DEPARTMENT OF HUMAN SERVICES

Legislative Report

Status of Long-Term Services and Supports

Aging and Adult Services, Disability Services, Mental Health, Nursing Facility Rates and Policy

August 2017

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $382,500.

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I. Executive Summary

This report summarizes the status of long-term services and supports for all persons who need or use these services and supports (that is, people with disabilities, older adults, children with mental health conditions, and adults living with mental illnesses). It was developed in response to a legislative mandate (Minnesota Statutes 144A.351) to biennially update the legislature on the status of long-term services and supports.

The report looks at policy directions and trends that influence long-term services and supports, describes progress made during the biennium and identifies gaps that need to be addressed in the long-term services and supports system. Changing needs, combined with federal and state policy directions, are the impetus behind changes to the Department of Human Services (DHS) Long-Term Services and Supports (LTSS) system to provide more flexible community-based service options that allow the people served by the LTSS system to be more integrated in their community with services better tailored to their needs.

Changes in expectations by and for people using long-term services and supports are further driving the system to become more person-centered and services to be more fully integrated in the community. Young people who have grown up in integrated school settings have different expectations than a generation ago, and that means new approaches are needed to support their expectations. Older adults are expressing greater interest in staying at home with supports in place. This report describes progress made on six goals from Reform 2020 that aim to improve outcomes of those receiving long-term services and supports. Data from various surveys, including the National Core Indicators, show that people are finding services that more flexibly meet their needs, leading to increased stability in their home and community. Most people surveyed reported feeling adequately informed when making decisions about their service options, and able to engage in activities important to them. Most people surveyed reported they received support and follow-up when making transitions from hospitals and rehabilitation facilities. In addressing the social determinants of health, however, while most people indicated satisfaction with many aspects of their lives, they needed support in other areas to live their best lives.

Highlights from the 2015-2016 Gaps Analysis study regional meetings are included in this report. Local information was gathered through 11 regional meetings with stakeholders, including lead agencies, services providers, consumers, and advocates. Discussions focused on identifying and addressing the gaps in service capacity that keep people from living their best lives. The service gaps identified across all populations as needing priority attention included the direct support workforce, transportation and housing. Major segments of the participants further identified the ability to access crisis stabilization, respite care, residential treatment and mental health providers as significant gaps in many parts of the state. The regional discussions also identified promising solutions to the service gaps they identified; making existing services go further by sharing or pooling resources was most frequently mentioned, with changes in the rates or rate structure also mentioned frequently.

The report closes with an assessment of what we have learned about some of the major challenges facing the long-term services and support system, and our recommendations to build on current efforts and find new ways to improve services that address Minnesota's changing demographics, increases in longevity, the workforce shortage, barriers to accessing services, and need for crisis services.

II. Legislation

Minnesota Statutes 2016, section 144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS: REPORT AND STUDY 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.

Minnesota Statutes 2016, 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

Thirty years ago, people who needed help with daily living tasks like bathing, dressing, eating and preparing meals, going to the bathroom, and other tasks were generally faced with the choice of when, instead of if, they would move from their home into an institution or similar-feeling facility. Today, the options and services available to those same people are many. This approach provides for a higher quality of life for people, as they have access to the right service at the right time, and, over time, more cost-effective services.

Long-term services and supports (LTSS)[1] are a spectrum of health and social services that support Minnesotans who need help with daily living tasks. LTSS can be provided in institutional settings, such as hospitals and nursing homes, or in people's homes and other community settings. By 1995, the balance in Minnesota's system had shifted from predominantly institution-based to predominantly home and community-based. Today, 83% of the people receiving LTSS get them through home and community-based services (HCBS)[2].

LTSS enable people to lead meaningful lives at all stages, according to their own goals, with opportunities to make meaningful contributions and build upon what is important to them. Services and supports are developed to be flexible, responsive, and accessible by people who have an assessed need for them. The LTSS system is managed to ensure its long-term availability to those who need it in the future. DHS works collaboratively with partners to set priorities, determine strategies and implement initiatives that support those goals. Our partners include people who need services (including older adults, people with disabilities and mental health conditions as well as their families), lead agencies, service providers and advocates, all working across state agencies, administrations and divisions to provide efficient, effective services.

Minnesota's LTSS system is always evolving to improve services and standards; applying the lessons we have learned have placed our state at the top, or near top, of national health care rankings for many years. Despite this positive evolution, the LTSS system does not go far enough in supporting people to achieve their highest quality of life. Challenges and pressures exist that threaten the sustainability of the system.

The Policy Directions section of the report discusses the path Minnesota has been on to address these issues.

[1] The term *long-term services and supports* (LTSS) refers to on-going supports that an individual needs due to a chronic health condition or disability. LTSS 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.

[2] The term *home and community-based services* (HCBS) refers only to those long-term services and supports that are delivered in homes or other community-based settings, not in institutional settings. HCBS are a subset of long-term services and supports.

The Trends section of this report discusses demographic, service and social trends, and the pressures these create on the LTSS system.

The Measuring Our Progress section focuses on the data that we collect, review, analyze and evaluate to inform the way we administer LTSS programs and develop future actions to improve the lives of people with disabilities and older adults.

In Services and Access Gaps, we review the results of recent discussions held throughout the state, and close with our Report Recommendations for the future.

Appendices include the Corporate Foster Care Annual Needs Determination Report and Nursing Home Report.

IV. Policy Directions

Policy directions guide how the Department of Human Services carries out its work. This section describes these guiding principles and highlights current efforts to ensure that people experience person-centered approaches, have informed choice and enjoy life in the most integrated setting. Current efforts include:

- Minnesota's Olmstead Plan,
- The federal HCBS Settings Rule released by the Centers for Medicare and Medicare,
- Minnesota's 245D licensing standards,
- The Positive Supports Rule, and
- Minnesota's nursing home payment reform (known as Value-Based Reimbursement)

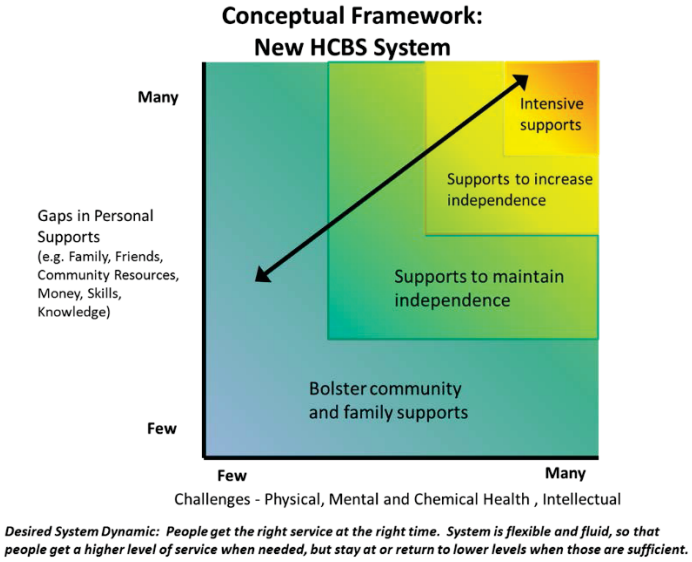
A. Guiding principles

Minnesota continues its work to implement several multi-year initiatives to transform long-term services and supports (LTSS). These initiatives and policy directions were guided by Reform 2020, a cross-cutting, bipartisan initiative to reform Medical Assistance. Reform 2020 has three main goals.

1. Better individual outcomes
    - Increased flexibility to better meet the needs of each individual
    - Increased stability in the community
    - Better-informed individual decision-making about LTSS options
    - Promotion of person-centered planning – life-long and crisis
    - Improved transitions between settings and programs, preventing avoidable health crises
    - Recognize and address the social determinants of health care need and cost
2. Right services at the right time
    - Low-cost, high-impact services reach people earlier
    - Decreased reliance on more costly services
    - HCBS, not institutional care, is the entitlement
3. Ensuring the future of LTSS
    - Increased sustainability of the LTSS system
    - Increased efficiency in the use of public LTSS resources

We are positioning the system to offer an array of flexible services that can be fitted to each individual's preferences and support the person in living his or her best life.

Figure IV-I: Conceptual diagram of a new HCBS system



Federal and state policies are being shaped by the 1990 federal Americans with Disabilities Act (ADA), and subsequent Supreme Court Olmstead Decision, which defined the civil rights of people with disabilities, and required states to provide services and supports to people with disabilities in the most integrated setting possible, with each state developing its plan for meeting these guidelines. The ADA and Olmstead Decision are shaping federal and state policy.

B. Current efforts

1. Minnesota's Olmstead Plan

Minnesota's Olmstead Plan, which was approved by the U.S. District Court on September 29, 2015, is a groundbreaking, comprehensive plan to provide people with disabilities opportunities to live, learn, work, and enjoy life in integrated settings of their choosing.

The plan lays out measurable goals, strategies and activities in many topic areas:

- Person-centered planning
- Transition services
- Housing and services
- Employment
- Lifelong learning and education
- Waiting lists
- Transportation
- Healthcare and healthy living
- Positive supports

- Crisis services
- Community engagement
- Preventing abuse and neglect
- Assistive technology

The Olmstead Plan website[3] includes additional information about Minnesota's Olmstead Plan, Olmstead Subcabinet, and Olmstead Implementation Office.

2. Centers for Medicare and Medicaid Services (CMS) HCBS Settings Rule

The federal Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) published regulations in the Federal Register[4], effective March 17, 2014, which, among other things, changed the definition of HCBS settings for the 1915(c) and 1915(i) Medicaid HCBS waivers. The new definition considers a setting's impact on a person's experience and outcomes, in addition to its location, geography or physical characteristics.

The federal HCBS rule raises expectations around what is possible for older adults and people with disabilities. It requires assurances that all people have information and experiences with which to make informed decisions. It also requires the services they receive to meet a prescribed set of standards set out in the rule and subsequent guidance from CMS.

The federal HCBS rule complements the goals and values of Minnesota's Olmstead Plan. It further supports people's rights to make informed choices and decide what is important both *to* them and *for* them. The rule requires:

- Person-centered service planning
- Conflict-free case management
- Settings to have characteristics that are home and community-based.

Minnesota has until March 17, 2022, to bring existing programs into compliance with the characteristics of settings that are home and community-based.

The CMS website[5] includes rule language, fact sheets and additional resources, but see the Person-Centered Bulletin-Part 1[6] for a list of the specific rule requirements regarding the person-centered planning process, service plans and review process.

[3] See www.dhs.state.mn.us/opc_home
[4] See www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider
[5] See www.medicaid.gov/medicaid/hcbs/guidance/index.html
[6] See www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs-285572.pdf

3. Licensing standards required by 245D

Minnesota Statutes, Chapter 245D established licensing standards that ensure and protect the health, safety and rights of people who receive services. These provider requirements apply to the majority of services delivered through the home and community-based services waivers for people with disabilities (Brain Injury, Community Alternative Care, Community Access for Disability Inclusion and Developmental Disabilities waivers) and some services provided through Elderly Waiver.

Licensing standards for providers include person-centered planning requirements as they relate to service delivery. The provider works with the person to develop and implement the plan the provider receives from the lead agency (county, tribe or managed care organization) case manager.

Chapter 245D requires home and community-based services providers to provide services that:

- Respond to the person's identified needs, interests, preferences and desired outcomes, as specified in the person's plan
- Are developed in a manner consistent with the principles of person-centered service planning and delivery, self-determination and providing the most integrated setting and inclusive service delivery options.

The Minnesota Office of the Revisor of Statutes has the complete 245D statutory language[7], and the language specific to person-centered planning and service delivery can be found in the Person-Centered Bulletin-Part 1[8].

4. Positive Supports Rule

With the implementation of Minnesota Statute 245D in January of 2014, and the Minnesota Rule 9544 in August 2015, all DHS-licensed providers must use positive supports in place of restrictive interventions. The rule prohibits the use of punitive practices and procedures, such as seclusion and restraint.

Minnesota Rule 9544, known as the "positive supports rule," governs positive support strategies, including person-centered planning, and restrictive. The "positive supports rule" applies to:

- Organizations that provide services and supports licensed under 245D to people with disabilities and people older than 65
- Other providers licensed under Minnesota Statute, Chapter 245A, when they serve people with developmental disabilities.

[7] See www.revisor.leg.state.mn.us/statutes/?id=245D
[8] See www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs-285572.pdf

The positive supports rule was required as a term of the Jensen Settlement Agreement. It has specific criteria for the use of positive support strategies, which are meant to increase the person's quality of life and allow him or her to live in the most integrated setting in the community. These strength-based strategies teach new skills and focus on improving a person's experience in his or her environment. This rule covers approved procedures, prohibited procedures and provider responsibilities.

The positive supports rule outlines requirements for service providers, including:

- Incorporating the principles of person-centeredness into the services provided
- Evaluating with the person, at least every six months, whether the services support the person's preferences, daily needs and activities, and the accomplishment of the person's goals.

Minnesota Rule 9544[9] is the complete positive supports-rule language, but see Person-Centered Bulletin-Part 1[10] for requirements specific to person-centered principles.

5. Nursing Home Payment Reform

Changing consumer preferences and state policy striving to "rebalance" its LTSS from institution-based to a greater emphasis on home-and community based models has resulted in a significant reduction in the number of nursing home beds in the state. However successful these strategies, there continues to be a need for nursing homes. Nursing home services are bundled into a comprehensive package of room, board and nursing care. Historically, the legislature approved occasional payment increases to address financial disparities, provide cost of living adjustments, and for special circumstances. However, nursing homes, advocates and legislators called for a more flexible system that would better reflect their costs, impact quality and strengthen the workforce. To address these goals, the 2015 legislature passed major reforms to Medicaid nursing home payment. This new system is known as "Value-Based Reimbursement" (VBR).

Minnesota has implemented several pay for performance strategies in nursing homes since 2006, including additional payments for high quality and for the successful achievement of quality improvement goals. VBR incorporates pay for performance by setting facilities' care-related payment rate limits based on their quality. In doing so, the state policy pays for higher costs if the services provided are of higher quality.

A primary driver leading to enactment of VBR was the hope that the new rate setting method and its additional funding would be helpful in building a stronger workforce. DHS has done an evaluation of the initial impacts of VBR. Direct care staff wages, benefits such as health insurance and continuing

[9] www.revisor.leg.state.mn.us/rules/?id=9544
[10] www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs-285572.pdf

education, staffing levels and staff retention increased in the system's first year. DHS continues to monitor VBR to determine its effects on costs, staffing issues, access to care, and quality.

The VBR evaluation report is available on the DHS website[11].

[11] mn.gov/dhs/assets/2017-03-nursing-facility-payment-reform_tcm1053-286209.pdf

V. Trends

Trends are an important driver of change in the way DHS does its work. This section of the report will cover:

- Population trends – changes in the demographics of Minnesota
- Service trends – changes in the way long-term services and supports are provided
- Changing needs and expectations – changes in the way society thinks about needs and the services and supports to meet those needs

A. Population trends

Minnesotans are living longer than ever before. By 2030, approximately one in five Minnesotans will be age 65 or older. Not only is the overall number of older adults increasing, but those born with or who acquired disabilities, and living with chronic conditions are living longer as well. People who historically would not have lived to be very old, are reaching older adulthood.

According to the Minnesota State Demographic Center's Minnesotans with Disabilities: Demographic and Economic Characteristics report, approximately 10.9% of people in the state have a disability, using the American Community Survey definition. The Minnesotans with Disabilities report also notes,

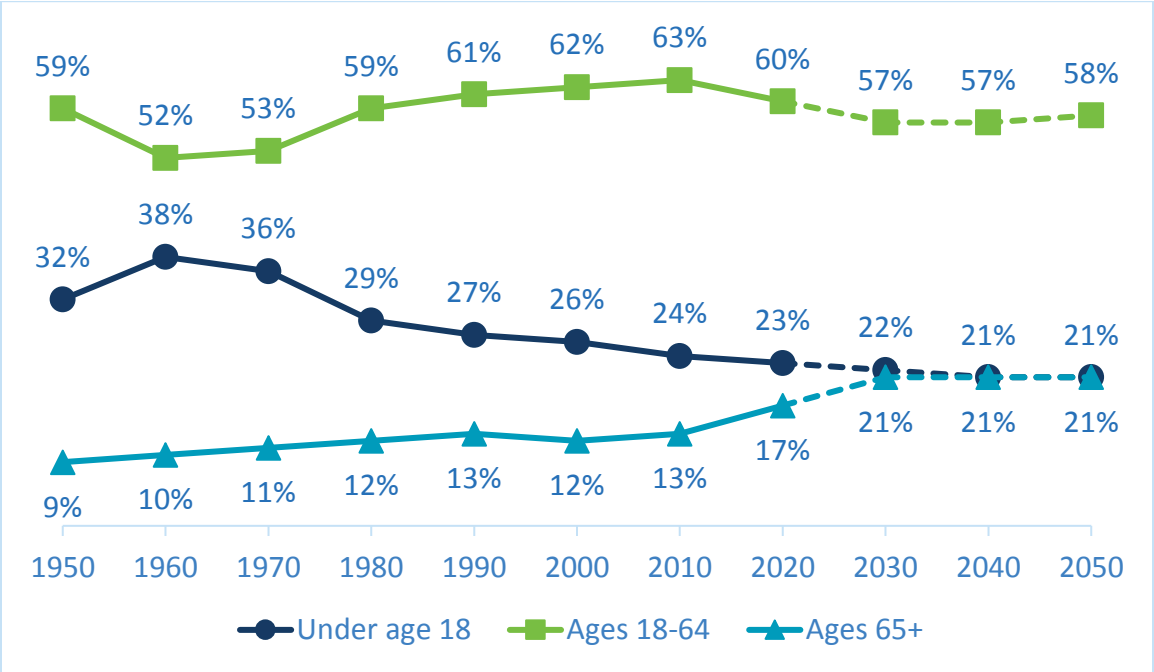
> In 2010, 10.0% of Minnesotans reported a disability; by 2015, that share had risen to 10.9%, reflecting about 593,700 state residents. Continued growth in the number and percentage of Minnesotans with disabilities is anticipated, given the overall aging of our state's population and rising disability prevalence later in life.

Approximately 20 percent of children experience an emotional disturbance and about 20 percent of adults experience a mental illness in a given year according to Community Supports Administration estimates. This equates to more than 300,000 children and 800,000 adults in Minnesota in a year.[12]

Figure V-I shows the growth in the population of Minnesota over time.

[12] For more information on the Mental Health service system see the Governor's Task Force on Mental Health Final Report at mn.gov/dhs/mental-health-tf/

Figure V-I. Historical and projected population shares by age[13]



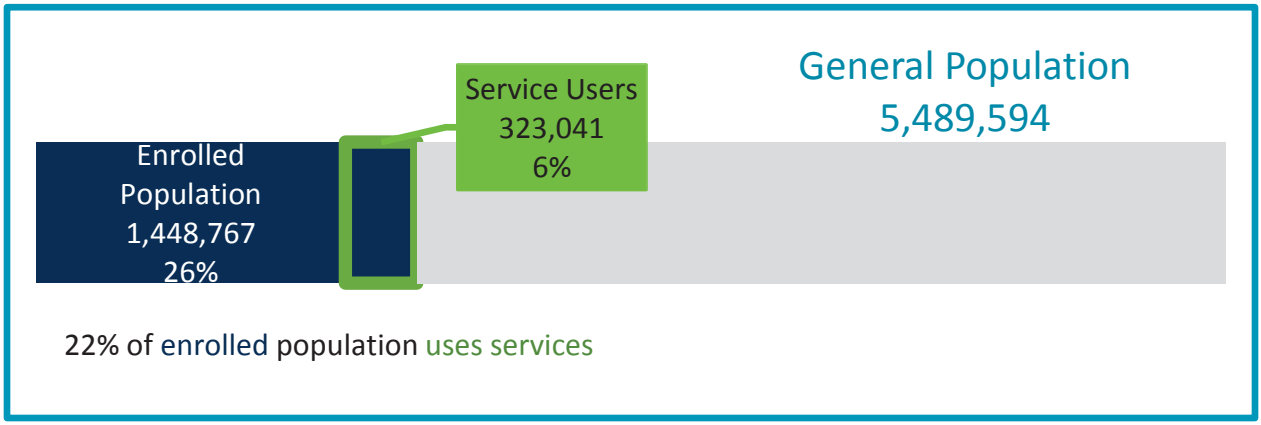
Figures V-II through V-V present data about three populations: a) the general population, b) the enrolled population, and c) the current home and community-based service (HCBS) user population[14]. The general population and the enrolled population represent groups of potential service users.

- The general population is everyone living in the state regardless of service use.
- The enrolled population is all people enrolled in Minnesota Health Care Programs (MHCP) anytime in state fiscal year 2015. It includes all current service users and those who have the potential, based on income and other criteria to use services in the near future.
- The current service user population includes people who received one or more HCBS or Mental Health services and supports in state fiscal year 2015. As noted in Figure V-II, not all people who could potentially use services, including those with a disability, do. In fact, only 6 percent of the general population use services.

[13] Source: MN State Demographic Center, "Demographic Considerations For Long-Range & Strategic Planning," March 2016. Available at: http://mn.gov/admin/images/demographic-considerations-planning-for-mn-leaders-msdc-march2016.pdf

[14] The full list of services used to define this population is available online: download the edoc, https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7301I-ENG (PDF)

Figure V-II. Population counts and proportions[15]



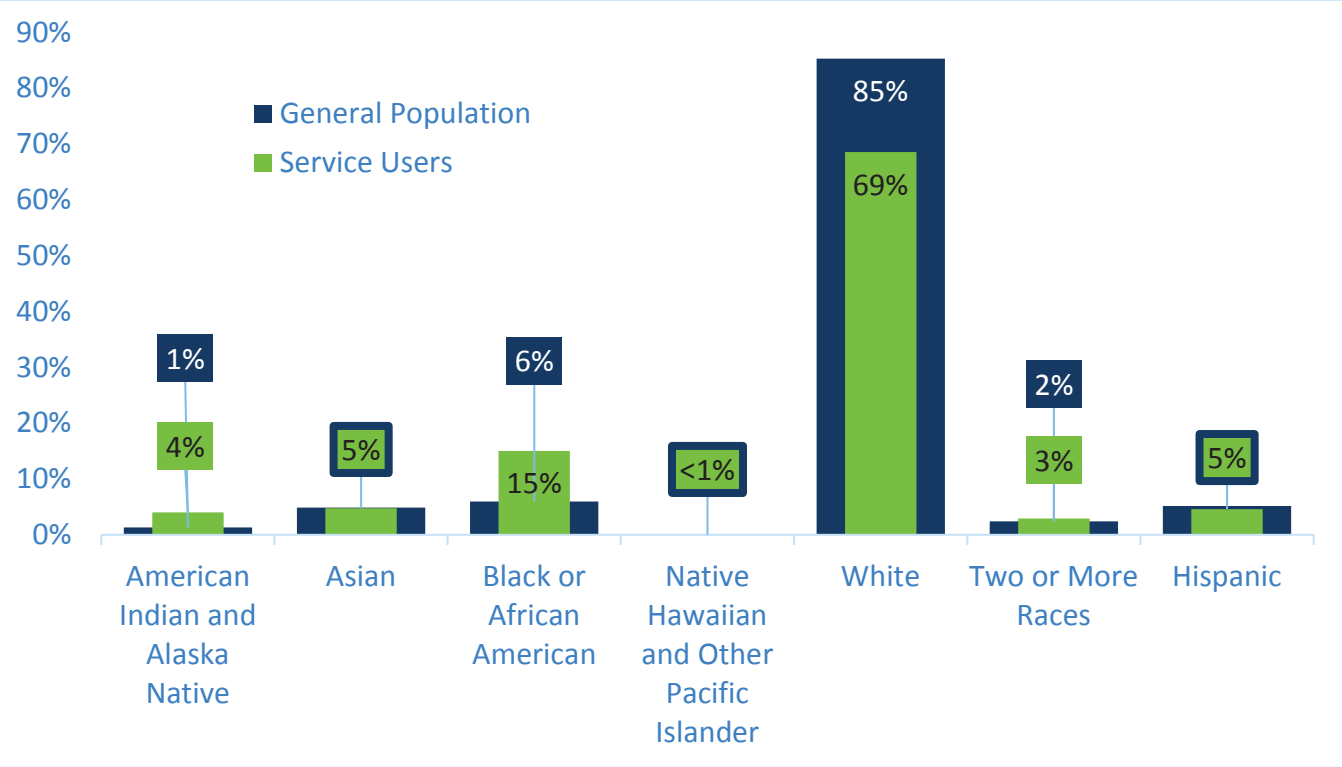
1. Demographic characteristics of potential and current service users

Demographic characteristics for the potential and current service user populations provide an idea of the makeup of each population. Data is broken out by demographic characteristics to provide additional insight into differences in service use and the need for providers that can meet the needs of different populations.

Enrolled users and service users are more diverse than the general population, and tend to be, demographically, fairly similar to each other. For example, Black or African American Minnesotans make up about 6 percent of the general population, 15 percent of the enrolled population, and 14 percent of the service user population. Rate of use, which is the percentage of the enrolled population who are actually using services, vary from 30 percent for American Indians to 13 percent for Native Hawaiians and Other Pacific Islanders.

[15] Source: U.S. Census Bureau, 2015 Population Estimates, Minnesota Department of Human Services Medicaid Management Information System (FY 2015, July 1, 2014-June 30, 2015)

Figure V-III. Percent of general population and service user population by race or ethnicity, undifferentiated by income[16]



2. Characteristics of current service users

Figures V-IV and V-V present the characteristics of all persons currently using services from the HCBS and/or Mental Health service systems. Current service users are broken out by service system:

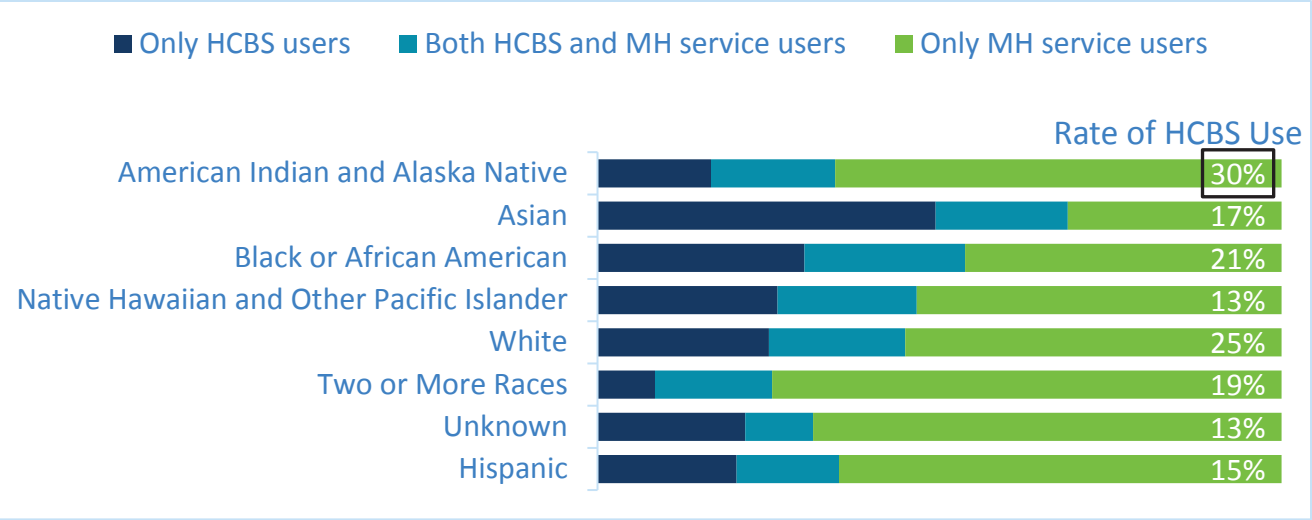
- **Only HCBS Users:** People using any home and community-based service, including all waiver and state plan services available or provided through publicly funded programs and those receiving services through fee-for-service or managed care.
- **Only MH Service Users:** People receiving any mental health treatment or therapeutic service or support available through the MHCP.
- **Both HCBS and MH Service Users:** People receiving both a MH service and HCBS service.

The type of services used vary by race and ethnicity as shown in Figure V-IV. For example, a higher proportion of Asians use only HCBS, while people of two or more races have a higher proportion who only use mental health services. Rate of use is included to show the percentage of people enrolled who

[16] Source: U.S. Census Bureau, 2015 Population Estimates, Minnesota Department of Human Services Medicaid Management Information System (FY 2015, July 1, 2014-June 30, 2015)

are currently using at least one HCBS. For example, 30% of all American Indians and Alaska Natives currently enrolled are currently using one or more HCBS services.

Figure V-IV. Service types used and rate of use[17] by race and ethnicity[18]

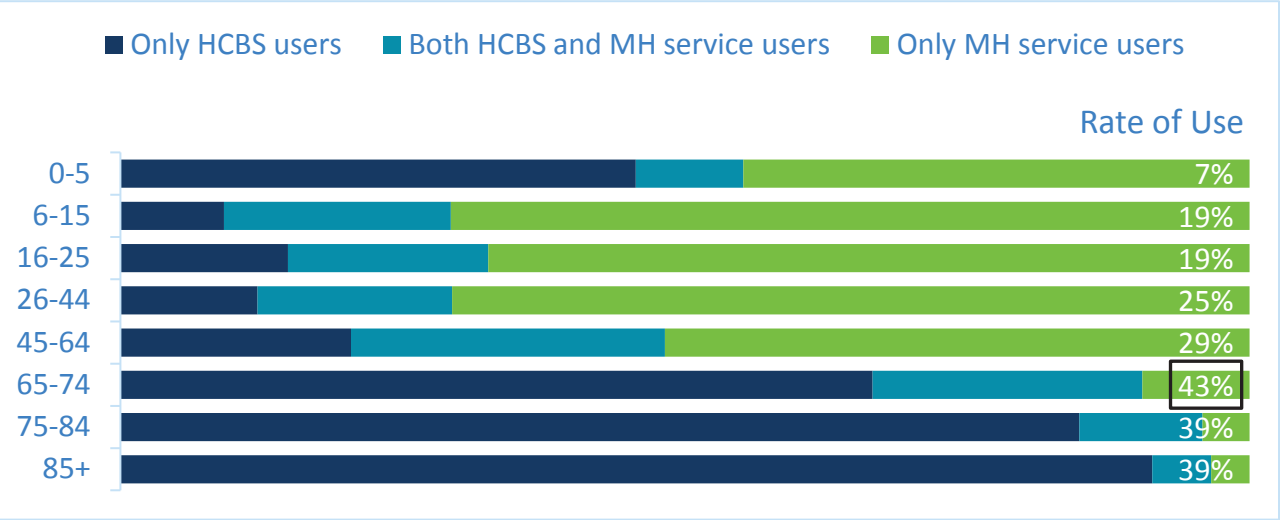


Use of HCBS or mental health services differs by age groups, as shown in Figure V-V. For example, mental health service use among older adults is much lower than for younger populations.

[17] Rate of use: percentage of people enrolled who are currently using services

[18] Source: U.S. Census Bureau, 2015 Population Estimates, National Center for Health Statistics, Bridged-Race Population Estimates (age), Minnesota Department of Human Services Medicaid Management Information System (FY 2015, July 1, 2014-June 30, 2015)

Figure V-V. Service types used and rate of use[19] by age[20]



B. Service trends

Most services used to be provided only in institutions. Now, many services are provided in people's home and community. Society is moving into an era of customization and individualization of services for people, so they are able to get just what they need, when they need it. DHS is promoting community integration, person-centeredness, choice, and independence. Trends in the service system demonstrate this change.

In state fiscal year 2016, DHS spent $4.5 billion on long-term services and supports. As shown in Figure V-VI, the majority of the spending was on services provided in the community. Many people were served through this funding. Over 75,000 people were served by waiver programs. Over 40,000 were served by PCA and approximately 1,500 people were served by Home Care Nursing. Approximately 1,500 were served by intermediate care facilities for people with developmental disabilities (ICF/DDs). Over 1,600 people were served through the Family Support Grant and over 2,600 through the Consumer Support Grant. Another 1,500 were served by Semi-Independent Living Services. Over 2,600 were served by HIV/AIDS programs.

[19] Rate of use: percentage of people enrolled who are currently using services

[20] Source: U.S. Census Bureau, 2015 Population Estimates, National Center for Health Statistics, Bridged-Race Population Estimates (age), Minnesota Department of Human Services Medicaid Management Information System (FY 2015, July 1, 2014-June 30, 2015)

Figure V-VI. SFY 2016 total long-term services and supports spending[21] (HCBS and Institutional), $4.5 Billion[22]

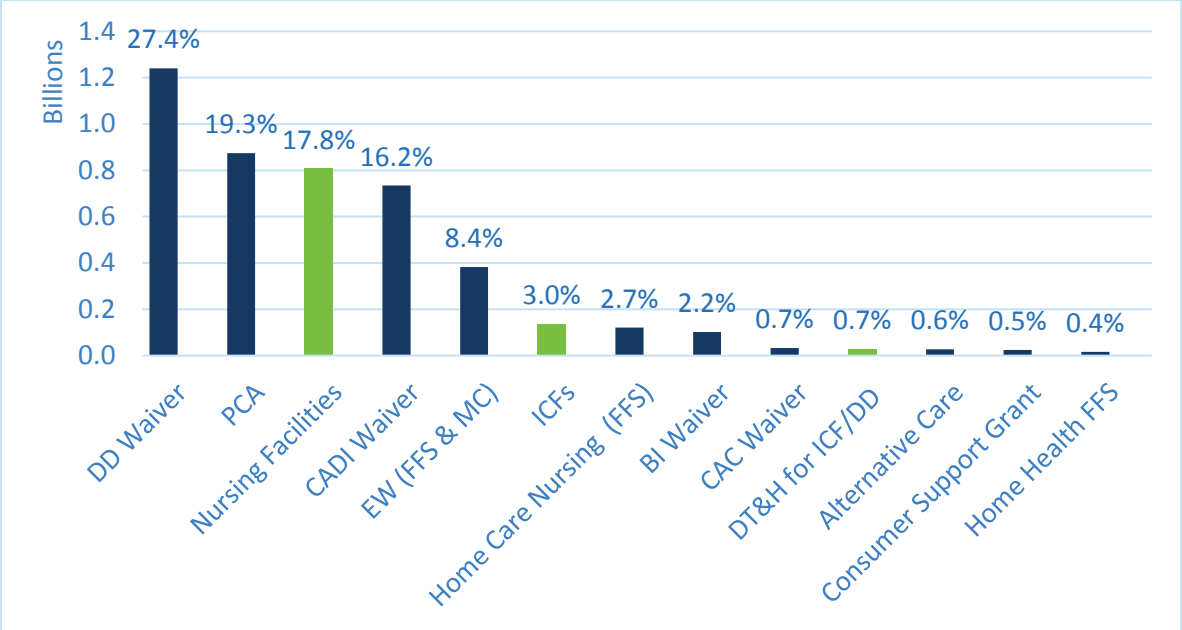


Figure V-VII reflects total (state, federal, and county) spending for LTSS for all populations. This shows that, over time, proportionally more of the total spending has gone to home and community-based services and less on institutional services.

Figures V-VIII A and B show the monthly average payment per person and the monthly average number of service users used to calculate the total forecasted spending. Although the cost is increasing slightly, the number of service users increase significantly. The total forecasted spending increase is due in large part because more people are using services.

[21] LTSS in the chart includes Developmental Disabilities waiver, Personal Care Assistance program, Nursing Facilities, Community Access for Disability Inclusion, Elderly Waiver (fee-for-service and managed care), intermediate care facilities, Home Care Nursing (fee-for-service), Brain Injury waiver, Community Alternative Care waiver, Day Training & Habilitation for intermediate care facilities, Alternative Care, Consumer Support Grants, and Home Health (fee-for-service).

[22] Source: February 2017 Forecast (FFS: Fee for service; MC: Managed care)

Figure V-VII. Total spending for long-term services and supports (in billions), by state fiscal year[23]

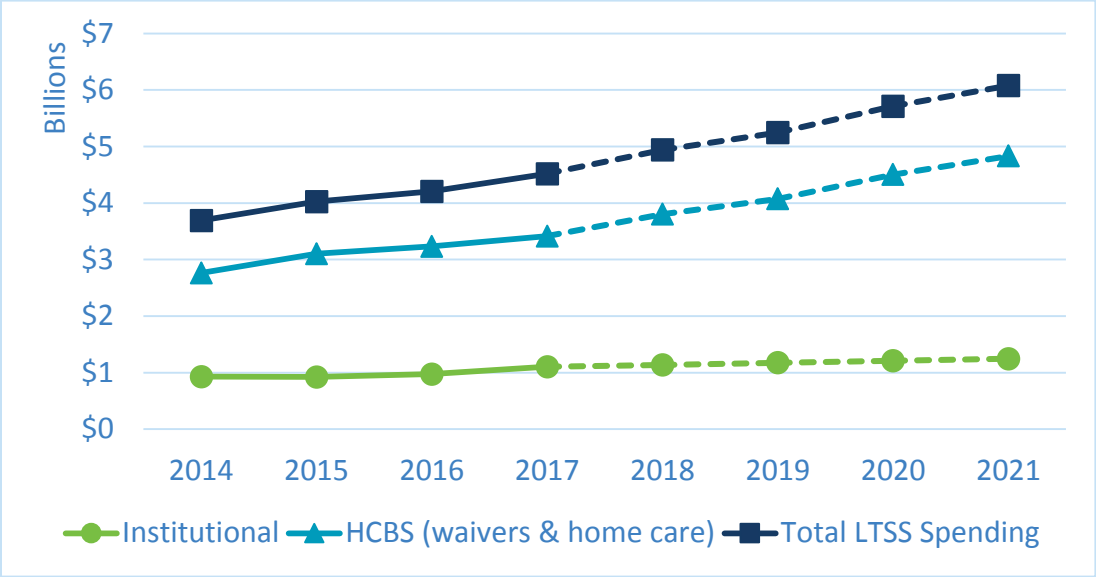


Figure V-VIII A. Monthly average payments per person[24]

	2014	2015	2016	2017	2018	2019	2020	2021
Institutional	$4,472	$4,594	$4,989	$5,657	$5,868	$6,097	$6,234	$6,376
HCBS (waivers & home care)	$3,641	$4,047	$4,093	$4,063	$4,213	$4,327	$4,411	$4,558

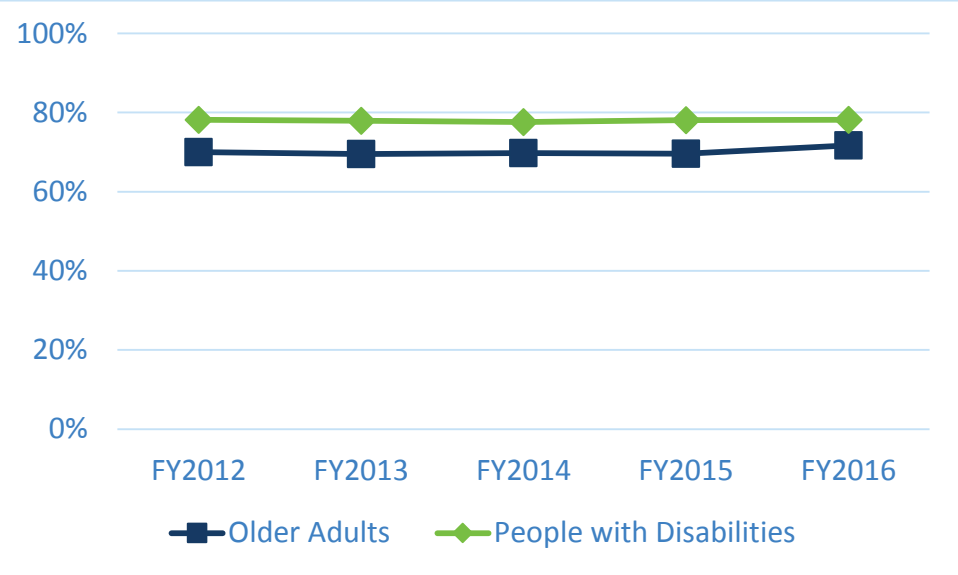
Figure V-VIII B. Monthly average service users

	2014	2015	2016	2017	2018	2019	2020	2021
Institutional	17,300	16,761	16,280	16,273	16,132	16,048	16,179	16,292
HCBS (waivers & home care)	56,010	57,602	58,598	63,412	66,808	70,073	76,148	78,931

[23] Source: February 2017 Forecast. These projections are as of February 2017 and do not take into account changes passed during the 2017 legislative session. HCBS spending includes fee-for-service payments as well as managed care payments under the Elderly Waiver. However, a small portion of HCBS spending is not included.
[24] HCBS spending only includes fee-for-service payments. There are additional payments made through managed care organizations, including a portion of Elderly Waiver and PCA spending.

DHS also serves a high proportion of older adults[25] and people with disabilities using HCBS in their own homes or family homes rather than in residential services. Residential services include customized living and foster care. Generally, people prefer to remain in their own or their family's home. Figure V-IX shows the trend, over time, of serving people in their own home. This proportion is expected to remain stable for the foreseeable future.

Figure V-IX. Percentage of People using Home and Community-Based Services in their Own Homes by State Fiscal Year[26]



Increasingly, individuals with more complex needs have been able to live in their community. In the past, fewer services were available in the community and people who needed more assistance had to move to institutional settings to receive that support. As specialized services have become increasingly available, people have been able to remain in their home and community.

DHS is working towards providing the right service at the right time, which often means reaching people earlier. This is good for people, since it builds wellbeing, and good for the system, because it is more cost-effective. If the system can provide a little bit of help for small problems, it can often prevent them from becoming bigger and keep people from needing more intensive services. One of the ways the Department reaches people earlier is through Senior LinkAge Line®, Disability Linkage Line (soon to be called the Disability Hub), and the Veterans Linkage Line (800Linkvet) which is operated by the Minnesota Department of Veterans Affairs. In calendar year 2016, 123,868 people were served by Senior LinkAge Line and 30,211 people were served by Disability Linkage Line. The linkage lines provide long-term care options counseling and assistance as well as act as the gateway for to older

[25] The older adult programs included are Elderly Waiver, Alternative Care, State Plan Home Care (Personal Care Assistance, Home Care Nursing, and Home Health Agencies) and Essential Community Supports. It does not include services funded through the Older Americans Act or state grant programs.
[26] Source: DHS MMIS Claims and Service Agreements

adults, veterans, people with disabilities, and their family and friends by connecting them with local services and supports, and helping them find solutions. The Senior LinkAge Line® provides care transitions through its Return to Community Initiative and also operates the federally designated State Health Insurance Assistance and Senior Medicare Patrol fraud awareness services as well as federally mandated Level One Preadmission Screening services. The Preadmission Screening and Resident Review reform efforts of 2013 allowed the linkages lines to identify people going into a skilled nursing facility for short term rehabilitation types of stays or longer term stays. This also gives the opportunity to identify people who are either going to need supports in the home upon discharge or who are in need of care transitions and options counseling following up.

Another key component of their work is health insurance counseling, which includes providing enrollment assistance into Medicare Parts A, B, D and Medicare Advantage or Medicare Special Needs Basic Care plans. Through their benefits assistance work the linkage lines are able to reach people well before they need intensive services and help people make better-informed choices about LTSS options. It gives an opportunity to educate consumers early about home and community-based options and caregiver services.

Another way DHS provides services earlier is through Older Americans Act programs for people age 60 and older. Older Americans Act programs provide a little extra help, such as a home-delivered meal or occasional respite from caregiving. Older Americans Act programs served 189,210 people in federal fiscal year 2016.

Other programs that aim to keep people from needing safety net programs include

- Disability Services Innovation Grants, mn.gov/dhs/partners-and-providers/grants-rfps/disabilty-innovation-grants.jsp
- Live Well at Home Grants, mn.gov/dhs/live-well
- Return to Community Initiative, www.mnaging.net/advisor/RTCI.aspx

C. Changing needs and expectations

DHS is committed to identifying and learning from changes in preferences, expectations, and needs of people who use LTSS to inform changes in the way services are developed. Everyone wants to be able to choose where they live and work, what services they use, and who provides those services. Youth who grew up in integrated school settings expect the world to be integrated as they transition to higher education and employment. Older adults want to choose where they receive the help that they need. DHS needs to ensure the system supports people in having a meaningful life, according to their own goals, with opportunities to make meaningful contributions and build upon what is important to them. The Department needs to work on making sure less-intensive supports and community-based options are available so people have a wider spectrum of options.

For children and young adults with disabilities (including those living with a mental health condition) who receive special education services and their peers, being integrated into regular classroom settings is important. It gives all children and youth the chance to learn from and build friendships with each other. In Minnesota, 112,375 students, age 6 to 21, received special education services in 2016. Across all disabilities, 60 percent of the students spent at least 80 percent of their time in a regular education setting, with only about 10 percent spending less than 40 percent of their time in a regular education setting.

As shown in Figure V-X, this varies significantly, however, when analyzed by the category of educational disability of those more likely to be involved in DHS home and community-based services programs. Although great strides have been made in helping children and youth with disabilities be integrated into regular classrooms, there are improvements to be made.

Figure V-X. Percent inside regular classroom by disability category

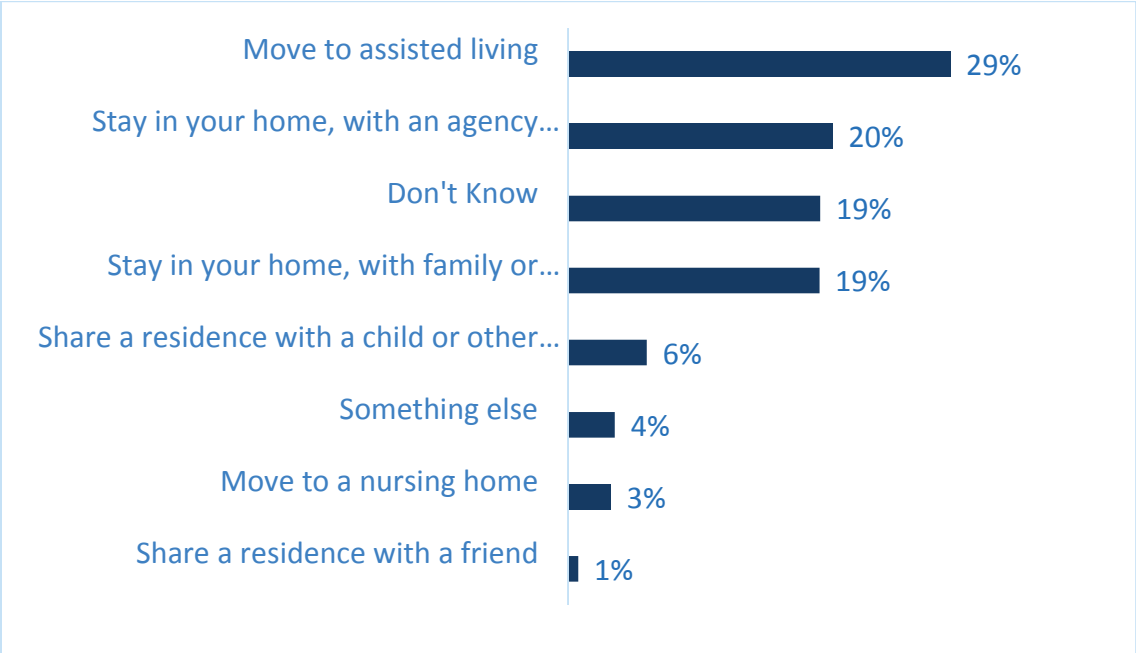
Disability category	Percent inside regular classroom at least 80% of the time	Percent inside regular classroom less than 40% of the time
All categories	60%	10%
Emotional disturbance	53%	12%
Autism	50%	20%
Intellectual disability	8%	45%
Multiple disabilities	4%	64%

Well-informed individual decision-making about LTSS options is integral to providing services that work for everyone. Although each person has individual needs and preferences, trends have emerged.

Figure V-XI shows data from the 2015 Survey of Older Minnesotans[27]. In response to the question "If you could no longer live independently for health reasons, what do you think you would most likely do?" 29 percent of people 65 and older said they would move to an assisted living and 20 percent would stay in their home with an agency providing care. This illustrates that people are aware that there are less restrictive options than a nursing home; they want to access these other options, and know that it is possible to stay at home and get the help they need. This is in sharp contrast to the not-so-distant past when many people believed nursing homes were their only option as they got older and needed help. However, improvements can be made. In the future, we hope more people are aware of the in-home services and supports available to them and choose to stay at home and receive this type of assistance.

[27] For more information see www.mnaging.net/en/Advisor/SurveyOlderMN.aspx

Figure V-XI. If you could no longer live independently for health reasons…



More people using LTSS services want to work. People with disabilities are pursuing competitive, integrated employment. DHS and its state agency partners need to continue developing the capacity to support all people who want to work in the community. For example, 46 percent of adults with intellectual and developmental disabilities participating in services have community-based employment as a goal in their service plan; 41 percent have a paid job in the community. Among people with physical disabilities under age 65 who participate in LTSS, 26 percent have a job in the community; a little over half of those employed make at least minimum wage. Surveys show that among those without a paid job, 41 percent would like one. Helping people find work could be a great benefit to our economy and society as a whole. It is a part of the solution to the workforce shortage.

More children are being recognized as having autism spectrum disorder. DHS is seeking to ensure services are available for them. The Department has begun implementing the Early Intensive Developmental and Behavioral Intervention benefit[28]. This benefit works by reaching people with autism while they are young, which can prevent the need for more intensive and costly services in the future. DHS is also focusing more attention on dementia as more people are recognized as having dementia. The Minnesota Board on Aging administers Dementia Grants[29] to increase awareness of Alzheimer's disease and other dementias, increase the rate of cognitive testing in the population at risk for dementias, promote the benefits of early diagnosis of dementias, and connect caregivers of people with dementia to education and resources.

[28] For more information see mn.gov/dhs/eidbi
[29] For more information see www.mnaging.net/en/Administrator/DementiaGrants.aspx

With the right services at the right time, we can ensure all Minnesotans who need services are receiving the supports they need to reach their full potential, while keeping the system sustainable.

VI. Measuring Our Progress

DHS supports people in having a meaningful life, identifying their own goals, finding opportunities to make meaningful contributions, and building upon what is important to them. These outcomes are achieved by modifying existing services, providing new services to targeted groups and testing innovative approaches, leading to better individual outcomes. The goal is to provide people with the right services, in the right way and at the right time, to ensure that services are functionally-driven according to a person-centered plan in order to achieve better individual outcomes and that ensure the sustainability of the system through efficiencies achieved.

This section reports on six sub-goals from Reform 2020 that aim to improve outcomes of those receiving LTSS:

1. Increased flexibility to better meet the needs of each individual
2. Increased stability in the community
3. Better-informed individual decision-making about LTSS options
4. Promotion of person-centered planning—life-long and crisis
5. Improved transitions between settings and programs, preventing avoidable health crises
6. Recognize and address social determinants of health care need and cost

A. Goal 1: Increased flexibility to better meet the needs of each individual

Increased flexibility of LTSS supports individuals to meet their needs and goals. A high proportion of older adults and people with physical disabilities surveyed say they have flexibility in their services and that their services meet their needs and goals[30].

- 69% say services meet all their needs and goals.
- 72% can choose or change what kind of services they get and determine how often and when they get them.

While the majority of people indicate their services meet their needs, gaps still exist. Of the adults with intellectual and developmental disabilities (I/DD) who were surveyed, 91 percent said that while the services and supports they receive help them live a good life, there are still many unmet needs[31].

- 44% need additional transportation services.
- 36% need more job assistance.

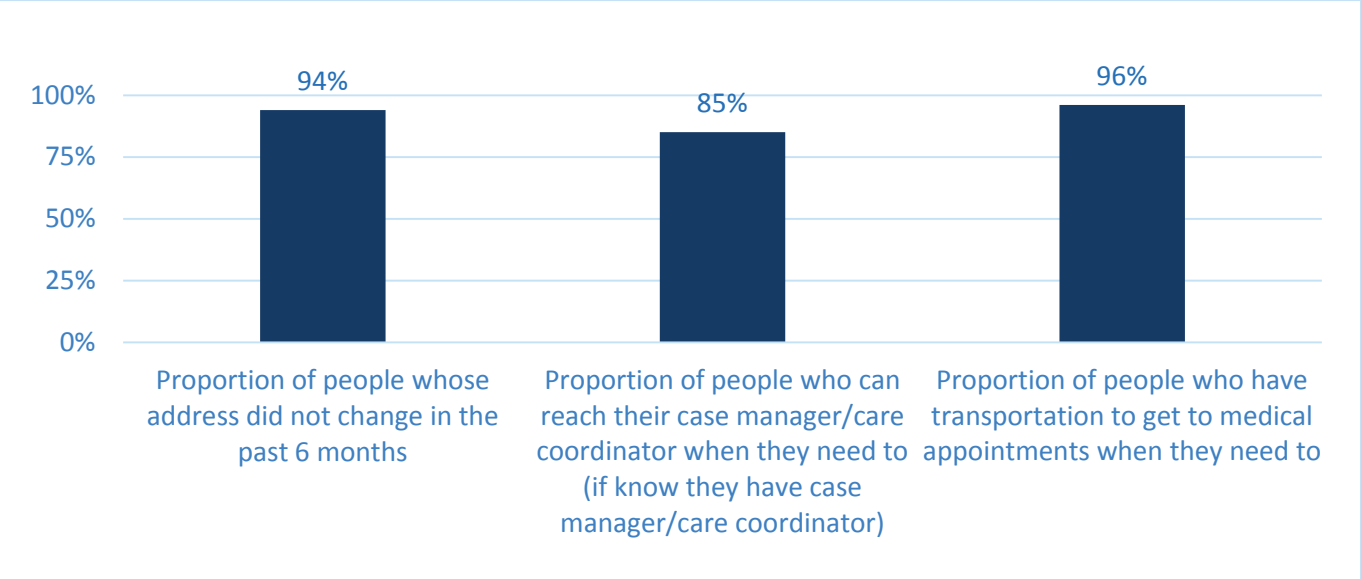
[30] Data from the 2016 National Core Indicators- Aging and Disabilities (NCI-AD) Survey. See nci-ad.org/
[31] Data from the 2016 National Core Indicators (NCI) survey. See www.nationalcoreindicators.org/

- 30% could use additional support to help develop or maintain social relationships.
- 26% believe they could use additional services from their case managers or service coordinators.
- 24% could use housing assistance.

B. Goal 2: Increased stability in the community

Consistent housing, access to services, and adequate support helps improve people's stability in the community. Figure VI-I shows that the majority of older adults and people with physical disabilities who were surveyed said they can reach their case managers, they have transportation to get to medical appointments, and their address did not change in the past six months[30].

Figure VI-I. Stability in the community[30]



While these data indicate the system is working well for most people, some individuals still have difficultly remaining in a stable living environment.

- 10% of people age 65 and older are planning to move from their home and another (about) 10% say they may move from their home. The top reasons for planning to move is to have a smaller house or apartment (24%), followed by climate (9%) and home maintenance (9%)[32].
- Residential services providers licensed under Minnesota Statutes Chapter 245D are required to notify (a) the person or the person's legal representative, (b) the case manager, and (c) DHS at least 60 days prior to "service termination" – involuntarily ending services and discharging a person from their services. Within the notification, providers must document all actions taken prior to giving notice in order to minimize or eliminate the need for discharge. In 2016, 236 people received notice of service termination and discharge.

[32] Data the from 2015 Survey of Older Minnesotans. See www.mnaging.net/en/Advisor/SurveyOlderMN.aspx

C. Goal 3: Better-informed individual decision-making about LTSS options

The LTSS system is complex. The more individuals know, the better decisions they are able to make about the services and supports they receive. People access resources to make informed decisions about LTSS options through in-person, over the phone, and online resources.

All individuals who receive services through a waiver have a case manager that helps them navigate the system and connect with services and supports. Among families and guardians of people with intellectual or developmental disabilities who do not live in the family home, of those surveyed, 91 percent usually or always get enough information to help them participate in planning services for their family member[33].

In addition to case managers, DHS partners with the Minnesota Board on Aging to help all Minnesotans and their caregivers to navigate the system through the Senior and Disability Linkage Lines and the MinnesotaHelp.info, Housing Benefits 101 (HB101), and Disability Benefits 101 (DB101) websites.

- In 2016, 154,079 people were served through in-person and telephone-based assistance through the Senior Linkage Line (123,868 persons served) and Disability Linkage Line (30,211 persons served).
- In 2016, there were 860,569 visits to the MinnesotaHelp.info (601,054), HB101 (40,862), and DB101 (218,653) websites.

D. Goal 4: Promotion of person-centered practices—life-long and crisis

The LTSS system must reflect that we understand, respect and honor the things each person thinks are important. The goal is for people to lead lives that are meaningful to them. To do this, the system must be person-centered and help people:

- Build or maintain relationships with their families and friends
- Live as independently as possible
- Engage in productive activities, such as employment
- Participate in community life.

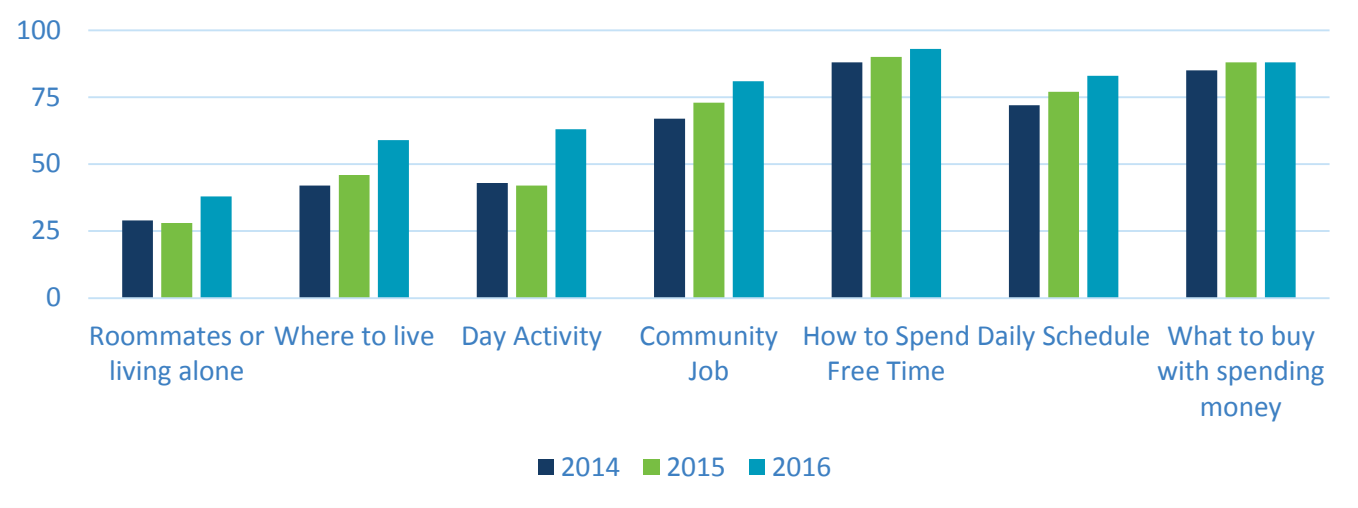
Most older adults and people with physical disabilities surveyed report that they are able to see friends and family, have transportation to go where they want to, and usually like how they spend their time[30].

- 90% can always or almost always see or talk to friends and family when they want to (if there are friends and family who do not live with person).
- 80% have transportation when they want to do things outside of their home.
- 94% like how they usually spend their time during the day.

[33] Data from the 2016 National Core Indicators- Family/Guardian Survey. See www.nationalcoreindicators.org/

"Informed choice" is a hallmark of person centered planning. The chart below indicates that Minnesota has made progress in assuring that people with I/DD make their own choices or have input into major life decisions[34].

Figure VI-II. Proportion of people with I/DD who made choices or had input about their lives: 2014 to 2016



Engagement of people with disabilities in competitive employment is an important indicator that individuals' interests, strengths and skills are supported. This does not mean that every person with a disability has to work at an unsupported, competitive job. Some may not want to or be able to. It does mean that everyone, regardless of ability, deserves the opportunity to pursue work that is meaningful and fulfilling to them.

- 26% of people with physical disabilities surveyed say they have full or part-time jobs and of those, 51% say their jobs pay at least minimum wage.[30]
- 41% of adults with I/DD surveyed say they have a paid job in the community.[31]

E. Goal 5: Improved transitions between settings and programs, preventing avoidable health crises.

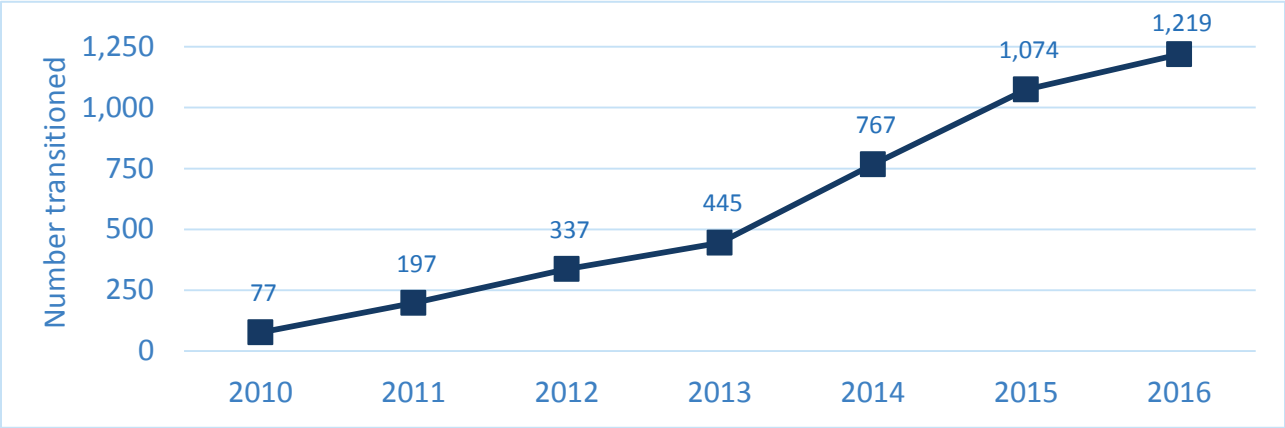
Improving transitions between settings and programs is key to preventing avoidable health crises and improving the quality of care received. Effective care transitions is a coordinated effort that supports people to transition from one level of care to another. Case managers and care coordinators play a key role in helping to facilitate these transitions. Survey results indicate that the majority of older adults and people with disabilities received a follow-up from someone after they transitioned home from a hospital or rehabilitation facility and that they felt comfortable with the transition.

[34] Data from the 2014, 2015, and 2016 NCI surveys. See www.nationalcoreindicators.org/

- 85% of older adults and people with physical disabilities surveyed report feeling comfortable and supported enough to go home after being discharged from a hospital or rehabilitation facility (if occurred in the past year).
- 83% of older adults and people with physical disabilities surveyed report someone followed-up with them after discharge from a hospital or rehabilitation facility (if occurred in the past year).

DHS supports initiatives to help people transition from and live in the most integrated setting. Two examples of this are Moving Home Minnesota (MHM) and Return to Community (RTC). MHM helps transition people from institutional settings to their homes and has served 235 individuals since 2013. RTC helps people who are privately paying and not on public programs transition from nursing homes into the community and has served 4,654 individuals since 2010.

Figure VI-III. Return to Community transitions: 2010 - 2016



F. Goal 6: Recognize and address the social determinants of health care need and cost

The social determinants of health care need and cost are broad and complex and include indicators such as health status, chronic conditions, food security, housing, access to transportation, and social connectedness. People receiving LTSS who were surveyed indicated that while they are doing really well in some areas, they need to be better supported in other areas[31,30].

- 4% of the adults with I/DD and 16% of the older adults and people with physical disabilities who were surveyed described their overall health as poor.
- 17% of the adults with I/DD who were surveyed have diabetes compared with just under 8% of Minnesota adults generally.
- 98% of older adults and people with physical disabilities say they have a primary care doctor.
- 54% sometimes or often feel lonely, sad or depressed.
- While 81% of older adults and people with physical disabilities reported they had one or more chronic health conditions, 89% of said they know how to manage those chronic conditions.
- 13% of older adults and people with physical disabilities ever skip a meal due to financial worries.

- 76% of older adults and people with physical disabilities say they feel in control of their lives.
- 30% of adults with I/DD report there is at least one place where the person feels afraid or scared – 10% feel afraid walking in their communities with 5% being afraid at home.

VII. Service Access and Gaps

A. Overview

The Gaps Analysis study gathers local information about the capacity of Minnesota's publicly funded home and community-based services (HCBS) system and continuum of mental health (MH) services and supports to meet the needs of all persons who need services. The Gaps Analysis is conducted every other year. Previously, the Gaps Analysis was conducted through a survey process that primarily asked county lead agencies to provide their perceptions about the availability of HCBS and MH services and supports. DHS contracted with Wilder Research to conduct the Gaps Analysis study for the 2015-2016 time period. For the 2015-16 analysis, the process was revised to provide an opportunity for regional stakeholders to review and use data from the past Gaps Analysis with a focus on solutions. The 2015-16 Gaps Analysis was conducted through 11 regional meetings, each attended by approximately 40 stakeholders including representatives of lead agencies; service providers; consumers; and advocates. The regional meetings provided an opportunity for participants to discuss and prioritize top service gaps, identify solutions to service gaps, and develop action plans to implement the solutions.

B. Current study

Eleven regional meetings were held around the state between April 13, 2017 and June 9, 2017. Based on feedback and suggestions from stakeholders and lead agencies, two meetings were held in the Metro region (Region 11) and Regions 6 and 8 were combined in a single meeting.

DHS identified a host for each of the meetings, and the host assisted in identifying and securing a site for the meeting. The dates and locations of the meetings are shown in Figure VII-I below.

Figure VII-I. Meeting dates, locations and attendees

Economic Development Region(s)	Date of meeting	Location of meeting	Number of attendees
Region 10 - Southeast[35]	Thursday, April 13, 2017	Rochester	45
Region 9 - South Central	Friday, April 14, 2017	Mankato	33
Region 6&8 – Southwest	Thursday, April 20, 2017	Granite Falls	35

[35] Although Waseca County is part of Region 9, it was included in the Region 10 meeting because it is part of a service consortium which is predominantly located in Region 10. White Earth Nation was included in the Region 2 meeting because the majority of their reservation geography is shared with counties in this region. Number of attendees does not include DHS staff and representatives or Wilder Research staff

Economic Development Region(s)	Date of meeting	Location of meeting	Number of attendees
Region 7 – East Central	Wednesday, May 03, 2017	St. Cloud	24
Region 5 – Central	Thursday, May 04, 2017	Brainerd	26
Region 1 – Northwest	Tuesday, May 09, 2017	Thief River Falls	28
Region 4 – West Central	Monday, May 15, 2017	Fergus Falls	31
Region 3 – Northeast	Wednesday, May 24, 2017	Duluth	31
Region 2 – North Central	Monday, June 05, 2017	Bemidji	36
Region 11 - Metro	Wednesday, June 07, 2017	Minnetonka	28
Region 11 - Metro	Friday, June 09, 2017	Eagan	25

1. Regional meeting participants

Approximately 40 stakeholders were invited to each regional meeting. These stakeholders included representatives from counties, tribes, and managed care organizations with administrative or contract authority to provide assessment and support planning (i.e., lead agencies); providers of HCBS and MH services and supports; advocates and current service users.

DHS representatives and staff from Wilder Research also attended the regional meetings to present data, facilitate activities, answer questions, and take notes during table discussions. This process is described in more detail in the "Preliminary findings" sub-section of this report.

2. Regional meeting process

Wilder Research staff facilitated and managed the logistics for each of the regional meetings with support from representatives from DHS. Each meeting began with an overview of the Gaps Analysis process and purpose by DHS division leadership, and a brief presentation by Wilder Research of data on demographic characteristics of the region's population, service utilization by the region's residents, and the 2013-14 Gaps Analysis. The remainder of the meeting consisted of three facilitated activities that helped participants to:

- Prioritize what they identified as service gaps for all persons who need services in the region
- Brainstorm solutions to service gaps identified as a priority

- Develop action plans to implement the most promising solutions

3. Reporting plan

Summaries of the incredible discussions that happened at each meeting are being developed and shared with participants and stakeholders. All regional meeting summaries will be available on the Gaps Analysis website[36] this fall. A final report will be written and posted to the Gaps Analysis website as well.

C. Preliminary findings

This section presents preliminary findings from the first nine regional meetings. These nine meetings reflect all of the meetings held in greater Minnesota. A comprehensive analysis of all 11 meetings, including the final two meetings in the Metro region, will be reported in a final summary of the 2015-16 Gaps Analysis. We encourage readers to review the final report upon its release for a comprehensive and detailed description of the complete findings.

1. Service gaps prioritized by regional meeting participants

During each regional meeting, a series of facilitated small-group activities helped participants identify a set of three prioritized service gaps for each of the four populations of interest: adults with mental health conditions, children with mental health conditions, older adults, and persons with disabilities. In lieu of service gaps, per se, some groups identified features of the service system that led to service gaps, such as workforce shortages, issues with transportation, or challenges related to regulations or licensing requirements. Throughout this section, we simply refer to all of these as "service gaps." Figure VII-II presents the frequencies at which service gaps by population area were identified as a priority by Greater Minnesota meeting participants.

Figure VII-II. Service gaps by population identified as a priority

Service gap for adults with mental health conditions	Frequency (out of 9)	Service gap for children with mental health conditions	Frequency (out of 9)
Housing	6	Workforce	6
Transportation	5	Crisis stabilization	4
Workforce	3	Residential treatment	3*
Psychiatrists/psychiatric prescribers/medication management	3	Transportation	3

[36] For more information see mn.gov/dhs/gaps-analysis

Service gap for older adults	Frequency (out of 9)	Service gap for persons with disabilities	Frequency (out of 9)
Transportation	8	Workforce	8
Workforce	6	Transportation	5

* Three regions prioritized residential treatment; one of these regions prioritized two forms of residential treatment.

Other service gaps identified as a priority by participants in at least one Greater Minnesota meeting included:

- For children with mental health conditions: Inpatient psychiatry beds (2 regions); Services for complex needs/multiple diagnoses (2); Chemical dependency/recovery support and services; Community-based resources/supports; Community Support Planner; Family/caregiver education and support; Peer support services; Services in jail/correctional settings and at transitions; and Supported employment.
- For adults with mental health conditions: Psychiatrists/psychiatric prescribers/medication management (2); Out-of-home placements (not residential treatment) (2); Day treatment; General access to services/evaluations/case management; Community-based resources/supports or Community Support Planner; Chemical dependency/recovery support and services; In-home services, home health, home health care; and Trauma training/support or trauma-informed services.
- For older adults: Respite care (2); Companion or homemaker services (2); Personal Care Assistant (2); Chore services; Crisis stabilization; Family/caregiver education and support; General access to services/evaluations/case management; Housing; Nutrition; and Regulations, licensing issues/challenges/barriers
- For persons with disabilities: Crisis services (2); Employment/employment supports (2); Funding/reimbursement rates; Foster care; and Subacute level care

A few common themes for one or more population group arise from the gaps identified as a priority at the nine greater Minnesota regional meetings.

The **Workforce** shortage is highlighted as a key issue for all persons who need services. This was the most common priority identified for children with mental health conditions and persons with disabilities, and the second most common priority identified for older adults (6 of 9 regions identified it for each population group). It also was identified by three Greater Minnesota meetings for adults with mental health conditions. Across meetings, some groups identified specific nuances of the workforce shortage

that they were specifically struggling with, such as recruitment or retention. Some of this additional detail will be discussed further in the final report.

Housing was also identified as a priority across multiple populations. It was the most common priority identified for adults with mental health conditions (6 of 9 regions identified it), and was also identified by participants as a priority in three Greater Minnesota meetings for people with disabilities and in one meeting for older adults. The housing category comprises all types of housing and includes housing with support services or supportive housing.

Transportation stood out as a common priority across the Greater Minnesota meetings for older adults (8 of 9 regions identified it). It also was the second most common priority for adults with mental health conditions and persons with disabilities, and the fourth most common for children with mental health conditions. The transportation category includes both medical and non-medical transportation.

Although not identified as frequently as workforce, housing, and transportation, several other service gaps were prioritized by multiple regions. At least four regions identified the following service gaps as a priority for a given population group:

- **Crisis stabilization** (children with mental health conditions)
- **Residential treatment** (children with mental health conditions)
- **Respite care** (persons with disabilities)

2. Gaps selected for solution development

During each regional meeting, participants voted on the service gaps identified as a priority to determine which ones would be the focus of subsequent activities related to solution development and action planning. The voting process resulted in a set of four to six service gaps, spanning all four populations, for which small groups worked to brainstorm solutions. Figure VII-III lists the service gaps selected for solution development by at least three greater Minnesota meetings. (Note that in the prioritization process, related gaps could be combined, so the list below includes some combined service gaps not listed above.)

Figure VII-III. Service gaps selected for solution development by at least 3 greater Minnesota meetings

Service gap	Frequency (out of 9)
Workforce	8
Transportation	8
Crisis stabilization	5
Housing	4

Service gap	Frequency (out of 9)
Psychiatrists/psychiatric prescribers/medication management	3
Respite care	3

Other service gaps selected for solution development by at least one greater Minnesota meeting included: Out-of-home placements (not residential treatment) (2 regions); Chemical dependency/recovery support and services; Children's residential treatment; Geriatric mental and behavioral health services; In-home services, home health, home health care; Inpatient psychiatric; beds; Nutrition; Regulations, Licensing issues/challenges/barriers; Services for complex needs/multiple diagnoses; Subacute level care; and Trauma training/support or trauma-informed services.

In eight of the nine Greater Minnesota meetings, participants selected the **workforce** shortage and **transportation** issues as key service gaps around which the groups worked to develop solutions. Multiple groups also brainstormed solutions around shortages in crisis stabilization, housing, psychiatrists/prescribers/medication management, respite care, and out-of-home placements.

3. Solutions selected for action planning

After the small groups brainstormed solutions to their selected service gaps, they were asked to identify the two most promising solutions from their list. This resulted in eight to twelve preferred solutions across the four to six service gaps for each meeting. Then, using a "walking caucus" approach, participants were asked to line up in front of the solution they most wanted to work on. This process was used to identify approximately four to six solutions for the region around which to develop action plans for implementation. Forty-eight action plans were developed across the nine greater Minnesota meetings.

The solutions chosen for action planning were coded to identify common features. Figure VII-IV lists the features of the solutions that came up at least three times in the nine Greater Minnesota meetings.

Figure VII-IV. Features of solutions selected for action planning

Solution feature	Frequency (out of 48)
Make existing services go further by pooling/sharing (regionally or another scale)	8
Increase/implement reimbursement rate/higher wages	5
Change structure/rules of reimbursement rates/payment	4

Solution feature	Frequency (out of 48)
More beds/out-of-home placements	4
Lessen (or increase flexibility of) rules/regulations/barriers (general; not specific to provider enrollment or reimbursement)	3
Other incentives (e.g., loan forgiveness, college/school credit for work in field)	3
New service type or model	3
Write legislative proposal/draft legislation/review or change legislation	3
Increase awareness/educate/inform public	3
Improve coordination across/communication among services across providers	3
Recruit/identify more workers/providers; advertise; increase number of workers/providers	3
Access/recruit *non-traditional* workforce (e.g., retirees, volunteers)	3

Across all the action planning solutions, the most common feature was to **make existing services go further by pooling or sharing resources**. This was a feature in eight of the 48 action planning solutions. Additionally, multiple solutions involved changes to the reimbursement system to either increase or implement reimbursement rates (sometimes noted as increasing wages) for service providers (included in five solutions) and changing the structure and rules for reimbursement or payment (included in four solutions).

Workforce and transportation shortages were the most common service gaps selected for solution development (8 of 9 selecting). Figure VII-V A and B list common features of solutions for these two service gaps. Features are only listed if they came up two or more times.

Figure VII-V A. Common features of solutions for Workforce shortages

Feature	Frequency (out of 8)
Other (non-wage) incentives (e.g. loan forgiveness, college/school credit for work in field)	3

Feature	Frequency (out of 8)
Increase/implement reimbursement rate/higher wages	3
Collaborate with education institutions to recruit/train	2
Recruit/identify more workers/providers; advertise; increase number of workers/providers	2
Professionalize the field/increase appeal of jobs	2

Figure VII-V B. Common features of solutions for Transportation shortages

Feature	Frequency (out of 8)
Change structure/rules of reimbursement rates/payment	3
Make existing services go further by pooling/sharing (regionally or another scale)	3
Lessen (or increase flexibility of) rules/regulations/barriers (general; not specific to provider enrollment or reimbursement)	2
New service type or model	2

For the workforce shortage, implementing or increasing reimbursement rates or increasing wages as well as offering other incentives were featured in three solutions. For the transportation shortage, changing the structure or rules to reimbursement or payment and making existing resources go further by pooling or sharing were featured in three solutions.

4. Feedback on the process from regional meeting participants

At the conclusion of each meeting, participants were invited to complete a brief post-meeting questionnaire. Overwhelmingly, participants indicated they not only felt the time they had spent was worthwhile (93%, N=255), but also indicated that they were committed to the action plan (96%, N=257). Most also indicated they were confident action plans developed would help to solve a service gap in their region (77%, N=248). Of those who participated in the past Gaps Analysis study, 94% (N=143) felt it a good idea to alternate between collecting data via a survey and holding regional meetings to plan actions.

D. Next steps

DHS plans to hold additional meetings with stakeholders, specifically persons who use services, their families and advocates. The Department has also consulted with tribal health directors about how best to gather input from tribes and they have recommended holding two separate meetings, one with the Ojibwe tribal nations and one with the Dakota tribal nations.

DHS is committed to continuing to work with action planning groups to digest the information collected through the Gaps Analysis study and identify ways to support their actions steps. For example, in the past the Gaps Analysis study results were used to guide grant funding and the development of specific training efforts. The results from these regional meetings will likely be used in a similar way.

The Department will check in with the action planning groups as well as various stakeholder groups (such as the County State Work Group, one or more Managed Care Organization workgroups, Tribal Health directors, and the HCBS Partners Panel) when the final report is completed this fall and again in 2018 as planning begins for the next Gaps Analysis study.

VIII. What We Have Learned

This section describes the major changes DHS and the State of Minnesota are experiencing and the pressures that must be addressed in effectively supporting well-being for everyone. These changes include:

- Diversity
- Aging and longevity
- Workforce shortage
- Barriers to accessing services
- Crisis services

A. Diversity

Minnesota's population is becoming more diverse. The state benefits greatly from a wide variety of backgrounds, cultures, and ideas; however, the long-term services and supports system is not adequately equipped to respond to the growing diversity of the population. DHS must include people from different cultures and backgrounds in developing the service delivery system to ensure their unique needs are met. The NCI-AD Survey looked at service-related and health outcomes for different race and ethnic groups. The survey found that Black and Hispanic/Latino older adults were less likely than whites to report that services met their needs. Hispanic/Latino older adults were more likely than whites to use some preventive care services such as dental visits, hearing exams, vision exam, flu shots, and access to primary care physicians. Among people with physical disabilities, Black and Asian adults were most disadvantaged in terms of self-rated health, physical function, and negative mood. Black adults with physical disabilities were less likely than whites to report that services meet their needs.

B. Aging and longevity

Increases in longevity mean people are needing services for longer periods of time and have more complex needs when they do need services. People with disabilities and some chronic conditions are also living longer, and often experiencing age-related health conditions at an earlier age.

An increase in the number of older adults could mean more people need services. The Minnesota State Demographic Center's Demographic Considerations for Long-Range & Strategic Planning Report[37] states

> Population aging is not just a short-term phenomenon to be weathered; rather, we are beginning a shift toward an older society that will be the reality for Minnesota well into the foreseeable

[37] Report available online at mn.gov/admin/assets/demographic-considerations-planning-for-mn-leaders-msdc-march2016_tcm36-219453.pdf

future. Thus, the demographically driven budget pressures that will play out over the next 15 to 30 years will require a permanent budget response, one that realigns with Minnesota's new age structure.

C. Workforce shortage

Minnesota, along with the rest of the country, is facing a workforce shortage. It is getting more difficult to fill direct service positions. Minnesota's relatively low unemployment rate and high demand for labor result in industries competing for workers. Some jobs are going unfilled, and employers will need to continue creative ways to be able to hire and retain workers. Potential employees can be selective, employers are adopting productivity-enhancing approaches to work, and the combination is putting extreme pressure on compensation to increase. With largely part-time work and low median wages, it is especially difficult to fill and retain direct care and support workers.[38]

The National Core Indicators Staff Stability Survey (a point-in-time survey conducted in December 2015) found that seven percent of full time and 13 percent of part time positions in direct care/support were vacant (compared to a rate of 3.6% for all occupations for the 4th quarter of 2015[39]). In addition, the turnover rate in Minnesota for direct care/support positions was 36 percent.[40] These measures confirm difficulties hiring and keeping people in direct care/support jobs.

D. Barriers to accessing services

Other barriers to accessing services have pressured the system for quite some time. In rural areas, the lack of availability of general service providers and specialty providers such as psychiatric prescribers and geriatricians creates difficulties for people in need of those services. Transportation is a problem for many people needing services. Housing, especially affordable housing, is another big need. The number of households that are cost burdened by their housing payment (spend more than 30 percent of their income on housing) increased by 63 percent between 2000 and 2015. Over half of lower-income households (income less than $50,000) are cost burdened. Service users must meet income eligibility requirements and are assumed to be lower-income households. This implies that many of the people DHS serves spend more than 30 percent of their income on housing. Most older adults, even those with low incomes, are home owners now, but in 15 to 25 years we expect them to transition to rental housing.

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[38] For more information see mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/aging/direct-care/ and the Direct Care/Support Workforce Summit Report at edocs.dhs.state.mn.us/lfserver/Public/DHS-7271A-ENG

[39] "Minnesota's Direct Care/Support Workforce", PowerPoint, May 24 2016, Minnesota Department of Employment and Economic Development.

[40] For more information see www.nationalcoreindicators.org/upload/core-indicators/2015_Staff_Stability_Survey_Report_V22.pdf

So right now we need to focus on home modifications and HCBS, but in the future we need more affordable rental options with services available.[41]

E. Crisis services

When someone who receives services is at risk of losing their placement in a residential program or their ability to remain in their home, the situation becomes a crisis. The system must act quickly and efficiently to best serve that person. To help streamline the process, DHS is implementing an intake system called the "single point of entry." It acts as a central system to accept and triage requests for crisis services for people with developmental or intellectual disabilities who have lost or are at immediate risk of losing their residential placement. Currently, DHS is working to expand this service to enable any person with a disability who has lost residential services to access the single point of entry system.

[41] For more information see the Minnesota Housing Finance Agency's 2017 Key Trends for Affordable Housing at www.mnhousing.gov/wcs/Satellite?c=Page&cid=1358904870907&pagename=External%2FPage%2FEXTStandardLayout

IX. Report Recommendations

Action planning from the Gaps Analysis process is just the beginning of a new and more comprehensive process. The first part of the effort is focused on identifying the gaps, through surveys and regional meetings, and the next two years will be focused on action planning and implementation. This allows regions and the state as a whole to more fully digest the results of the surveys and meetings and work together to take steps toward addressing the identified gaps. DHS will engage with stakeholders including counties, regions, tribal nations, providers, people using services and their families to move these action plans forward.

Key issues identified through action planning and other analysis for this report that warrant further action to address include:

- Address workforce and provider shortages
    - Develop strategies for employment of people with disabilities as part of the solution
    - Increase flexibility to retain older workers
    - Identify practices that will help employers better match people to the work
    - Use Innovation and Live Well at Home grant funding to solicit and test ideas along with promising practices for hiring and retaining staff
    - Explore strategies from the 2016 Workforce Summit including further rate and pay changes that increase income for direct support workers
    - Continue roll-out of the Direct Support Registry to make it easier to connect people who need direct support with direct support workers
- Address barriers to accessing services
    - Continue engaging stakeholders in identifying and developing solutions to barriers
- Address the shortage of affordable housing, especially housing with support services
    - Promote and further develop services that help people find and maintain housing
    - Continue to work across agencies to make affordable, accessible housing options available
- Address transportation difficulties
    - Continue working across agencies and regions to develop innovative options with a regional or cross-county approach to transportation issues
    - Explore and address rate and reimbursement policies to support cost effective transportation options
    - Support Innovation and Live Well at Home grant funding for pilot programs to try new approaches in transportation services
- Continue working to support people to make meaningful choices about the services and supports they receive

- Include people from different cultures in developing and evaluating our service delivery system to ensure their unique needs are met and services are provided in a culturally sensitive manner.

X. Appendices

A. Corporate Foster Care Annual Needs Determination Report

1. Background and Introduction

Minnesota Statute 245A.03, Subd. 7 (e) requires the commissioner to conduct an annual resource needs determination review for corporate foster care. DHS has incorporated the 2017 Corporate Foster Care Needs Determination report into the LTSS report as an appendix.

A corporate foster care setting is defined as a licensed foster care setting in which the license holder does not reside. A community residential setting is defined as a licensed foster care setting in which the license holder does not reside and all people who live in the setting are on the same disability waiver. These settings typically use a shift-staff model of support. For this report, we will use the term "corporate foster care" to refer to both settings.

There is a licensing moratorium on the development of new corporate foster care beds. The statewide baseline set July 1st, 2013 by state law is 13,700 corporate adult and child foster care beds. The DHS Disability Services Division (DSD) manages and tracks changes in capacity in relation to the 13,700 bed cap. DSD works with the DHS licensing, mental health and housing divisions to manage statewide resources and capacity.

Exceptions to the moratorium do not count towards the statewide corporate foster care capacity. These license exceptions are:

- For people who require hospital level of care;
- For settings that require Chapter 144D housing with services registration;
- For people needing new corporate foster care development due to the closure of a nursing facility, ICF/DD, regional treatment center or due to restructuring of state-operated facilities; and
- For people who no longer require the level of care provided by state-operated facilities, namely Minnesota State Security Hospital or Anoka Regional Treatment Center.

This report includes information and data on the corporate foster care capacity of the state. It also covers DHS's key activities during the past year. Current legislative changes and recommendations for future action conclude the report.

2. Information and Data on Corporate Foster Care Capacity

This section will discuss the current corporate foster care capacity, including the number of beds by region and the number of exceptions in this fiscal year and the last fiscal year.

a) *Current Statewide Capacity*

As of June 30th 2017, there were a total of 13,808 licensed corporate foster care beds in Minnesota. This total represents a 110 bed (0.8%) increase over FY2016. The increase in FY2017 is due to 136 people moving into corporate foster care through exceptions to the moratorium, primarily due to people moving from ICFs/DD. When exceptions are removed, the capacity count declined by 0.19% in FY2017 and remains within the maximum allowed under the moratorium.

The 136 exceptions in FY2017 represents a significant increase from the 22 that occurred in FY2016. We expect a similar or increased number of exceptions in FY2018 due to closure of more ICF/DD institutions.

b) *Capacity by Region*

Four regions had a decrease in licensed corporate foster beds while eight regions had an increase. Both decreases and increases in beds were minimal, ranging from -2.57% to 3.33%. The number of licensed corporate foster care beds for FY2016 and FY2017 is broken down by region (Table 1).

Table 1. Current # of DHS licensed beds – SFY 2016 and SFY 2017 by region

Region #[42]	Region Name	Largest County	SFY 2016[43] Licensed Bed Count	SFY 2017[44] Licensed Bed Count	% Difference
1	Northwest Corner	Polk	238	237	-0.42%
2	North Central	Beltrami	259	258	-0.39%
3	Northeast Corner	St. Louis	1,548	1560	0.78%
4	North West	Clay	935	911	-2.57%
5	Central	Crow Wing	582	597	2.58%
6	West	Kandiyohi	817	828	1.35%
7E	Central East	Chisago	511	528	3.33%
7W	Central West	Stearns	868	866	-0.23%

[42] These regions are the regional resource specialist areas. See referenced map for the regions' boundaries.

[43] Licensed bed count was calculated on last day of State Fiscal Year 2016.

[44] Licensed bed count was calculated on last day of State Fiscal Year 2017.

Region #[42]	Region Name	Largest County	SFY 2016[43] Licensed Bed Count	SFY 2017[44] Licensed Bed Count	% Difference
8	Southwest Corner	Lyon	442	448	1.36%
9	South Central	Blue Earth	951	951	0.00%
10	Southeast Corner	Olmsted	1,493	1529	2.41%
11	Metro	Hennepin	5,050	5095	0.89%
	Other	adj/unknown	4	0	
Totals			**13,698**	**13,808**	**0.80%**
Approved Exceptions			**FY2016: 22** **Cumulative: 186**	**FY2017: 136** **Cumulative: 322**	
Moratorium Capacity Count[45]			**13,512**	**13,486**	**-0.19%**

3. Key Activities during Fiscal Year 2017

During the past year, DHS successfully worked on the following key activities to improve the corporate foster care service delivery system, including managing the moratorium and grants, making progress on Olmstead goals, implementing person-centered practices, and improving two waiver services.

a) *Managing the Moratorium*

DHS approved requests to the extent the moratorium allowed while maintaining the capacity to approve requests that are critical to people's health and safety. DHS prioritized requests for individuals with complex needs, such as urgent health and safety needs, who were unable to remain in their current setting and could not be served within the current corporate foster care capacity of the county/region. An

[45] The moratorium capacity count is calculated by subtracting the cumulative approved exceptions from the number of licensed beds.

example of an urgent health and safety need is when a provider demits[46] a person from a residential setting and that individual does not have options for another home.

b) *Grantees Make Progress to Develop Alternatives to Corporate Foster Care*

State FY 2017 marks the fourth year of renewable lead agency grant contracts (awarded by DHS) to develop alternatives to corporate foster care. The current four grantees are:

- Brown-Blue Earth-Nicollet counties;
- Stearns County;
- Washington County; and
- Anoka-Dakota-Hennepin-Ramsey counties.

From July 1st 2016 to March 31st 2017, the grant has helped 84 people move out of corporate foster care.

c) *Housing Access Services Grant Program*

The Housing Access Services Grant program helps people with disabilities move to homes of their own; not owned, leased or controlled by a Medicaid services provider. From July 2009 through March, 2017 (our most recent data), the program has helped 1,872 persons. This program has helped reduce demand for potential moves into corporate foster care. The success of this continuing grant program contributed to the expansion of the Medicaid waiver service Housing Access Coordination (see "Changes to Waiver Services" section).

d) *Technology for Home Grant Program*

Technology for Home offers at home, in person assistive technology (AT) consultation and technical assistance to help people with disabilities live more independently. Expert consultants work in teams to provide cost effective solutions and communicate with the county to develop a plan for people who receive home care or home and community based waiver services. They:

- Consult with eligible people in their own homes, workplaces, or public locations;
- Connect people to resources that will help them live in their own homes;
- Conduct follow up to ensure effective training, set up and installation; and
- Serve on the person's team to develop a plan to assure that AT goals have been met.

Between March 2015 and March 2017, the Technology for Home program provided 9147 instances of service to help individuals with their assistive technology needs.

[46] Demit is a term that refers to service termination, a situation in which the provider gives notice to terminate residential services for an individual.

e) *Minnesota's Olmstead Plan*

The vision of Minnesota's Olmstead Plan is people with disabilities living, learning, working and enjoying life in integrated settings. The Plan runs from 2015 – 2020 and reaches across eight state agencies. There are thirteen topics addressed in the Plan, including person-centered planning, transition services and housing and services.

As directed by the Plan, DHS established new standards and tools for assessment and planning. These mandate lead agencies to support people to have the opportunity to explore, understand and develop options for where they live; to be asked where and how they want to live; and to be able to make informed choices. DHS is providing training and building training capacity throughout the state for people to develop person-centered practice skills.

DHS created new tools and practices for data collection. This enables us to know what individuals choose and to track the system's progress in supporting people in integrated settings of their choice. Data will show the demand for various forms of housing, including corporate foster care.

In accordance with the Plan, DHS is creating new services and policies that provide more flexibility and increased opportunity for living in one's own home. Examples include the Person-Centered, Informed Choice and Transition Protocol; Assistive Technology additions to the Olmstead plan; and updates to the Housing Benefits 101 website resource.

f) *Implementation of Person-Centered, Informed Choice and Transition Protocol*

Since March 2016, lead agencies have been required to adhere to person-centered standards for support planning, laid out in the Person-Centered, Informed Choice, Transition Protocol. DHS has provided training and technical assistance to lead agencies as they incorporate the protocol into their processes and practices. Beginning in January 2018, DHS will monitor lead agency compliance to the protocol and require remediation and corrective action when plans don't meet key criteria. Central to the protocol is assurance that people have the opportunity to make informed choices, as well as the opportunity to explore and develop options.

g) *Changes to Waiver Services*

In FY2017, there were two notable changes to disability waiver services relative to helping people access housing and obtain support to live in their own homes.

(1) Housing Access Coordination

Changes to the housing access coordination (HAC) waiver service launched July 1, 2016. This service is now available under all of the disability waivers.

HAC helps people plan for, find and move to homes of their own that are not owned, leased or controlled by disability services providers. A provider is reimbursed for actual time spent helping a person get housing.

(2) New Waiver Service: Individualized Home Supports

DHS received approval of a waiver amendment in the spring of 2017 for individualized home supports. These supports are expected to be available in late calendar year 2017.

Individualized home supports is a new waiver service DSD developed to support people in their own homes. Individualized home supports (IHS) are designed to support a person in his or her own home and within his or her community holistically by providing support (e.g. supervision, cuing) and training in four broad community living service areas. With multiple service-delivery methods, IHS increases a person's choices and options of how and where services are delivered to meet his or her service needs. To support community access, an IHS service provider cannot have any financial interest in the property or housing in which services are delivered. This service is available to people who are on the Brain Injury (BI), Community Alternative Care (CAC) and Community Access for Disability Inclusion (CADI) waivers.

h) *Legislative Changes*

The 2017 Minnesota Legislature acted upon previous recommendations by passing law that will accomplish the following:

- Create an exception to the moratorium on foster care for people transitioning from the residential care waiver to foster care services;
- Create an exception to the moratorium on foster care for people residing in an unlicensed site for which a license is required;
- Clarify the DHS Commissioner's authority to close or relocate foster care beds in order to address the needs determination findings;
- Expand income supports to help people move out of group settings and afford housing in the community; and
- Grant authority to establish two new Medical Assistance benefits: Housing Transition Services to help people find an obtain housing, and Tenancy Support Services to help people maintain housing stability.

4. Conclusions

In FY2017, DHS increased the number of corporate foster care beds primarily to meet the needs of people living in ICF/DD facilities that were closing. Other approvals were for individuals with complex behavioral and/or medical needs who could not remain in their current setting.

DHS's ability to manage within the moratorium depends on the number of people with complex needs who require new corporate foster care capacity and upon the potential for reducing licensed capacity as people are able to move into their own home.

B. Nursing Homes

As this report demonstrates, Minnesota has made strides to "rebalance" its LTSS from institution-based to a greater emphasis on home-and community based models. Multiple policy initiatives over the past 30 years have contributed to this shift in focus.[47] However successful these strategies, 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.

1. Nursing Home Quality

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 believes that it 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.

a) *The Nursing Home Report Card*

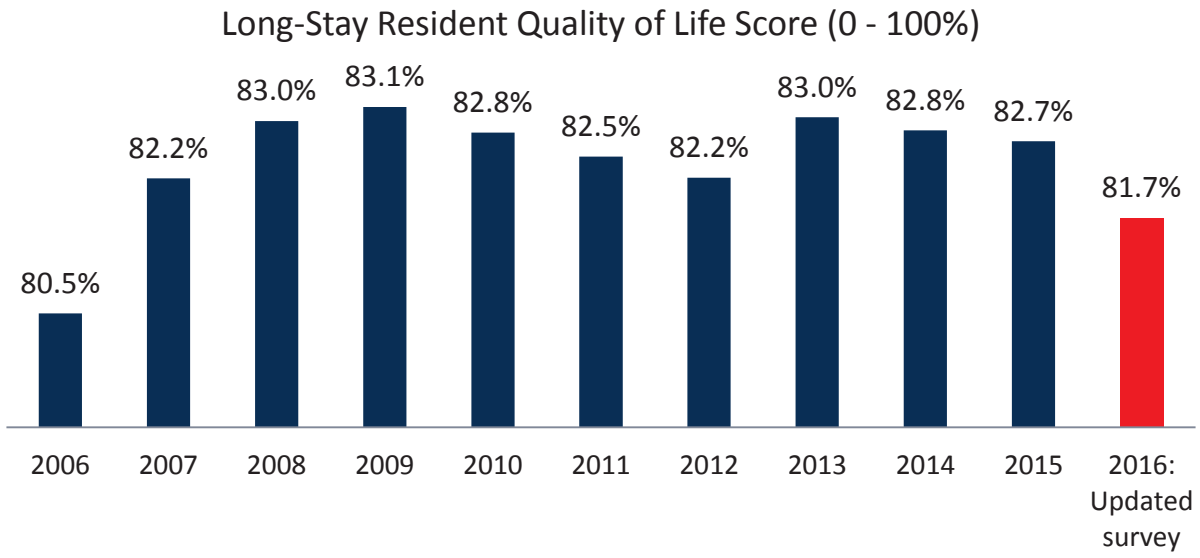
Since 2006, MDH and DHS have collaborated to publish the Minnesota Nursing Home Report Card (http://nhreportcard.dhs.mn.gov/). It is interactive, allowing users to view quality and cost information for a specific nursing home, or, alternatively, to specify a location they are interested in and to select 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 on eight measures, and it sorts the facility list according to 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.

[47] Rebalancing programs and strategies during this time: (a) Moratorium on new licensure and 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 home consolidation; (k) Return to Community Program; (l) Nursing home level of care; (m) Essential Community Supports; (n) Moving Home Minnesota Program; (o) Olmstead planning; and (p) Nursing home quality payments focusing on transitions.

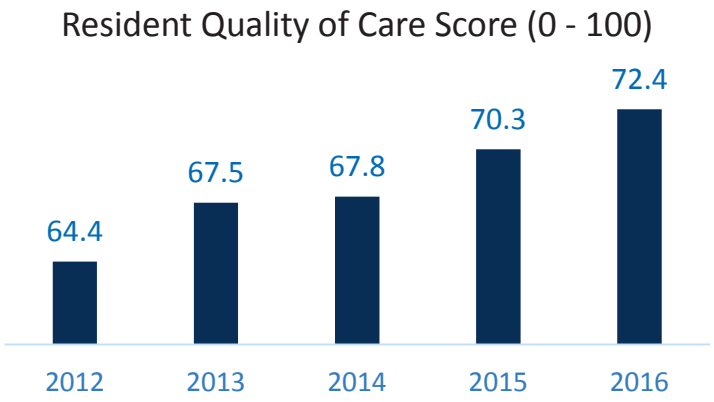
b) *Quality Trends*

The Report Card shows the user quality trends for their selected nursing facilities. This section highlights trends for three key quality measures: resident quality of life, clinical quality of care and MDH inspections.

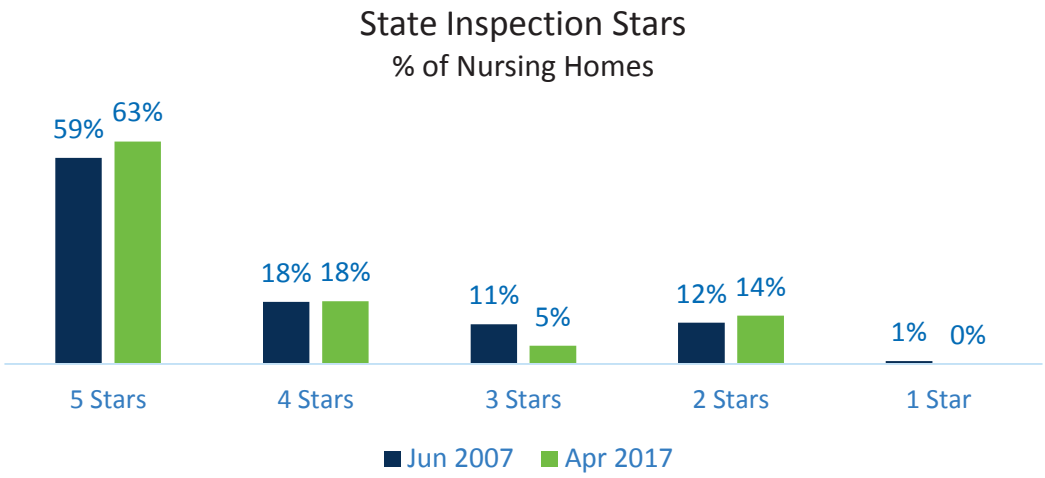
DHS contracts with a survey firm to interview a random sample of residents in every Medical Assistance-certified facility in the state. Resident quality of life has gradually risen and fallen over the past ten years, improving 0.3% on average with high points in 2009 and 2013. In 2016, DHS updated its survey to better reflect life in nursing homes today. DHS also launched a short-stay experience survey in 2016.



To assess quality of care, DHS uses resident assessment information completed by nursing home staff and audited by MDH. Since an updated assessment was introduced in 2011, quality of care has steadily improved by 3% on average each year. The quality of care includes 21 processes and outcomes that are risk-adjusted to allow fair comparison of facilities.



Finally, the MDH inspection quality measure looks at current inspections, past inspections, complaint inspections, and special focus by Federal regulators. Four percent more nursing homes earn five stars today compared to 2007. However, 2% more homes earn two stars, suggesting inspection findings are moving slightly toward each end of the range.



c) *Pay for Performance*

Alongside regulating quality and reporting quality information to the public, DHS offers nursing homes two major pay for performance opportunities.

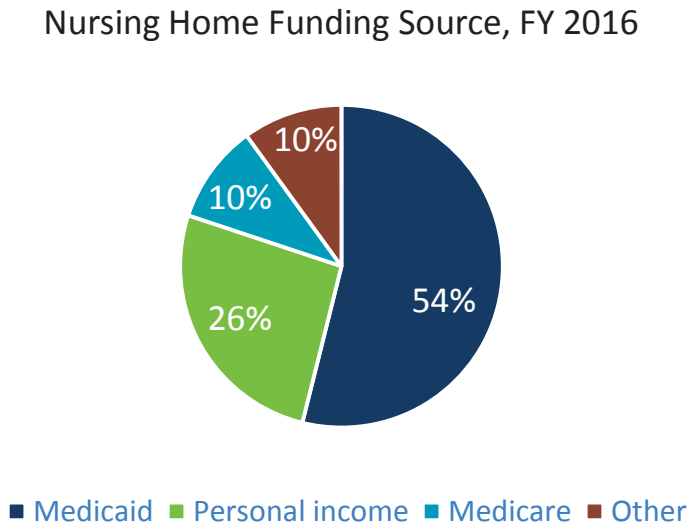
In 2007 DHS opened the Performance-based Incentive Payment Program (PIPP) to interested nursing homes. PIPP is a voluntary competitive program designed to reward innovative projects that improve quality or efficiency or contribute to rebalancing long-term services and supports (LTSS). Selected projects receive temporary payment rate increases of up to 5%. Of the money rewarded, 80% is contingent on carrying out the project. The remaining 20% is contingent on achieving specific outcomes. At the time of this writing, almost three-fourths of Minnesota nursing facilities have participated in the program, representing 252 different quality improvement projects.

In 2013 DHS began offering the Quality Improvement Incentive Payment (QIIP) program. QIIP is a voluntary non-competitive program that recognizes and provides financial reward for meaningful levels of nursing home 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 their quality measure of interest. DHS may add rebalancing measures, such as community discharge rates, to the program in the future.

2. Nursing Home Payments and Costs

Approximately $2 billion is spent annually on nursing home care in Minnesota. This includes state and federal dollars as well as private pay and funds from other sources. Medicaid pays for over half; personal income pays for a quarter; and Medicare and other sources each pay for a tenth.

In 2016, Medicaid spending on Minnesota nursing homes equaled $909 million. This total includes recipient cost-sharing and managed care, which plays an important role in funding nursing home stays.



The average charge for facility care is $226 per day[48]. Daily charges are higher or lower depending on one's particular nursing and clinical needs.

3. Nursing Home Industry Size

This section of the report addresses the question: "Will Minnesota soon experience a shortage of nursing home beds, and specifically, is the moratorium on adding new beds still needed?"

Number of Facilities and Beds. As of June 2017, Minnesota had 381 licensed nursing homes and licensed and certified boarding care homes with a total of 29,604 beds in active service. Of these, 368 facilities and 28,770 beds were certified to participate in the Medicaid program.

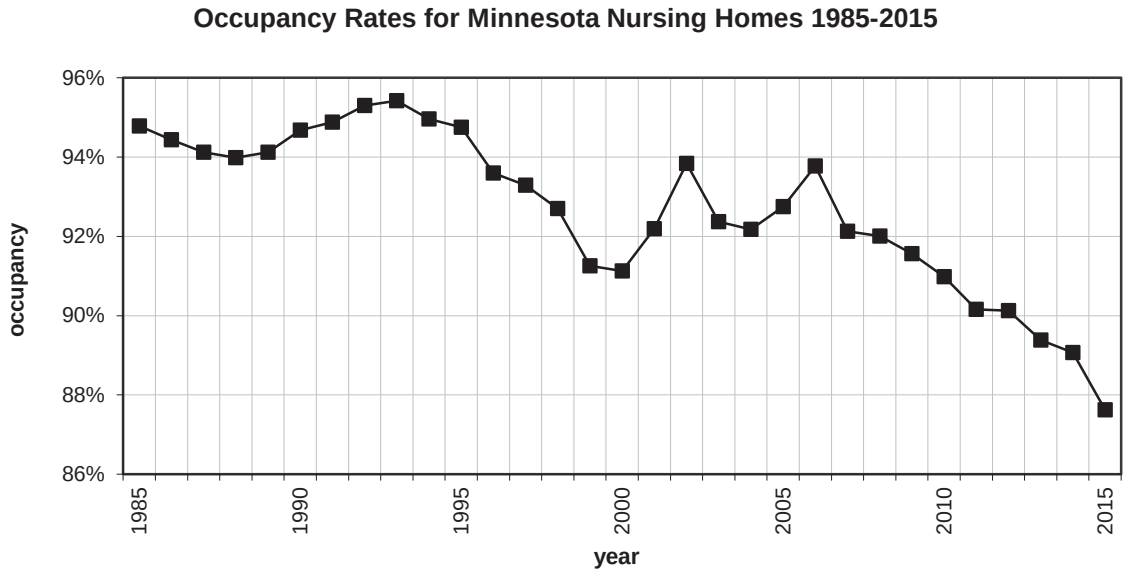
The number of nursing homes and licensed beds has been declining since 1987, when the number of facilities and beds in Minnesota peaked at 468 facilities with 48,307 beds. By June 2017, 87 facilities had closed altogether (net of new facilities opened) and 16,314 beds had been completely delicensed. An additional 2,389 beds were out of active service, in layaway status. The supply of active beds has declined by 39% in the last 30 years. In the last three years, the bed supply has declined by 1,275 beds or 4%.

Beds per 1,000 Elderly. Thirty years ago, Minnesota's rate of nursing home beds for people age 65+ was almost twice the national average. However, Minnesota's rate has sharply declined since then, particularly for people age 85+. In 2014, the most recent year with national data available, Minnesota's

[48] In the first year of the new Value-Based Reimbursement (VBR) payment system, daily charges rose by about 20% on average.

beds per 1000 age 65+ was only 8% above the U.S. average. The state's rate for those 85+ was 4% below the U.S. average.

Occupancy. Occupancy is 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 87.6% in 2015. 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 1) age-intensity adjusted beds per thousand, 2) out migration between counties to access beds, 3) availability of non-institutional LTSS, 4) declarations of hardship due to insufficient access by local county agencies and area agencies on aging or 5) other relevant factors.

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. However, no new beds have been added to date as a result of this process.

Nursing Facility Utilization. With more Minnesotans over the age of 65 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 the past 30 years. In 1984, the utilization rate for persons aged 65+ was 8.4 %, and by 2015, it had declined to 3.1%—a 63% reduction. The utilization rate for people age 85+ declined even more dramatically, from 36.4% in 1984 to 11.6% in 2013, a 68% 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%
2015	3.1%		11.6%	

In summary, the number of nursing facility beds available in Minnesota has been declining steadily for many years, and the need for beds has declined along with their availability. Occupancy of beds is at an all-time low; rates of utilization of beds by the elderly are declining; and the new hardship provision should address hardship in areas where it may begin to present itself.

The 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.