

INFORMATION BRIEF
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Updated: January 2017

Long-Term Care Services for the Elderly

Elderly people in Minnesota can receive services from Medical Assistance and other state programs. This information brief summarizes Medical Assistance eligibility for persons who are elderly (age 65 and over) and describes home care, elderly waiver, nursing facility, and other Medical Assistance services commonly used by persons who are elderly. The information brief also describes the following state programs for the elderly—Long-Term Care Consultation Services, Alternative Care, essential community supports, Group Residential Housing, and programs administered by the Minnesota Board on Aging.

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Overview of Medical Assistance

Medical Assistance (MA), the state's Medicaid program, provides payment for health care services provided to low-income persons who belong to an eligible group, and who meet income and asset limits and other eligibility requirements.

Eligible groups include the elderly, persons with disabilities or who are blind, families and children, pregnant women, and adults without children. MA income and asset limits vary across the different eligibility groups.

The federal government pays a share of the cost of state MA expenditures. This is referred to as the federal medical assistance percentage (FMAP). Minnesota's FMAP for covered services is 50 percent. Minnesota pays the remaining 50 percent for most services (some services have a county share).¹

Eligibility for the Elderly

In order to be eligible for full coverage of MA services as elderly, an individual must:

- be age 65 or older;
- have net income that does not exceed the program income limit for the elderly of 100 percent of federal poverty guidelines (FPG) (\$990/month for one-person households and \$1,337/month for two-person households);²
- meet the program asset limit of \$3,000 for an individual and \$6,000 for two persons in a household, with \$200 added for each additional dependent³ (The homestead, household goods, and other specified items are not considered assets when determining eligibility); and
- meet requirements related to citizenship and residency.

Individuals who do not meet the MA income limit may qualify through a spenddown. An individual who is elderly can qualify under a spenddown by incurring medical bills in an amount that is greater than the amount by which his or her income exceeds the MA spenddown limit for the elderly of 80 percent of FPG (\$792/month for one-person households and \$1,070/month for two-person households).

¹ For example, counties are responsible for 20 percent of the cost of nursing facility placements of persons with disabilities under age 65 that exceed 90 days. For this and other required county shares, see Minnesota Statutes, section 256B.19, subdivision 1.

² The federal poverty guidelines are updated every year, usually in February. New DHS income standards based on the updated guidelines are effective July 1 of each year.

³ In addition, if an applicant for MA payment of long-term care services has exhausted benefits under a private sector long-term care insurance policy issued on or after July 1, 2006, that qualifies under the state's long-term care partnership program, an amount of assets equal to the dollar amount of benefits paid out under the qualifying policy is disregarded for purposes of determining eligibility for MA payment of long-term care services. These assets are also protected against estate recovery and are not subject to asset transfer penalties.

Spousal Asset Division

When one spouse of a married couple seeks MA coverage for care in a nursing facility or other long-term care services under the Elderly Waiver, or alternative care, for a continuous period expected to last at least 30 consecutive days, the MA program divides the total assets of the married couple and calculates a protected spousal share for the spouse remaining in the community. The protected spousal share is equal to one-half of all nonexempt assets owned by either spouse, subject to a minimum and maximum amount set by law.⁴

The spouse remaining in the community can retain the protected spousal share. The spouse receiving long-term care services must reduce his or her assets to the MA asset limit of \$3,000, but may in some cases transfer assets to the community spouse, either to bring the assets of the community spouse up to the spousal share minimum or to raise the income of the community spouse and dependent family members to specified minimum levels.

Eligibility for Medicare Cost-Sharing

Certain Medicare enrollees who do not meet the income and asset standards for full coverage of MA services are eligible for MA coverage of Medicare cost-sharing only. The table below summarizes MA coverage for these groups of Medicare enrollees.

Eligibility Category	Income Limit	Asset Limit	Medicare Cost-Sharing Coverage
Qualified Medicare Beneficiaries (QMBs)	≤ 100% FPG	\$10,000 for an individual \$18,000 for a married couple	Premiums, coinsurance, copayments (except for Part D), and deductibles for Medicare Parts A and B
Specified Low-Income Medicare Beneficiaries (SLMBs)	> 100% but < 120% of FPG	\$10,000 for an individual \$18,000 for a married couple	Medicare Part B premium only
Qualifying Individuals (QI) ⁵	≥ 120% but < 135% of FPG	\$10,000 for an individual \$18,000 for a married couple	Medicare Part B premium only
Qualified Disabled and Working Individuals	≤ 200% of FPG	Must not exceed twice the SSI asset limit ⁶	Medicare Part A premium only

⁴ For more information on the division of spousal assets, see the House Research information brief [Medical Assistance Treatment of Assets and Income](#), August 2016.

⁵ Ongoing funding for coverage of qualifying individuals was provided by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H.R. 2, Pub. L. No. 114-10, signed into law on April 16, 2015. Prior to this, funding was renewed periodically by the U.S. Congress.

⁶ The Supplemental Security Income asset limit is \$2,000 for an individual and \$3,000 for a married couple.

Medicare enrollees who qualify for full coverage of MA services also qualify for coverage of Medicare cost-sharing as QMBs.

MA Cost-Sharing

Federal law requires Medicaid cost-sharing to be “nominal.” Cost-sharing does not apply to pregnant women and children, and other exceptions apply. MA enrollees are subject to the following cost-sharing:

- \$3 for nonpreventive visits
- \$3.50 for nonemergency visits to a hospital ER
- \$3 per brand-name drug/\$1 per generic (\$12 per month limit). Antipsychotic drugs are exempt from copayments when used to treat mental illness.
- A monthly family deductible of \$2.85 (adjusted annually by the increase in the medical care component of the Consumer Price Index for all Urban Consumers)

In Minnesota, the MA payment rate for providers is reduced by the amount of the copayment. Providers cannot deny services to enrollees who do not pay the copayment. Total monthly cost-sharing is limited to 5 percent of family income.

MA Health Care Services for the Elderly

This section provides information on MA covered services and the managed care system under which most elderly MA enrollees receive services. This section also describes home care, personal care assistant services, Elderly Waiver, and nursing facility services in more detail.

MA Covered Services

MA enrollees who are elderly receive coverage for the standard MA covered services available to all other MA eligibility groups. MA benefits include federally mandated services and services provided at state option. In addition to covering standard medical services such as physician, inpatient hospital, dental, and therapy services, MA also covers many services used heavily by elderly persons. These include the following:

- Nursing facility services
- Home health care
- Personal care assistant services
- Home care nursing
- Prescription drugs

Medicare serves as the primary payor and MA as the secondary payor, for elderly (and disabled) MA enrollees who are also enrolled in Medicare. As secondary payor, MA pays only for those services not covered by Medicare and also for any Medicare cost-sharing obligations.

Service Delivery Through Managed Care

MA enrollees who are elderly are required to receive health care services from prepaid health plans through Minnesota Senior Care Plus and have the option of receiving services through Minnesota Senior Health Options (MSHO).

Minnesota Senior Care Plus has provided services to elderly enrollees enrolled in county-based purchasing initiatives since June 1, 2005. Minnesota Senior Care Plus covers all MA state plan services, elderly waiver (EW) services, and 180 days of nursing home services for enrollees not residing in a nursing facility at the time of enrollment.

Elderly enrollees in Minnesota Senior Care Plus must enroll in a separate Medicare plan to obtain their prescription drug coverage under Medicare Part D. However, elderly enrollees also have the option of receiving managed care services through the MSHO, rather than Minnesota Senior Care Plus. MSHO includes all Medicare and MA prescription drug coverage under one plan. Since 1997, MSHO provided a combined Medicare and MA benefit as part of a federal demonstration project; the program now operates under federal Medicare Special Needs Plan (SNP) authority.⁷ DHS also contracts with SNPs to provide MA services. Enrollment in MSHO is voluntary. As is the case with Minnesota Senior Care Plus, MSHO also covers EW services and 180 days of nursing home services. Most elderly MA enrollees are enrolled in MSHO rather than Minnesota Senior Care Plus because of the integrated Medicare and MA prescription drug coverage. For state fiscal year 2016, average managed care enrollment of elderly enrollees was 49,200 and average monthly enrollment in EW fee-for-service was 2,403.

Home Care Services

Home care provides medical and health-related services and assistance with day-to-day activities to people in their homes. Home care can also be used to provide short-term care for people moving from a hospital or nursing home back to their home and can also be used to provide continuing care to people with ongoing needs. Home care services may be provided outside a person's home when normal life activities take the individual away from home.

Home care services provided to MA enrollees must be:

- medically necessary;
- ordered by a licensed physician;
- documented in a written service plan;
- provided at a recipient's residence (not a hospital or long-term care facility); and
- provided by a Medicare-certified agency.

⁷ A Medicare Special Needs Plan is a Medicare managed care plan that is allowed to serve only certain Medicare populations, such as institutionalized enrollees, dually eligible enrollees, and enrollees who are severely chronically ill and disabled. SNPs must provide all Medicare services, including prescription drug coverage.

A registered nurse from a Medicare-certified home health agency completes an assessment to determine the need for service. The assessment identifies the needs of the person, determines the outcomes for a visit, is documented, and includes a plan. Most home care services must be prior authorized. The maximum benefit level is one visit per day for home health aide services, one visit per discipline per day for therapies (except respiratory therapy), and two visits per day for skilled nurse visits.

Home care services include the following:

- Intermittent home health aide visits provided by a certified home health aide
- Medically oriented tasks to maintain health or to facilitate treatment of an illness or injury provided in a person's place of residence
- Personal care assistant (PCA) services
- Home care nursing
- Therapies (occupational, physical, respiratory, speech)
- Intermittent skilled nurse visits provided by a licensed nurse
- Equipment and supplies

About 65 percent of PCA and home health agency service recipients over the age of 65 are also on the EW. This does not include people on other waivers.

Home health agency program statistics (does not include managed care enrollees) for fiscal year 2016:

- Total MA expenditures: \$16.5 million
- Monthly average recipients: 3,204
- Average monthly cost per recipient: \$430

Home care nursing statistics for fiscal year 2016:

- Total MA expenditures: \$121.3 million
- Monthly average recipients: 765
- Average monthly cost per recipient: \$13,218

Personal Care Assistant (PCA) Services

Personal Care Assistants provide assistance and support to the elderly, persons with disabilities, and others with special health care needs living independently in the community.

In order for a person to receive PCA services, the services must be:

- medically necessary;
- authorized by a licensed physician;
- documented in a written service plan; and
- provided at the recipient's place of residence or other location (not a hospital or health care facility).

In addition, recipients of PCA services must be in stable medical condition, be able to direct their own care or have a responsible party who provides support, and have a need for assistance in at least one activity of daily living or a Level I behavior.⁸

The determination of the amount of service available to a person is based on an assessment of needs. PCA services provided include the following:

- Assistance with activities of daily living (e.g., eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning)
- Assistance with instrumental activities of daily living (e.g., meal planning and preparation, managing finances, and shopping for essential items)
- Assistance with health-related procedures and tasks
- Intervention for behavior, including observation and redirection

PCA program statistics (does not include managed care enrollees) for fiscal year 2016:

- Total MA expenditures: \$607.7 million
- Monthly average recipients: 20,795
- Average monthly cost per recipient: \$2,435

Elderly Waiver Services

The Elderly Waiver (EW) provides home and community-based services not normally covered under MA to MA enrollees who are at risk of nursing facility placement. In addition, EW recipients are eligible for all standard MA covered services.

In order to receive EW services, an enrollee must:

- be age 65 or older;
- need nursing facility level care as determined by the long-term care consultation process, and choose community care; and
- meet the EW income standard.

In addition, the cost of EW services cannot exceed the estimated cost of nursing facility services.

The EW uses an income standard that is higher than the income standard used by the regular MA program. Individuals with incomes that do not exceed a special income standard of 300 percent of the Supplemental Security Income (SSI) level (\$2,199/month⁹) are able to qualify for EW and regular MA services. These individuals must contribute any income above a maintenance needs

⁸ Level I behavior means physical aggression towards self, others, or destruction of property that requires the immediate response of another person ([Minn. Stat. § 256B.0659](#), subd. 1, para. (c)).

⁹ The special income standard is adjusted each January 1. The dollar amount specified is effective for calendar year 2016.

allowance (\$988/month¹⁰) towards the cost of EW services. This is referred to as the individual's waiver obligation. If the amount of income above the maintenance needs allowance is greater than the cost of EW services, individuals can retain any excess income that remains after the waiver obligation is met. No contribution is required towards the cost of regular MA services.

Individuals with incomes that do not exceed the maintenance needs allowance are eligible for EW and MA services without meeting a waiver obligation. Individuals with incomes that exceed the special income standard must spend down to the regular MA spenddown standard for the elderly of 80 percent of FPG (\$792/month) to qualify for EW and MA services.

Services available through the EW include the following:

- Adult day service
- Assisted living
- Training for informal caregivers
- Case management
- Chore, companion, and homemaker services
- Licensed community residential services
- Extended home care services
- Home-delivered meals
- Home and vehicle modifications
- Nonmedical transportation
- Respite care
- Specialized supplies and equipment
- Telehomecare
- Transitional supports

Consumer Directed Community Supports (CDCS) is an option available under the EW (and other home and community-based waivers and the Alternative Care program) that gives enrollees greater flexibility and control in developing a service plan, managing a budget, paying for services, and hiring and managing direct care staff.

EW program statistics for fee-for-service enrollees for fiscal year 2016:

- Total MA expenditures: \$45.4 million
- Monthly average recipients: 2,370
- Average monthly cost per recipient: \$1,609

EW program statistics for managed care enrollees for fiscal year 2016:

- Total MA expenditures: \$356.4 million
- Monthly average recipients: 20,935

¹⁰ The maintenance needs allowance is adjusted each July 1. The dollar amount specified is effective for the period July 1, 2016, through June 30, 2017.

- Average monthly cost per recipient: \$1,340

Nursing Facility Services

Nursing facility services under MA are a package of room and board and nursing services. Acute care services such as hospitalization are paid for separately under MA; this is also usually the case for therapy and other ancillary services.

In order to be eligible for nursing facility care, an MA enrollee must:

- be screened by a long-term care consultation team; and
- be determined by the team to need nursing facility-level care.

The screening team assigns each nursing facility resident one of 48 case-mix classifications under the Resource Utilization Groups (RUGs) case-mix system.¹¹ Each classification is assigned a weight that represents the amount of care needed. This weight is used in calculating reimbursement rates for nursing services.

MA recipients receiving care in nursing facilities are required to contribute most of their income towards the cost of care, except for a personal needs allowance of \$97 as of January 1, 2016, and other allowed exclusions.

Nursing facilities are reimbursed by MA on a resident-per-day basis. The nursing home reimbursement levels are adjusted under the RUGS case-mix system to reflect the varying care needs of residents.

MA rates and private pay rates do not vary within a facility. This is due to Minnesota's equalization law, which prohibits nursing facilities from charging private pay residents more than residents whose care is paid for by MA.

The 2015 Legislature authorized a new system for nursing facility reimbursement rates, which DHS calls the value-based reimbursement system. The 2016 rate year, which began on January 1, 2016, is the first year that DHS reimburses nursing facilities under the new system. Under the value based-system, DHS sets facility reimbursement rates based on the cost of providing care to residents. A nursing facility's rate has five components: direct care, other care, other operating, internal fixed costs, and property. Although the new system ties a facility's rate to its costs, DHS will not reimburse the facility for unlimited costs; a facility's rate will only reflect its care-related costs up to a limit. If a facility's care-related costs are greater than its limit, the facility's rate would not reflect the portion of the costs in excess of the limit. As with previous systems, facilities' rates are case-mix adjusted—facilities receive higher rates to care for more-resource intensive patients.

¹¹ RUGS classifies nursing facility residents into 48 groups based on information collected using the federally required minimum data set. There will also be penalty and default groups for a total of 50 RUG levels. The RUGS case-mix reimbursement system for nursing homes is described in [Minnesota Statutes, sections 144.0724 and 256B.438](#).

At a minimum, there is a 15-month lag between when a facility accrues a cost and when the cost is reflected in the facility's rate. This is due both to the differences between the rate year and the reporting period, and the time it takes DHS to calculate facilities' rates.

Nursing facilities in Minnesota must file a cost report with DHS by February 1 of each year. A facility's cost report covers the previous reporting year, which runs from October 1 to September 30. DHS uses these cost reports to calculate a facility's rate for the following rate year. The rate year runs from January 1 to December 31.

Because of this reporting cycle, a facility's reimbursement rate will always reflect its historical costs, rather than its present costs. If a facility's costs increase from one year to the next, its rates will lag behind the facility's costs.

Under previous cost-based reimbursement systems, DHS adjusted facilities' rates to account for this lag between reporting and rate setting. Rates were increased by multiplying a facility's payment rate by the rate of inflation between when it submitted a cost report and when its rate took effect. The current value-based system does not include such an inflationary adjustment.

MA nursing facility statistics for fiscal year 2016:

- Total MA expenditures: \$807.7 million
- Monthly average recipients: 14,625
- Average monthly payment per recipient: \$4,602
- Average payment per day: \$167.27

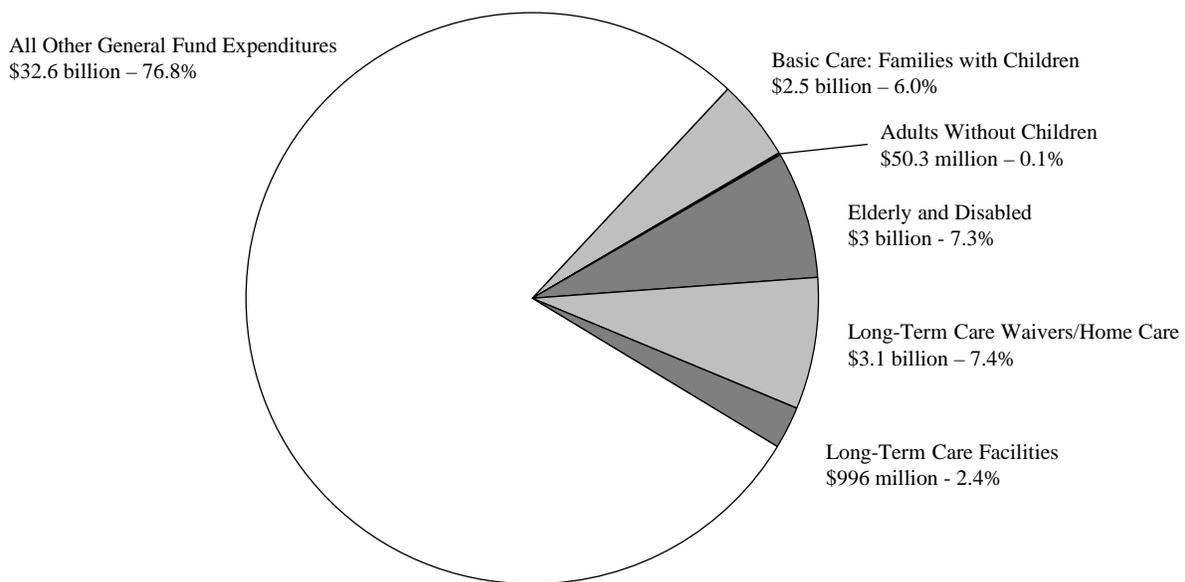
MA Long-Term Care Expenditures and Recipients

This section contains pie charts and bar graphs that highlight various aspects of MA long-term care spending. In figures 1 and 5 to 7, the long-term care facilities and long-term care waivers home care categories include both elderly and disabled MA enrollees.

Figure 1 shows state MA general fund expenditures by category and as a percentage of total general fund spending. During the 2016-2017 biennium, state MA general fund expenditures are projected to be \$9.6 billion—23 percent of total state general fund expenditures. Spending on long-term care services for the elderly and disabled (both facility and community-based) will account for 43 percent of state general fund MA spending (\$4.1 billion).

Figure 1

**Medical Assistance State Expenditures and Percent of
Total General Fund Expenditures**
FY 2016-17 Total GF Expenditures: \$41.5 billion
FY 2016-17 Total State Share MA Expenditures: \$9.6 billion



Source: November 2016 Forecast

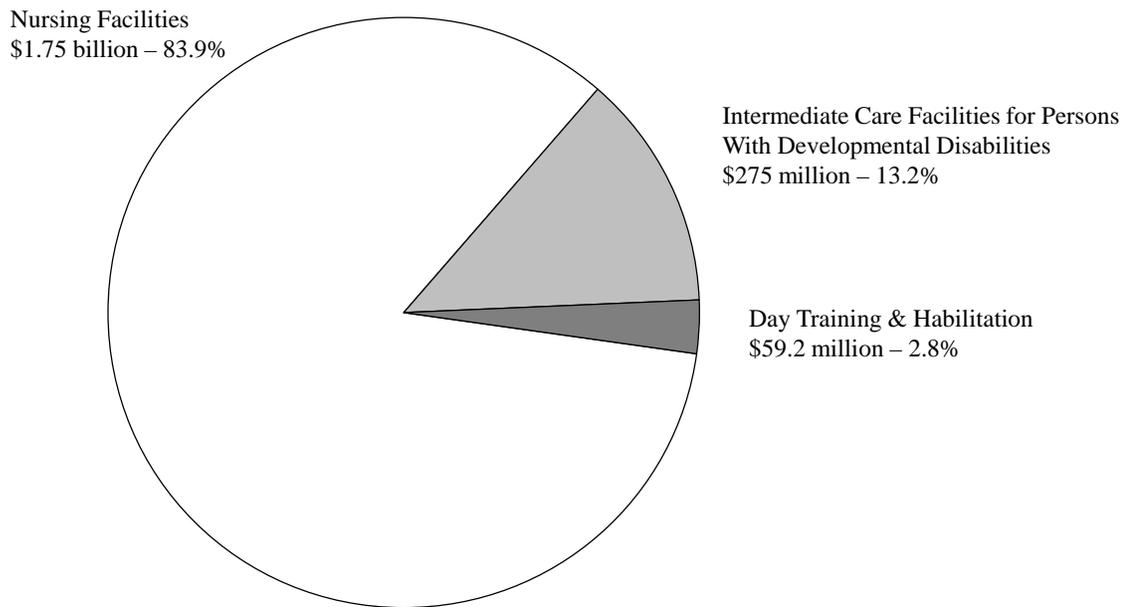
Note: MA expenditures and total general fund expenditures include health care access fund spending for MA.

Figure 2 shows MA long-term care (LTC) facility spending by category. Spending for nursing facility services is projected to account for over three-quarters of total state MA spending for LTC facility services of \$1 billion for the 2016-2017 biennium.

Figure 2

**Medical Assistance Long-Term Care Facilities
FY 2016-17**

Federal Share: \$1.1 billion; State Share: \$1 billion

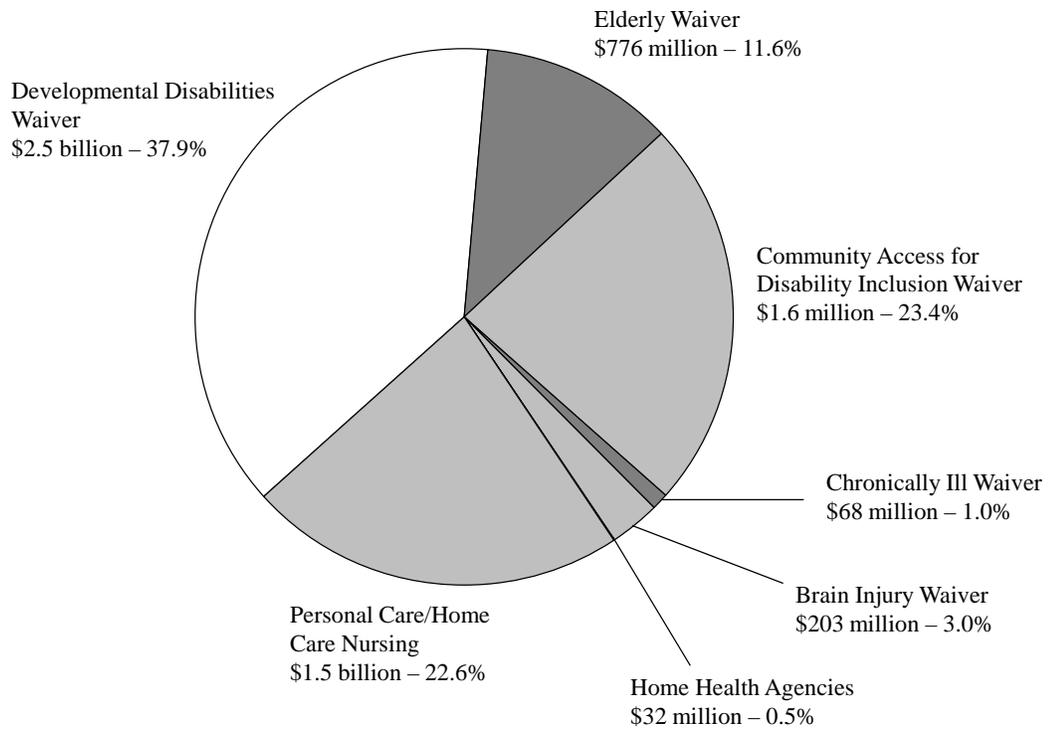


Source: November 2016 Forecast

Figure 3 shows MA LTC waiver and home care spending by category. Services provided through the home and community-based waiver for persons with developmental disabilities (DD waiver) are projected to account for 38 percent of LTC waiver and home care spending for the 2016-2017 biennium. Services provided through the Community Access for Disability Inclusion Waiver (CADI) are projected to account for 23 percent of spending for this category.

Figure 3

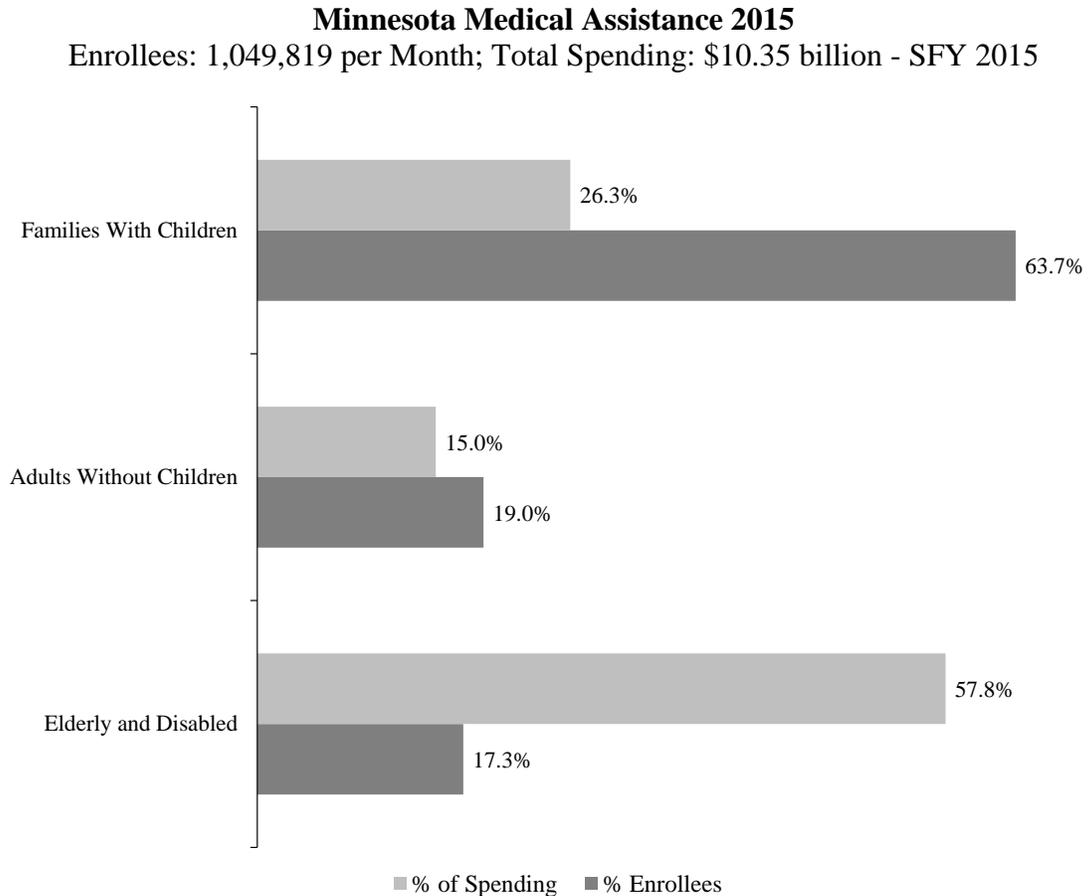
**Long-Term Care Waivers and Home Care
FY 2016-17**
Federal Share: \$3.4 billion; State Share: \$3.3 billion



Source: November 2016 Forecast

Figure 4 compares the percentage of MA enrollees in each major eligibility category to the percentage of MA spending for that eligibility category for fiscal year 2015. Families with children (both those on the Minnesota Family Investment Program and others) made up about 64 percent of MA enrollees but accounted for 26 percent of MA spending. In contrast, elderly and disabled enrollees made up about 17 percent of MA enrollees but accounted for about 58 percent of MA spending.

Figure 4

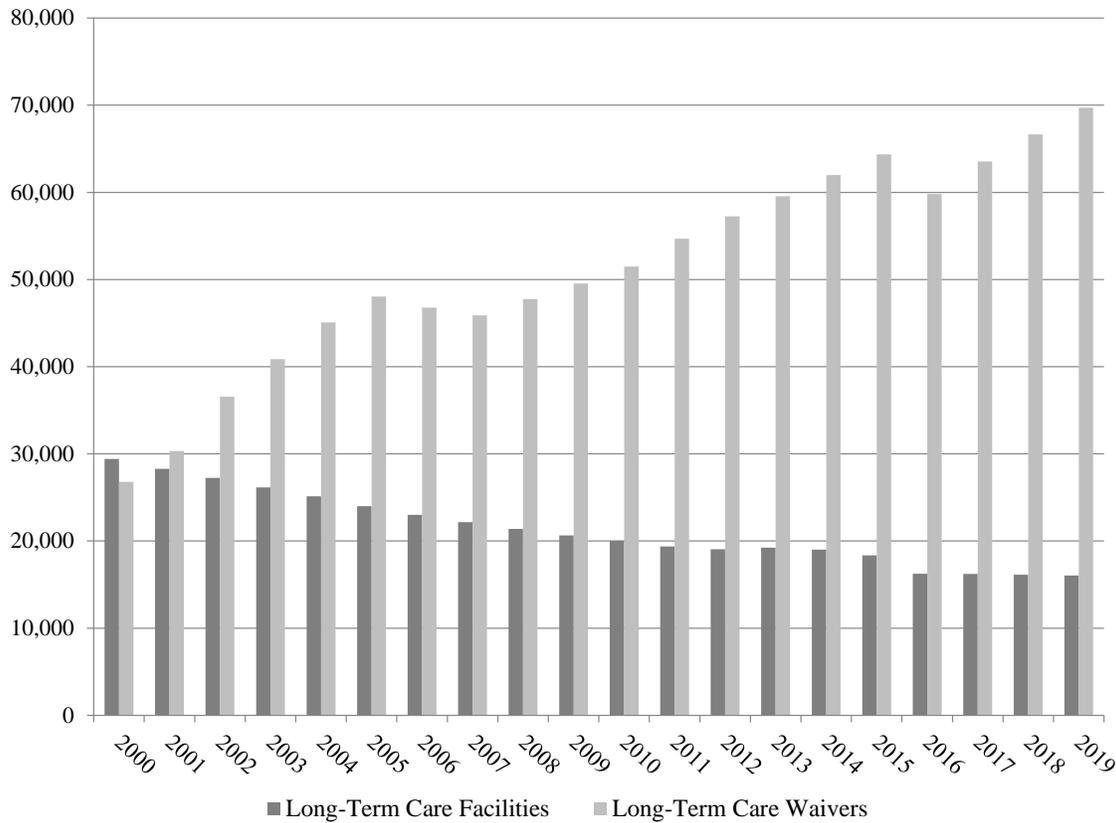


Source: House Fiscal Analysis Department

Figure 5 compares the number of MA enrollees (measured on an average monthly basis) receiving services in a long-term care facility¹² with the number receiving waiver/home care¹³ services over time. The number of enrollees receiving services in LTC facilities has declined over time, while the number of MA enrollees receiving home and community-based waiver or home care services has increased over the same period. For example, the average number of enrollees per month receiving services in a long-term care facility declined from 29,423 in fiscal year 2000 to 16,757 in fiscal year 2015. During the same period, the average number of enrollees per month receiving waiver or home care services increased from 26,798 to 57,602.

Figure 5

**Monthly Average Recipients
 Long-Term Care Facilities and Long-Term Care Waivers and Home Care**



Note: Figures for FY 2017 and beyond are projections based on the November 2016 Forecast.

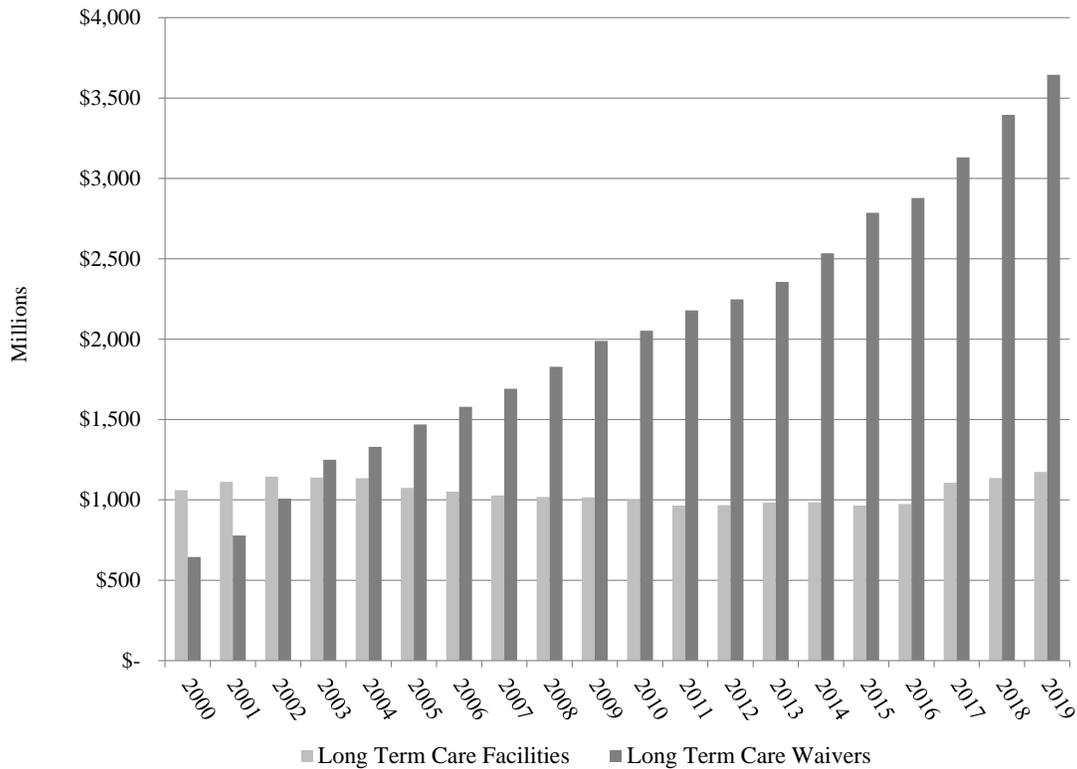
¹² For this figure and figure 6, long-term care facility means a nursing facility, intermediate care facility for persons with developmental disabilities (ICF/DD), or state-operated services mental illness facility (excluding state-operated community services).

¹³ For this figure and figure 6, long-term care waivers and home care includes MA home and community-based waivers, home health agency services, personal care assistance, and home care nursing services.

Figure 6 compares expenditures for MA long-term care facilities and waiver/home care services over time. MA long-term care facility expenditures decreased from \$1.06 billion in fiscal year 2000 to \$924.09 million in fiscal year 2015. During that same period, MA expenditures for waivers and home care increased from \$644.8 million to \$2.8 billion.

Figure 6

**Total Annual Expenditures
 Long-Term Care Facilities and Long-Term Care Waivers and Home Care**

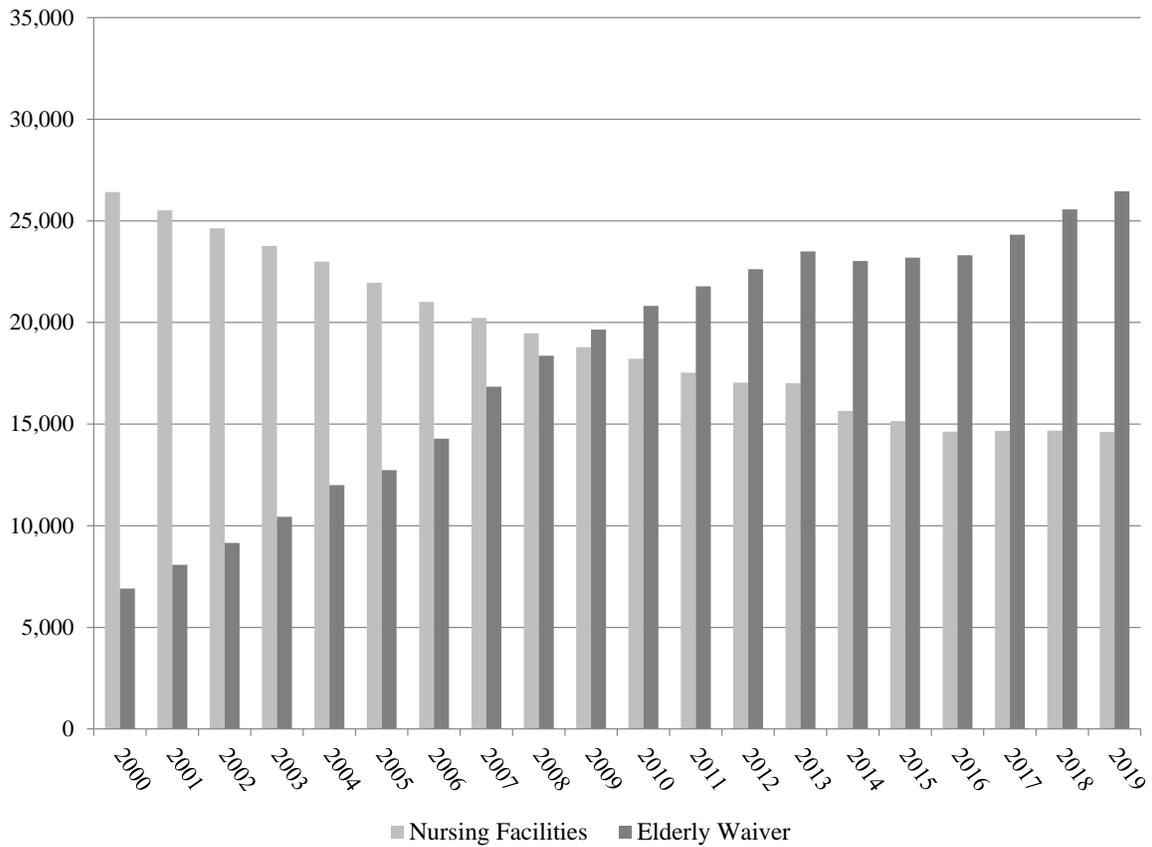


Note: Figures for FY 2017 and beyond are projections based on the November 2016 Forecast.

Figure 7 compares average monthly enrollees age 65 and over in nursing facilities to average monthly enrollees receiving services under the Elderly Waiver over time. In recent years, average monthly enrollees receiving nursing facility services declined from 26,419 in fiscal year 2000 to 15,148 in fiscal year 2015. During that same period, average monthly enrollees receiving services through the Elderly Waiver increased from 6,904 to 23,194.¹⁴

Figure 7

**MA Nursing Facilities and Elderly Waiver
 Average Monthly Recipients**



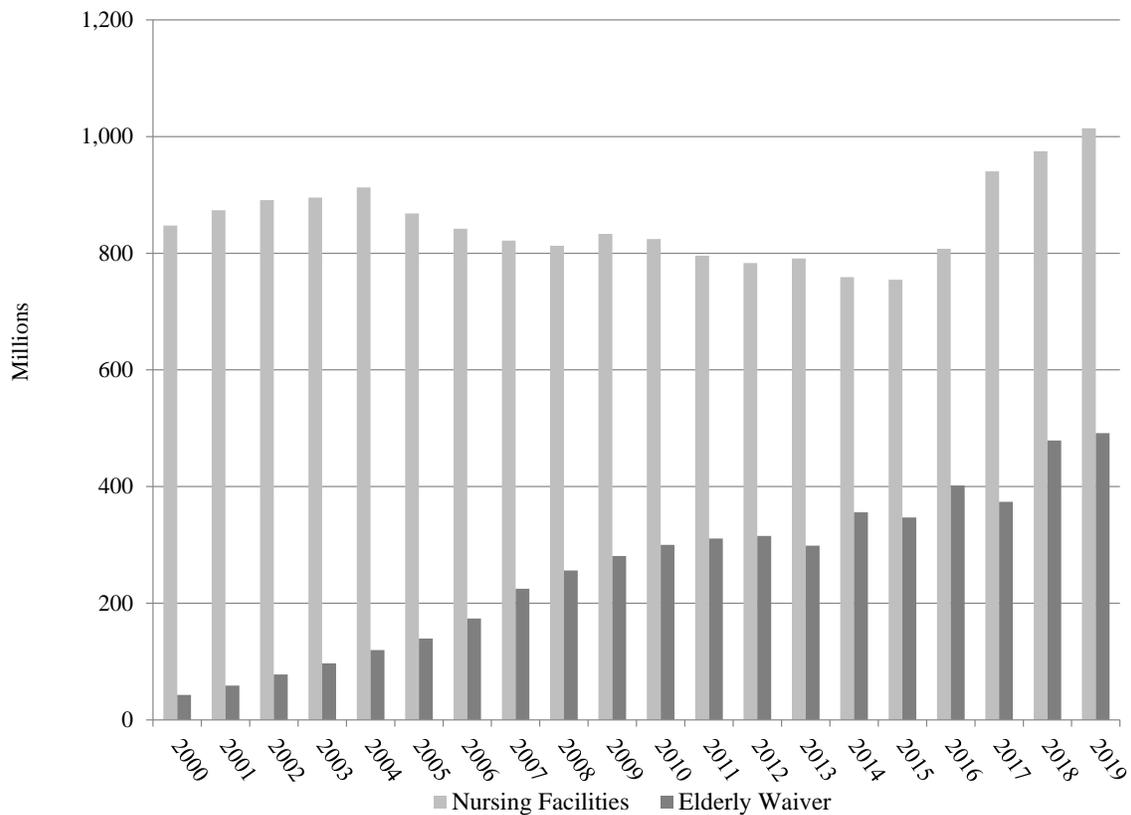
Note: Figures for FY 2017 and beyond are projections based on the November 2016 forecast.

¹⁴ Elderly waiver recipients include both persons receiving the service through fee-for-service and those receiving the service under managed care.

Figure 8 compares total MA annual expenditures for nursing facilities (for persons age 65 and over) and Elderly Waiver services over time. Nursing facility expenditures were \$847.7 million in fiscal year 2000 and decreased to \$754.5 million in fiscal year 2015. During that period, total expenditures for elderly waiver services increased from \$42.8 million in fiscal year 2000 to \$347.1 million in fiscal year 2015. Nursing facility expenditures begin to rise in fiscal year 2016 due to a new payment rate system taking effect.

Figure 8

**MA Nursing Facilities and Elderly Waiver
 Total Annual Expenditures**



Note: Figures for FY 2017 and beyond are projections based on the November 2016 forecast.

State Programs for the Elderly

This section provides information on the following state programs for the elderly—Long-Term Care Consultation Services, the Alternative Care program, essential community supports, Group Residential Housing, and programs administered by the Minnesota Board on Aging.

Long-Term Care Consultation Services

Long-term care consultation services provide screening, assessment, and information and education services to help individuals access and decide on the appropriate level of long-term care services that meet their needs and reflect their preferences. Long-term care consultation services are available to any individual with long-term or chronic care needs.

State law requires all applicants to MA-certified nursing facilities to be screened prior to admission to determine if they need a nursing facility level of care. This preadmission screening is a face-to-face assessment conducted by a certified assessor.

Each county has a long-term care consultation team of certified assessors that includes a social worker and a public health nurse or registered nurse.

Counties are also required, as part of preadmission screening, to assess individuals to determine whether alternatives to nursing facility care, such as Alternative Care services and elderly waiver services, are appropriate.

The total annual expenditure for long-term care consultation services in fiscal year 2016 was \$103.5 million.

Alternative Care Program

The Alternative Care program (AC) provides home and community-based services to individuals who are not MA enrollees, but who are at-risk of nursing facility placement.

In order to qualify for AC services, individuals must:

- be age 65 or over;
- screened by a long-term care certified assessor, be determined to need nursing facility level care, and choose community care; and
- have a gross monthly income that is greater than 120 percent of FPG, or have gross assets greater than the standard MA asset limit, and have combined assets and income no greater than the cost of 135 days of nursing facility care.

In addition, the monthly cost of alternative care services must not exceed 75 percent of the MA payment rate for nursing care for the person's case-mix classification.

Services available through AC include the following:

- Adult day care
- Caregiver training and education
- Case management
- Chore, companion, and homemaker services
- Home care and personal care services
- Home-delivered meals
- Environmental modifications and adaptations
- Nonmedical transportation
- Nutrition service
- Respite care
- Specialized supplies and equipment
- Telehomecare

Enrollees meeting certain income and asset criteria are required to pay a monthly fee to help offset the cost to the state of providing AC services. Fees are determined based on the following table.¹⁵

Adjusted income		Assets	Monthly fee
<100% FPG	and	< \$10,000	None
≥ 100% FPG but < 150% FPG	and	< \$10,000	5%
≥ 150% FPG but < 200% FPG	and	< \$10,000	15%
≥ 200% FPG	and	< \$10,000	30%
	or	≥ \$10,000	30%

The AC program was a state-funded program until fiscal year 2014 when the state began receiving federal MA funding as well.

AC program statistics for fiscal year 2016:

- Total expenditures: \$27.1 million
- Monthly average recipients: 2,574
- Average monthly cost per recipient: \$882

¹⁵ Generally, adjusted income is total income minus recurring medical expenses, with additional deductions allowed for married individuals. Generally, assets are total assets minus most assets excluded under MA, with additional exclusions allowed for married individuals. See [Minn. Stat. § 256B.0913](#), subd. 12.

Essential Community Supports

The essential community supports (ECS) program provides targeted services to persons age 65 and older who need essential community support, but whose needs do not meet the nursing home level of care.

Services must be available to a person who:

- is age 65 or older;
- is not eligible for Medical Assistance (MA);
- has received a community assessment and does not require the level of care provided in a nursing facility;
- meets the financial eligibility criteria for the alternative care program;
- has a community support plan; and
- has an assessed need for at least one of the support services offered under ECS in order to maintain his or her community residence.

Transitional ECS may be available to a person who:

- is age 21 or older;
- lives in his or her own home or apartment;
- meets the financial eligibility criteria for AC;
- was receiving nursing facility services or home and community-based long-term services and supports on January 1, 2015;
- lost eligibility for continuing Medical Assistance payment of nursing facility services or home and community-based long-term services and supports at his or her 2015 annual assessment due to the changes in the nursing home level of care standard;
- is not eligible for personal care attendant services; and
- has an assessed need for at least one of the support services offered under ECS in order to maintain his or her community residence.

Services available through ECS include the following:

- adult day services
- caregiver support
- homemaker support
- chore services
- a personal emergency response device or system
- home-delivered meals
- community living assistance
- service coordination/case management (not to exceed \$600 per person in a 12-month authorization period)

ECS benefits are limited to \$424 per person per month.

ECS program statistics for fiscal year 2016:

- Total expenditures: \$624,312
- Monthly average recipients: 222
- Average monthly cost per recipient: \$234

Group Residential Housing (GRH)

GRH is a state-funded income supplement program that pays for room-and-board costs for low-income adults residing in a licensed or registered setting with which a county human services agency has negotiated a monthly rate.

In order to be eligible for GRH payments, a person must have county approval for residence in a GRH setting and must: (1) be aged, blind, or over 18 years old and disabled, and meet specified income and asset standards; or (2) belong to a category of individuals potentially eligible for General Assistance and meet specified income and asset standards.

Beginning July 1, 2015, the GRH basic room and board rate is \$891 per month. Recipients in certain GRH settings may also qualify for a supplemental payment that is in addition to the GRH basic room and board rate. GRH pays for room and board in a number of licensed or registered settings, including:

- adult foster care;
- board and lodging establishments;
- supervised living facilities;
- noncertified boarding care homes; and
- various forms of assisted living settings registered under the Housing with Services Act.

Persons residing in a setting with a GRH rate are usually considered to be living in the community in their own home. As such, these persons can receive services from most community sources, such as home care and home and community-based waiver programs.

GRH program statistics for fiscal year 2016:

- Total expenditures: \$149.5 million (general fund)
- Average monthly recipients: 19,627
- Average monthly payment per recipient: \$635

Programs Administered by the Board on Aging

The Minnesota Board on Aging is a 25-member board whose members are appointed by the governor. Board staff are provided by DHS and the board is housed within that agency. One of the duties of the board is to administer programs funded through the federal Older Americans Act (OAA). The board is the agency designated by the state to receive OAA funds for distribution to Area Agencies on Aging.

In fiscal year 2016, the board received about \$25.9 million in federal funds and \$18.3 million in state funds for programs that it administers. Some of these programs are described below.

- ***Senior LinkAge Line and related information and assistance services.*** A free telephone service that provides elderly persons with information on and assistance in accessing a range of community services, such as transportation, housing, home care, chore help, caregiver support, meal delivery and nutrition, access to prescription drugs (through RxConnect), and health insurance counseling. The Senior LinkAge Line phone number is 1-800-333-2433.
- ***MinnesotaHelp.*** Provides individuals with information and guidance on long-term care planning, decision-making, and resources. Individuals can access a directory of long-term care, health care, housing, disability, and human services providers and organizations at www.MinnesotaHelp.info. The information provided can be tailored to the location and needs of the individual.
- ***Senior Nutrition Services.*** Senior dining services (also referred to as congregate meals) provide nutritionally balanced meals to individuals age 60 and over, and their spouses, at various sites in the community. Home-delivered meals provide meals to homebound individuals age 60 and over in their place of residence. There is no charge for these services, but donations are requested to pay for the cost. Each year about 47,000 individuals are served congregate meals, 13,000 are served home-delivered meals, and grocery delivery is provided to 600 individuals.
- ***Caregiver Grants.*** Grants provided to Area Agencies on Aging and service providers to fund respite care, education and training in caregiving, and support groups for family caregivers. In fiscal year 2015, \$479,000 was appropriated from the state general fund for caregiver grants.
- ***Dementia Grants.*** These grants are state-funded competitive grants for regional and local projects and initiatives 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, or connect caregivers of persons with dementia to education and resources. Eligible applicants include, but are not limited to, community health boards, school districts, colleges and universities, community clinics, tribal communities, nonprofit organizations, and other health care organizations. For fiscal year 2017, \$750,000 was appropriated from the state general fund for dementia grants.

- ***Minnesota Senior Corps.*** A network of programs that provide elderly persons with volunteer opportunities. The Retired and Senior Volunteer Program (RSVP) assists persons age 55 and over in volunteering at hospitals, youth recreation centers, and other community organizations. The Senior Companion Program (SCP) allows seniors age 55 and over to assist at-risk, frail elderly in daily living tasks. The Foster Grandparent Program (FPG) allows seniors age 55 and over to serve as mentors, tutors, and caregivers for children and youth with special needs. Each year more than 20,000 volunteers provide services through these programs. In fiscal year 2015, \$1.988 million was appropriated from the state general fund for Minnesota Senior Corps.
- ***Ombudsman for Long-Term Care.*** This office serves as an advocate for and investigates and resolves complaints concerning health, safety, welfare, and rights for people receiving long-term care services. This office is primarily state funded, but also receives some OAA funding.

For more information about public assistance programs, visit the health and human services area of our website, www.house.mn/hrd/.