems integration

In addition to evaluating the gaps and capacity of individual-level services, the current Gaps Analysis study assessed gaps in other crucial features of the services system that allow people to live in less restrictive, community settings. Like the individual-level services, these systems-level components show some significant gaps but also some opportunities for strengthening.

- **Housing:** Subsidized housing falls short of demand in three-quarters of counties. The housing most needed by people receiving services is subsidized rental housing with support services, which meets demand in only 8 percent of counties. This is one of the main resources needed to help people be able to remain in their communities.

- **Employment:** Employment support is especially needed by people with disabilities and adults with mental health conditions. The main barriers to providing this help are limited availability of transportation, a shortage of suitable jobs in the community, and a lack of supported employment services.

- **Transportation:** A large majority of lead agencies (counties, tribe and managed care organizations) report that transportation options are not meeting the needs of people receiving services, and over one-quarter of people who receive services and who were surveyed had been unable to get somewhere in the past month. Lead agencies' top priorities were expanding last-minute or unplanned transportation options, increasing days and times of availability, and increasing assisted or escorted service. The top priorities for people who receive services were reliability, affordability, and increased schedule options.

- **Cultural responsiveness:** Two-thirds of people report their providers "have a very good understanding" of their cultural and ethnic background. People of color and multi-racial people said their services were consistent with their values and culture less often than white consumers (52% "almost or always" vs 72%). In most other respects, differences based on race were not statistically significant. Again, caution should be noted when interpreting consumer feedback, due to the relatively low number of respondents within some groups of interest to this study. Key stakeholders feel providers generally strive to be culturally responsive, but need continued education and recruitment of more diverse staff to be adequately responsive to people from diverse cultures.

- **Overall service system:** The state of Minnesota is leading implementation of a set of principles to assure that services "will empower and support people with disabilities of all ages and abilities to live with dignity and independence in the most integrated setting consistent with their own preferences and based upon their own choice" (Olmstead Plan vision statement, 2012). Lead agencies (counties, tribe and managed care organizations) generally report that their practices are consistent with these principles, and a majority of people who were surveyed agreed. The two principles not meeting standards as rated by lead agencies were the availability of transportation and sufficiently trained workforce for the

service system. People who received services gave their lowest rating to the ability to have choice in housing.

Residential services and foster care

The 2009 Minnesota Legislature authorized a moratorium on growth of foster care for adults and children. In 2011, legislation followed establishing a statewide capacity reduction for foster care. The 2009 legislature authorized grant funding to increase access to housing and technology to support alternatives to foster care, and local planning grants. State initiatives continue to develop alternatives to foster care for people who seek more independent options.

Lead agencies identified many obstacles or barriers to foster care bed repurposing. Lead agencies were asked to identify potential obstacles or barriers to foster care bed repurposing[3] their county or tribe may face. Six different barriers were identified by over half of lead agencies, including lack of available accessible housing, lack of transportation, and lack of other less restrictive, alternative residential service providers (65 percent each). Other common barriers included lack of support from the person, family and/or guardian (62 percent), lack of residential support service providers for consumers (61 percent), and lack of funds (58 percent).

When asked to indicate the services and supports they would most likely strengthen or develop to increase alternatives to corporate foster care settings, lead agencies most often selected transportation (61 percent). Over half of the lead agencies also indicated they would most likely strengthen or develop behavioral programming (57 percent), 24-hour emergency services (54 percent), and night supervision services (52 percent).

B. Home and Community-Based Services Critical Access Study

DHS contracted with Abt Associates (Abt) to provide additional detail about the extent to which the long-term services and supports (LTSS) that individuals need and prefer (i.e., HCBS) are or are not currently available to state Medical Assistance beneficiaries. DHS was additionally seeking measures and analyses to define “critical” access that could be used for tracking over time, in conjunction with the mandated Gaps Analysis Study. The specific research areas for the study were:

- Current HCBS utilization patterns and trends, both at the state level and among specific subpopulations;
- The relationship between the number of people receiving publicly-funded HCBS with potential total demand for these services;

[3] Although the term “re-purposing” was not defined in the survey, the term is commonly understood to mean making foster care beds available for others who have a need and may include specialization of services or moving capacity to areas of the state where needed.

- The size and scope of the population potentially eligible for HCBS waiver services who do not currently receive them; and
- Factors that may affect critical access such as provider mix and geographic and political configuration.

In measuring critical access, Abt was directed to examine the experience of four cohorts:

- Older adults with disabilities (ages 65 and older);
- Children and adults with disabilities (under age 65);
- Children and youth with mental health conditions (less than 18 years of age with a mental health diagnosis); and
- Adults living with mental illness (ages 18 and older with a mental health diagnosis).

Abt consulted with DHS management and program staff to create a consensus definition of HCBS users based on services used, rather than program (i.e. HCBS waiver) eligibility. Similarly, DHS staff and researchers collaborated to define mental health diagnoses and categories of service that were then used to define beneficiary subpopulations and measure HCBS and mental health treatment utilization, as well as to articulate specific research questions to help quantify different dimensions of "access." The resulting analyses described below are primarily based on SFY13 Medical Assistance claims and administrative data (assessment and MAXIS), provider registries and data from the American Community Survey.

Current HCBS Use Patterns and Trends

In SFY13 there were **125,375 people** who received at least one HCBS from the list of more than 120 different services analyzed as part of the study. Compared to the Minnesota Health Care Programs (MHCP) population overall, people using HCBS had significantly higher median age and were more likely to be eligible for both Medicare and Medical Assistance and have lower incomes. More than half of the MHCP population age 65 and older used HCBS, compared to only about 8 percent of those younger than 65.

The **types of services used** varied by subpopulation. Older adults were most likely to have received homemaker, skilled nursing, and customized living services, whereas personal care assistance (PCA) services predominated among younger HCBS users. Children and youth with mental conditions were more than twice as likely (59 percent compared to 22 percent) to receive PCA compared to adults with similar diagnoses.

Use of residential HCBS, such as customized living or foster care, averaged about 40 percent among those eligible in all population groups except children and adolescents with a mental health diagnosis (who averaged about 8 percent). The absence of a spouse or partner living in the home and required assistance with select activities of daily living were characteristics associated with residential service use.

More than 50 percent of HCBS users had a mental health, autism, attention deficit or chemical dependency diagnosis. This is twice the rate found in the overall MHCP population. The most common diagnoses were mood and anxiety disorders. HCBS use rates among people with mental health diagnoses were generally the same for specific HCBS regardless of whether or not the person also received mental health treatment services.

About one-fifth of the MHCP population with a mental health, autism, attention deficit or chemical dependency diagnosis received HCBS, while approximately three-quarters received mental health treatment services. Within this group, individuals with autism were most likely to receive HCBS and mental health treatment services, while those with chemical dependency disorders were least likely to receive either type of service.

More than 12,000 people receiving HCBS were identified as having **Alzheimer's disease or a related condition (ARC**). Slightly more than half were identified as having an ARC based only on assessment data rather than by a diagnosis on a claim. People with ARC were more often older and white, with higher levels of need for assistance with activities of daily living, and more likely to receive customized living, when compared to other people receiving HCBS.

Relationship between Current HCBS Population and Potential Demand

According to the American Community Survey data (2008-2012), there were over **440,000** people with disabilities who receive public insurance in Minnesota, which is approximately 3.5 times the number of people who used HCBS in SFY13.

HCBS use rates increased with age. The number of people who used HCBS over age 74 was about 95 percent of the estimated number of people with incomes below 200 percent of the federal poverty level (FPL) in the state of the same age.

The **rate of HCBS usage among low-income individuals** (less than 200 percent of FPL) varied between about 20 and 25 percent across counties, with no obvious outliers.

Size and Scope of Potentially-eligible Population

In May 2015[4], the population of people who potentially could use HCBS included about 5,006 on waiting lists or who had been assessed as eligible and not receiving HCBS. The total number is comprised of 1,420 people waiting for the CADI waiver and 3,586 waiting for the DD waiver. Statutory statewide average enrollment limits for the CADI and DD waivers increased on July 1, 2015, permitting increased new waiver enrollment. CADI waiver limits were eliminated while DD waiver limits increased from 15 to 25 people per month. In SFY2013, there were 17,000 people in institutional settings, such as skilled nursing facilities, intermediate care facilities or residential treatment centers; and more than 200,000 individuals with potentially-disabling diagnoses such as traumatic brain injuries, autism spectrum disorders, developmental disabilities

[4] The report uses May 2015 data for the waiver waiting list to align with Minnesota's Olmstead Plan goals.

or multiple chronic conditions. Some of these individuals may already be on a waiting list for waiver services.

Critical Access Measures

Average provider caseloads among active HCBS providers varied by service type, ranging from 2.5 people for PCAs to more than 50 people for Day Training & Habilitation (DTH) providers. The geographic distribution of individual PCAs and customized living facilities was very similar, with the same counties showing the highest concentrations.

Distances between HCBS providers and the people they served varied by service type, with individual PCAs having the lowest average distance between zip codes. About 30 percent of 1-to-1 PCA users lived in the same zip code as their workers.

For HCBS users with a mental health diagnosis who received three or more HCBS, the **most common cluster of HCBS** were administrative case management, home health aide, homemaker, PERS and nursing services. For HCBS users under age 65, the most common cluster of services was administrative case management, DT&H and respite. Among older adults receiving HCBS, home health, homemaker, personal emergency response system (PERS) and nursing services was the most prevalent combination.

To further evaluate critical access, Abt researchers examined the effect of provider supply on service planning for people who need HCBS (as documented under "planned" services on individuals' assessment forms), and whether services that were "planned" on a person's assessment form were actually received. Provider supply was defined as the number of providers per 10,000 low-income residents (<200 percent FPL). This analysis controlled for other individual characteristics—such as diagnosis, functional limitation and age—that might also predict services planned and used. Results suggested that **provider supply does have an independent effect on HCBS access**, both for service planning and service receipt.

- At the county level, the supply of adult day care, meal delivery, nursing, home health aide, PERS, and DT&H had a statistically significant impact on whether those services were planned for individuals.
- Across state economic development regions, respite, PCA, meal delivery, nursing, Home Health Aide, employment services, PERS, and DTH provider supply all predicted whether or not a service was planned.
- Across counties, whether people actually received planned transportation, respite, targeted case management, behavioral programming, nursing, or chore services was affected by the supply of those providers.
- Across state economic development regions, the supply of active home health aide, chore services, and DT&H providers affected whether these services were received when planned.

VII. Foster Care Needs Determination

A. Background

Minnesota Statute 245A.03, Subd. 7 (e) requires the commissioner to conduct a resource needs determination process for corporate foster care. Corporate foster care is defined as licensed foster care settings where the license holder does not reside. These settings typically use a shift-staff model of support. The statute requires the commissioner to annually report to the legislature on the following:

- Information and data on the overall capacity of licensed long-term care services;
- Actions taken to manage statewide long-term care services and supports resources; and,
- Any recommendations for change to the legislative committees with jurisdiction over the health and human services budget

B. Information and data on overall corporate foster care capacity

Current statewide capacity

The commissioner tracks and maintains information on current licensed capacity for corporate foster care in Minnesota. Exhibit 13 provides a summary of capacity across the state by region, including a comparison between the corporate foster care licensed capacity in June 2014 and June 2015.

Exhibit 13. Current Number of DHS licensed beds – SFY 2014 vs SFY 2015 by region

Region		Largest County	6/30/2014	6/30/2015	Difference
1	Northwest Corner	Polk	237	241	4
2	North Central	Beltrami	248	252	4
3	Northeast Corner	St. Louis	1536	1548	12
4	North West	Clay	935	943	8
5	Central	Crow Wing	570	577	7
6	West	Kandiyohi	837	831	-6
8	Southwest Corner	Lyon	429	441	12
9	South Central	Blue Earth	949	951	2
10	Southeast Corner	Olmsted	1449	1477	28
11	Metro	Hennepin	5063	5082	19

Region		Largest County	6/30/2014	6/30/2015	Difference
7E	**Central East**	Chisago	521	514	-7
7W	**Central West**	Stearns	896	885	-11
	Other	adj/unknown	5	4	-1
Totals			**13675**	**13746***	**71**

*Note that statewide baseline set July 1, 2013 by legislative action is 13,700 corporate adult and child foster care beds. The total in this column is higher, but moratorium exceptions lower the count to within the required baseline.

Input from stakeholders on housing and residential service needs

The commissioner combined the August 2015 corporate foster care needs determination report with the report on the status of long-term care services and supports, as previously discussed with legislators and stakeholders. This allowed the collection of data to occur through the same process, thus avoiding duplication of requests for information from counties and tribes (collectively referred to as lead agencies), and service recipients. DHS is using the information received from the data collection to meet multiple purposes. The data collection process asked respondents to think about the two year period of 2013 and 2014.

The input received through this process contains a significant amount of information about service availability, quality, gaps, and barriers for supporting people with disabilities in their communities. The following information reflects ratings and insights provided by multiple informants, including lead agency staff, service providers, persons with disabilities and their caregivers, tribal representatives, and other key stakeholders. Key findings and themes related to housing and residential service needs emerged, and include:

- Respite care services
  - Respite care was most often cited by lead agencies and providers as a service least likely to meet the demand for people with disabilities.
  - Respite care services became less available during 2013 and 2014 than the previous survey period. Respite care includes out-of-home, in-home, crisis, evening, and weekend options.
- Service gaps
  - Overall, one-third of persons with disabilities felt that the services and supports they received in the past 12 months met all their needs.
  - When asked about how services could better meet their needs, persons with disabilities primarily felt they needed better accessibility and quality of assistance. Some also indicated they needed more housing options.

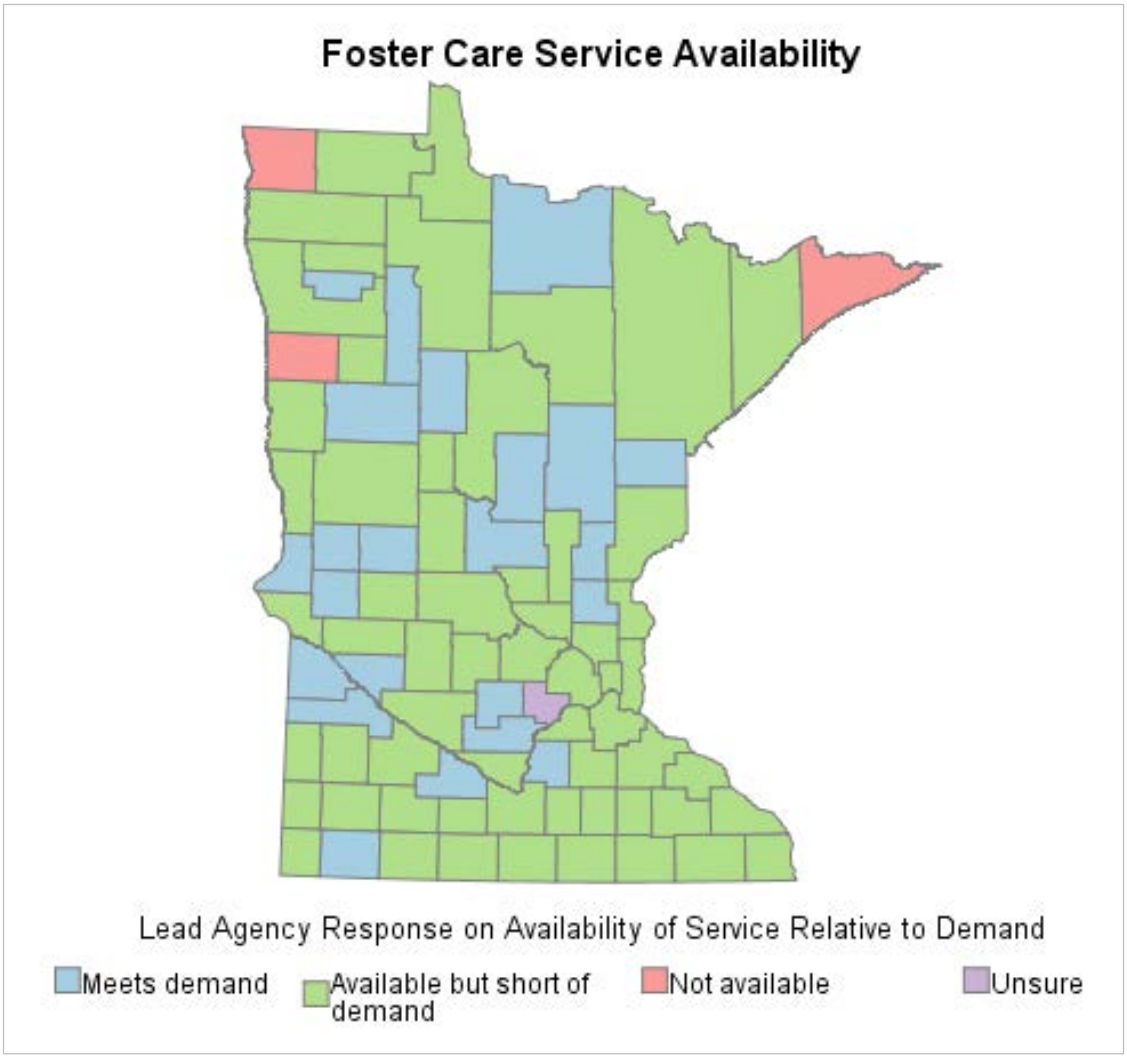
  - In terms of services for persons with disabilities that have the largest or most significant gaps in capacity, lead agencies most frequently cited out-of-home respite care, services in foster care, and crisis respite care. These services were also among the top five services becoming less available over the last two years. Excluding placement of services in immediate neighboring communities, lead agencies reported that foster care and crisis respite care were most often being met by service providers that were located outside their county or tribe.
  - Service providers also indicated that out-of-home respite care, services in foster care, and crisis respite care were some of the most significant service gaps in their service areas.
  - Several stakeholders mentioned that persons with disabilities in rural areas have more difficulties in accessing services, and for persons with brain injuries specifically, there is a lack of services for Native American communities.
  - Geographic location of providers or the distance to services is the biggest barrier faced by persons with disabilities, mentioned by both lead agencies and providers.
- Strategies to address service gaps
  - Many lead agencies did not identify any strategies that were underway to address gaps. Those lead agencies that did identify a strategy were asked how well it was working. The lead agency staff most often said that it is not working well or the implementation process is too slow, or it is too soon to tell, as the strategy was still in the planning stage or was just being implemented.
  - Lead agencies indicated that it would be most helpful to increase the availability of services with gaps by recruiting additional providers and increasing reimbursement rates or funding.
  - Other stakeholders mentioned many strategies for increasing the availability of services with gaps, including more funding, more staff/providers, better allocation of resources from DHS, change in policy/legislation, better coordination of services across agencies, more education about services, and help for persons with disabilities to navigate the system.
  - 67% of lead agencies reported there were people with disabilities currently living in their homes who are at risk of having to move into provider-controlled settings. This is the highest proportion of the four study populations. The main needs that must be met to help them remain in their homes are affordable housing and personal care assistants (PCA).
  - 57% of lead agencies reported there were people with disabilities currently in provider-controlled settings who could be helped to move back to their homes or their communities if the appropriate help were available; the main kinds of help needed is affordable or subsidized housing.

Available Adult Corporate Foster Care Across the State

Lead agency findings from a survey conducted as part of the 2015 Gaps Analysis indicate that when asked about the availability of corporate foster care compared to the recipient demand of the service, most lead agencies indicated corporate foster care availability does not meet the

demand for the service. 69% of lead agencies, encompassing 89% of the state's population, stated that corporate foster care settings are available in their county, but that availability falls short of demand. The lead agencies that did indicate that foster care availability adequately meets the demand within their county tend to be rural lead agencies with fewer people. While 26% of the lead agencies in the state make up this group, it only encompasses 9% of the state's population.

Below is a statewide map illustrating these survey findings.



Additional Analysis

DHS has completed additional analysis about the current use of corporate foster care services in Minnesota. The goal of this analysis is to provide detailed information about how corporate foster care varies across the state, highlighting areas of the state that may have greater concentrations of corporate foster care as well as areas of the state that have very limited

corporate foster care services available for their population. This analysis looks at the following measures:

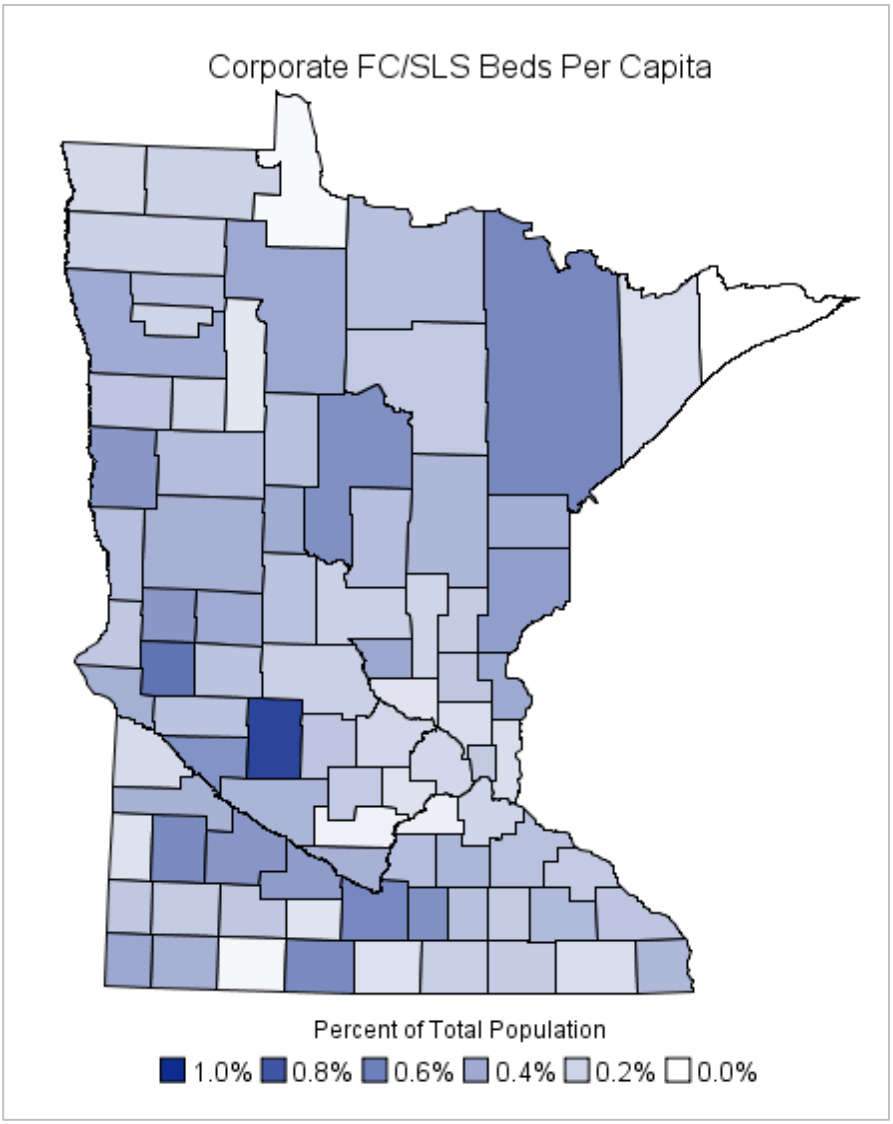
- Corporate foster care per capita
- Corporate foster care per disability waiver population
- Percentage of corporate foster care recipients living outside of their home county
- Percentage of corporate foster care recipients that are from other lead agencies

Corporate Foster Care Per Capita

This analysis looks at how the use of corporate foster care compares to the general population. Corporate foster care per capita is calculated for each county by taking the total number of people living in corporate foster care settings in that county divided by the total population in that county.

On average, lead agencies experience a corporate foster care per capita of 0.3%, meaning the average county has 1 out of every 333 people in their county residing in corporate foster care settings. Statewide, across all county borders, the state has a concentration of 0.25%.

Below is a map illustrating the distribution of this measure across the state.



As seen in the map above, there are some lead agencies in which the percentage of the population living in corporate foster care settings is significantly higher than the average. The table below lists lead agencies that have concentrations of corporate foster care that are greater than one standard deviation above the average. This table also highlights in the last column, the extent to which the county exceeds the range of normal distribution by calculating how many recipients surpass the margin of one standard deviation above the average.

Exhibit 14: Lead agencies with Corporate Foster Care Per Capita greater than One Standard Deviation Above the Mean

County	Percent of Population	Corp. FC Recipients	County Population	Recipient Count Exceeding One St. Dev Above Mean
Kandiyohi	0.88%	373	42,351	182

County	Percent of Population	Corp. FC Recipients	County Population	Recipient Count Exceeding One St. Dev Above Mean
Stevens	0.66%	64	9,748	20
Blue Earth	0.56%	368	65,218	75
St. Louis	0.56%	1,128	200,398	226
Lyon	0.55%	141	25,648	26
Martin	0.55%	112	20,429	20
Cass	0.52%	150	28,604	21
Waseca	0.52%	100	19,075	14
Chippewa	0.51%	62	12,146	7
Redwood	0.50%	78	15,755	7
Clay	0.49%	294	60,426	22
Grant	0.48%	29	5,990	2
Brown	0.47%	119	25,465	4
Pine	0.46%	133	29,125	2

There are also some lead agencies in which the percentage of the population living in corporate foster care settings is significantly lower than the average. The table below lists lead agencies that have concentrations of corporate foster care that are greater than one standard deviation below the average. This table also highlights in the last column, the extent to which the county is low on the range of normal distribution by calculating how many recipients surpass the margin of one standard deviation below the average. This means that if the county were at within one standard deviation from the average, this is the additional number of recipients that would be expected to reside in that county.

Exhibit 15: Lead agencies with Corporate Foster Care Per Capita greater than One Standard Deviation Below the Mean

County	Percent of Population	Corp. FC Recipients	County Population	Recipient Count Exceeding One St. Dev Below Mean
Faribault	0.14%	20	14,192	1
Lincoln	0.14%	8	5,830	1
Carver	0.13%	128	95,463	15
Watonwan	0.13%	14	11,136	3
Sherburne	0.12%	112	90,203	23
Clearwater	0.11%	10	8,837	3
Scott	0.07%	97	136,926	108
Sibley	0.07%	10	15,074	13
Jackson	0.04%	4	10,265	11
Lake of the Woods	0.03%	1	3,932	5
Cook	0.00%	0	5,185	8

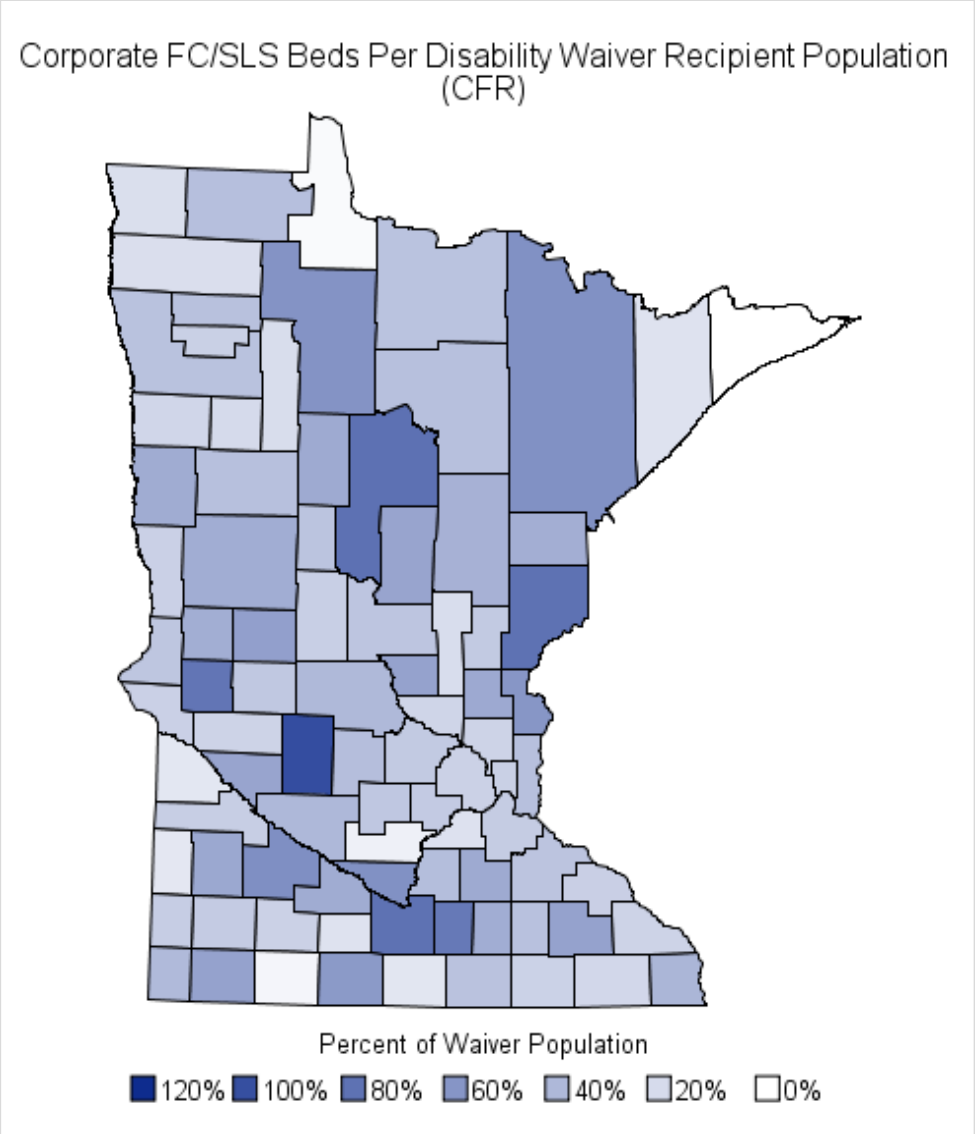
County	Percent of Population	Corp. FC Recipients	County Population	Recipient Count Exceeding One St. Dev Below Mean
White Earth Tribe	0.00%	0	9,562	14
Leech Lake Tribe	0.00%	0	10,660	16

Corporate Foster Care per Disability Waiver Population

This analysis considers how the use of corporate foster care within a particular county compares to the disability waiver population of that county. The measure, Corporate Foster Care per Waiver Population, is calculated by taking the total number of people in corporate foster care settings in that county divided by the total waiver population for which that county is the county of financial responsibility (CFR).

On average, county waiver populations experience a corporate foster care concentration of 37%. Statewide, across all county borders, 35% of all disability waiver recipients are living in corporate foster care setting.

Below is a map illustrating the distribution of this measure across the state.



As seen in the map above, there are some lead agencies in which the percentage of the waiver population living in corporate foster care settings is significantly higher than the average. For example, Kandiyohi County has more recipients living in corporate foster care settings than they have in their total CFR population. This means that many recipients living in corporate foster care settings in their county are from other lead agencies in the state.

In addition to Kandiyohi, there are other lead agencies in which there are particularly high concentrations of corporate foster care. The table below lists lead agencies that have concentrations of corporate foster care that are greater than one standard deviation above the average. This table also highlights in the last column, the extent to which the county exceeds the range of normal distribution by calculating how many recipients surpass the margin of one standard deviation above the average.

Exhibit 16: Lead agencies with Corporate Foster Care Per HCBS Waiver Population greater than One Standard Deviation Above the Mean

County	Recipients in Corp FC (COR) Per CFR Waiver Population	Corp FC Recipients	Total CFR Population	Recipient Count Exceeding One St. Dev Above Mean
Kandiyohi	101%	373	370	166
Cass	81%	150	186	46
Pine	80%	133	166	40
Blue Earth	80%	368	460	110
Stevens	78%	64	82	18
Waseca	76%	100	132	26
Redwood	63%	78	123	9
Nicollet	62%	121	194	12
St. Louis	62%	1,128	1,812	113
Beltrami	61%	185	304	15
Chisago	60%	219	367	13
Martin	57%	112	195	3

There are also some lead agencies in which the percentage of the waiver population living in corporate foster care settings is significantly lower than the average. The lead agencies that are low on this measure may indicate areas in the state where the availability of the service does not meet the probable demand for the service.

The table below lists lead agencies that have concentrations of corporate foster care that are greater than one standard deviation below the average. This table also highlights in the last column, the extent to which the county is low on the range of normal distribution by calculating how many recipients surpass the margin of one standard deviation below the average.

Exhibit 17: Counties with Corporate Foster Care Per HCBS Waiver Population greater than One Standard Deviation Below the Mean

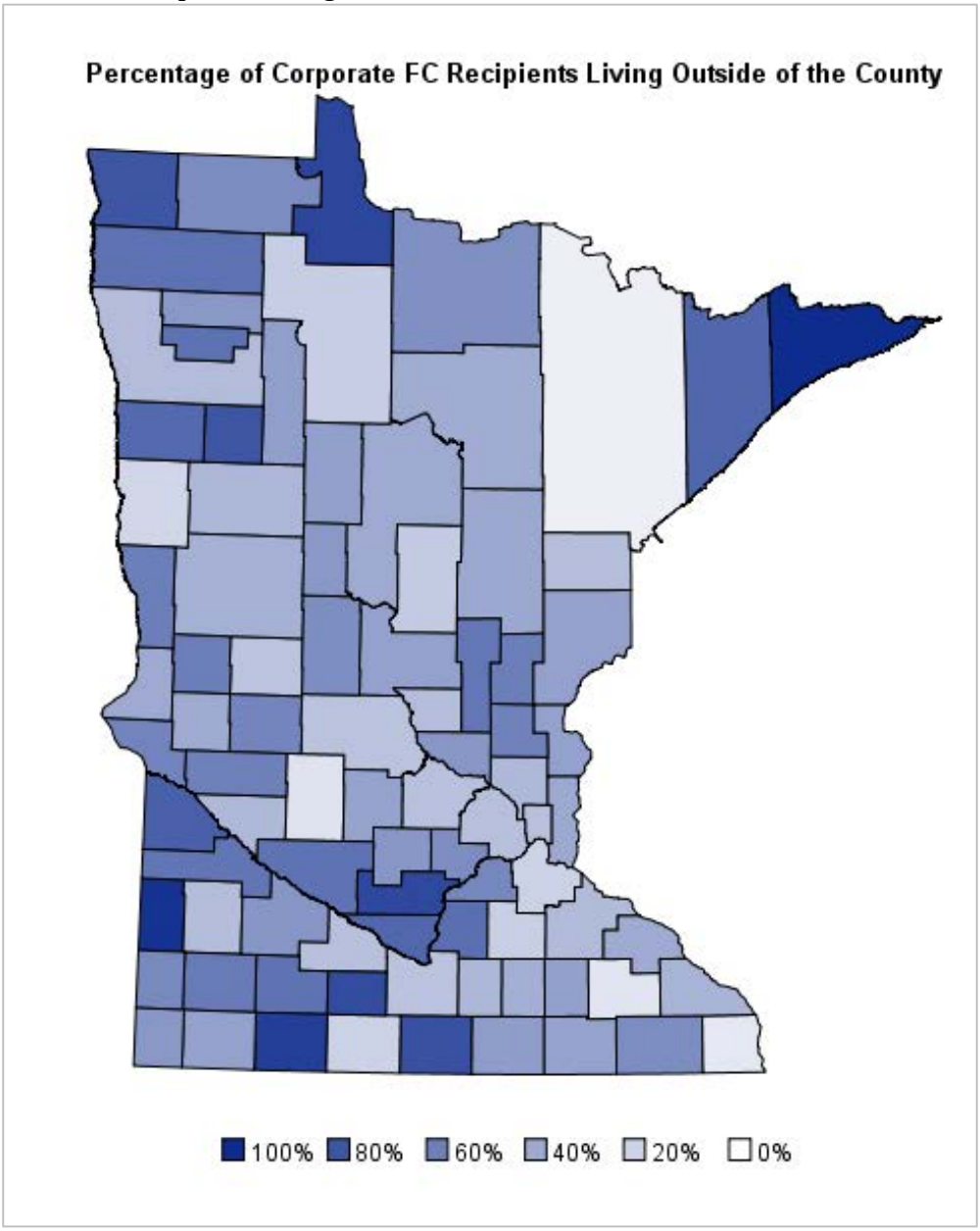
County	Recipients in Corp FC (COR) Per CFR Waiver Population	Corp FC Recipients	Total CFR Population	Recipient Count Exceeding One St. Dev Below Mean
Scott	16%	97	588	9
Lake	16%	17	105	2
Watonwan	16%	14	87	2
Faribault	14%	20	142	6
Lac qui Parle	13%	12	89	4
Lincoln	13%	8	60	3
Sibley	8%	10	123	12
Jackson	5%	4	78	10

County	Recipients in Corp FC (COR) Per CFR Waiver Population	Corp FC Recipients	Total CFR Population	Recipient Count Exceeding One St. Dev Below Mean
Lake of the Woods	3%	1	40	6
Cook	0%	0	33	6
White Earth Tribe	0%	0	41	7
Leech Lake Tribe	0%	0	8	1

Percentage of Corporate Foster Care Recipients Living in a Different County

This analysis looks at whether there are particular lead agencies that have higher percentage of their corporate foster care recipients living outside of their county. This analysis found that on average, lead agencies' recipients of corporate foster care live in a different county about 48% of the time.

Below is a map illustrating the distribution of this measure across the state.



As seen in the map above, there are some lead agencies have a significantly higher than the average percentage of corporate foster care recipients that live in settings outside their county. Cook County and White Earth Tribe have one hundred percent of their corporate foster care recipients living in other lead agency jurisdictions. The table below lists all the lead agencies in which this percentage is greater than one standard deviation above the average.

Exhibit 18: Lead agencies with a Percentage of Corporate Foster Care Recipients Living Outside the County that is greater than One Standard Deviation Above the Mean

County	% of CFR Corp FC Recipients Living in Another County	Number of Corp. FC Recipients Living in Another County
Cook	100%	9
White Earth Tribe	100%	5
Lincoln	96%	26
Jackson	91%	40
Lake of the Woods	88%	7
Sibley	86%	43
Watonwan	84%	38
Faribault	82%	55
Mahnomen	80%	16
Kittson	80%	16
Lac qui Parle	75%	33
Lake	72%	23
Nicollet	72%	53
Norman	71%	24

There are also lead agencies that have lower percentages of corporate foster care recipients moving to other lead agencies. The table below lists lead agencies in which the percentage of corporate foster care recipients that live outside the county is greater than one standard deviation below the average.

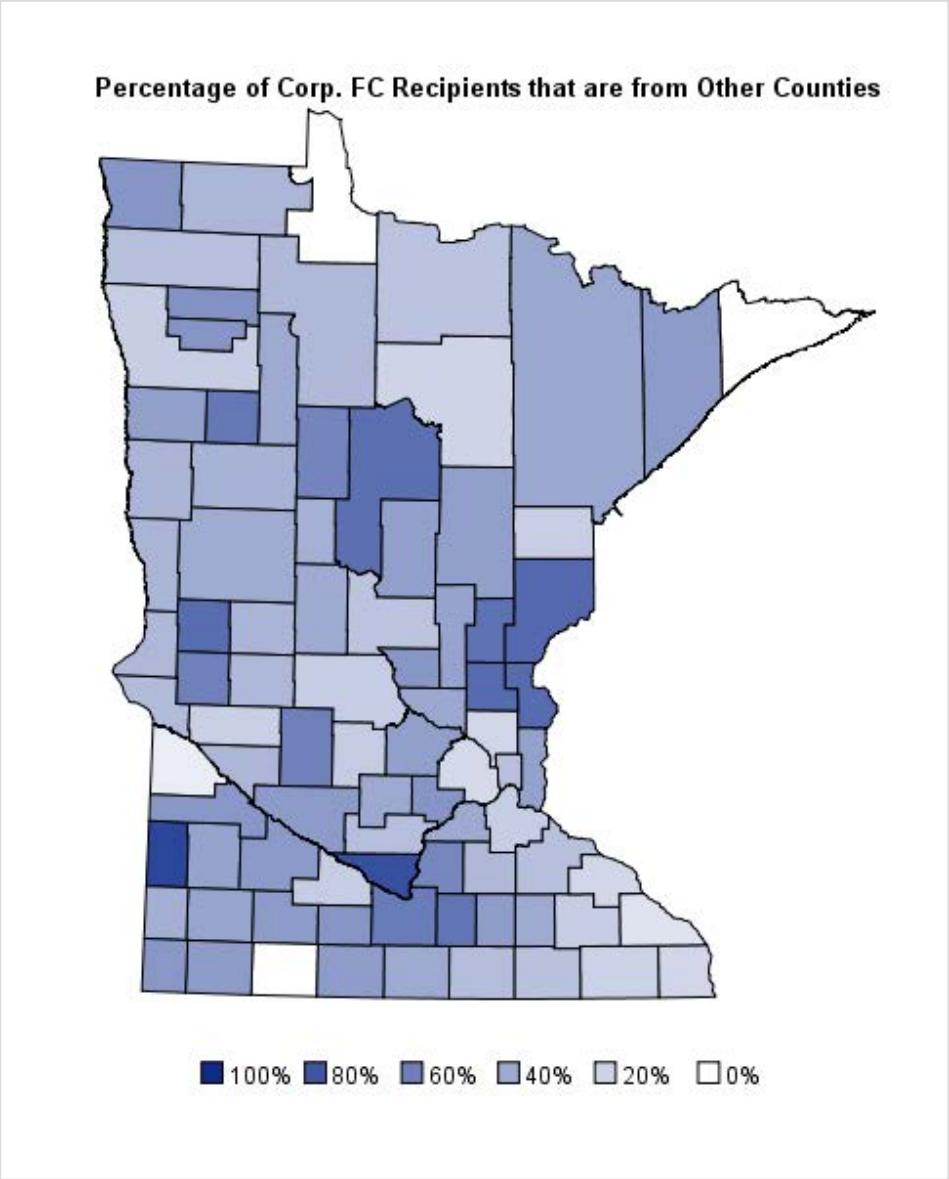
Exhibit 19: Lead agencies with a Percentage of Corporate Foster Care Recipients Living Outside the County that is greater than One Standard Deviation Below the Mean

County	% of CFR Corp FC Recipients Living in Another County	Number of Corp. FC Recipients Living in Another County
Crow Wing	25%	34
Beltrami	23%	37
Rice	23%	43
Dakota	21%	164
Martin	21%	16
Clay	19%	45
Kandiyohi	13%	22
Olmsted	12%	53
Houston	11%	6
St. Louis	7%	53

Percentage of Corporate Foster Care Recipients That are from a Different County

This analysis calculates for each county, the percentage of corporate foster care recipients living in the county that are from other lead agencies. Where the previous measure looked at which lead agencies had high or low percentages of recipients moving to other lead agencies, this measure looks at what particular lead agencies have high or low percentages of corporate foster care recipients moving into their county.

On average, 40% of a county's corporate foster care population comes from another county in the state. Below is a map illustrating the distribution of this measure across the state.



As seen in the map above, there are some lead agencies have a significantly higher than the average percentage of corporate foster care recipients that live in settings outside their county.

The table below lists the lead agencies in which this percentage is greater than one standard deviation above the average.

Exhibit 20: Lead agencies with a Percentage of Corporate Foster Care Recipients that are from Another County that is greater than One Standard Deviation Above the Mean

County	% of total Corp. FC Population that is from Another County	Number of Corp. FC Recipients From Another County
Lincoln	88%	7
Nicollet	83%	100
Pine	71%	94
Isanti	70%	72
Chisago	69%	152
Grant	69%	20
Cass	67%	101
Kanabec	67%	26
Waseca	65%	65
Mahnomen	64%	7
Blue Earth	62%	227
Kandiyohi	60%	224
Stevens	59%	38

There are also lead agencies that have lower percentages of corporate foster care recipients living in their county from other parts of the state. The table below lists lead agencies in which the percentage of corporate foster care recipients that are from another county is greater than one standard deviation below the average.

Exhibit 21: Lead agencies with a Percentage of Corporate Foster Care Recipients that are from another County that is greater than One Standard Deviation Below the Mean

County	% of total Corp. FC Population that is from Another County	Number of Corp. FC Recipients From Another County
Swift	22%	6
Fillmore	21%	7
Itasca	20%	23
Houston	19%	12
Wabasha	19%	10
Anoka	19%	99
Hennepin	18%	388

County	% of total Corp. FC Population that is from Another County	Number of Corp. FC Recipients From Another County
Winona	13%	18
Lac qui Parle	8%	1
Jackson	0%	0

Trends

As a final measure, this analsyis looked at where there are any trends across these measures that indicate specific lead agencies that have particularly high and/or low concentrations of corporate foster care relative to other lead agencies in the state.

The table below identifies the lead agencies that may exhibit a corporate foster care concentration that is subsantially higher than the average county in Minnesota by ranking high on at least three of the measures in this report: high corporate foster care per capita, high corporate foster care per waiver population, low percentage of corporate foster care recipients being served in other countes, and high percentage of corporate foster care living in the county but originally from another county.

Exhibit 22: Lead agencies Exhibiting High Corporate Foster Care Concentration

County	High Corp FC Per Capita	High Corp FC Per Waiver Population	Low % of Corp FC in other lead agencies	High % of Corp FC that are from other lead agencies
Kandiyohi	X	X	X	X
Stevens	X	X		X
Blue Earth	X	X		X
St. Louis	X	X	X	
Martin	X	X	X	
Cass	X	X		X
Waseca	X	X		X
Pine	X	X		X

The table below identifies the lead agencies that may exhibit a corporate foster care concentration that is subsantially lower than the average county in Minnesota by ranking low on at least three of the measures in this report: low corporate foster care per capita, low corporate foster care per waiver population, high percentage of corporate foster care recipients being served in other countes, and low percentage of corporate foster care living in the county but originally from another county.

Exhibit 23: Lead agencies Exhibiting Low Corporate Foster Care Concentration

County	Low Corp FC Per Capita	Low Corp FC Per Waiver Population	High % of Corp FC in other lead agencies	Low % of Corp FC that are from other lead agencies
Jackson	X	X	X	X
Lincoln	X	X	X	
Faribault	X	X	X	
Watonwan	X	X	X	
Sibley	X	X	X	
Lake of the Woods	X	X	X	
Cook	X	X	X	
White Earth Tribe	X	X	X	
Lac qui Parle		X	X	X

C. Actions taken to manage statewide resources

The Disability Services Division uses a consistent process to track statewide corporate foster care capacity. The Disability Services Division provides support to each county by interpreting policy, problem solving, advising on the use of forms and the qualifications for exceptions to the corporate foster care moratorium. Requests related to corporate foster care include development requests that qualify as exceptions to the corporate foster care moratorium, as identified in statute. When there is available capacity, there are also allowances that are considered that do not meet the moratorium exception criteria, but are identified as critical needs. The goal of the moratorium is to retain current capacity at the established statutory baseline, not to decrease capacity.

The Department of Human Services approved 145 county requests for foster care capacity changes involving 385 additional beds and 316 bed closures. This resulted in a net increase of 69 beds. Requests were approved to the extent allowable within the moratorium limit while maintaining capacity to approve requests that are critical to client health and safety.

The Division gave priority to requests required to assure ongoing access to critical supports. The Division also gave priority to requests that addressed strategic capacity within a county or region. Examples include foster care development to accommodate children, to assure critical access to respite services, and accommodate individuals with complex needs.

The following table summarizes request activity during the report period:

Exhibit 24. Regional requests approved for corporate foster care development or closure

Region		Largest County	# of requests	Beds added	Beds reduced	Total beds
1	Northwest Corner	Polk	1	1		1
2	North Central	Beltrami	7	1		1
3	Northeast Corner	St. Louis	26	83	-82	1
4	North West	Clay	12	20	-18	2
5	Central	Crow Wing	10	18	-8	10
6	West	Kandiyohi	13	28	-23	5
8	Southwest Corner	Lyon	1	2		2
9	South Central	Blue Earth	9	19	-12	7
10	Southeast Corner	Olmsted	20	48	-37	11
11	Metro	Hennepin	36	148	-125	23
7E	Central East	Chisago	5	6	-8	-2
7W	Central West	Stearns	5	11	-3	8
	Other	adj/unknown				
Totals			**145**	**385****	**-316**	**69**

**note that beds added include both 1) moratorium exceptions and 2) urgent health and safety needs. An example of urgent need is the provider demission of an individual from a corporate foster care home without any options for another home, leaving institutionalization as the only choice

In SFY2015, thirty-six (36) beds were approved that were exceptions to the moratorium, nearly half the number of beds requested in SFY2014. Exceptions to the moratorium are provided in state statute and include:

- License exception for persons requiring a hospital level of care including CAC and BI-NB waiver recipients
- License exception for settings that require Minn.Stat.Chapter 144D housing with services registration (80% or more of the residents are age 55 or older)
- License exception for the closure of a nursing facility, ICF/DD, regional treatment center or due to restructuring of state-operated facilities and closure plan in place (including Jensen Settlement claimants moving into the community)

- Transition out of Minnesota State Security Hospital
- Transition out of Anoka Regional Treatment Center

Exhibit 25 summarizes the number of exception requests approved during state fiscal year 2014 and state fiscal year 2015.

Exhibit 25. Results SFY 2014 vs SFY 2015 moratorium exceptions

SFY	# of exception requests to DSD from lead agencies via DHS Form 6021	# of beds requested and approved
14	18	66
15	23	36

The Disability Services Division works in cooperation with the Licensing Division and Housing Division to manage statewide resources and capacity.

Also, SFY2015 marks the second year of a two-year renewable contract with six lead agencies to affect development of alternatives to corporate foster care. Considerable progress has been made on the following deliverables:

- Fifty (50) people with very high support needs, who would otherwise require the staffing/supports typical of a corporate foster care setting (e.g. having 24-hour awake staff and a 2:4 staffing ratio) will be moved or in the process of moving to alternate settings within the region covered by this collaborative effort
- At least twenty-five (25) people with disabilities, who receive home and community-based services, or their representatives, will participate in at least three planning events
- County waiver service coordinators, case managers and supervisors organized to build person-centered practices for service planning, behavioral transition planning, natural supports community integration planning and meet new 245D requirements. This effort puts into practice the skills that county staff develops through training in person-centered planning (sponsored by the STATE and conducted by the University of Minnesota)
- Using these person-centered field practices, people who want to move from sites outside the region back to their home communities are assisted to do so, and they are served in a more fully integrated manner, utilizing home and community-based services and natural supports
- An annual audit designed to assure that client assessments and work plans completed using a person-centered approach and include person-centered options
- Stakeholders identified as key to successful development of viable alternatives to corporate foster care
- Cooperative relationships established with those stakeholders willing to work on this effort

- Working with stakeholder partners, develop strategies for creating alternative living options that create a coordinated regional effort that can continue beyond the span of the grant
- Existing non-corporate foster care housing and service options utilized for individuals currently living in corporate foster care homes and desiring to live in a more integrated community living settings
- Ensure that alternatives to corporate foster care that are delivered as part of the grant are aligned with the intent of the Centers for Medicare and Medicaid Services guidance on allowable settings for home and community-based services
- Ensure that people with disabilities are included early in the planning process, including giving feedback on plans.

VIII. Recommendations

DHS views the analysis of the results of the Gaps Analysis and Critical Access Studies summarized in this report as just the beginning of an important process. The two studies provide a wealth of information on the current system and offer an important opportunity to work together to determine what it means and how it can inform efforts to strengthen the HCBS system for all four populations. The Department is committed to working with stakeholders, including lead agencies, providers and others, to further analyze and interpret the data to inform specific program and policy development efforts. DHS will look to key stakeholder groups such as the HCBS Partners Panel to participate in a process that involves more in-depth analysis of the key topics and issues identified through this report and the analysis completed so far.

Key issues identified through the two studies that warrant further analysis and action to address include:

- the workforce and provider shortages (including but not limited to the challenges of recruitment and retention of both),
- geographic disparities in the availability of services and barriers that need to be addressed,
- the shortage of affordable housing especially housing with support services, and
- the need to improve coordination between the HCBS system and continuum of mental health services and supports to better support people with complex needs.

In addition, the analysis of potential measures of critical access provide the basis for a more systematic approach to measuring critical access and determining the strategies and resource needs to address the barriers related to access. It also provides a mechanism to determine where there are similarities and differences in the experiences of the four populations in accessing HCBS and how that can inform the strategies.

The study results will also be used to inform the Department's efforts, in partnership with the other participating state agencies and stakeholders, to implement the Olmstead Plan. The studies serve to highlight the capacity of the HCBS system and the continuum of mental health services and supports to support individuals in the community and the barriers that need to be addressed in order for the state to fully realize the vision for community living articulated in the Olmstead Plan.

IX. Nursing Homes

Central to 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. The Minnesota Department of Human Services (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 licensing 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 has an obligation to nursing home residents and to the public to go beyond using a regulatory approach to quality assurance and use the purchasing activity to leverage quality.

Design of Quality Measures

DHS has worked with MDH, stakeholders and other experts 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

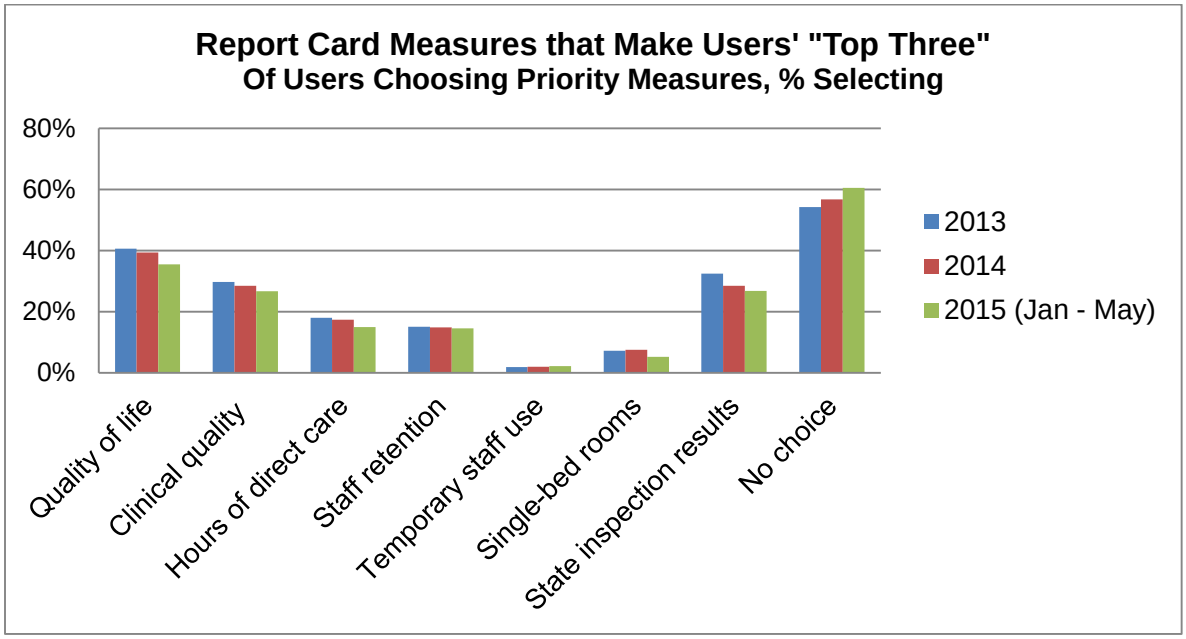
Public Disclosure of Quality Measures, the Nursing Home Report Card

Beginning in January 2006 MDH and DHS published the web-based Minnesota Nursing Home Report Card (http://nhreportcard.dhs.mn.gov/). It is interactive in that it allows users to view quality measurement information 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 including five-star ratings for all seven measures for all listed facilities, and it sorts the list according to the scores of those facilities with emphasis placed on the measures prioritized by the user. The user can then select a facility from the list and see more detail on its quality measure scores.

Other key features of the Report Card include side-by-side facility displays to allow comparisons of quality; over two years of performance history shown for each facility; 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 26.

Exhibit 26: Report Card Measures that Make Users' "Top Three"



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

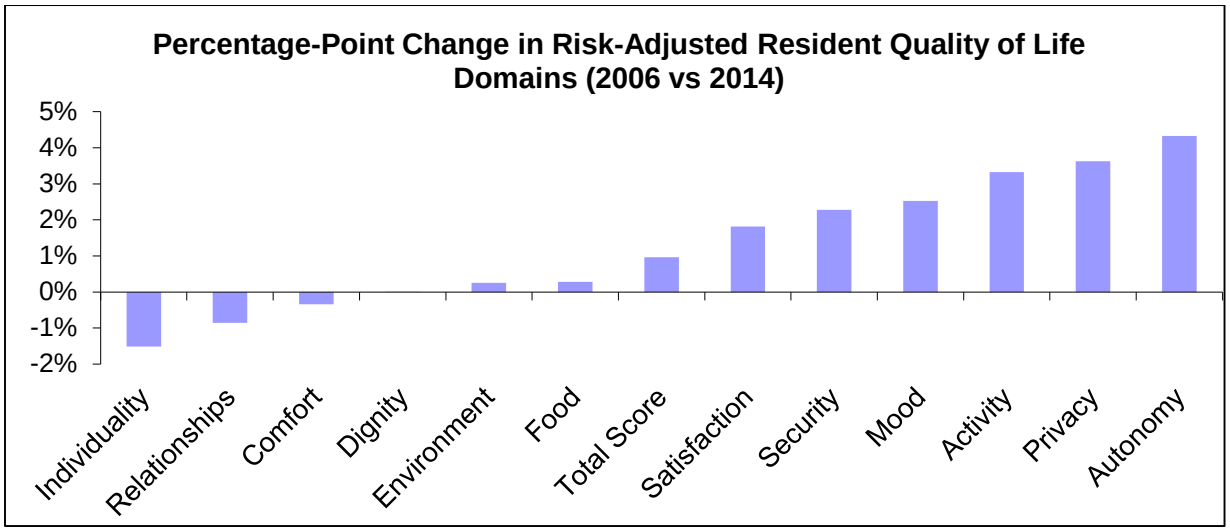
measures are ready for public consumption. It is then important to seek ways to improve the measures over time, guided in part by research and user feedback. Upcoming changes include the addition of measures of hospitalization, community discharge, and family satisfaction.

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 27 shows improved scores on nine quality of life domains and the residents' overall quality of life score since the survey's first full fielding in 2006, with autonomy, or resident choices, showing the most improvement. One domain declined slightly, while two others declined significantly: individuality, which dropped as residents felt staff were less interested in their lives; and relationships, which dropped because residents reported staff were less likely to just visit or to be their friend.

Exhibit 27: Percentage-Point Change in Risk-Adjusted Resident Quality of Life Domains (2006 vs. 2014)



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, in which DHS co-sponsors a quality of life-themed fellowship, and shares provider innovations via periodic conferences and by facilitating provider connections, as well as the Quality Improvement Incentive Payment Program, both of which are discussed

further below. In 2015, DHS also pilot-tested a new mailed satisfaction survey for short-stay residents, to better understand and help facilities improve those experiences.

Exhibits 28 and 29 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 MDS uses resident interviews for several indicators and adds three new short-stay indicators, marked "SS" (versus "LS" for long-stay).

Exhibit 28 shows change since 2004 for indicators that were not affected by the MDS revision. Scores on 11 of 15 indicators improved during this time, with inappropriate use of antipsychotic drugs and ADL improvement the best areas of positive change, and bowel incontinence care an area for concern.

Exhibit 28: Percentage-Point Change in MN Risk-Adjusted Clinical Quality Indicators (2004 vs. 2014)

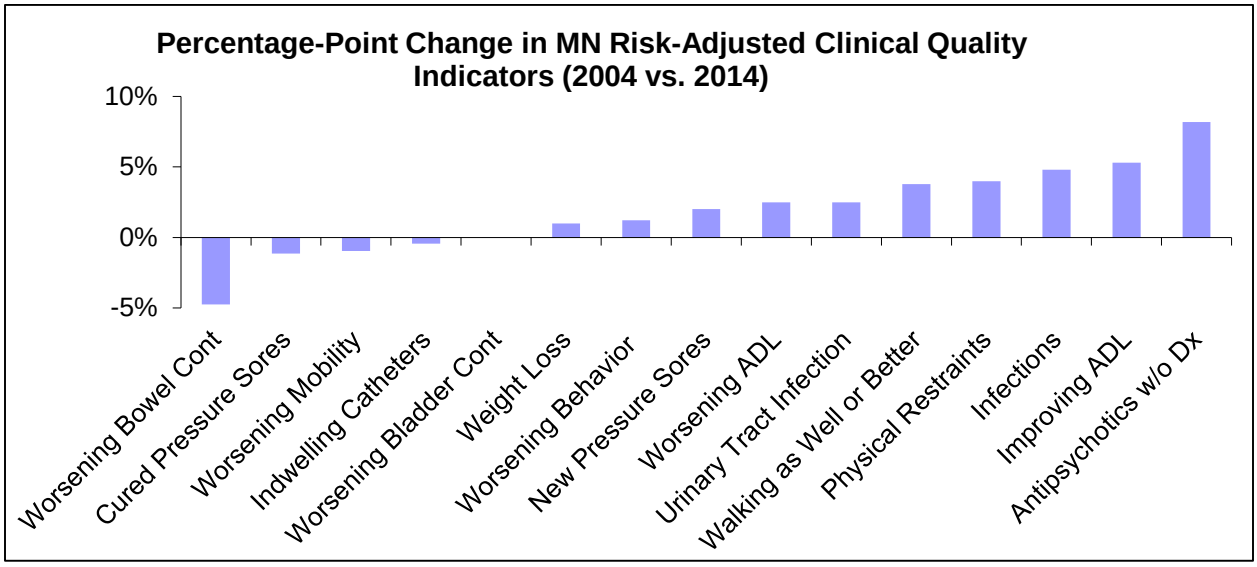
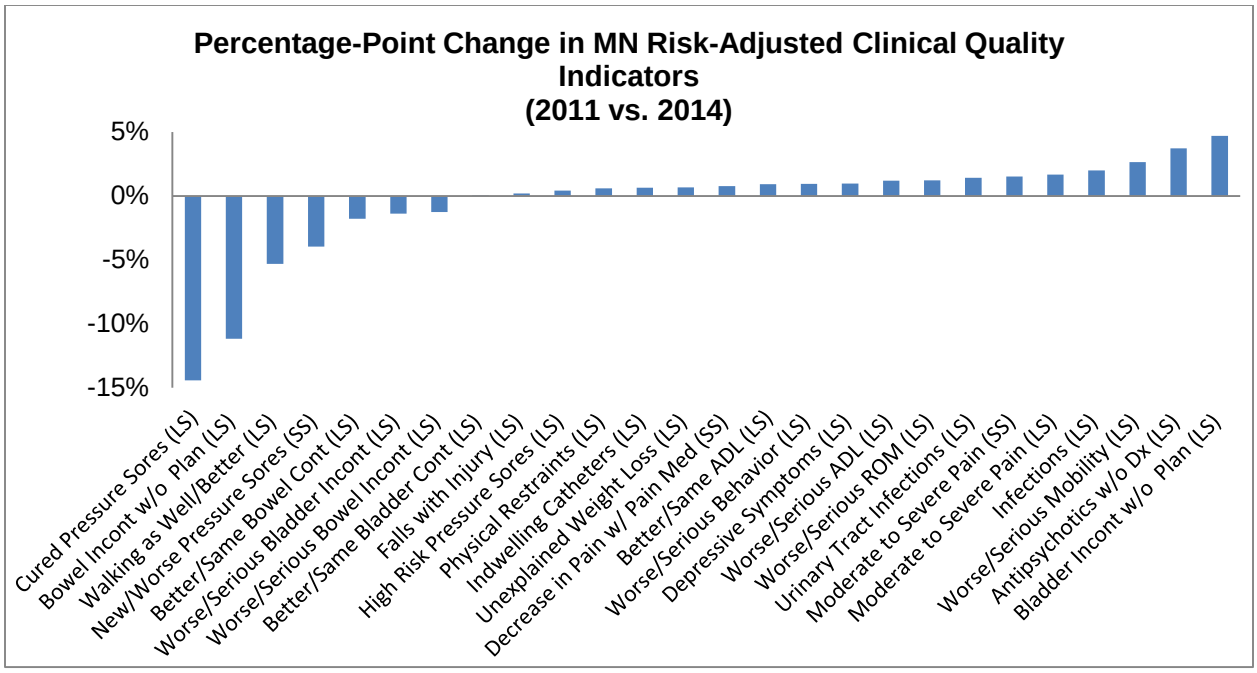


Exhibit 29 shows change since 2011 for these plus 11 that were affected by or newly created after the MDS revision. Scores on 19 of 26 measures have improved, with particularly positive change in the areas of bladder incontinence care and inappropriate use of antipsychotic drugs. However, seven have worsened during this time, especially cured pressure sores and worsening bowel continence care.

Exhibit 29: Percentage-Point Change in MN Risk-Adjusted Clinical Quality Indicators (2011 vs. 2014)



Additional measure trends can be found in graphs located an expanded version of this section of the report which will be available in September 2015 on the DHS website. Please watch for it or contact DHS at 651-431-2280 for information on how to gain access to it.

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%. 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, two-thirds of Minnesota nursing facilities have participated in the program, representing 186 different quality improvement projects.

In 2013 DHS launched the Quality Improvement Incentive Payment (QIIP) program. QIIP is a voluntary non-competitive program that recognizes and provides financial reward for meaningful levels of provider improvement in quality of care or quality of life, and allows providers to determine the strategies they will use to achieve their goals. Facilities may earn up to $3.50 per

day for one year based on their level of improvement on the quality measures they elected to work on.

B. Nursing Home Costs/Expenditures

In State Fiscal Year 2014, $759.0 million was spent by the Medicaid Program for nursing home care in Minnesota, of which the state share was $366.9 million. For the year ending September 30, 2014, nursing facilities reported total revenues of $2.39 billion, as shown in Exhibit 11, below, with an estimate of revenues for non-MA certified nursing homes of $70 million, yielding a total estimated revenue of $2.460 billion.

Exhibit 30: Estimated Total Nursing Home Revenues in Minnesota (2014) by Source of Payment

Estimated Total Nursing Home Revenues in Minnesota (2014) by Source of Payment	
Source	**Amount ($s in millions)**
MA payments, including recipient resources and managed care	$988
Private pay	493
Medicare Part A and Part B	454
Other	455
Estimated revenues of non-MA nursing homes	70
Estimated **Total** Nursing Home Revenues	$2,460

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.

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 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 picture of the actual financial status of Minnesota nursing facilities. Data is provided covering the seven report years ending September 30, 2008, through September 30, 2014. 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 expanded report referenced above.

D. Industry Size

Rightsizing the nursing home industry has been a major policy theme for Minnesota for over 30 years.[5] This section of the report will address the question: "Will Minnesota soon experience a shortage of nursing home beds, and specifically, should the moratorium on adding new beds be repealed?"

Number of Nursing Facilities and Number of Beds. As of September 30, 2014, Minnesota had 387 licensed nursing homes and licensed and certified boarding care homes with a total of 30,879 beds in active service, with 370 facilities and 29,309 beds certified to participate in the Medicaid Program.

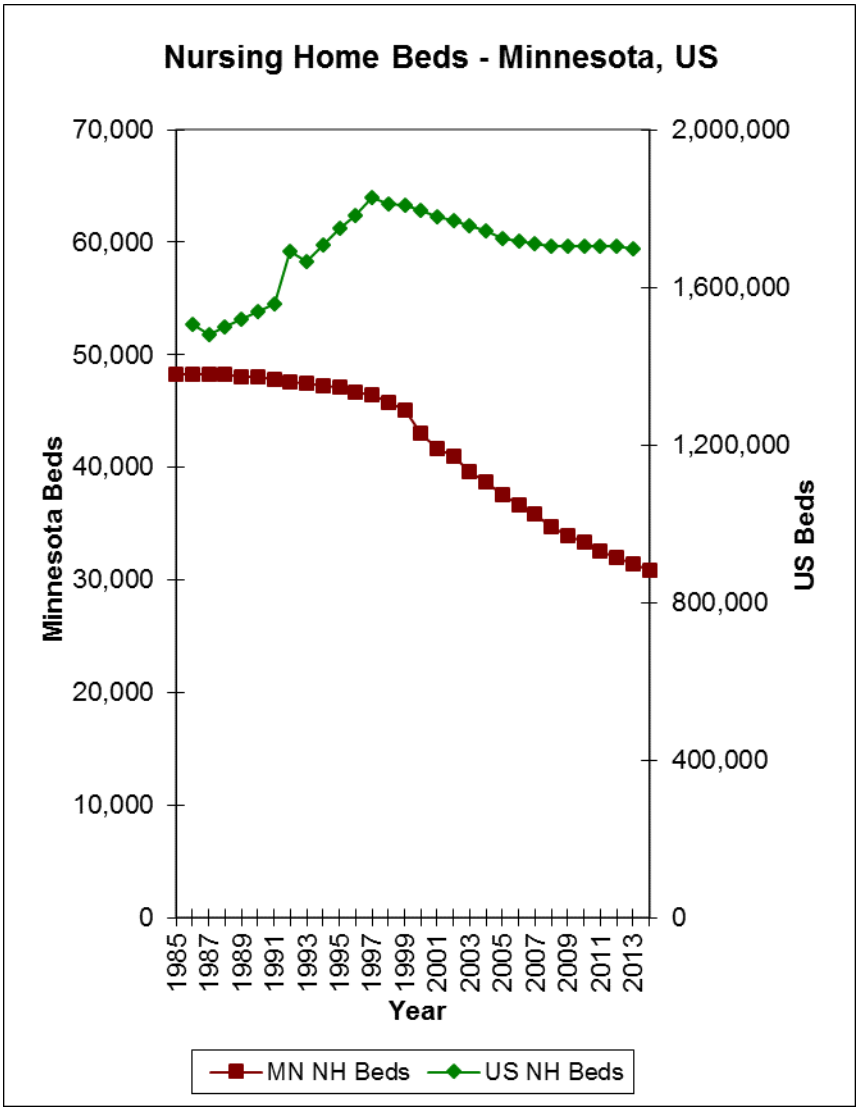
The number of nursing homes and licensed beds has been declining since 1987, when the number of facilities and beds in Minnesota peaked at 468 facilities with 48,307 beds. By September 2014, 81 facilities had closed altogether (net of new facilities opened) and 15,719 beds had been completely delicensed. An additional 1,709 beds were out of active service, in layaway status. The supply of active beds has declined by 36% over the 27 years since the 1987 peak. In the last two years, the bed supply has declined by 1,087 beds or 3.4%.

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. In 2011, Minnesota had only 13% more beds per 1000 age 65+ and had 0.4% fewer for the 85+ population than the national average. And in 2012, the most recent year with national data available, Minnesota had only 10.9% more beds per 1000 age 65+ and had 1.9% fewer for the 85+ population than the national average.

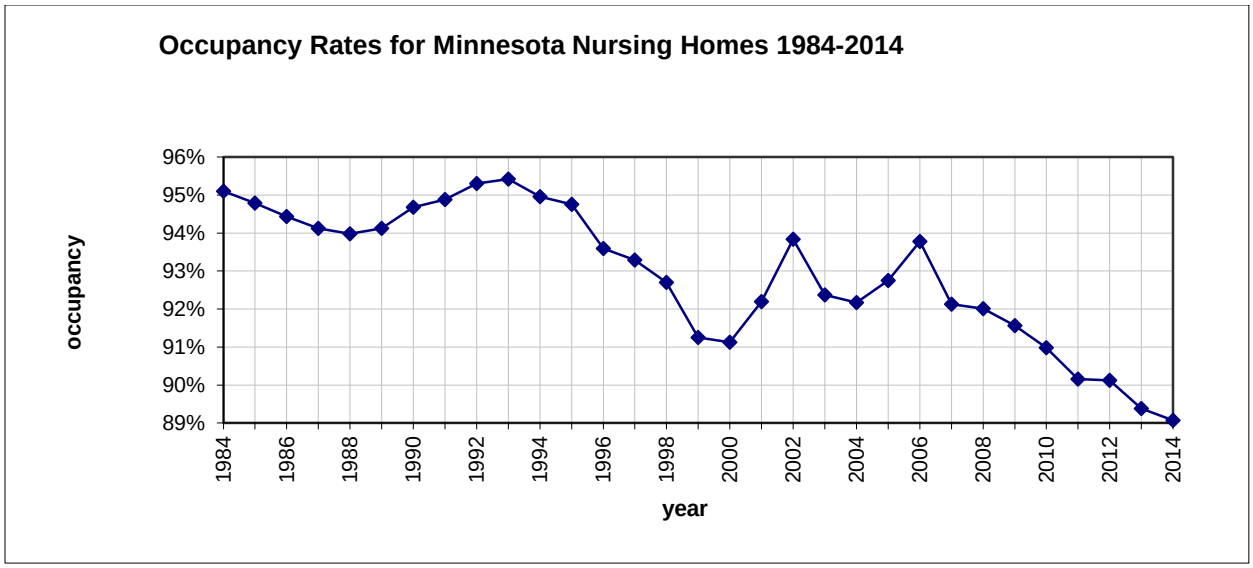
[5] Programs and strategies that have been enacted (and modified) during this period to assist in rebalancing LTSS: (a) Moratorium on new licensure and MA certification of nursing home beds; (b) Pre-admission screening, now LTC Consultation; (c) Funding for HCBS, through Elderly Waiver and Alternative 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) Senior Linkage Line; (j)Nursing facility consolidation; (k) Return to Community Program; (l) NF level of care; (m) Essential Community Services; (n) Moving Home Minnesota Program; and (o) Olmstead planning.

Exhibit 31 provides more detailed comparisons of Minnesota data on nursing home supply with comparable national data.

Exhibit 31: Comparisons of Minnesota Nursing Home Supply with Comparable National Data



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 89.1% in 2014. 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 put a financial strain on facilities and reduce the overall efficiency of the industry.

Hardship Areas. The distribution of nursing home beds is not uniform across the state. Minnesota statute 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. MDH, in consultation with DHS, began a process in August 2013, and again in August 2015, 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. The August 2013 process did not result in any beds being added.

Nursing Facility Utilization. With increasing numbers of elderly and declining numbers of nursing home beds, why are occupancy rates declining? 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 29 years. In 1984, the utilization rate for persons aged 65+ was 8.4 %, and by 2013, it had declined to 3.2 %—a 62 % reduction. The utilization rate for people age 85+ declined even more dramatically, from 36.4% in 1984 to 12.6% in 2013, a 65%

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.

Nursing Home Utilization Rates in Selected Years from 1984 - 2013 for Persons 65+ and 85+ in Minnesota				
Year	65+ Utilization	Annual Rate of Change	85+ Utilization	Annual Rate of Change
1984	8.4%		36.4%	
1987	8.1%	-1.2%	35.1%	-1.2%
1989	7.8%	-1.9%	33.4%	-2.5%
1993	7.6%	-0.6%	30.8%	-2.0%
1994	7.1%	-6.6%	28.7%	-6.8%
1996	6.9%	-1.4%	28.2%	-0.9%
1998	6.1%	-6.8%	24.3%	-7.2%
2000	5.8%		22.8%	
2001	5.6%	-4.3%	21.3%	-6.5%
2002	5.5%	-1.3%	20.6%	-3.2%
2005	5.2%	-2.1%	20.1%	-0.8%
2006	4.9%	-5.6%	18.7%	-7.3%
2007	4.7%	-4.3%	17.6%	-5.7%
2008	4.4%	-6.9%	17.1%	-2.9%
2009	4.0 %	-8.0%	15.1%	-11.9%
2010	3.9%	-3.5%	14.9%	-0.9%
2011	3.7%	-3.6%	14.1%	-4.9%
2012	3.5%	-7.0%	13.4%	-5.6%
2013	3.2%	-7.4%	12.6%	-6.0%

Will Minnesota soon experience a shortage of nursing home beds, and specifically, should the moratorium on adding new beds be repealed? The growth in the elderly population causes policy makers to be concerned that access to nursing facility services will become constrained. Perhaps the state needs to alter or remove the moratorium to allow new nursing homes to be built. Three steps are taken to answer this question:

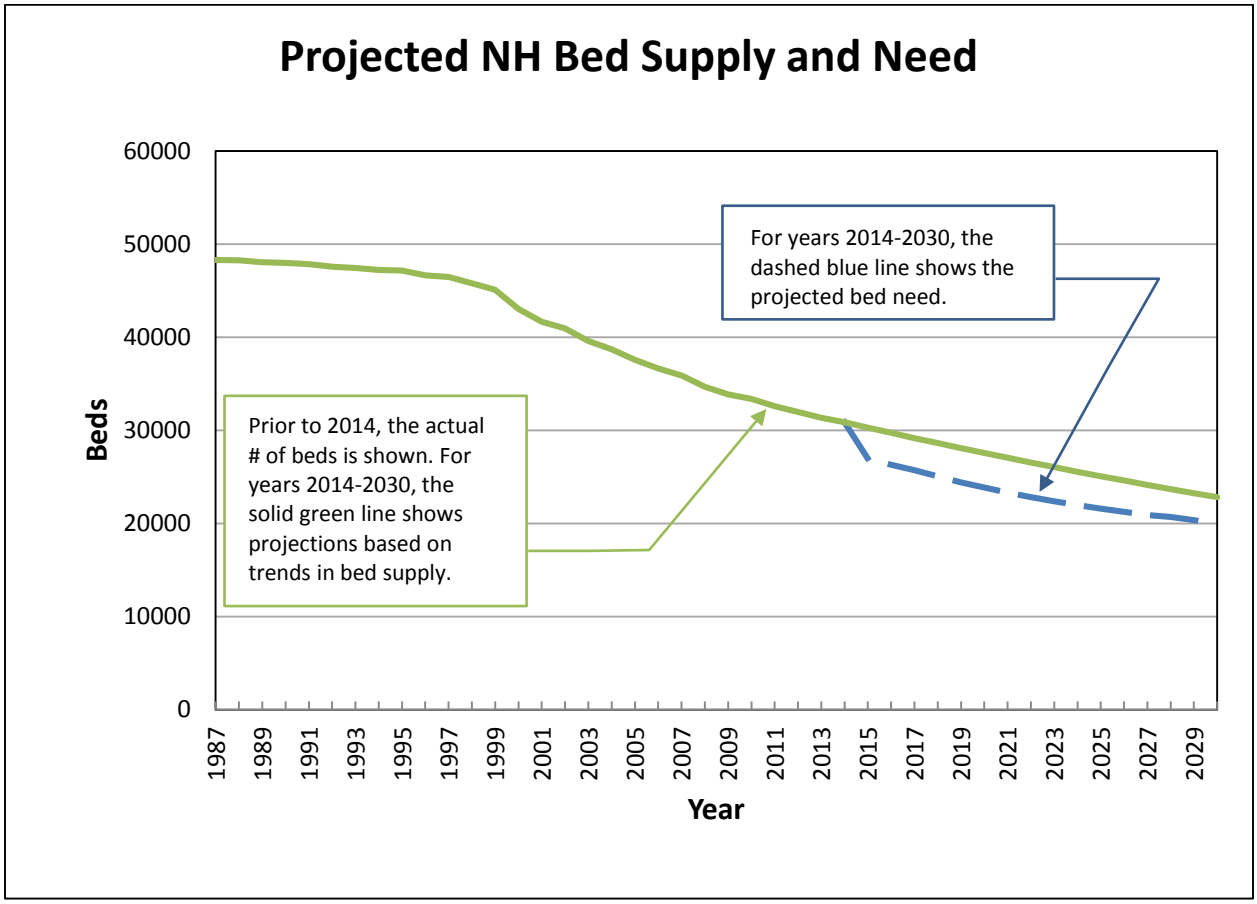
- Project bed availability based upon the downward trend in the number of beds
- Project bed need based upon the downward trend in the rate of utilization of nursing home services and the upward trend in the elderly population
- Compare these two projections to see how the current surplus in bed supply will likely change.

Projected availability based on changes in the number of beds. The number of nursing home beds in Minnesota has been decreasing consistently over the last 25 years. The projection for the

next 16 years continues the trend, going from 30,879 actual beds in 2014 to 22,825 projected beds in 2030.

Projected need based on the changing utilization rate of nursing home services and population estimates. Utilization rates have been falling consistently for 29 years. Therefore, this projection assumes a continuation of this trend as well, and applies it to population estimates to project future bed need.

The exhibit below compares the bed availability projection with the bed need projection. Minnesota starts with an actual surplus in 2014 of 3,335 beds. That surplus is projected to be 2,900 beds in 2030.



In conclusion, 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, and specifically, should the moratorium on adding new beds be repealed?" 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.

So, yes, the moratorium on new nursing home beds is still needed. The evidence that Minnesota will not experience a shortage of nursing facility beds during the next several years is very strong. Nonetheless, Minnesota should:

- Watch for local and regional access problems,
- Continue to allow the use of the existing mechanism that allows beds to be relocated from high bedded areas 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.