**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**7500 Security Boulevard, Mail Stop S2-25-26**
**Baltimore, Maryland 21244-1850**


**State Demonstrations Group**

May 30, 2024

Julie Marquardt
Acting Assistant Commissioner and State Medicaid Director
Minnesota Department of Human Services
540 Cedar Street
St. Paul, Minnesota 55164-0983

Dear Director Marquardt:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Final Report, which is required by the Special Terms and Conditions (STCs), specifically STC 35, "Final Report," of Minnesota's section 1115 demonstration, "Minnesota 2020 System Reform" (Project No: 11-W-00286/5), approved from October 18, 2013, through June 30, 2018, and was subsequently temporarily extended through January 31, 2020. This report covers the demonstration period from October 2013 through October 2019.[1] CMS determined that the Final Report, submitted on May 17, 2021, and revised on March 25, 2022, is in alignment with the CMS-approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state's Final Report.

This demonstration authorized expenditure authority for individuals ages 65 and older who meet nursing facility level of care criteria but have combined adjusted income and assets exceeding Medicaid standards to receive home and community-based services (HCBS). In alignment with the approved Evaluation Design, the Final Report largely relies on quantitative descriptive analysis and presents service utilization trends for both the demonstration population and an in-state comparison population that also received HCBS. The report shows promising trends in outcomes in alignment with the demonstration's goals. For example, the rate of demonstration participants utilizing consumer-directed community supports consistently increased throughout the evaluation period, which was also higher among the demonstration participants compared to the comparison population. Additionally, the rate of demonstration participants utilizing a nursing facility was approximately halved by the end of the demonstration period while the utilization in the comparison population decreased by 20 percent.

[1] The state will include analysis for November 1, 2019 through January 31, 2020 in its evaluation for the current demonstration approval period, effective through January 31, 2025.

We look forward to our continued partnership on the Minnesota 2020 System Reform section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2024.05.30 10:00:43 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Sandra Porter, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

# Minnesota's Reform 2020 Section 1115 Demonstration Waiver
## Alternative Care Program: Report June 2021

*May 17, 2021*

Revised March 25, 2022

Prepared for the Minnesota Department of Human Services

Prepared by Greg Arling and Zachary Hass, School of Nursing, Purdue University and Mark Woodhouse, University of Minnesota School of Public Health.

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# A. Executive Summary

This is the most recent in a series of annual reports from the evaluation of Minnesota's Reform 2020 Section 1115 Demonstration Waiver. The waiver was approved for the period beginning October 18, 2013. The waiver pertains to Minnesota's Alternative Care (AC) Program, which provides home and community-based services (HCBS) to people ages 65 and older who meet nursing facility level of care criteria, and who have combined adjusted income and assets exceeding Medicaid standards for aged, blind and disabled categorical eligibility, but whose income and assets would be insufficient to pay for 135 days of nursing facility care.

Minnesota's AC program has been in operation for a number of years; however, prior to the Reform 2020 waiver, it was supported exclusively through state funds. Although AC was approved for Medicaid funding, the eligibility criteria and mix of HCBS services did not change after the waiver was approved.

The AC program complements the state's Elderly Waiver (EW), a home and community-based waiver for people aged 65 and older that meet nursing facility level of care criteria. Although the AC program includes fewer HCBS services, the service definitions, provider standards, and provider rates for the AC program are the same as those specified in Minnesota's federally approved Elderly Waiver.

The goals of AC are as follows:

- Provide access to coverage for home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
- Provide access to consumer-directed coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
- Provide high-quality and cost-effective home and community-based services that result in improved outcomes for participants measured by less nursing home use over time.

## Evaluation Approach

The evaluation focused on trends in the AC program before and after the implementation of the AC waiver. We wanted to detect any changes (if any) in population being served or their use of services. We were interested particularly in any unintended negative consequences, particularly changes in service use or increased nursing facility stays. The EW program offered a convenient comparison group to take into account secular trends, e.g., external policy or program changes that may have influenced both the AC and EW programs.

### Methods

We compared characteristics of the AC and EW community populations (i.e. EW participants in non-residential service settings) for the years 2013, when the AC waiver was implemented, through 2019. The analysis involved comparison of repeated cross-sectional samples each year. The main data sources were MMIS LTC Screening Documents, Medicaid Claims, and the nursing

facility Minimum Data Set (MDS). All reporting of service use, including CDCS, is based on service codes on claims, including encounter data. It is not based on screeners or service agreements.

## Hypotheses and Results

*Hypothesis 1: The level of need, demographic characteristics, and service use patterns for Alternative Care participants will not change over time, neither alone nor in comparison to Elderly Waiver participants in non-residential settings*. We found the following:

*Demographic Characteristics of AC Participants from 2013 through 2019*

Age - AC participants were significantly older than EW participants in each year. However, when considering the trend over the entire period, the AC population became younger on average. From 2013 to 2019, the percentage AC participants age 65-74 increased from 21% to 31%, while the percentage of AC participants age 85 and older dropped from 43% to 32%. During the same period, the percentage of EW participants age 65-74 ranged from 41% to 43%, and the percentage age 85 and older ranged from 18% to 20%.

Gender - The majority of both AC and EW participants were female. Over the 2013-2019 period, the percentage of AC participants who were female ranged from 75% to 72%, while the percentage EW participants who were female ranged from 71% to 69%.

Marital Status - Higher percentages of EW participants tended to be married, while higher percentages of AC participants tended to be widowed or divorced. As a note of caution: from 18% to 24% of AC Participants had missing data on marital status. Therefore, it is difficult to draw valid conclusions about differences in marital status.

Race/Ethnicity - Whites made up the vast majority of AC participants in all years, although the percentage declined from 94% in 2013 to 89% in 2019. On the other hand, racial and ethnic minorities were much more highly represented among EW participants, and their percentages increased from 39% in 2013 to 51% in 2019. A note of caution: up to 22% of AC participants had missing data on race and ethnicity.

Geographic Location – More than half of both AC and EW program participants reside in the Twin Cities seven-county metro area. The EW participants were significantly more likely than AC participants to reside in the Twin Cities seven-county metro area. The percentage of EW participants in the Twin Cities increased from 62% in 2013 to 68% in 2019, and the percentage of AC participants in the Twin Cities increased from 52% in 2013 to 59% in 2019.

Living Arrangement- The percentage of AC participants living alone declined somewhat from 2013 to 2019, from 65% to 62%. The EW participants showed a more pronounced downward trend in living alone from 52% in 2013 to 44% in 2019.

*Health and Functional Conditions*

Case-Mix - The AC participants showed a downward trend in the low need category from 51% in 2013 to 26% in 2019. The percentage of EW participants in the low need category also declined, but not a steeply, from 55% in 2013 to 41% in 2019. On the other hand, AC participants in the moderate need category increased from 37% in 2013 to 59% in 2019, whereas the percentage

of EW participants in the moderate need category increased only slightly from 32% in 2013 to 37% in 2019. A note of caution: patterns in the need categories may have been confounded by a change in NF-LOC criteria on January 1, 2015.

Dependencies in Activities of Daily Living - Among AC participants the percentage with a critical ADL need for positioning/bed mobility remained steady at approximately 8% over the years. Transferring need increased from 22% to 26% between 2014 and 2015, but remained steady in the next years. The only significant change between years in levels of dependency in other ADL areas was from 2014 and 2015, the years when the LOC criteria changed.

Professional conclusions are indicated by the assessor upon completion of an assessment, and are intended to capture an assessor's overall opinion about the person's need and/or presenting problems or conditions. The AC participants increased significantly across time in several problems areas as recorded in the professional conclusions of the assessment. Increases in need were indicated for ADL conditions (79% in 2013 to 87% in 2019); frequent behavioral symptoms (27% in 2013 to 67% in 2019); neglect/abuse risk (25% in 2013 to 49% in 2019); frequent institutional stays (9% in 2013 to 39% in 2019); unstable health condition (10% in 2013 to 30% in 2019); needs evening/night direct care for special treatments (4% in 2013 to 13% in 2019); and complex care management (6% in 2013 to 15% in 2019). The EW participants experienced relatively little increase in need as indicated by the professional conclusions, although there were notable increases in need based on frequent behavioral symptoms, self-care risk, and neglect/abuse risk. When comparing AC and EW Participants in 2019, the AC participants were significantly more likely than EW participants to have problems in ADL conditions (87% vs. 71%); complicated condition (21% vs. 14%); frequent behavioral symptoms (67% vs. 30%); general frailty (37% vs. 24%); frequent institutional stays (39% vs. 8%); unstable health condition (30% vs. 10%); needs evening/night direct care for special treatments (13% vs. 2%); and complex care management (15% vs. 4%).

*AC and EW Participant Service Use*

The AC participants' use of most services underwent relatively little change from 2013 to 2019. Significant declines occurred in home health (31% in 2013 to 24% in 2019); home health aide (23% in 2013 to 10% in 2019); homemaker (59% in 2013 to 45% in 2019); PERS (53% in 2013 to 46% in 2019). The service use patterns of AC and EW participants were substantially different in several areas. In 2019, AC participants were significantly more likely than EW participants to use; CDCS (10% vs. 3%); home delivered meals (37% vs. 21%); PERS (46% vs. 34%); and specialized supplies and equipment (26% vs. 10%). In contrast, EW participants were significantly more likely than AC participants to use adult day services (24% vs. 4%), personal care assistance (40% vs. 17%), and non-medical transportation (31% vs. 12%). Both AC and EW participants are required to receive AC or waiver case management service, including people who choose the consumer-directed service option. AC participants appear to be more likely to use case management services; however, this is likely due to a difference in program design where case management services are covered under administrative costs for EW participants in managed care so it is not captured in this data.

*Hypothesis 2: Alternative Care participants will experience equal or better access to consumer-directed service (CDCS) options over time, when examined alone and compared to Elderly Waiver participants in non-residential settings*. We found the following:

The use of CDCS increased from 4% in 2013 to 10% in 2019 for AC participants. The rate of CDCS service use remained relatively constant between 2% and 3% over the period for EW participants.

*Hypothesis 3: Alternative Care participants will experience equal or less frequent nursing facility use over time, when examined alone and compared to Elderly Waiver participants in non-residential settings.*

The percentage of AC participants spending any time in a nursing facility declined from 26% in 2013 to 14% in 2019. Although the rate of nursing home use declined, the mean number of nursing home days per nursing facility user increased somewhat from 73.9 in 2013 to 78.6 in 2019. The rate of nursing home use for EW participants was significantly lower than for AC participants, and it declined somewhat from 15% in 2013 to 12% in 2019. There was no consistent pattern over time among EW participants in their mean number of nursing home days.

## Conclusions

The evaluation found changes over time in the characteristics of the AC participant population and its services use. In general, the level of assessed needs for the AC population increased over the years. On average, use of some services, such as home health, home health aide, and homemaker, declined. However, the use of CDCS increased and nursing home use declined, which were consistent with hypothesized directions.

We have no evidence of harmful effects or that assessed needs are not being met through the use of paid services and informal supports. The current use of services may be both efficient and effective, even though needs have increased over the years.

The evaluation findings raise additional questions about why the types of services used by AC participants are different than those used by EW participants and contrasts in the racial and ethnic composition of the populations. Although the populations differ in financial eligibility requirements, the AC and EW participants are similar in their health and functional conditions, they both have to meet NF-LOC criteria, and the programs share a goals of delaying or avoiding nursing home use.

# B. General Background Information about the Demonstration

This is one of a series of reports from the evaluation of Minnesota's Reform 2020 Section 1115 Demonstration Waiver. The evaluation is being carried out by researchers at the University of Minnesota and Purdue University. This June 2021 report is the fifth annual report dealing with the Alternative Care waiver. The first report was issued in June 2017. Each report used a similar approach to the evaluation, although prior reports have focused on periods immediately before (2012-2013) and after (2014 forward) the waiver implementation. The current approach, takes a longer view of trends over 7-year period of 2013 through 2019.

## B.1 Overview

The Reform 2020 waiver allows Minnesota to receive federal financial participation for the Alternative Care (AC) program, which was implemented under the waiver beginning November 1, 2013. Formerly a state-funded program, AC program provides home and community-based services (HCBS) to people ages 65 and older who meet nursing facility level of care criteria, who have combined adjusted income and assets exceeding Medicaid standards (i.e., Medical Assistance (MA)) standards for aged, blind and disabled categorical eligibility, but whose income and assets would be insufficient to pay for 135 days of nursing facility care. Acute, preventive and primary care benefits are not covered under the program.

Minnesota's AC program has been in operation since 1981; however, prior to the waiver, it was supported exclusively through state funds. The assumption underlying the AC program is that connecting seniors with community services earlier may divert them from nursing facilities, delay conversion to Medicaid, and encourage more efficient use of services if full Medicaid eligibility is established. The eligibility criteria and mix of HCBS services did not change after the waiver was approved.

The AC program complements the state's Elderly Waiver (EW), a home and community-based waiver for people aged 65 and older that meet nursing facility level of care criteria. Although the AC program includes fewer HCBS services, the service definitions, provider standards, and provider rates for the AC program are the same as those specified in Minnesota's federally approved Elderly Waiver. Services are provided by qualified and enrolled Medicaid providers.

Currently each of Minnesota's HCBS waivers and the AC program include Consumer Directed Community Supports (CDCS). This service option gives individuals receiving waiver or AC services a self-directed option to develop a plan for the delivery of their services within an individual budget. CDCS gives a person flexibility in service planning and responsibility for self-directing his or her services, including hiring and managing support workers. CDCS participants are supported by a financial management services (FMS) provider assists the person with employer-related and other financial responsibilities. CDCS allows individuals to substitute individualized services for what is otherwise available in the traditional menu of services in the HCBS programs.

## B.2 Program Eligibility

Alternative Care is available to eligible individuals who meet all of the following *financial requirements*:

- Those with combined income and assets insufficient to pay for 135 days of nursing facility care, based on the statewide average nursing facility rate
- Those not within an uncompensated transfer penalty period or other long-term care ineligibility status
- Those with home equity within the home equity limit applicable under the state plan
- Those assessed a participant contribution for authorized AC services (AC fee) fulfill that contribution.

*Functional eligibility* for nursing home care and identification of needed services for Alternative Care program is performed using the Long-term Care Consultation process, which uses the same nursing facility level of care criteria, assessment tool, and service planning process that is used for the Elderly Waiver.

## B.3 Benefits and Services

The benefits available under Alternative Care are the same as the benefits covered under the federally approved Elderly Waiver, ***except:***

- Alternative Care **does not cover** transitional support services, customized living services, and adult foster care services or services that meet primary, preventive, and acute health care needs
- Alternative Care **additionally covers** nutrition services and discretionary benefits

The comprehensive list of Alternative Care benefits includes:

- Adult day service/adult day service bath;
- Family caregiver training and education and family caregiver coaching and counseling/assessment;
- Case management and conversion case management;
- Chore services;
- Companion services;
- Consumer-directed community supports;
- Home health services;
- Home-delivered meals;
- Homemaker services;
- Environmental accessibility adaptations;
- Nutrition services;
- Personal care;
- Respite care;
- Skilled nursing and private duty nursing;
- Specialized equipment and supplies including Personal Emergency Response System (PERS);
- Non-medical transportation;
- Tele-home care;
- Discretionary services

# C. Evaluation Questions and Hypotheses

The Reform 2020 demonstration waiver was approved for the period beginning October 18, 2013. Since the federal waiver authorization did not result in any changes to the fundamental aspects of the State's original Alternative Care program, the state did not anticipate any significant changes to the size, characteristics, or service use of the AC population after approval of the AC waiver.

The evaluation focuses on trends in the AC program during and after the implementation of the AC waiver, 2013-2019. We wanted to detect any changes (if any) in population being served or their use of services. We were interested particularly in any unintended negative consequences.

Since the AC program was very similar to the EW program, aside from financial eligibility requirements, the EW program offered a convenient comparison group. The EW comparison group allowed us to take into account secular trends, e.g., external policy or program changes that may have influenced the AC program. Many trends affecting AC are likely also to affect EW.

## C.1 Program Goals

The goals of the Alternative Care program are to:

- Provide access to coverage for home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
- Provide access to consumer-directed option of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
- Provide high-quality and cost-effective home and community-based services that result in improved outcomes for participants measured by less nursing home use over time.

## C.2 Comparison Population

The target populations included in the evaluation consist of Alternative Care (AC) program participants and Elderly Waiver (EW) participants. Elderly Waiver participants are very similar to Alternative Care program participants. Both groups: 1) are aged 65 and above, 2) must have an assessed need for a nursing facility level of care, and 3) are using home and community-based services to meet their needs and remain living in the community instead of in a nursing facility.

Residential services are not available through AC. However, Elderly Waiver participants can access residential services (i.e., customized living, adult foster care, and residential care services). Our analysis focused on Elderly Waiver participants in non-residential settings. We excluded Elderly Waiver participants with any claims for residential services in the period under study.

## C.3 Hypotheses

We evaluated changes in the client populations and service use over time within the AC program itself and in AC compared to the EW program. The evaluation covers the periods 2013 (the year the AC waiver was approved) through 2019.

1. **The level of need, demographic characteristics, and service use patterns for Alternative Care participants will not change over time, neither alone nor in comparison to Elderly Waiver participants in non-residential settings.** We used the following measures:

- Case mix status (low-need vs. high-need) for AC and EW
- Activities of daily living (ADL) dependencies and professional conclusions
- Acuity rate differences between AC and Elderly Waiver non-residential participants
- Use of home and community-based services
- Use of nursing facility care

2. **Alternative Care participants will experience equal or better access to consumer-directed service (CDCS) options over time, when examined alone and compared to Elderly Waiver participants in non-residential settings.** We used the following measures:

- Authorized consumer-directed community supports
- Difference in CDCS use between AC and Elderly Waiver non-residential participants

3. **Alternative Care participants will experience equal or less nursing facility use over time, when examined alone and compared to Elderly Waiver participants in non-residential settings.** We used the following measures:

- Proportion of participant entering nursing facilities
- Number of nursing facility days

# D. Methodology

The aim of this interim report was to gain a better understanding of similarities and differences between the AC program and EW waiver populations each year from 2013 (the year the waiver was approved) through 2019.

In comparing the demographics, case-mix and functional limitations of the AC and EW participants, we conducted a repeated cross-sectional analysis with October 1 in each year (2013-2019) as a representative date. For the repeated cross-sectional analysis of HCBS and nursing home use we averaged the monthly use of services over the 12-month calendar year. The data were incomplete at the end of 2019; therefore, we calculated a monthly average from January – September in that year.

In the sections below, we describe evaluation data sources, major variables, samples and statistical analysis.

## D.1 Data Sources

**LTC Screening Document.** This form is used to document pre-admission screening and long-term care consultation (LTCC) assessment and other administrative activities. It is used to record public programs eligibility determination as well as to collect information about people screened, assessed, or receiving services under home and community-based services programs. For the current version of the form: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3427-ENG.

**Medicaid Claims.** Medicaid Management Information Systems (MMIS) is the largest health care payment system in Minnesota. The MN Department of Human Services (DHS) uses MMIS to validate and pay HCBS and health care claims, including managed care capitation payments, for over 525,000 Minnesotans enrolled in Minnesota Health Care Programs (MHCP). All reporting of service use, including CDCS, is based on service codes on claims, including encounter data. It is not based on screeners or service agreements.

**Minimum Data Set (MDS).** This is a federally mandated assessment used in nursing facilities (NF). Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). The MDH conducts regular audits of the MDS data submitted by NFs to ensure the data are accurate.

## D.2 Major Variables

| **Variable** | **Source (Primary first, additional sources for confirmation or fallback in order of priority)** |
|---|---|
| Program Status | MMIS Eligibility File, MMIS Waiver Enrollment File, MMIS Claims, LTC Screening Document, MDS |
| Age | MMIS Eligibility File, LTC Screening Document |
| Gender | MMIS Eligibility File, LTC Screening Document |
| Marital Status | LTC Screening Document, MMIS Eligibility File |
| Race/Ethnicity | MMIS Eligibility File, LTC Screening Document |

| | |
|---|---|
| Geographic Location | LTC Screening Document, MMIS Eligibility File |
| Living Arrangement | LTC Screening Document |
| Case Mix | LTC Screening Document |
| ADL Dependencies | LTC Screening Document |
| Professional Conclusions | LTC Screening Document |
| Service Utilization | MMIS Claims, including Encounter data, MDS (Nursing Facilities) |

### D.3 Samples

**Repeated cross-sectional analysis of participant characteristics at a single point-in-time each year**. We selected a cross-section of participants who were eligible for either Alternative Care (AC) or Elderly Waiver (EW) on October 1 or who became eligible during that month in each year from 2013 through 2019. We have a "snap-shot" of the population each year, which includes new entrants as well as participants who carried over from prior years. The mix of continuing participants and new entrants could be changing over time. Our snapshot is capturing both the change in the mix and the aging of the population. Separating the two dynamics would require much more complex modeling.

We excluded EW participants who were in residential services (i.e., adult foster care or customized living), since they are less comparable to the AC participants both in terms of population composition and service use. Where available, we took descriptive variables from Medicaid administrative data. Some variables can only be sourced from the LTC Screening Document (SDOC), particularly those describing health and functional status of participants. For those variables, we chose a reference assessment for each participant based on the recency and type of assessment.

**Repeated cross-sectional analysis of service utilization over 12-month periods**. We selected individuals who were eligible at any time during each of the calendar years 2013, 2014, 2015, 2016, 2017, 2018, or 2019. We then aggregated service use over the entirety of each calendar year in order to smooth out utilization of services that are not typically used monthly or whose level of use might vary widely month to month.

### D.4 Statistical Analysis

Tests of statistical significance are based on a two-tailed Chi-square test, t-test for independent populations or t-test for paired populations, with an alpha of $p<.001$.

## E. Results

### E.1 Characteristics of AC and EW Community Participants in October of Each Year

The first step in the analysis was to compare the demographic, case mix and functional characteristics of the AC program and EW community participants at the October 1 time points in 2013-2019.

Table 1 presents the demographics, health and function, and professional conclusions related to need for each population. We tested the statistical significance of differences between groups and between years within groups with a two-tailed Chi-square test and a saturated Poisson model with contrasts. Since the samples were so large, we used a stringent alpha of $p<.001$. We report on the statistical significance of differences in the characteristics between AC and EW participants at each time point (cross-sectional comparisons) and differences between subsequent years within the AC and EW participants (longitudinal comparison).

### E.1.1 Demographics

**Age**

AC participants were significantly older than EW participants in each year. Compared to EW participants, higher percentages of AC participants were age 85 or older. There were no significant year-to-year change in the age distribution for either AC or EW participants from 2013-2019. However, when considering the trend over the entire period, the AC population became younger on average. From 2013 to 2019, the percentage AC participants age 65-74 increased from 21% to 31%, while the percentage of AC participants age 85 and older dropped from 43% to 32%. During the same period, the percentage of EW participants age 65-74 ranged from 41% to 43%, and the percentage age 85 and older ranged from 18% to 20%.

**Gender**

The majority of both AC and EW participants were female. Over the 2013-2019 period, the percentage of AC participants who were female ranged from 75% to 72%, while the percentage EW participants who were female ranged from 71% to 69%.

**Marital Status**

Higher percentages of EW participants tended to be married, while higher percentages of AC participants tended to be widowed or divorced. As a note of caution: from 18% to 24% of AC participants had missing data on marital status. Therefore, it is difficult to draw conclusions about differences in marital status over time among AC participants or to compare them to EW participants.

**Race/Ethnicity**

Whites made up the vast majority of AC participants in all years, although the percentage declined from 94% in 2013 to 89% in 2019. On the other hand, racial and ethnic minorities were much more highly represented among EW participants, and their percentages increased from 39% in 2013 to 51% in 2019. In the same years. A note of caution: from 12% to 22% of AC participants had missing data on race and ethnicity, and the absence of this data increased in the years 2017, 2018, and 2019.

**Geographic Location**

The EW participants were significantly more likely than AC participants to reside in Twin Cities seven-county metro area (i.e., Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington counties), although the percentage living in the Twin Cities increased from 2013 to 2019 for both groups. The percentage of EW participants in the Twin Cities increased from 62% in 2013

to 68% in 2019, and the percentage of AC participants in the Twin Cities increased from 52% in 2013 to 59% in 2019.

**Living Arrangement**

The percentage of AC participants with a planned arrangement of living alone declined somewhat from 2013 to 2019, from 65% to 62%. The EW participants showed a more pronounced downward trend in living alone from 52% in 2013 to 44% in 2019.

## Table 1. Demographic Characteristics of AC and EW Community (Non-Residential) Participants in October 2013 - 2019

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Participants | 2736 | 14842 | 2719 | 14958 | 2536 | 14891 | 2490 | 15241 | 2543 | 16218 | 2544 | 16952 | 2584 | 17677 |
| Age | | | | | | | | | | | | | | |
| Mean | 82 | 77 | 81 | 77 | 81 | 77 | 80 | 77 | 80 | 77 | 80 | 77 | 79 | 77 |
| 65-74 | **21%** | **41%** | **24%** | **41%** | **24%** | **40%** | **27%** | **40%** | **29%** | **42%** | **29%** | **43%** | **31%** | **43%** |
| 75-84 | **36%** | **40%** | **34%** | **40%** | **37%** | **40%** | **36%** | **40%** | **36%** | **39%** | **38%** | **39%** | **37%** | **39%** |
| 85-94 | **38%** | **17%** | **37%** | **17%** | **35%** | **18%** | **32%** | **17%** | **31%** | **17%** | **29%** | **16%** | **27%** | **16%** |
| 95+ | **5%** | **2%** | **4%** | **2%** | **4%** | **2%** | **4%** | **2%** | **4%** | **2%** | **4%** | **2%** | **5%** | **2%** |
| Gender | | | | | | | | | | | | | | |
| Female | **75%** | **71%** | 74% | 71% | 73% | 71% | 73% | 71% | 73% | 70% | **72%** | **69%** | 72% | 69% |
| Male | **25%** | **29%** | 26% | 29% | 27% | 29% | 27% | 29% | 27% | 30% | **28%** | **31%** | 28% | 31% |
| Marital Status# | | | | | | | | | | | | | | |
| Widowed | **49%** | **35%** | **46%** | **33%** | **43%** | **32%** | **45%** | **32%** | **45%** | **32%** | **41%** | **30%** | **37%** | **28%** |
| Divorced/Separated | **28%** | **38%** | **30%** | **38%** | **31%** | **39%** | **31%** | **39%** | **31%** | **39%** | **34%** | **40%** | **34%** | **40%** |
| Married | **11%** | **15%** | **12%** | **16%** | **14%** | **17%** | **11%** | **15%** | **11%** | **14%** | **11%** | **16%** | **14%** | **18%** |
| Never Married | **11%** | **11%** | **12%** | **12%** | **12%** | **12%** | **13%** | **13%** | **13%** | **14%** | **14%** | **14%** | **15%** | **15%** |
| Race/Ethnicity# | | | | | | | | | | | | | | |
| Asian | **0%** | **17%** | **0%** | **17%** | **0%** | **18%** | **0%** | **18%** | **1%** | **19%** | **0%** | **20%** | **1%** | **21%** |
| Black/African American | **3%** | **17%** | **5%** | **18%** | **5%** | **20%** | **6%** | **21%** | **6%** | **23%** | **6%** | **24%** | **7%** | **25%** |
| Hispanic | **1%** | **2%** | **1%** | **2%** | **1%** | **3%** | **1%** | **3%** | **1%** | **3%** | **1%** | **3%** | **1%** | **3%** |
| Native American | **1%** | **2%** | **1%** | **2%** | **1%** | **2%** | **1%** | **2%** | **1%** | **2%** | **1%** | **2%** | **1%** | **2%** |
| White | **94%** | **61%** | **93%** | **60%** | **93%** | **57%** | **92%** | **56%** | **91%** | **53%** | **91%** | **51%** | **89%** | **49%** |
| Other | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| Multiple | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** | **0%** |
| Geography | | | | | | | | | | | | | | |
| 7-County Metro Area | **52%** | **62%** | **54%** | **62%** | **54%** | **63%** | **55%** | **65%** | **57%** | **66%** | **58%** | **67%** | **59%** | **68%** |

| | 2013 | | 2014 | | 2015 | | 2016 | | 2017 | | 2018 | | 2019 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Greater Minnesota | **48%** | **38%** | **46%** | **38%** | **46%** | **37%** | **45%** | **35%** | **43%** | **34%** | **42%** | **33%** | **41%** | **32%** |
| Geography by MSA | | | | | | | | | | | | | | |
| Twin Cities Central | **55%** | **64%** | **57%** | **65%** | **57%** | **66%** | **59%** | **67%** | **61%** | **68%** | **64%** | **70%** | **68%** | **74%** |
| Other Central | **7%** | **7%** | **8%** | **7%** | **8%** | **7%** | **7%** | **7%** | **7%** | **7%** | **6%** | **7%** | **4%** | **4%** |
| Outlying | **6%** | **4%** | **6%** | **4%** | **6%** | **4%** | **6%** | **4%** | **6%** | **4%** | **6%** | **4%** | **5%** | **3%** |
| Rural | **29%** | **24%** | **27%** | **23%** | **26%** | **23%** | **25%** | **21%** | **23%** | **20%** | **21%** | **19%** | **18%** | **18%** |
| Unknown | **3%** | **1%** | **3%** | **1%** | **3%** | **0%** | **4%** | **1%** | **3%** | **1%** | **4%** | **1%** | **4%** | **0%** |
| Living Arrangement | | | | | | | | | | | | | | |
| Live Alone | **65%** | **52%** | **66%** | **52%** | **65%** | **50%** | **65%** | **48%** | **63%** | **47%** | **63%** | **45%** | **62%** | **44%** |

Note: Statistically significant differences ($p < .001$) between AC and EW in individual years are **bolded**. Significant differences in characteristics between years for the AC or EW participants are underlined (different from following year), wavy underlined (different from previous year), or double underlined (different from following and previous year).

# Marital status information was missing for 21% of participants in 2013, 18% in 2014, 19% in 2015, 20% in 2016, 20% in 2017, 22% in 2018, and 24% in 2019. Race/ethnicity was missing for 12% of participants in 2013, 12% in 2014, 12% in 2015, 12% in 2016, 13% in 2017, 19% in 2018, and 22% in 2019.

## E.1.2 Case Mix and Functional Limitations

Table 2 provides summary information for the AC and EW populations using the most recent assessment information in MMIS related to their program participation in October of each year. Items reported in Table 2 come from the LTCC form[1].

**Case-Mix**
Case mix is a classification tool that is used in both AC and EW programs to establish monthly budget limits for HCBS services. The classification is based on assessed need in:

- Eight activities of daily living (ADLs): bathing, dressing, grooming, walking, toileting, positioning, transferring, and eating
- The need for clinical monitoring in combination with a physician-ordered treatment, and
- The need for staff intervention due to behavioral or cognitive needs.

After assessment, the individual is assigned a case mix classification of A-L based on their combination of ADLs, clinical monitoring and behavioral/cognitive needs. For purposes of this evaluation, the case mix classifications have been grouped as follows:

- Low Need (A, L): This group includes individuals with 0-3 ADL dependencies
- Moderate Need (B, D, E): This group includes individuals with 4-6 ADL dependencies and/or behavioral/cognitive needs.
- High Need (G, H, I, J): This group includes individuals with dependencies in 7 or 8 ADLs (G), and those with specific other needs in combination with 7-8 ADL dependencies.
- High Need Clinical (C, F, K, V): This group includes individuals with varying number of dependencies but who have an assessed need for clinical monitoring at least once every 8 hours.
- Other/Missing

The AC participants showed a downward trend in the low need category from 51% in 2013 to 26% in 2019. The percentage of EW participants in the low need category also declined, but not a steeply, from 55% in 2013 to 41% in 2019. Most of the shift among AC participants was from the low to moderate need category. The AC participants in the moderate need category increased from 37% in 2013 to 59% in 2019. Percentage of EW participants in the moderate need category increased only slightly from 32% in 2013 to 37% in 2019.

A note of caution: patterns in the need categories are confounded by a change in NF-LOC criteria on January 1, 2015. With the introduction of new NF-LOC criteria, there appeared to be a general pattern of upcoding on several assessment items. This upcoding was most evident in the period from between 2014 and 2015, although it could have affected trends through 2019.

[1] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3427-ENG

**Critical Dependencies in Activities of Daily Living**

The functional assessment includes information about limitations and dependencies in eight activities of daily living. Toileting, positioning/bed mobility and transferring are considered "critical dependencies" because needed assistance cannot be easily scheduled.
Among AC participants the percentage with a critical ADL need for positioning/bed mobility remained steady at approximately 8% over the years. Transferring need increased from 22% to 26% between 2014 and 2015, but remained steady in the next years.

Prior to 2014, the toileting assessment item captured information about levels of incontinence. The DHS staff discovered that it had low reliability for individuals who were incontinent but who managed their incontinence independently. In 2014, a new toileting item was included to specifically address the need for supervision or physical assistance in toileting rather than experience with incontinence. When this clarifying item was added to the assessment, both the AC and EW participants experienced a significant decline in toileting need as measured by the new need for assistance item.

Table 2 includes figures for the new measure of the toileting critical need. The decline in toileting need between 2013 and 2014 is likely to be the result of this change in how need for assistance is assessed rather than any true change in participant toileting status. From 2014 to 2015, the percentage of AC participants having a critical toileting dependency dropped again, but then remained steady in subsequent years. A change in coding between 2014 and 2015 may have been a delayed response to the separation between the coding of the experience of incontinence and the need for assistance in completion toileting, including managing incontinence.

**Other ADL Dependencies**

The only significant change between years in levels of dependency in other ADL areas were from 2014 and 2015, the years when the LOC criteria changed. The increases between these years were mainly among EW participants rather than AC participants. The AC participants overall were less ADL dependent than EW participants in each of the years 2013-2019.

**Professional Conclusions**

Professional conclusions are indicated by the assessor upon completion of an assessment. They are intended to capture an assessor's overall opinion about the person's need and/or presenting problems or conditions. These conclusions are not tied to other assessment items.

The AC participants increased significantly across time in several problems areas according to the recorded professional conclusions: ADL conditions (79% in 2013 to 87% in 2019); frequent behavioral symptoms (27% in 2013 to 67% in 2019); neglect/abuse risk (25% in 2013 to 49% in 2019); frequent institutional stays (9% in 2013 to 39% in 2019); unstable health condition (10% in 2013 to 30% in 2019); needs evening/night direct care for special treatments (4% in 2013 to 13% in 2019); and complex care management (6% in 2013 to 15% in 2019). The EW participants experienced relatively little increase in the professional conclusions in most of these areas (notable increases were in frequent behavioral symptoms, self-care risk, and neglect/abuse risk).

The AC Participants by 2019 were significantly more likely than EW Participants to have problems in several professional areas: ADL conditions (87% vs. 71%); complicated condition (21% vs. 14%); frequent behavioral symptoms (67% vs. 30%); general frailty (37% vs. 24%); frequent institutional stays (39% vs. 8%); unstable health condition (30% vs. 10%); needs evening/night direct care  for special treatments (13% vs. 2%); and complex care management (15% vs. 4%).

## Table 2. Case Mix and Functional Characteristics of a Cross-section of AC and EW Community Clients in October 2013-2019

| | | 2013 | | 2014 | | 2015 | | 2016 | | 2017 | | 2018 | | 2019 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Variable** | **Value** | **AC** | **EWC** | **AC** | **EWC** | **AC** | **EWC** | **AC** | **EWC** | **AC** | **EWC** | **AC** | **EWC** | **AC** | **EWC** |
| Number of Participants | | 2736 | 14842 | 2719 | 14958 | 2536 | 14891 | 2490 | 15241 | 2543 | 16218 | 2544 | 16952 | 2584 | 17677 |
| Case Mix | | | | | | | | | | | | | | | |
| | Low Need | **51%** | **55%** | **48%** | **54%** | **42%** | **47%** | **36%** | **46%** | **31%** | **45%** | **28%** | **44%** | **26%** | **41%** |
| | Moderate Need | **37%** | **32%** | **40%** | **32%** | **47%** | **38%** | **52%** | **38%** | **57%** | **38%** | **57%** | **38%** | **59%** | **37%** |
| | High Need ADL | **7%** | **11%** | **6%** | **12%** | **6%** | **13%** | **6%** | **14%** | **7%** | **15%** | **8%** | **16%** | **8%** | **17%** |
| | High Need Clinical | **2%** | **2%** | **4%** | **1%** | **3%** | **2%** | **4%** | **2%** | **3%** | **1%** | **4%** | **1%** | **4%** | **1%** |
| | Other/Missing | **3%** | **1%** | **2%** | **1%** | **2%** | **1%** | **2%** | **1%** | **2%** | **1%** | **3%** | **1%** | **3%** | **1%** |
| Critical ADL Dependency | | | | | | | | | | | | | | | |
| | Bed Mobility (2+) | **8%** | **11%** | **8%** | **12%** | **8%** | **13%** | **8%** | **13%** | **8%** | **14%** | **8%** | **15%** | **9%** | **16%** |
| | Transferring (2+) | **19%** | **21%** | **19%** | **22%** | **22%** | **26%** | **24%** | **28%** | **25%** | **30%** | **25%** | **30%** | **26%** | **32%** |
| Toileting & Continence | | | | | | | | | | | | | | | |
| | Toileting (1+) | **60%** | **53%** | **51%** | **46%** | **41%** | **43%** | **36%** | **41%** | **33%** | **41%** | **32%** | **41%** | **32%** | **41%** |
| Other ADL Dependencies | | | | | | | | | | | | | | | |
| | Bathing (4+) | **48%** | **53%** | **48%** | **54%** | **48%** | **56%** | **46%** | **57%** | **45%** | **56%** | **45%** | **56%** | **44%** | **55%** |
| | Dressing (2+) | **30%** | **41%** | **30%** | **42%** | **34%** | **47%** | **36%** | **48%** | **38%** | **49%** | **40%** | **49%** | **39%** | **50%** |
| | Eating (2+) | **20%** | **24%** | **21%** | **24%** | **20%** | **27%** | **21%** | **27%** | **22%** | **28%** | **23%** | **29%** | **23%** | **30%** |
| | Grooming (2+) | **20%** | **30%** | **21%** | **32%** | **21%** | **36%** | **27%** | **37%** | **30%** | **38%** | **33%** | **39%** | **34%** | **40%** |
| | Walking (3+) | **5%** | **3%** | **5%** | **3%** | **5%** | **3%** | **4%** | **3%** | **5%** | **3%** | **5%** | **3%** | 4% | 3% |
| Professional Conclusions | | | | | | | | | | | | | | | |
| | ADL Condition | **79%** | **74%** | **78%** | **73%** | **79%** | **74%** | **83%** | **74%** | **86%** | **73%** | **86%** | **72%** | **87%** | **71%** |
| | IADL Condition | **96%** | **98%** | **96%** | **97%** | **97%** | **98%** | **97%** | **98%** | **97%** | **97%** | **97%** | **96%** | **97%** | **95%** |
| | Complicated Condition | **14%** | **14%** | **20%** | **16%** | **21%** | **18%** | **21%** | **17%** | **20%** | **16%** | **21%** | **15%** | **21%** | **14%** |
| | Impaired Cognition | **26%** | **22%** | **28%** | **22%** | **35%** | **26%** | **31%** | **28%** | **30%** | **27%** | **28%** | **26%** | 26% | 26% |
| | Frequent Behavioral Symptoms | **27%** | **20%** | **31%** | **22%** | **41%** | **28%** | **52%** | **30%** | **60%** | **30%** | **64%** | **30%** | **67%** | **30%** |
| | Self-Care Risk | **60%** | **56%** | **58%** | **55%** | **65%** | **71%** | **66%** | **78%** | **67%** | **78%** | **67%** | **78%** | **68%** | **78%** |
| | Neglect/Abuse Risk | **25%** | **18%** | **30%** | **21%** | **39%** | **34%** | **45%** | **42%** | **47%** | **46%** | 48% | 50% | 49% | 51% |
| | General Frailty | **28%** | **25%** | **29%** | **24%** | **33%** | **27%** | **35%** | **27%** | **38%** | **26%** | **37%** | **25%** | **37%** | **24%** |

| | | 2013 | | 2014 | | 2015 | | 2016 | | 2017 | | 2018 | | 2019 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Variable** | **Value** | **AC** | **EWC** | **AC** | **EWC** | **AC** | **EWC** | **AC** | **EWC** | **AC** | **EWC** | **AC** | **EWC** | **AC** | **EWC** |
| | Frequent Institutional Stays | **9%** | **7%** | **12%** | **7%** | **19%** | **9%** | **31%** | **9%** | **37%** | **9%** | **40%** | **8%** | **39%** | **8%** |
| | Significant Hearing Impairment | **22%** | **13%** | **19%** | **11%** | **17%** | **12%** | **13%** | **11%** | **10%** | **10%** | 10% | 9% | 8% | 8% |
| | Need for Restorative / Rehabilitative Treatments | **14%** | **11%** | **13%** | **10%** | **12%** | **10%** | **13%** | **10%** | **13%** | **9%** | **14%** | **9%** | **13%** | **9%** |
| | Unstable Health Condition | **10%** | **10%** | **11%** | **9%** | **13%** | **10%** | **21%** | **10%** | **26%** | **10%** | **28%** | **10%** | **30%** | **10%** |
| | Needs Evening/Night Direct Care for Special Treatments | **4%** | **2%** | **5%** | **2%** | **6%** | **3%** | **10%** | **2%** | **12%** | **2%** | **14%** | **2%** | **13%** | **2%** |
| | Complex Care Management | **6%** | **8%** | **6%** | **5%** | **8%** | **5%** | **13%** | **6%** | **14%** | **5%** | **14%** | **5%** | **15%** | **4%** |
| | Uncorrected Visual Impairment | **18%** | **14%** | **17%** | **14%** | **17%** | **14%** | **16%** | **15%** | **13%** | **14%** | 12% | 13% | 11% | 13% |

Note: Statistically significant differences ($p < .001$) between AC and EW in individual years are **bolded**. Significant differences in characteristics between years for the AC or EW participants are underlined (different from following year), wavy underlined (different from previous year), or double underlined (different from following and previous year).

## E.2 Service Use of AC and EW Community Participants by Calendar Year

The next step in the analysis was to compare the service use of the AC and EW community participants over different 12-month time periods: 2013 – 2019. We used claims paid in the CY in order to account for services that may have less than monthly delivery, or that may have episodes of high use throughout a person's service year. Note that we had incomplete service use data for 2019; we analyzed claims January – September 2019.

Table 3 shows the number of unique participants and total service use months for calculating utilization rates in Table 4. The rates of utilization (Table 4) were calculated by dividing the services used by the user months (Table 3) for each service. We tested the statistical significance of differences between groups with a two-tailed Chi-square test. Since the samples were so large, we used a stringent alpha of $p < .001$. We report here on the statistical significance of changes in service between years within the AC and EW participant groups, and differences in service use between the AC and EW participants in each year.

**Number of AC and EW Users and User Months**

The number of AC user months declined steadily from 32,986 in 2013 to 30,489 in 2018 (Table 3) [Note: figures for 2019 are incomplete].The number of unique AC participants declined from 3,964 in 2013 to 3,652 in 2018. In contrast, The EW user months rose substantially from 176,886 in 2013 to 200,570 in 2018, while the number of unique participants rose from 19,383 in 2013 to 22,042 in 2018.

**Changes in AC Service Use Over Time**

The AC participants' use of most services underwent relatively little change from 2013 to 2019. Significant declines occurred in home health (31% in 2013 to 24% in 2019); home health aide (23% in 2013 to 10% in 2019); homemaker (59% in 2013 to 45% in 2019); PERS (53% in 2013 to 46% in 2019). Use of other services did not increase with the exception of CDSC. The use of CDCS increased from 4% in 2013 to 10% in 2019 and CDCS case management increased from 2% in 2013 to 6% in 2019.

**Services for AC Compared to EW Participants**

The service use patterns of AC and EW participants were substantially different in several areas. In 2019 AC participants were significantly more likely than EW participants to use case management (68% vs. 17%); CDCS (10% vs. 3%); home delivered meals (37% vs. 21%); PERS (46% vs. 34%); and specialized supplies and equipment (26% vs. 10%). In contrast, EW participants in 2019 were significantly more likely than AC participants to use adult day services (24% vs. 4%), personal care assistance (40% vs. 17%), and non-medical transportation (31% vs. 12%). According to DHS staff, the high percentage of AC participants with case management claims is likely due to the lead agencies billing for case management when participants make inquiries about past due or unpaid fees. Also, for people in managed care, they do not submit encounter claims for case management, it's paid out of MCO administrative cost category.

**Table 3. Number of User Months and Unique Participants with AC and EW by Calendar Year**

| | AC | | EWC | |
|---|---|---|---|---|
| Year | User Months | Unique Participants | User Months | Unique Participants |
| 2013 | 32,986 | 3,964 | 176,886 | 19,383 |
| 2014 | 32,679 | 3,872 | 179,228 | 19,993 |
| 2015 | 30,921 | 3,679 | 178,190 | 19,934 |
| 2016 | 29,727 | 3,587 | 181,850 | 20,164 |
| 2017 | 30,210 | 3,652 | 189,207 | 20,728 |
| 2018 | 30,489 | 3,652 | 200,570 | 22,042 |
| 2019 | 22,660 | 3,336 | 156,421 | 21,597 |

Note: figures for 2019 are for the period January – September 2019.

**Table 4. Service Use of AC and EW Community Program Participants by Calendar Year**

| | | AC | | | EWC | | |
|---|---|---|---|---|---|---|---|
| Type of Service | Year | Unique Users | User Months | Utilization Rate | Unique Users | User Months | Utilization Rate |
| **Adult Day Services** | 2013 | 206 | 1,461 | **4%** | 3,551 | 32,620 | **18%** |
| | 2014 | 196 | 1,387 | **4%** | 3,799 | 35,151 | **20%** |
| | 2015 | 168 | 1,250 | **4%** | 3,930 | 37,238 | **21%** |
| | 2016 | 178 | 1,238 | **4%** | 4,151 | 40,214 | **22%** |
| | 2017 | 171 | 1,114 | **4%** | 4,463 | 43,206 | **23%** |
| | 2018 | 163 | 1,166 | **4%** | 4,792 | 47,163 | **24%** |
| | 2019 | 134 | 794 | **4%** | 4,907 | 37,380 | **24%** |
| **Case Management** | 2013 | 3,678 | 20,891 | **63%** | 8,082 | 44,513 | **25%** |
| | 2014 | 3,575 | 21,489 | **66%** | 8,040 | 44,793 | **25%** |
| | 2015 | 3,368 | 19,897 | **64%** | 7,027 | 38,212 | **21%** |
| | 2016 | 3,253 | 19,222 | **65%** | 6,163 | 35,982 | **20%** |
| | 2017 | 3,309 | 19,533 | **65%** | 5,947 | 35,236 | **19%** |
| | 2018 | 3,270 | 20,591 | **68%** | 6,348 | 36,621 | **18%** |
| | 2019 | 2925 | 15299 | **68%** | 5778 | 26819 | **17%** |
| **CDCS Services** | 2013 | 143 | 1,253 | **4%** | 334 | 2,961 | **2%** |
| | 2014 | 151 | 1,362 | **4%** | 353 | 2,977 | **2%** |
| | 2015 | 175 | 1,456 | **5%** | 334 | 3,115 | **2%** |
| | 2016 | 206 | 1,661 | **6%** | 368 | 3,295 | **2%** |
| | 2017 | 240 | 1,941 | **6%** | 411 | 3,731 | **2%** |
| | 2018 | 302 | 2,385 | **8%** | 530 | 4,533 | **2%** |
| | 2019 | 331 | 2204 | **10%** | 578 | 3992 | **3%** |
| **CDCS Case Management** | 2013 | 100 | 510 | **2%** | 69 | 403 | **0%** |
| | 2014 | 138 | 716 | **2%** | 82 | 407 | **0%** |
| | 2015 | 152 | 743 | **2%** | 63 | 334 | **0%** |

| Type of Service | Year | AC Unique Users | User Months | Utilization Rate | EWC Unique Users | User Months | Utilization Rate |
|---|---|---|---|---|---|---|---|
| | 2016 | 159 | 767 | **3%** | 64 | 359 | **0%** |
| | 2017 | 200 | 996 | **3%** | 78 | 375 | **0%** |
| | 2018 | 241 | 1,319 | **4%** | 134 | 612 | **0%** |
| | 2019 | 299 | 1411 | **6%** | 127 | 526 | **0%** |
| **Chore Services** | 2013 | 303 | 2,000 | **6%** | 714 | 4,506 | **3%** |
| | 2014 | 280 | 1,880 | **6%** | 675 | 4,381 | **2%** |
| | 2015 | 257 | 1,570 | **5%** | 704 | 4,348 | **2%** |
| | 2016 | 250 | 1,529 | **5%** | 696 | 4,022 | **2%** |
| | 2017 | 241 | 1,368 | **5%** | 662 | 3,780 | **2%** |
| | 2018 | 222 | 1,500 | **5%** | 670 | 4,144 | **2%** |
| | 2019 | 189 | 1075 | **5%** | 601 | 3064 | **2%** |
| **Companion Services** | 2013 | 147 | 940 | 3% | 556 | 4,247 | 2% |
| | 2014 | 117 | 775 | 2% | 518 | 3,936 | 2% |
| | 2015 | 106 | 679 | 2% | 553 | 3,828 | 2% |
| | 2016 | 86 | 551 | 2% | 508 | 3,967 | 2% |
| | 2017 | 78 | 564 | 2% | 508 | 3,957 | 2% |
| | 2018 | 94 | 593 | 2% | 539 | 3,891 | 2% |
| | 2019 | 78 | 411 | 2% | 469 | 2587 | 2% |
| **Home Delivered Meals** | 2013 | 1,766 | 12,984 | **39%** | 5,869 | 47,862 | **27%** |
| | 2014 | 1,752 | 12,896 | **39%** | 5,658 | 45,376 | **25%** |
| | 2015 | 1,640 | 12,425 | **40%** | 5,442 | 43,682 | **25%** |
| | 2016 | 1,580 | 11,457 | **39%** | 5,304 | 41,459 | **23%** |
| | 2017 | 1,619 | 11,641 | **39%** | 5,321 | 42,091 | **22%** |
| | 2018 | 1,597 | 11,301 | **37%** | 5,725 | 44,247 | **22%** |
| | 2019 | 1405 | 8272 | **37%** | 5261 | 33060 | **21%** |
| **Home Health** | 2013 | 1,448 | 10,223 | **31%** | 6,711 | 51,480 | **29%** |
| | 2014 | 1,400 | 10,093 | **31%** | 6,622 | 50,879 | **28%** |
| | 2015 | 1,289 | 9,146 | **30%** | 6,394 | 49,137 | **28%** |
| | 2016 | 1,225 | 8,785 | **30%** | 5,958 | 46,307 | **25%** |
| | 2017 | 1,200 | 8,580 | **28%** | 5,699 | 44,090 | **23%** |
| | 2018 | 1,096 | 7,849 | **26%** | 5,773 | 43,419 | **22%** |
| | 2019 | 902 | 5416 | **24%** | 5167 | 31733 | **20%** |
| **Home Health Aide** | 2013 | 1,081 | 7,686 | **23%** | 3,612 | 23,725 | **13%** |
| | 2014 | 973 | 7,095 | **22%** | 3,429 | 22,764 | **13%** |
| | 2015 | 852 | 6,235 | **20%** | 3,227 | 21,229 | **12%** |
| | 2016 | 746 | 5,348 | **18%** | 2,293 | 17,700 | **10%** |
| | 2017 | 645 | 4,463 | **15%** | 2,027 | 15,690 | **8%** |
| | 2018 | 526 | 3,702 | **12%** | 1,976 | 14,435 | **7%** |
| | 2019 | 392 | 2301 | **10%** | 1695 | 10248 | **7%** |

| Type of Service | Year | AC Unique Users | User Months | Utilization Rate | EWC Unique Users | User Months | Utilization Rate |
|---|---|---|---|---|---|---|---|
| **Homemaker Services** | 2013 | 2,428 | 19,502 | **59%** | 10,732 | 98,053 | **55%** |
| | 2014 | 2,335 | 19,113 | **58%** | 10,766 | 97,270 | **54%** |
| | 2015 | 2,158 | 17,586 | **57%** | 10,498 | 94,230 | **53%** |
| | 2016 | 2,024 | 16,211 | **55%** | 10,383 | 91,608 | **50%** |
| | 2017 | 2,002 | 15,322 | **51%** | 10,486 | 93,401 | **49%** |
| | 2018 | 1,935 | 14,724 | **48%** | 11,257 | 99,841 | **50%** |
| | 2019 | 1628 | 10161 | **45%** | 10699 | 75438 | **48%** |
| **PERS** | 2013 | 2,156 | 17,505 | **53%** | 7,643 | 68,577 | **39%** |
| | 2014 | 2,049 | 17,115 | **52%** | 7,665 | 68,573 | **38%** |
| | 2015 | 1,926 | 16,035 | **52%** | 7,712 | 67,764 | **38%** |
| | 2016 | 1,833 | 14,961 | **50%** | 7,557 | 66,746 | **37%** |
| | 2017 | 1,847 | 14,949 | **49%** | 7,762 | 68,680 | **36%** |
| | 2018 | 1,832 | 14,664 | **48%** | 8,242 | 71,806 | **36%** |
| | 2019 | 1595 | 10521 | **46%** | 7815 | 53939 | **34%** |
| **Personal Care** | 2013 | 535 | 4,200 | **13%** | 5,982 | 56,441 | **32%** |
| | 2014 | 556 | 4,202 | **13%** | 6,244 | 57,765 | **32%** |
| | 2015 | 555 | 4,271 | **14%** | 6,418 | 60,764 | **34%** |
| | 2016 | 555 | 4,265 | **14%** | 6,896 | 64,280 | **35%** |
| | 2017 | 664 | 4,938 | **16%** | 7,465 | 71,326 | **38%** |
| | 2018 | 707 | 5,374 | **18%** | 8,197 | 79,192 | **39%** |
| | 2019 | 632 | 3904 | **17%** | 8287 | 62265 | **40%** |
| **Specialized Supplies/Equipment** | 2013 | 1656 | 7976 | **24%** | 4767 | 17197 | **10%** |
| | 2014 | 1549 | 7471 | **23%** | 4683 | 16433 | **9%** |
| | 2015 | 1421 | 6780 | **22%** | 4439 | 16933 | **10%** |
| | 2016 | 1425 | 7086 | **24%** | 4569 | 16383 | **9%** |
| | 2017 | 1457 | 7365 | **24%** | 4727 | 17575 | **9%** |
| | 2018 | 1463 | 7907 | **26%** | 5210 | 19774 | **10%** |
| | 2019 | 1333 | 5930 | **26%** | 4534 | 15184 | **10%** |
| **Transportation** | 2013 | 516 | 3131 | **9%** | 6333 | 48443 | **27%** |
| | 2014 | 530 | 3305 | **10%** | 6764 | 51126 | **29%** |
| | 2015 | 559 | 3562 | **12%** | 6847 | 51777 | **29%** |
| | 2016 | 532 | 3033 | **10%** | 7279 | 55941 | **31%** |
| | 2017 | 554 | 3240 | **11%** | 7638 | 58964 | **31%** |
| | 2018 | 608 | 3678 | **12%** | 8138 | 63511 | **32%** |
| | 2019 | 527 | 2647 | **12%** | 7929 | 49189 | **31%** |

Note: Statistically significant differences ($p < .001$) between AC and EW in individual years are **bolded**. Significant differences in service use between years are underlined (different from following year), wavy underlined (different from previous year), or double underlined (different from following and previous year).

Figures for 2019 are for the period January – September 2019.

**Nursing Facility Use by AC and EW Participants**

Table 5 shows use of nursing facilities over a subsequent 12-month period for participants enrolled in January of each year from 2013-2018, and January – September 2019. The percentage of AC participants spending any time in a nursing facility declined from 26% in 2013 to 14% in 2019. Although the rate of nursing home use declined, the mean number of nursing home days per nursing facility user increased somewhat from 73.9 in 2013 to 78.6 in 2019. The rate of nursing home use for EW participants was significantly lower than for AC participants, and it declined somewhat from 15% in 2013 to 12% in 2019. There was no consistent pattern over time among EW participants in their mean number of nursing home days.

**Table 5. Nursing facility use over subsequent 12 months for AC and EW participants in January of each calendar year.**

| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|
| **AC** | | | | | | | |
| Participants Enrolled in January of Year | 2,784 | 2,727 | 2,644 | 2,501 | 2,493 | 2,566 | 2,464 |
| Number of Participants Using a Nursing Facility at any Time in Year | **720** | **679** | **641** | **653** | **549** | **448** | 347 |
| Percentage of Participants Using a Nursing Facility | **26%** | **25%** | **24%** | **26%** | **22%** | **17%** | 14% |
| Mean Nursing Facility Days per Participant during the Year | **19.1** | **18** | **17.2** | **19.1** | **16.6** | **13.9** | **11.1** |
| Mean Nursing Facility days per Nursing Facility User During the Year | **73.9** | 72.2 | **70.8** | **73.1** | **75.6** | **79.6** | 78.6 |
| **EW** | | | | | | | |
| Participants Enrolled in January of Year | 14,704 | 14,850 | 14,975 | 15,043 | 15,299 | 16,517 | 17,071 |
| Number of Participants Using a Nursing Facility at any time in year | **2,151** | **2,143** | **2,147** | **2,175** | **2,097** | **2,077** | 2,034 |
| Percentage of Participants Using a Nursing Facility | **15%** | **14%** | **14%** | **14%** | **14%** | **13%** | 12% |
| Mean Nursing Facility days per recipient during year | **11.1** | **10.3** | **10.8** | **9.6** | **10.9** | **8.8** | **7.8** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mean Nursing Facility days per Nursing Facility user during year | **75.6** | 71.5 | **75.1** | **66.6** | **79.7** | **70.1** | 65.1 |

Note: Statistically significant differences ($p < .001$) between AC and EW in individual years are **bolded**. Significant differences in NF use between years are underlined (different from following year), wavy underlined (different from previous year), or double underlined (different from following and previous year).
Note: figures for 2019 are for the period January – September 2019.

## H. Interpretations, Policy Implications and Interactions with Other State Initiatives[2]

*In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.*

Minnesota's Alternative Care (AC) 1115 demonstration waiver is one program on a continuum that serves older adults in their homes and communities. For older adults who are eligible for Medicaid, the Elderly Waiver and certain State Plan services provide long-term services and supports. The Elderly Waiver is the state's home and community-based service (HCBS) alternative to nursing facilities for people who meet the nursing facility level of care and are eligible for Medicaid. State Plan services, such as personal care assistance, also provide support for people who need assistance with activities of daily living in order to remain in their homes and communities. In 2015, Minnesota also implemented the Essential Community Supports (ECS) program. This program provides a limited HCBS benefit set to people who are age 65 or older and need support to remain living in the community but are not eligible for Medicaid and do not meet the nursing facility level of care.

The Alternative Care program is part of Minnesota's overall strategy of reaching older adults early in their need for LTSS, before they spend down to Medicaid. By reaching people early, when their needs are relatively modest, we can provide less-expensive services, prevent or delay their spenddown to MA, and prevent or delay the use of more expensive services such as nursing home or Elderly Waiver. In addition to reaching people early with low-cost home and community-based services through AC, Minnesota has implemented programs through its Aging and Disability Resource Center (ADRC) to help people make informed decisions and explore home and community-based options. Long Term Care Options Counseling ensures

[2] Completed by Minnesota Department of Human Services

people have information about a full range of options before making a decision to move to assisted living and the Return to Community Initiative assists private paying nursing home residents to move out early in their stay.

The evaluation noted that the assessed needs of AC participants increased over time. For example, there was a downward trend in the proportion of people in the low need case mix categories and increases in the moderate need, high need, and high need clinical groups. In addition, the evaluation described increased needs noted by assessors in the professional conclusions section of the assessment. The professional conclusions section is used to convey an assessor's overall observations, but not all fields are required. While this data is not as reliable as the assessment data used to determine case mix, it does provide supporting context for the conclusion that, on average, the needs of the population served on Alternative Care increased over time. This trend of an increase in the high need case mix categories is consistent with the total waiver population trends across the state. Additionally, the State of Minnesota updated the Nursing Facility Level of Care criteria which was expected to decrease the number of people with lower need case mixes who met the eligibility criteria. The Minnesota Department of Human Services interprets the changes on case mix representation in AC participants as an indication that the Alternative Care program is meeting its intended goal to serve people in the community, rather than in a nursing facility or other more intensive HCBS service.

The evaluation also noted changes in the service use patterns among AC participants. AC participants had lower rates of nursing facility service use that declined throughout the study period. In addition, the use of CDCS services increased, which is consistent with a stated goal of this program. The evaluation also showed declines in the use of some services, such as, home health aide, and homemaker services. The evaluation did not explore what caused that change, nor whether other paid or unpaid supports were being used as a substitute. This decrease in home health aide and homemaker services is seen across several waivers in the state. In addition, differences between service use patterns of the AC participants and EW participants using non-residential services may be impacted by the fact that EW participants have access to other Medicaid state plan services or other underlying differences in the needs and preferences of the two populations. The Department does analyze changes in service use over time to understand challenges and the changing preferences of people using services.

The evaluation also showed that the racial and ethnic composition of AC participants is different than Elderly Waiver participants using non-residential services. While this evaluation did not explore factors that may drive that difference, the Department is conducting other analyses to better understand whether there are institutional biases that affect access to services. For example, a current multi-year evaluation funded by Minnesota's Money Follows the Person demonstration project is currently underway. The Department recognizes demographic differences in service use and program enrollment, and is actively working to understand them and further equity in the HCBS system.

Across the key hypotheses, the evaluation findings show consistent patterns and outcomes for Alternative Care participants over the time periods included. Minnesota interprets the findings in this interim evaluation show that the Alternative Care program continues to be an integral

and necessary part of Minnesota's home and community-based service continuum serving older adults.

This is an ongoing waiver. Minnesota interprets the findings in this report to show that the Alternative Care 1115 demonstration waiver continues to represent a key piece of the state's strategy to offer a continuum of home and community-based services for older adults. Final recommendations and lessons learned will be more robust when the final evaluation report is available.

## I. Attachment

Evaluation Design: Provide the CMS-approved Evaluation Design