Wisconsin Association of Homes and Services for the Aging, Inc.

204 South Hamilton Street • Madison, WI 53703 • 608-255-7060 • FAX 608-255-7064 • www.wahsa.org

Long Term Care Reform: WAHSA's Blueprint for Change

1. Retain Nursing Facility Medicaid Base Funding
2. Future Role of Nursing Facilities
3. Increase Nursing Facility Capital Rates
4. "Floating Licenses" & Continuing Care Organizations
5. Private Pay Incentives
6. Divestment Loopholes
7. Bed Buyout and Debt Buy-Down
8. Private Partnerships/Facility Closures
9. Allow Non-County LTC Organizations to Manage Dollars
10. Pay for Quality
11. Eliminate CBRF Size Restrictions
12. Pass-Through for Educational Advancement
13. Regionalization and Augmentation of MA Rates (Supplementation)
14. Chapter 50 Revisions
15. Reorganize and Rename BQA
16. Nursing Facility Respite Care and Crisis Intervention
17. Streamline Case Management
18. Integrate Acute/Primary and LTC
19. Liability Insurance Issues
20. Regional Dental Centers
21. Specialized Equipment & Supplies Grants
22. Technology and Service Delivery Innovation
23. Medicaid RCAC Room and Board Funding
24. Funding Coordination

June 2004

Wisconsin Association of Homes and Services for the Aging, Inc.

204 South Hamilton Street • Madison, WI 53703 • 608-255-7060 • FAX 608-255-7064 • www.wahsa.org

Long Term Care Reform: WAHSA's Blueprint for Change

This document has been prepared in response to a request by Secretary Helene Nelson, Department of Health and Family Services, for WAHSA's ideas on how to achieve long term care reforms over the next five years. It focuses primarily on ways to implement a more rational nursing facility policy, recognizing the realities of continued facility "rightsizing" and the need for more immediate LTC reform. The proposals summarized in this document are largely excerpts from other WAHSA LTC reform documents previously submitted to DHFS and state legislators. The following summarizes the proposals and does not attempt to furnish the reader with the full implementation details associated with each. Instead, this document is intended to facilitate a meaningful and structured dialogue with DHFS, legislators and other parties on how to achieve substantive LTC reforms.

- **Retain Nursing Facility Medicaid Base Funding:** When a nursing facility is closed or elects to downsize (or "rightsize") the Medicaid dollars appropriated for these nursing facilities are not always retained in the Medicaid budget to fund nursing facility care. For example, the pending closures of Kilbourn Care Center and Highland Health Care Center will result in some loss of Medicaid base funding for nursing facilities. WAHSA proposes that nursing facility "savings" be reinvested in nursing facility payments (see below). To do otherwise simply perpetuates the nursing facility funding crisis. At a time when nursing facilities are suffering from unprecedented losses and operational challenges, Medicaid nursing facility funding can no longer be asked to subsidize other elements of the Medicaid program.

WAHSA also proposes that DHFS be authorized to maintain base-level funding for nursing homes. Under this proposal, for Medicaid budgeting purposes, any positive difference between the current year Medicaid base funding for nursing homes and a reestimated nursing home Medicaid base would be invested in nursing home improvement (e.g., rate increases, private room incentives, buyouts, rightsizing, etc.,--See proposals below.) Section 49.45(6v), Wis. Stats., would need to be revised to retain base level funding for nursing homes.

- **Future Role of Nursing Facilities:** WAHSA urges the DHFS to develop long term care policies that recognize the appropriate role of nursing facilities within the care and service delivery continuum. Persons will continue to utilize nursing homes, and to some extent ICFs-MR, for restorative and rehabilitative services, end-of-life care, chronic health care, dementia care, behavioral interventions, mental health services, respite care, developmental disability services. This means that state policies should not create unnecessary barriers for persons to access the care and service options offered by nursing facilities and ICFs-MR. For example, any preadmission screening or case management requirements should not cause delays or restrict access to necessary care/service options (Note: nearly 80% of all nursing home admissions are from hospitals). Advocacy efforts to expand long term care and service options, long supported by WAHSA and its members, should not utilize anti-nursing facility rhetoric. Instead, the DHFS and the provider community should work together to achieve a healthy, affordable and ethical system.

- **Increase Nursing Facility Capital Rates:** Since nearly two-thirds of all nursing facility residents are on Medicaid, the DHFS should help nursing facilities modernize their physical environments. If Medicaid dollars are not available to help fund this transition from 1960s-designed care settings, it is unreasonable to expect facilities (i.e., private payers) to totally assume this financial burden. WAHSA suggests that the DHFS adopt Medicaid reimbursement policies that would:
    1. Freeze a nursing facility's equalized value at its current level if the facility agrees to convert at least 25% of its licensed beds to private rooms.

2. Increase the maximum equalized value to $99,000 per bed for replacement facilities to establish the necessary incentive for organizations to invest in more efficient and consumer-preferred facilities. WAHSA also requests the DHFS to examine ways to reward those facilities that already have converted to private rooms and/or self-financed replacement or major renovation projects.
3. Allow any facility operating savings generated by physical plant update or replacement projects to be retained by the facility.

- **"Floating Licenses" & Continuing Care Organizations:** WAHSA encourages the DHFS to study options under which nursing facilities could be granted "floating licenses." WAHSA acknowledges the federal regulatory barriers to this proposal. However, federal officials have challenged States to become more innovative and visionary in advancing long term care reforms and we believe that these officials would be receptive to this proposal. As envisioned, facilities could provide SNF, RCAC or CBRF services; if a nursing facility resident no longer needed SNF level of care but would prefer to remain at that facility, the license for that particular resident's room should be allowed to "float" to a CBRF or a RCAC license if the room meets the respective physical plant requirements. The public payment rate for an eligible resident would shift correspondingly from SNF care to the lower MA waiver rate. This option, when appropriate and agreed to by the organization, ultimately could lead to the facility's partial conversion/renovation to CBRF/RCAC licensure. The facility should be allowed to retain overall capital payments for the nursing facility even during the "float periods" (See options below). Because not all nursing facilities will have beds available to "float" and still meet their community's skilled care needs, the long term care organization should be authorized to opt in or out of this program option.

- **Private Pay Incentives:** The States of Oregon and Washington are merely two examples of states with budget problems associated with long term care policies that predominantly rely on a publicly-funded system. Recent cutbacks in those states highlight the fiscal pressures caused by broadly defined, entitlement-based long term care systems. The National Conference of State Legislatures' (NCSL) summary of recent budget battles in Oregon is particularly worth noting. The NCSL indicates that Oregon has intensified its focus on promoting personal

responsibility for long term care and personal planning emphasis (See Attachment I). DHFS should shift its LTC reform discussions to place significantly greater emphasis on attracting greater private investment in and payment for long term care services. DHFS should explore strategies to increase the use of medical/LTC savings accounts, reverse mortgages, Roth-type IRAs for LTC and other ways to promote personal responsibility for LTC. As a matter of policy, it is much more preferable to encourage private payment for LTC than to impose strict estate recovery/anti-divestment requirements (See below). Wisconsin officials should aggressively seek Congressional approval of H.R. 1406 which would create long term care partnerships under which individuals who first exhaust coverage of under a state qualified long term care insurance plan may shelter some or all of their assets while qualifying for Medicaid. This program has been implemented with reported success in California, Connecticut, Indiana, and New York. In addition, more private pay dollars could be brought into nursing homes if Medicaid residents were charged a higher rate for private rooms. Currently, Medicaid residents wishing to reside in a private room are charged the difference between a private pay semi-private room and a private pay private room rate. The administrative rule could be amended to allow facilities to charge Medicaid residents in private rooms an added fee. This fee for a Medicaid private room could be limited to no more than the difference between the Medicaid rate and the private pay rate for a private room. This added fee would be paid for either by the resident or their family/guardian.

- **Divestment Loopholes:** The DHFS should advance statutory language to close widely utilized Medicaid divestment strategies (See State of Minnesota's Medicaid proposal submitted to the Centers for Medicare and Medicaid Services). As a matter of policy, it is imperative that these revisions be passed prior to establishing/broadening entitlement for Medicaid-covered LTC options.

- **Bed Buyout and Debt Buy-Down:** The DHFS should use Medicaid savings to buy-out nursing facility beds and/or to reduce nursing facility operating debt. Under the "Buyout" option, DHFS could pay facilities to close or to significantly reduce their licensed bed capacity. By doing this, DHFS could offer meaningful incentives for certain facilities to create more

private resident rooms, while other facilities could be given an affordable exit strategy (i.e., The DHFS also could purchase 100% of a facility's licensed bed capacity) if the facility determines that it is unlikely to have long term financial viability and its service area does not have a bed shortage. These option were first identified in the DHFS' September 18, 1995 LTC concept paper. A variation of these options would be for DHFS to "Buy-down" a facility's operating debt. By doing so, the DHFS could target those facilities with significant capital debt and no real hope of generating the Medicaid funding needed to make their current mortgages affordable. In exchange for debt buy-down, the facility would agree to reduce its bed capacity. Before these options are implemented, it is strongly recommended that the DHFS complete an analysis of nursing home access, utilization and bed availability by region. The State of Minnesota recently completed such an analysis (See Appendix II).

- **Private Partnerships/Facility Closures:** More nursing facility closures are expected over the next several months. In some cases where the DHFS has determined that quality and financial concerns likely will drive closure of a facility, the Department should consider partnerships with private LTC organizations to take over struggling facilities. When the DHFS determines that closure is imminent, private organizations could be offered the following incentives to help manage the resident relocations and related operational expenses {Note: This proposal is not directed at facilities that, while struggling to overcome Medicaid underfunding, are expected to continue operating.}:

    1. A phase-down agreement to ensure that the troubled facility could be operated safely and without incurring additional losses (WAHSA assumes that private LTC organizations could oversee and close a facility more cost-effectively than placing the facility under state receivership and having DHFS manage the closure).

    2. The private LTC organization would not be responsible for any previously issued state regulatory fines/forfeitures issued to the troubled facility.

    3. The licensed beds from the troubled facility would be transferred to the private LTC organization's nursing facility.

4. The LTC organization would be free to use these additional beds in various ways, including: building a new replacement facility, negotiating a phase-down agreement for its nursing facility, or receiving Medicaid waiver funding for assisted living from DHFS. Under one scenario envisioned by WAHSA, the LTC organization's nursing facility could return the beds to DHFS and, under a phase-down agreement, convert its existing nursing facility's semi-private rooms to private rooms and receive an adequate capital rate to fund this conversion.

- **Allow Non-County LTC Organizations to Manage Dollars:** Private entities offering a menu of continuing care options should be permitted to manage publicly funded LTC dollars as a way to appropriately and cost-effectively transition MA clients from high to lower cost care settings. WAHSA has proposed that the DHFS Life Lease legislation (AB 920) be modified to include this option. In addition to counties being able to manage the relocations and associated dollars, other private entities (e.g., not-for-profit LTC organizations offering an array of facility and community-based options)) should be authorized under AB 920 to manage the relocations. These entities should be provided the option of directly managing the relocation and costs for persons wishing to receive services from the LTC organization but outside the organization's nursing facility. {Consider this scenario: A LTC organization may be able to appropriately care for an Alzheimer's nursing home resident in its CBRF dementia program. The resident and her guardian have a well-established positive relationship with the organization and many of its staff. The guardian does not want the resident to be cared for by any other entity and, while pleased with the quality of care and services provided by the organization's nursing facility, is willing to consider relocation only to the organization's CBRF. Under this proposal, the organization could work with the guardian to secure this alternative placement, a placement that would not have been possible if the relocation receiving care/services from another provider.} WAHSA also envisions that similar options could be developed for ICFs-MR to manage care and services for persons with a developmental disability. Additionally, state policies should not create barriers for the establishment of LTC options within continuing care organizations. For example, there should be no restrictions for COP and waiver funding for adult day care or residential options co-located on the campus which includes a nursing facility.

- **Pay for Quality:** DHFS should work with the provider community to investigate strategies to more directly and effectively link payment to quality. WAHSA suggests that the DHFS explore options that increase payments to facilities with: nursing staffing levels in excess of 3.3 hours/resident day (excluding pool help); low staffing turnover or high retention rates; low or no pool help; a high proportion of private resident rooms; and high performance measures (e.g., lower utilization of restraints compared to the national average, or high level of customer satisfaction). Facilities with higher quality could be surveyed less frequently but at least every 15 months, as required under federal law. WAHSA acknowledges that linking payment to quality in long term care presents a series of analytical and systems challenges. Therefore, the association pledges to work in partnership with the DHFS and the University of Wisconsin to accomplish this important work.

- **Eliminate CBRF Size Restrictions:** The DHFS-imposed restrictions {under ss.46.27 (7)(cm), 46.27 (11)(b)6, and 46.277(4)(d)2)} limiting the size of CBRFs as a condition of receiving COP or Medicaid waiver funding should be eliminated. These size limitations should give way to consumer choice and an appropriate recognition of the economies of scale of larger facilities. While some policymakers may prefer the smaller facilities, many consumers actually prefer the community aspects of somewhat larger facilities and the amenities offered by campus-based LTC organizations. Further, the LTC workforce shortage and elderly demographics will challenge LTC delivery models that do not rely on staff serving multiple clients at a single location.

- **Pass-Through for Educational Advancement:** The Medicaid nursing facility reimbursement formula should fully fund LTC career ladders. For example, Medicaid could pay the tuition fees for CNAs to become LPNs or RNs, for LPNs wishing to pursue their RN degree and for RNs to pursue an advanced practice degree, providing these individuals continue to work in LTC. Under this arrangement, federal Medicaid funds would finance 60% of the tuition costs, and Wisconsin would benefit by addressing the well-documented nursing shortage.

Funding and cost-reporting associated with this option should be provided under a separate, cost-based cost center within the nursing home reimbursement formula.

- **Regionalization and Augmentation of MA Rates (Supplementation):** While years of discussions have been held on options to recognize and support regional specialized care/services, to date no state policies have been advanced to formally embrace this concept. Examples of a specialized regional facility would be Trempealeau County Health Care Center and Clark County Health Care Center. To help establish and sustain regional centers, the DHFS should advance, authorize/approve supplementation of Medicaid payments (either by other counties or by the Medicaid program). This could be done by linking Medicaid or county supplemental payments to room and board, non-covered services, or for "bed/service reserve fees." Further, the Medicaid payment system could include an add-on for specialized services in designated care/service facilities.

- **Chapter 50 Revisions:** The DHFS should work to pass 2003 Assembly Bill 842 in the next session of the legislature (or perhaps include this bill in its 2005-07 biennial budget recommendations) and work with provider groups to explore "fit and qualified" provisions. Financially penalizing facilities only serves to further push those facilities towards bankruptcy and does nothing to increase the quality of care and services provided to residents.

- **Reorganize and Rename BQA:** This Bureau should be renamed the Bureau of Quality Improvement-- BQI-- and should be reorganized to better utilize its Provider Regulation & Quality Improvement Section (PRQI). By name ***and*** function, the BQI should adopt a philosophy that the imposition of fines and financial penalties on providers is indicative of failure on the part of the provider ***and*** the regulators. The PRQI staff should advise facilities on how to achieve regulatory compliance and share best practices from other providers.

- **Nursing Facility Respite Care and Crisis Intervention:** The DHFS should encourage nursing facilities to provide short-term respite care for a period not to exceed 13 days. During this time, nursing facilities should be paid by Medicaid to provide respite care

including an evaluation of the client's physical and mental well-being. Respite residents should not be included in the standard nursing facility survey process unless the survey was complaint generated. Similar regulatory polices should be adopted to foster the use of nursing facilities as providers of short-term admissions for crisis intervention services for persons with serious mental health and behavioral challenges. The ICFs-MR also should be viewed by DHFS as available to provide crisis intervention and respite care for persons with a developmental disability.

- **Streamline Case Management:** Family Care enrollees who reside in a nursing facility or assisted living facility are assigned a case manager by the county's care management organization. In some instances, the county case manager performs a redundant service and residents are required to undergo a second battery of assessment questions and procedures. The resident often finds this process both confusing and exhausting. Family Care architects should eliminate redundant assessment and monitoring processes. WAHSA proposes that assessments and case management services for nursing facility residents should be provided by the nursing facility. If the county CMO requests additional assessment and case management services beyond the level typically provided by the nursing facility to non-Family Care residents, the CMO should reimburse the facility for the added costs of these services. Provisions which limit CMO nursing facility reimbursement rates to a facility's Medicaid rate should be amended to require the CMO to establish payments at a level no lower than a facility's Medicaid rate. CMO payments to nursing facilities should be negotiated by the entities and CMO should be authorized to pay facilities for services not included in the Medicaid rate.

- **Integrate Acute/Primary and LTC:** WAHSA urges the DHFS to pursue LTC pilot reforms that integrate acute, primary and long term care. Nursing facilities have proven to offer cost-effective options and reduce both the incidence and cost of hospitalizations (see the Evercare Choice Model at: **www.evercareonline.com/products/choice.html** and also WAHSA's 1997 LTC Visions paper at: **www.wahsa.org/ltc.htm**) Nursing facilities may cost more than home and community-based care, but the research also notes that there are vast differences between these resident-client populations (see CHSRA's October 31, 2003 study).

- **Liability Insurance Issues:** The DHFS and OCI should propose liability caps as a way to lower liability insurance coverage for LTC providers. The cost of liability insurance has skyrocketed in recent years and threatens the future viability of many facility and community-based providers.

- **Regional Dental Centers:** Given the well-documented lack of available dental care for Medicaid clients throughout Wisconsin, the DHFS should authorize the establishment of regional dental centers in or on the campus of LTC organizations. Medicaid could fund a FTE dentist and this practitioner could serve persons from within the organization and the greater community. The LTC organization would be responsible for providing the dental office and related space for the center.

- **Specialized Equipment & Supplies Grants:** As a way to encourage facilities to serve high-cost, specialized populations, the DHFS should offer one-time grants to facilities for the purchase of related equipment or supplies. For example, grants could be used to purchase specialized mattresses, mechanical lifts that accommodate obese residents, or high-cost medical supplies.

- **Technology and Service Delivery Innovation:** The DHFS should review and amend its nursing facility, CBRF and RCAC regulations to allow and promote the use of innovative service and delivery technology. For example, if a regulation requires a physician visit or an RN assessment, when appropriate, this requirement could be met using remote telemedicine technology.

- **Medicaid RCAC Room and Board Funding:** The DHFS should amend its MA waiver to enable funding for room and board in RCACs rather than restricting reimbursement to care/services. This option would help create more affordable RCAC placements by capturing federal Medicaid matching funds.

- **Funding Coordination:** The DHFS should become the lead agency responsible for coordinating the federal and state funding available for seniors, including HUD, food stamps, Medicaid, and drug discounts/cards/purchasing.

WAHSA
June 2004 /11

Attachment I

May 19, 2004

NATIONAL CONFERENCE of STATE LEGISLATURES

OREGON

The top issue for long-term care programs and services in Oregon in 2002 and 2003 was lack of funding as the state grappled with major budget deficits. Still, work continued on developing long-range plans for future services for senior citizens and people with disabilities through the efforts of a task force created in 2001.

The Budget

Oregon voters failed to approve a January 2003 ballot measure that proposed a state income-tax increase to eliminate the state's $482 million deficit. The 2002 legislature had directed the termination of a self-directed support services home and community-based waiver program for people with developmental disabilities if the referendum did not pass. The program was created to respond to the settlement of the *Staley vs. Kitzhaber* lawsuit in December 2000, which called for the state to increase funding for community services for people with developmental disabilities through 2007. The number of people receiving support services was to increase by 4,600 during the agreement's six-year period. In August 2002, the Oregon Advocacy Center warned the state that it would return to court if budget cutbacks caused the state to backtrack on the settlement of the lawsuit.

After the referendum failed, however, the legislature rebalanced the budget in a bill signed by the governor on March 4. That bill restored some of the funds cut or planned to be cut by the Department of Human Services (DHS) through the end of fiscal year 2003. The legislature restored $7.4 million of $11.9 million in planned cuts for the *Staley* settlement. DHS had frozen enrollments on February 1, 2003. Department officials said they anticipated being able to keep the program open through the end of the biennium (June 30) by limiting the growth of new enrollments. In early March, they said they were in negotiations with the *Staley* plaintiffs " ... on possible revisions to the agreement due to the budget crisis."

The outlook for long-term care services remained bleak, however, as budget shortfalls for FY 2003-2005 continued to threaten many programs and services. DHS estimated that major reductions in the governor's proposed budget to programs for people with developmental disabilities included " ... eliminating all non-residential services, impacting 5,500 people who were covered by the *Staley* settlement agreement." The proposed budget also eliminated cost of living adjustments for all long-term care providers, reducing provider reimbursement rates for nursing homes and assisted living facilities, and eliminating the Oregon Project Independence Program.

Planning and Reports

The Governor's Task Force on the Future of Services to Seniors and People with Disabilities, which had been created by executive order on June 30, 2001, issued an initial report in September 2002. The task force was

charged with developing a long-range plan on the future of services to senior citizens and people with disabilities and recommending legislative action and levels of funds needed to implement the plan. ***The task force said all Oregonians, regardless of their incomes, needed to begin taking " ... personal responsibility for making healthy behavior choices and for planning and preparing for ... possible long-term care needs." (Emphasis Added)*** The group identified eight overarching recommendations that required attention and implementation within the next year. The following were among the recommendations.

- Developing measures to determine whether services in various settings achieve outcomes, promote quality of life and are cost-effective.

- Encouraging personal responsibility by educating Oregonians about the need to engage in healthy lifestyles and planning for future long-term needs.

- Providing information and education on long-term care needs, services and planning, including conducting a public action campaign and expanding education of consumers and families about various long-term care options.

- Increasing system capacity by developing the long-term care work force and providing family caregiver supports.

- Maintaining a safety net for those who cannot afford to pay for their care.

Source: http://www.ncsl.org/programs/health/forum/ltc/ltcor.htm

2004

Attachment II

June 1, 2004

DHS Releases Rebalancing Long-Term Care Report

Progress Has Been Made But Legislators Told Additional Work is Needed

Last Thursday, the Department of Human Services released a report to the Minnesota Legislature titled "Status of Long-Term Care in Minnesota 2003." The report contains information previously gathered for two separate reports: (1) The bed distribution study for nursing facilities; and (2) The gaps analysis for home and community-based services. The report includes demographic trends, estimates of the need for long-term care, and the status of home and community-based services across the state. The following is a summary of the key findings included in the report. To access the complete study, go to Hot Topics on the MHHA Web site.

Demographic Trends & Need for Long-Term Care

- **The highest growth rate is occurring within Minnesota's population over 85. This group is expected to grow 25 percent in the next 10 years.**
- **Demographic changes will also reduce the number of family members and workers available to provide care at the very time when the need for long-term care will be at an all-time high.**
- **While age-specific disability rates have declined by 1 percent or more per year for the past several decades, the number of elderly needing long-term care will continue to rise due to the large increases in the overall numbers of elderly.**
- **The most recent National Long-Term Care Survey completed by the National Center for Health Statistics found that 15.6 percent of the 65+ population needs community-based long-term care while 4.2 percent need skilled services.**

Informal Home & Community-Based Services

- **Since 1988, the percent of care provided informally by family members dropped from 97 percent to 91 percent in 2001. During the same time period, the proportion of older Minnesotans that purchased services increased 16 percent.**

- **Additional help is secured through volunteer-based programs to supplement what is provided informally through family or through purchased services. It is estimated that there are now between 500 and 700 volunteer based programs (such as Red Cross, Block Nurse or church affiliated programs) operating in communities throughout Minnesota.**

- **In 2003, nearly 240,000 Minnesotans over age 60 were served by programs provided through the Area Agencies on Aging using federal Older Americans Act funds i.e. senior nutrition, transportation, chore, or respite services.**

Gaps Analysis

- **93 percent of counties reported that there were more home and community care options in their county in 2003 than in 2001 (the first year the Gaps Analysis was conducted). 60 percent of counties described their supply of H&CBS as "adequate."**

- **Transportation services remain the biggest gap despite a decrease in the percentage of counties reporting it as a critical service gap from 66 percent in 2001 to 42 percent in 2003.**

Community Service/Service Development Grants

- **Since 2001, about $8.6 million in grant funds have been awarded to nearly 200 projects in 46 counties.**

- **The projects have expanded services to nearly 20,000 older persons in Minnesota.**

Publicly Funded Home & Community-Based Services

- **In the past three years, the number of persons 65+ served through the EW, AC and MA home care programs has increased 25 percent from 23,000 to nearly 30,000 Minnesotans.**

- **The expenditures for H&CBS have increased 50 percent—from $130 million to nearly $200 million during the same period.**

- **The state's February 2004 forecast for elderly long-term care estimates that H&CBS will increase from 19,000 persons served monthly in 2000 to 27,000 in 2007. At the same time, demand for nursing home care will continue to decline from 25,000 persons served monthly in 2000 to 22,000 in 2007.**

Impact of 2003 Legislative Changes to Alternative Care Program

The 2003 Legislature enacted major policy changes in the AC program including tightening eligibility criteria, expanding monthly fees, and imposing state recovery provisions (liens), in an effort to reduce program expenditures. As a result, the number of clients on the AC program dropped from 7,100 in June 2003 to 5,900 in December 2003. About 10 percent have moved to a nursing home.

Senior Housing

There are an estimated 80,000 units of senior housing in Minnesota and 9,500 board and care/adult foster care units. About 50 percent of the 80,000 units are considered assisted living.

In 2001, 50 counties identified affordable senior housing as the biggest gap followed by adult foster care, assisted living and market rate rental. In 2003, 27 counties reported subsidized or affordable housing developments, 17 reported creation of adult foster care, and 16 reported development of assisted living.

Assisted Living

- **There are now 907 assisted living residences registered in Minnesota, comprised of 40,086 units serving an estimated 35,000 seniors.**

- **The number of residences doubled (426 to 907) between 1997 and 2004 and the number of available units tripled (13,000 to 40,086).**

- **By comparison, there are 432 nursing facilities with 39,530 beds. This marks the first time that Minnesota has had more assisted living residences and units than nursing homes and nursing home beds.**

- **The number of EW and AC clients receiving "congregate residential care" (assisted living) has grown from 4,285 clients in 2000 to 7,403 in 2003 -- a 73 percent increase.**

Nursing Homes

- **The number of nursing home beds peaked in 1987 at 48,307 beds and as of Sept. 30, 2003, the number of beds had decreased to 39,530 -- an 18 percent reduction.**

- **The number of beds per 1000 for the 65+ age group dropped from 83.9 in 1993 to 65.7 in 2002. During the same period the beds per 1,000 for the 85+ age group dropped from 643.2 to 431.4 (which is below the national average). In 1998 Minnesota had the fifth highest ratios in the country, by 2002 the state had dropped to the 10th highest.**

- **In 1984, the utilization rate was 8.4 percent. By 2002 it declined to 5.5 percent -- a 52 percent drop.**

Publicly Funded Nursing Home Care

- **The average daily cost of a nursing home in Minnesota is now $136.14 or $49,691 annually.**

- **Expenditures for nursing home care in the MA program were nearly $1 billion in 2003 or 20 percent of the total MA budget.**

- **MA expenditures for nursing home care grew from $900 million in 2001 to $973 million in 2003 despite serving 3,246 fewer seniors.**

Projections

- **The state must address whether it has an adequate supply of nursing home beds for the foreseeable future or if additional beds will be needed; therefore, DHS made projections based upon both historic changes in the number of beds and utilization of nursing home services.**

- **The projections based on nursing home utilization are likely to be a better barometer of future demand than changes in the number of beds.**

- **In previous analyses of bed need (1999 and 2001), the three-year trend line showed the steepest decline in the number of beds needed. The three-year trend line based on utilization is the first time that it suggests an eventual increase in bed need.**

- **Given the volatility of the three-year trend line, DHS recommends watching this and seeing if the trend persists.**

- **At this time no strategies to encourage further bed closures are being actively pursued by DHS.**

Long-Term Care Benchmarks

- **Benchmark #1: Percent of public long-term care dollars spent on institutional vs. community care for persons 65+**
- **Benchmark #2: Percent of nursing home residents 65+ that are case mix A**
- **Benchmark #3: Percent of EW/AC recipients that are case mix B-K**
- **Benchmark #4: Ratio of nursing home beds per 1000 persons 65+**
- **Benchmark #5: Percent of EW/AC recipients in assisted living that are case mix B-K**

Progress on 2001 Long-Term Care Reforms

This analysis makes it clear that much progress has been made on the long-term care reform set in motion in 2001.

The five long-term care benchmarks all indicate that the measures are changing in the direction called for in the 2001 reform.

Key systems changes are being made that will support continued reform.

A number of future challenges exist including:

- **Developing consumer-and family-directed services;**
- **Managing chronic care;**
- **Expanding community capacity and infrastructure;**
- **Addressing technology needs and labor shortages;**
- **Addressing challenges in assisted living; and**
- **Reforming long-term care financing.**

The report acknowledges that since the reform efforts of 2001, the state has seen major budget deficits that have had an impact on the rate of progress toward achieving the state's "rebalancing" goals. It goes on to say, "It is unclear whether the rate of progress on reform efforts to date is adequate to prepare us for the upcoming challenges that the state will face as the baby boom generation begins to grow old and need long-term care." The report suggests "we may need to take bolder steps in the next two years in order to move forward more quickly as the retirement of the boomer generation draws closer."