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Minnesota Long-Term Care Consultation Services

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STATE POLICY IN PRACTICE……
MINNESOTA'S LONG TERM CARE CONSULTATION (LTCC) SERVICES

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Summary

More states are developing policies and programs to help individuals learn and act upon their choices for long-term care and supportive services. This State Policy in Practice technical assistance document describes a program created by the Minnesota Legislature that provides long-term care choice counseling and services designed to help people live in community settings. Minnesota's Long Term Care Consultation (LTCC) services have made it possible for people of all ages, regardless of income or acuity, to receive information about services, assessment of their needs for services, help with planning and locating services to maintain their community residence, determination on whether they qualify for public services and assistance in transitioning from an institution to a community setting. They can get all of this help for free in the privacy of their own homes. Medicaid funds are used for enrollees. People under 65 living in a nursing facility receive a face-to-face assessment within 40 days of entry into the facility. If someone wants to leave an institution, LTCC staff coordinate relocation for Medicaid enrollees and assist others with assessment, planning and service referrals. Medicaid services are available for relocation coordination. This is a very comprehensive program and it appears to be meeting its stated objectives.

Major Points

- In 2001, the Minnesota Legislature revised Minnesota's Preadmission Screening (PAS) Program and renamed it Long Term Care Consultation (LTCC) Services, dramatically changing the scope of this program.

- LTCC services include an assessment of needs, assistance in identifying and recommending cost-effective home and community-based services, development of a community support plan, preliminary determination of eligibility for public program support, and transition assistance for people who are currently institutionalized.

- LTCC services are available to all Minnesotans regardless of income or acuity.

- Each county board of commissioners, or two or more counties together, must establish a local LTCC team of at least one social worker and one public health nurse who are responsible for providing LTCC services to all persons who request those services, regardless of their eligibility for Minnesota health care programs.

- Individuals requesting, or recommended for, assessment, services planning, or other assistance intended to support community-based living must be visited by a LTCC services team within ten (10) working days of the request.

- Minnesota requires a face-to-face assessment for people under 65 within forty (40) calendar days of admission, if a face-to-face assessment was not completed prior to the admission. Individuals under 21 cannot be admitted to a nursing facility without a face-to-face assessment and prior approval of the state.

- By statute, transition assistance is available to people residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with mental retardation (ICFs/MR) if they request assistance or if they are referred. Transition assistance must include assessment, community support plan development, referrals to Minnesota health care programs and housing assistance.

- No individual or family member can be charged for an initial assessment or initial support plan development.

- Beginning January 1, 2003, counties are responsible for paying for 20% of the state Medicaid matching requirements for nursing facility expenses incurred by persons with disabilities under 65 after they have been in the facility over ninety (90) days. This provision creates a financial incentive for assisting people under 65 who want to relocate from a facility.

- Minnesota built its long-term care consultation services on its longstanding program of pre-admission screening. Preliminary data analyses suggest positive policy outcomes.

Background

In 2001, Minnesota revised its Preadmission Screening (PAS) Program and renamed it Long Term Care Consultation (LTCC) Services. The Legislature believed that additional services were needed to "assist persons with long-term or chronic care needs in making long-term care decisions and selecting options that meet their needs and reflect their preferences." The intended goal is to prevent or delay nursing home placement by providing information and assistance, and to provide transition assistance after nursing home admission for those who request it. The amended law also clearly states that it is state policy "to ensure that individuals with disabilities or chronic illness are served in the most integrated setting appropriate to their needs and have the necessary information to make informed choices about home and community-based options" (Minnesota Statutes 256B.0911).

The PAS Program was developed and implemented in the early 1980s as part of the state's strategy to decrease reliance on nursing facilities for long-term care and ensure that all new residents of a nursing facility actually required that level of care. Over time, PAS units at the county level were also assigned responsibility for the federally-mandated Pre-Admission Screening and Annual Resident Review (PASARR) screening, and for determining whether a person met a "nursing home level of care" for purposes of determining Medicaid waiver eligibility.

While the preadmission screening process for nursing facility admission continues, and includes ways to identify people who may later need transition assistance, the LTCC process provides information and education to all Minnesotans regardless of income or acuity. It includes an assessment of needs, assistance in identifying and recommending cost-effective home and community-based services, development of a community support plan, preliminary determination of eligibility for public program support, and transition assistance for people who are currently institutionalized.

Program Practices

Long-Term Care Consultation (LTCC) Services

The 2004 Minnesota statute defines long-term care consultation services as:

- providing information and education to the **general public** (emphasis added) regarding availability of long-term care consultation;
- assessment of the health, psychological, and social needs of individuals;
- assistance in identifying services to maintain a person in the least restrictive environment;
- providing recommendations on cost-effective community services available to the individual;
- development of an individual community support plan;
- providing information on eligibility for health care programs;
- preadmission screening to determine the need for nursing facility level of care;
- preliminary eligibility determination for health care programs for individuals who need a nursing facility level of care, with appropriate referrals for final determination;

- providing recommendations for nursing facility placement when there are no-cost effective community services available; and,
- assistance to transition people back to community settings after facility admission.

As described in the goals section of the statute, these services provide information to individuals to allow them to make informed choices about long-term care services, help them understand the support services available in a community setting (clearly stating the legislative preference for community services) and assist with transitioning back to the community after a facility admission.

LTCC Services Team

Each county board of commissioners, or two or more counties together, must establish a local consultation team consisting of at least one social worker and one public health nurse who are responsible for providing LTCC services to all persons in that county or counties who request those services, regardless of their eligibility for Minnesota health care programs.

Community Assessment and Support Planning

Individuals requesting, or recommended for assessment, services planning, or other assistance intended to support community-based living must be visited by a LTCC services team within ten (10) working days of the request. If a person is living at home, the community assessment is normally completed in the person's home. The team assesses the health and social needs of the person in a face-to-face interview using a state-provided form, and delivers written recommendations for either facility or community-based services. The team is required to document that the most cost-effective alternatives to nursing facilities were offered to the individual.

If the person chooses to use community-based services, the LTCC team must provide a written community support plan, regardless of whether the individual is eligible for Minnesota health care programs, and the individual may even request assistance with a community support plan without participating in a complete assessment. The community support plan identifies the individual's natural supports, available community supports, private pay services options and the potential support from public programs.

The LTCC team must also give the individual receiving an assessment or support, planning information about the purpose of preadmission screening and assessment, information about Minnesota's health care programs, the person's right to confidentiality, the freedom to accept or reject the recommendations of the team and the right to appeal the county's decision on eligibility for public programs.

People Under 65

Minnesota requires a face-to-face assessment for people under 65 within forty (40) calendar days of admission, if a face-to-face assessment was not completed prior to the admission. People under 21 cannot be admitted to a nursing facility without a face-to-face

assessment and prior approval of the state. People under 65 may be admitted using a telephone screening if there is no need to determine nursing facility level of care or they are otherwise exempt from screening. If a person under 65 is admitted to a facility on an emergency basis, the nursing facility must notify the county on the next working day, so that the LTCC team can determine whether an immediate face-to-face assessment needs to be done.

At the assessment, the LTCC team or a county case manager must present information about home and community-based options so the individual can make informed choices and knows about the availability of transition assistance services. If the person chooses home and community-based services, the LTCC team member or case manager must complete a written relocation plan within twenty (20) working days of the face-to-face meeting. The plan must describe the services needed for the person to move out of the facility and a time line for the move, designed to ensure a smooth transition to the individual's home and community. In addition, a person under 65 must receive another face-to-face assessment every twelve (12) months to review the person's service choices and available alternatives, unless the individual indicates in writing that annual visits are not desired and then an assessment is completed every three years.

Transition Assistance

By statute, transition assistance is available to people residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with mental retardation (ICFs/MR) if they request assistance or are referred. Transition assistance must include assessment, community support plan development, referrals to Minnesota health care programs and housing assistance.

The counties must develop transition processes with institutional social workers and discharge planners to ensure that people admitted to a facility receive information that transition assistance is available, that assessments are completed within ten (10) working days and there is a plan for transition and follow-up for the individual's return to the community. If a person who is eligible for a Minnesota health care program is admitted to a nursing facility, a LTCC member or case manager must be included in the discharge planning process.

Relocation Services Coordination

To assist people who want to move from an institution to the community, the Legislature authorized the use of relocation targeted case management (TCM) for persons of any age receiving Medicaid residing in an institution (Minnesota Statutes 256B.0621). This service may include:

- assessment of the beneficiary's need for TCM services;
- development and/or implementation of a relocation plan;
- development, completion, and regular review of a written individual service plan;
- routine contact or communication with the beneficiary or other individuals necessary to the development or implementation of the goals of the relocation plan;

- coordinating referrals for, and provision of, case management services for the beneficiary with appropriate service providers;
- coordinating and monitoring overall service delivery to ensure quality of services;
- traveling to conduct a visit with the beneficiary or other relevant person necessary to develop or implement the goals of the individual service plan; and,
- coordinating with the institutional discharge planner within the 180 day period before the individual's discharge.

The TCM may be provided during the last 180 days of the institutional stay, and institutions are defined as hospitals, nursing facilities, including certified boarding care homes, ICFs/MR and regional treatment centers. Relocation targeted case managers must visit the eligible institutionalized individual within twenty (20) working days of a request for assistance. If assistance is not provided in a timely manner, the individual can obtain TCM services from any other enrolled provider.

Counties may also assist people with some of the expenses needed for transition. Hennepin County has paid for expenses such as rental deposits, furniture and security deposits, and the state is currently in the process of amending its home and community-based services waivers to cover transition expenses (Bartolic, 2005a).

Financing

As stated previously, county government has the responsibility for long-term care consultation services. They are reimbursed monthly by certified nursing facilities in the county for services for individuals 65 and older, based on the number of licensed beds in each facility. The payment covers staff salaries and expenses related to the LTCC services provided. The counties are paid on a fee-for-service basis for individuals under 65. Minnesota data show that in state fiscal year 2004, counties completed 85,221 screenings and/or assessments and that approximately $6 million dollars was allocated for LTCC services, one-third of which was paid for by the state. No individual or family member can be charged for an initial assessment or initial support plan development.

It is also interesting to note that the 2002 Legislature changed financing of the state Medicaid match. Beginning January 1, 2003, counties are responsible for paying for 20% of the state Medicaid matching requirements for nursing facility expenses incurred by persons with disabilities under 65 after they have been in the facility over ninety (90) days. This provision creates a financial incentive for assisting people under 65 who want to relocate from a facility. Hennepin County paid approximately $8 million in 2004 under this provision (Bartolic, 2005a).

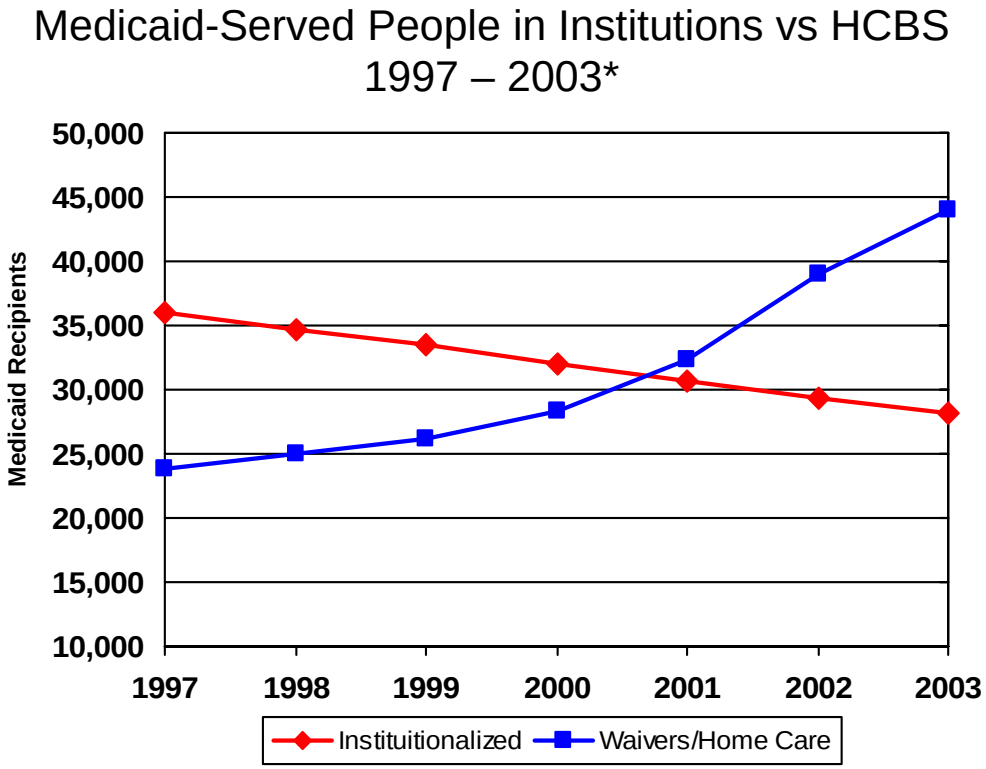
Program Results

Analyzing program results relating to balancing long-term care spending between institutional and home and community-based services, and promoting information about LTC choices usually focuses on trends in expenditures, people served and locations where they receive services. Of course, it would be difficult to assume that the addition of long-term care consultation services would be the only factor affecting so much money and so many people,

especially given the variability in public funding and the competition for LTC funding. However, we present the following observations for consideration.

LTCC services were authorized by the Legislature in 2001. It is assumed that it took a number of months before the program became fully operational. For the purpose of this review, we assume that program impact could have been experienced by October 1, 2001, the beginning of federal fiscal year (FFY) 2002 (October 2001-September 2002) and three months after the state fiscal year 2002 began (July 2001-June 2002). The additional resources provided by relocation targeted case management were added beginning in January 2003. Therefore, we explore changes occurring in fiscal years 2002 and 2003.

Figure 1



*Data for 1997- 2003 represent state fiscal years.
Source: Minnesota Department of Human Services

The data show that the number of people served in institutions decreased slightly more in 2002 (-4.2%) and 2003 (-4.1%) compared with the base period 1997-2001 (-3.7% average yearly decrease), but reflected a consistent decline in institutional use throughout the entire period studied. These data also show that the number of people served in waivers and home care increased dramatically in 2002 (20.7%) and in 2003 (12.8%), compared to the base period 1997-01 (8.8% average annual growth).

Table 1

Percentage Change in Minnesota LTC Expenditures 1997-2003

Year	Total Long Term Care Expenditures	HCBS Expenditures	Nursing Facility Expenditures	ICFs/MR Expenditures
1997-2001 average annual growth rate	5.725	18.1	1.25	-2.2
2002	12.5	32.3	-0.9	-4.5
2003	10.5	19.2	4.1	-6.1

Source: Burwell, Sredl & Eiken. (2004 & 2005).

The expenditure data in Table 1 reflect a small average annual increase in institutional spending for nursing facilities between 1997-2001 of about 1.25% and a small *decrease* in average annual spending for ICFs/MR of -2.2%. The average annual growth rate for HCBS expenditures between 1997-2001 was approximately 18.1%.

However in 2002, data reflect a 32.3% increase in HCBS expenditures and 2003 data show a 19.2% expenditure increase. Both of these increases are greater than the average annual growth during the 1997-01 base period (18.1%) with 2002 showing a very significant increase.

The institutional expenditure data for 2002 reflect nursing facility *decrease* of -.9% and 2003 show a 4.1% increase. These data combined show a two year average annual increase of 1.6%, closely following the base period average (1.25%). However, the 2003 nursing facility expenditure increase could reflect Minnesota's use of the Medicaid Upper Payment Limit to receive additional federal matching dollars without having to contribute additional state funds and may not reflect actual additional money spent on nursing facility care (Burwell, Sredl & Eiken, 2003, 2004). For ICFs/MR, the data show a *decrease* in 2002 of -4.5% and in 2003 of -6.1%. These decreases are significantly greater than the average annual rate of *decrease* in the 1997-2001 base period of -2.2%. .

Trends Analysis

The data show substantially higher increases on average in the number of people supported by home and community-based services both in 2002 and 2003, and also show notably higher increases in expenditures for those years. The institutional decreases in both people served and expenditures in 2002-03 are not significantly different from trends in 1997-2001.

Although one cannot draw a direct correlation between the implementation of the LTCC services and the significant increase in people served and expenditures in home and community-based settings, it is worth noting that the significant increases occurred at the same time as consultation services were being implemented. Further research and analysis is needed to evaluate the outcomes of this policy change.

Replication Requirements

Minnesota built its long-term care consultation services on its longstanding program of pre-admission screening. Pre-admission screening had accomplished a great deal in ensuring that only those needing institutional care gained entry and in implementing assessment of nursing home level of care for public program eligibility. It even had success in improving communication with people about community options, but this was not really a major goal of the process.

Long-term care consultation (LTCC) is focused on all people needing long-term care regardless of acuity or income. LTCC team members go to people's homes to do assessments and provide planning and resources to help people receive services at home and in community settings. They do more work with people who are admitted to institutions during their early residency there, especially with people under 65, and they facilitate relocation services if a person wants to move from an institution to the community. Their work is both diverting people from unnecessary institutional stays and transitioning people out who don't need institutional services.

Minnesota had a legislature that mandated and financed this program. Although the legislation was dramatic in scope and included much detail on how the program was to be operated, it followed many years of discussion and debate about how to serve the future "baby boom" generation and how to address the desires of persons with disabilities of all ages to have additional community long-term support options. The Executive branch had been supporting measures to help balance the long-term care system for many years and moved quickly to implement the legislation. However, the counties were responsible for implementing the program, and would have liked to have had more time to add these services and develop implementation strategies and protocols.

Minnesota had the right combination to implement this reform: a legislative and executive branch that had studied and debated the issue; state policy makers who agreed upon goals and objectives and were willing to finance the reform; support from most stakeholders in long-term care; and county governments willing to be partners in the program.

Conclusion

Minnesota's LTCC services have made it possible for people of all ages, regardless of income or acuity to receive information about services, assessment of need for service, help with planning and locating services to maintain their community residence and assistance in determining whether they qualify for public services, all in the privacy of their own homes. They can also get the same services if they enter an institution, and people under 65 receive a face-to-face assessment within 40 days of entry into a nursing facility. If someone wants to leave an institution, Medicaid services are available for relocation coordination. This is a very comprehensive program and appears to be meeting its stated objectives.

The data show that the number of people served by home and community-based services, and the spending on those services, increased substantially during the years that the LTCC services were implemented. While we cannot attribute that outcome directly to LTCC implementation, it is worth noting the directional trends.

Another trend worth noting is that Minnesota now spends about 56% of its Medicaid long-term care supports on home and community-based services, and 44% on institutional services (Burwell, et al, 2005), the 5th highest state in the country for its proportion of Medicaid LTC spending on home and community-based services. These percentages have increased from 29.7% in FFY 1997 to 41.6 % in FFY 2001 to 52.8% in 2003.

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