REPORT

TO THE

MINNESOTA STATE LEGISLATURE

REGARDING AN ASSESSMENT

OF THE

IMPACT OF THE MORATORIUM ON THE

MEDICAL ASSISTANCE CERTIFICATION OF

NURSING HOME AND BOARDING CARE HOME BEDS

* * * *

Prepared Pursuant to

Minnesota Statute §144A.071

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EXECUTIVE SUMMARY

The 1983 Minnesota Legislature imposed a moratorium on the Medicaid certification of new nursing home or boarding care home beds and on the upward certification of existing beds. The provisions of the moratorium are contained in Minn. Stat. §144A.071 (1983 Supp.). This report is submitted pursuant to Minn. Stat. §144A.071, Subd. 4 (1983 Supp.) which requires that the Commissioner of Health annually assess and report to the Legislature on the impact of the moratorium. The enactment of the moratorium was one of the major elements of the 1983 Legislature's initiatives to curtail increasing Medicaid expenditures. It was the Legislature's finding "that a moratorium on medical assistance certification of new nursing home beds and on changes in certification to a higher level of care is necessary to control nursing home expenditure growth and enable the state to meet the needs of its elderly by providing high quality services in the most appropriate manner along a continuum of care".

From 1978 to May, 1983, the number of Medicaid certified nursing home and boarding care home beds increased from 43,927 beds (23,366 SNF and 20,561 ICF) to 46,207 beds (28,839 SNF and 17,368 ICF). During this period of time the percentage of skilled beds increased from 53.2% to 62.4% of the total certified beds. As of November 30, 1983, the total number of certified beds increased to 46,678 beds (29,540 SNF and 17,138 ICF). An additional 1,148 beds (726 SNF and 422 ICF) will be Medicaid certified in accordance with the exception provisions of the moratorium.

This report consists primarily of a comparative evaluation based on information derived from the licensure and certification of long term facilities, e.g. Certificate of Need, Survey and Compliance, Quality Assurance and Review, Health Systems Agencies, Department of Public Welfare, etc. The report addresses the Department's implementation of the law and provides a description of provider's reaction to the moratorium.

An assessment of the impact of the moratorium by geographic area and its effect upon services is complicated since the law permits additional certified beds to enter the system. The 6 month period from the effective date of the law to November 30, 1983 cutoff date for the data used in this report does not provide a sufficient time period for full and comprehensive analysis of the impact of the moratorium or for identification of service deficits or problems. Subsequent annual reports may be more informative on these issues.

The Department recommends that the moratorium continue and that additional exceptions to the moratorium not be considered by the 1984 Legislature. The Department is also recommending that resources be provided to assure for an in-depth assessment of the impact of the moratorium.

REPORT TO THE MINNESOTA STATE LEGISLATURE REGARDING AN ASSESSMENT OF THE IMPACT OF THE MORATORIUM

INTRODUCTION*

Minnesota Statute §144.A071 (1983 Supp.), as enacted by the 1983 Minnesota Legislature, imposes a moratorium on the addition of Title XIX (Medicaid) skilled nursing facility (SNF) beds or intermediate care facility (ICF) beds and prohibits the upgrading of the certification status of any existing certified beds. This law was signed by the Governor on May 22, 1983, and became effective at 12:01 a.m. on May 23, 1983. As of that date, the Commissioner of Health was required to deny the certification of new beds or the upward change in certification status of existing beds unless the request for certification qualified under one of the exception provisions in subdivision 3 of the law. A copy of the moratorium law is included as Exhibit A. (See Appendix, page A-12).

Prior to the moratorium, unless a facility was unable to meet federal certification rules, the provisions of the Minnesota Certificate of Need Law (CON), Minn. Stat. §145.832 to 145.845, served as the only control over the increase in certified beds or changes in certification status. As will be discussed below, while the CON review did limit requested increases in either the addition of new beds or in changes in the certification status of existing beds, there was still a significant increase in the number of SNF and ICF beds. Notwithstanding the availability of a CON for new beds or for changes in the certification status of existing beds, the moratorium precludes the certification of those beds unless one of the four exception provisions is met.

This report is prepared in response to the legislative mandate that the Commissioner of Health monitor and assess the impact of the moratorium. The specific language incorporated into the statute is as follows:

> "The commissioner of health shall submit to the Legislature, no later than January 15, 1984, and annually thereafter, an assessment of the impact of the moratorium by geographic area, with particular attention to service deficits or problems and a corrective action plan".

The following report, containing findings, implications and recommendations is based on an analysis of relevant information collected by the Department. This report also includes the rationale for Department denials relating to certification requests as a result of the moratorium.

*A glossary of terms defining licensure and certification terminology is included. (See Appendix, page A-1).

STUDY OF MORATORIUM IMPACT

Introduction

The purpose of the study is to assess the impact of the moratorium in order to determine its effect on the provision of services within geographic areas of the state. The report rationale, methodology, findings, their implications and the recommended corrective action are reported below.

Rationale for the Moratorium

The legislative findings contained in Minn. Stat. §144A.071, Subd. 1 (1983 Supp.) establish the Legislatures' rationale for the moratorium.

In reviewing medical assistance (MA) expenditures the Legislature found that these expenditures were increasing more rapidly than the state's ability to pay. It also found that nursing home care and ancillary services comprised over half of the total MA costs and that continued construction of nursing home beds consumed the majority of the resources that could be used to establish alternative services in both the home and community. It noted that the increased conversion of ICF nursing home beds to SNF status inhibited the ability to control expenditures, and that with the scheduled repeal of the Certificate of Need Law, effective June 30, 1984, both the addition of new beds and the reclassification of certified beds to a higher level of care would accelerate nursing home costs. It felt that an adequate number of nursing home beds currently exists in Minnesota to serve the needs of the elderly and that the resources to develop a continuum of care would be seriously jeopardized if additional Medicaid certified beds were allowed. To prudently manage the state budget and to enable the state to more appropriately meet the needs of the elderly population, the Legislature viewed a moratorium on Medicaid certification as both an immediate and essential measure.

The resulting statute requires that the total number of Medicaid certified beds remain at or decrease from the number of beds certified at each level of care as of May 23, 1983. The Commissioners of Health and Public Welfare are required to deny the certification of any new beds or the upgrading of existing beds which could not qualify under the exception provisions established in subdivision 3 of the statute.

Historical Data

The report of the Minnesota State Health Plan, September, 1982, (See Exhibit B, Appendix, page A-14) indicates that the current number of nursing home beds exceeds the HSA's bed-to-population goal but are not evenly distributed by county. It also states that an excess of beds is projected to continue beyond 1995 and that expansion of inpatient nursing home beds, except for Central Minnesota, is unnecessary at this time but the need for services in non-institutional settings is needed statewide.

An MDH unpublished report, Certificate of Need Review in Minnesota: Past Effectiveness and Issues for the future*, which assesses the impact of the CON law was reviewed to identify changes in both the number of certified beds and the level of care approvals occurring during a five year period preceding the passage of the moratorium law, i.e. 1978 to March 1983. The significant increase in the number of certified beds and the change in certification status from ICF to SNF was one of the legislative findings that prompted the imposition of the moratorium. Table I, (See Appendix, page A-4) indicates changes in the total number of certified beds from 1978 to March 1983. As noted in this table, the number of SNF beds increased 23.4% (+5473 beds) and the number of ICF beds decreased 15.5% (-3193 beds). While the total number of certified beds increased only 5%, the percentage of SNF beds increased from 53.2% in 1978 to 62.4% of the total certified beds in 1983.

The increase in certified beds was the result of two processes, the addition of new beds and the reclassification of beds to a higher certification level. Table II, (See Appendix, page A-5) indicates the level of care bed changes which occurred. This table includes CON review from the period of 1978 to September, 1983. It should be noted that this time frame does differ from the March, 1983 cutoff date used for Table I and that the total of the new beds and recertified beds for each certification level does not equal the total number of bed changes. This difference is due to the fact that the CON law exempts from review changes in bed capacity or changes in bed categories of less than 10 beds or less than 10% of the licensed bed capacity, whichever is less, over a two year period (MN Stat. §145.833, Subd. 5(a)(2)). Since these changes were not subject to CON review they were not reflected in the unpublished CON report statistics.

The two tables support the legislative finding that there has been a significant trend in the reclassification of existing certified beds to a higher level of care.

Methodology and Analysis

The study methodology consisted primarily of comparative evaluation from the data available to the programs involved in the licensure and certification of long term care facilities, e.g. Certificate of Need, Survey and Compliance, Quality Assurance and Review, Health Systems Agencies, Department of Public Welfare, etc.

As of May 23, 1983, Minnesota had 42,715 licensed nursing home beds of which 29,182 were certified for Medicaid as SNF beds, and 13,533 as ICF I beds. The 3,590 licensed boarding care home beds were certified as ICF II (See Table III, Appendix, page A-6). As of November 30, 1983, approximately six months after the effective date of the moratorium, the total number of Medicaid certified beds was 29,540 SNF, 13,664 ICF I and 3,474 ICF II. This reflects an increase of 358 SNF beds, 131 ICF I beds and a decrease of 116 ICF II beds (See Table III). Additionally, 726 SNF beds, 364 ICF I beds and 58 ICF II beds will be Medicaid certified (See Table IV, Appendix, page A-7) upon completion of construction in accordance with the "commenced construction" or "to replace a bed decertified" exceptions in subdivision 3 of the law. This projects a total of 30,266 SNF beds, 14,028 ICF I beds, and 3,532 ICF II beds at such a time as all appropriate licensing and certification clearances have been made.

*This report is scheduled for publication in late February, 1984.

An assessment of the impact of the moratorium by geographic area and its effect upon services is complicated at this time because previously approved beds will continue to enter the system upon completion of construction projects. The 6 month period from the effective date of the law to the November 30, 1983 cutoff date for this report does not provide a sufficient time period for full and comprehensive analysis of the impact of the moratorium for valid identification of service deficits or problems. In response to the law's requirement that the Commissioner of Health implement the necessary mechanisms to analyze the moratorium, the necessary base line information, i.e. the number of certified beds as of the effective date of the law and the number of beds added or to be added under the exception provisions have been tabulated. However, these statistics alone would not be sufficient to identify the impact of the moratorium on the provision of long term care services in the various geographic areas nor would the statistical information be sufficient to identify service deficits or problems. Subsequent annual reports may be more informative on these issues.

During the period of approximately six months prior to the law's enactment, 37 facilities apparently anticipated a curtailment on the upgrading of Medicaid bed certification levels. Each of these facilities requested an upward change in the level of care for ten beds or less, thus requiring no Certificate of Need involvement. This resulted in an addition of 463 SNF beds between January 1, 1983 and May 23, 1983, an increase of 45.8% over the preceding six month period of July 1, 1982 through December 31, 1982 (See Table V, Appendix, page A-8).

It is interesting to note that from January 1982 through May 22, 1983, the number of reclassification requests averaged only 4.2 requests per month. However, during the two month period immediately preceding the effective date of the moratorium the number of requests substantially increased i.e. in March 1983, MDH received 12 requests involving 184 beds and in April, 1983, 11 requests involving 158 beds. Of the 71 requests received for reclassification of beds from ICF to SNF between January 1982 and May 22, 1983, 50 of the requests were for 10 beds or less and therefore exempt from CON review (See Table V).

During the same period of January 1982 through May 22, 1983 there were 47 facilities involving 1,300 beds requiring CON approval for reclassifying beds from ICF to SNF. Of these, 32 facilities involving 788 beds received CON approval and 15 facilities involving 517 beds were denied (See Table VI, Appendix, page A-9).

Issues

Exception Provisions

Subdivision 3 of the law contains 4 exceptions to the moratorium. As discussed earlier, an unkown number of certified beds will be added by virtue of the projects falling within these exceptions.

The statute requires that exceptions to the moratorium are to be evaluated and that each request must be approved prior to the actual certification. The basic elements of the four exceptions are as follows:

Subd. 3(a). This exception will allow for the certification of beds which were decertified after the effective date of the moratorium and will also permit the certification of new beds or changes in certification level to address an extreme hardship situation.

Subd. 3(b). This exception will allow for the certification of beds in a facility that "commenced construction" prior to the effective date of the law.

Subd. 3(c). This exception will allow for the certification of beds in a new nursing home that is needed to meet the special dietary needs of residents and contains the criteria to verify the need for special dietary provisions.

Subd. 4(d). This exception will allow for a change in certification status if the change results in a decrease in the reimbursement amount.

Department Implementation

In response to this mandate, the Department evaluated each facility's request for the certification of new beds or for a change in certification status to assure that the facility would clearly qualify under one of the exceptions to the law prior to certifying the beds. Questions have been raised in relation to the exact circumstances under which the exceptions will apply, particularly as it relates to Subdivisions 3(a) and (d). The law contains extensive findings indicating clear legislative intent to immediately curtail the certification of any new beds which could not qualify under the exception provisions of the statute and to maintain at or decrease from the total number of SNF and ICF beds certified at each level as of May 23, 1983.

A number of steps are required to be followed prior to the Department's certification of any nursing home bed. For example, a facility may be required to obtain a CON approval, an engineering clearance from the MDH and pass a Medicaid health survey conducted by the MDH, etc. The MDH determines for Title 19 whether the facility meets the standards for participation in the Medicaid program. The DPW can execute a provider agreement and make Medicaid payments to a facility for services only if MDH certifies the facility as meeting the requirements to provide the services established under federal law 42 CFR 442. The effective date of a provider agreement cannot be earlier than the date the MDH determines by an on-site visit that the facility is in compliance with the standards set for the level of care requested. Until all such steps have been successfully completed, certification cannot be granted. A number of facilities were at one step or another in the certification process when the moratorium took effect. Unless a facility met one of the exceptions in subdivision 3 of the law, a number of facilities were denied their certification request since the effective date of their certification could not occur prior to May 23, 1983.

The replacement provision of subdivision 3(a) has been interpreted by MDH to be "facility specific". Therefore, replacement of decertified beds was limited to those situations when, after the effective date of the moratorium, Medicaid decertification

of all or a portion of a facility's beds occurs for purposes relating to the construction or remodeling of that facility. Then, at the completion of the project the facility can request that the same number of beds at the same level of care that had been decertified, be again certified. The certification of these replacement beds cannot be granted until the promulgation of temporary rules as authorized under Minnesota Laws 1983, Chapter 199, Section 16. The rules will establish the procedures for obtaining the certification of replacement beds.

The Department's analysis of the "hardship provision" has identified that no county presently meets this statutory exception. While 13 counties standing independently met these criteria, the consideration of the contiguous Minnesota counties results in a finding that all counties are 10% above the national average of beds, i.e. 63.19 beds per 1,000 persons over 65 years of age (See Exibit C, Appendix, page A-22).

To assure consistency in the application of "commenced construction" MDH has required the facility to submit to MDH copies of all documents required under subdivision 3(b) as evidence that all of the law's criteria were met. Facilities which could not provide the evidence that all conditions were met, e.g. a building permit not granted prior to the effective date of the law, were denied certification in accordance with legislative intent to control medical assistance expenditures.

No MDH action has been required relating to the special dietary provision in subdivision 3(c) since no requests for certified beds under this exception have been received.

As noted previously the moratorium clearly is concerned with the expenditure of state monies. Since the state does not expend any money for reimbursement under the federal Medicare Program, the MDH has viewed the exception provision contained in subdivision 3(d) as applying only to a change in Medicaid certification status. MDH and DPW have determined that a change in status of a facility's Medicare beds to Medicaid certification would increase, not decrease, the reimbursement monies expended by the state. MDH has, therefore, denied such a facility request.

Provider Reaction

As of the date of the issuance of this report, Department denials for new certified beds or level of care changes upward have resulted in two legal challenges related to the Department's interpretation of the exception provisions. In addition, Department denials have generated letters and telephone calls from providers and other interested parties, including residents, to the Department, the Governor and legislators requesting relief from the Department's interpretation of the law. A description of the two legal challenges follows.

In one case, litigation has been brought against the Department for denial of the provider's request for reclassification of 30 ICF I beds to the SNF level of care. The facility contended that it submitted the necessary information for a waiver request under the Certificate of Need Act for licensure reclassification of boarding care beds and for reclassification upward of existing certified beds. The Department contends that the facility failed to meet the exceptions in subdivision 3 and was, therefore, properly denied the reclassification upward of Medicaid beds.

The second case involves a facility-requested administrative hearing in response to the Department's denial of Medicaid certification for five new beds reclassified to nursing home licensure from hospital licensure. It is the facility's position that Medicaid certification should be approved based upon subdivision 3(d) which permits certification "when the change in certification status results in a decrease in the reimbursement amount". It contends that the expenditures associated with these five nursing home beds would be less than those associated with acute care hospital beds. It is MDH's position that though the rate may be less, the statutory exception relates only to the long term care portion of the Medicaid fund, and, therefore, the prime consideration is the impact upon this portion of the Medicaid expenditures. MDH further contends that since the hospital beds are Medicare certified and the state does not expend any monies for reimbursement under Medicare any newly certified Medicaid beds would increase, not decrease, the reimbursement monies expended by the state. Both MDH and DPW also take the position that the facility has not established a case for their contention that a decrease in Medicaid monies would necessarily result and feel that conceivably there could be an increase or there could be no effect at all.

Some providers have attempted to utilize the QA&R recommendations for level of care changes in support of their request for reclassification upward (A brief description of the QA&R program is contained in the glossary of terms). The 1982 and 1983 QA&R data was reviewed for those providers. The analysis of the data demonstrates for the most part, that the level of care changes recommended in 1983 had also been recommended in 1982 without any action taken at that time by the facility to upgrade their status (See Table VII, Appendix, page A-10).

Trends in Complaints, Admissions and Service Provisions

- OHFC complaint investigations identified that, of the 17 facilities denied reclassification upward of existing certified beds, only 3 had complaints registered against them since the effective date of the moratorium. An analysis of those complaints revealed that the allegations in one facility were not substantiated and those substantiated in the second facility had no relationship to the denial for reclassification. The third facility, without MDH authorization of the reclassification, had notified patients and families of impending transfers based upon their assumption of the necessary MDH approval.

- Survey and Compliance activities conducted subsequent to the effective date of the moratorium for 9 of the facilities denied reclassification upward revealed that the deficiencies cited had no relationship to the denial of the reclassification request.

- The Minnesota Preadmission Screening Program designed to provide an alternative to institutionalization through the provision of alternative care grant programs has been in operation for approximately 18 months. Title 19 recipients are reviewed in a cooperative relationship by a public health nurse and county social worker for determination of appropriate placement in a nursing home or in an alternative care program. Exhibit D (see Appendix, page A-27) is a copy of the statistical data received from the DPW covering the period of January 1982 through June 1983. During that period slightly over one half of the persons seeking nursing home admission, were actually placed in a nursing home while the remainder were referred to other programs for necessary services.

STUDY IMPLICATIONS

Summary

The major findings are enumerated below:

- The 6 month period from the date of enactment is too short to reliably assess or predict the effect of the legislation.

- A review of the MDH Quality Assurance and Review (QA&R) data citing recommendations for level of care changes for MA recipients residing in the certified health care facilities who were denied their request for upgrading of their certification status did not substantiate a need for the higher level of care beds.

- The provider's anticipation of a curtailment on the upward reclassification of Medicaid certification resulted in an increased number of requests not requiring CON review for the 6 month period preceding the effective date of the moratorium. This accelerated activity alone increased the number of SNF beds by 463 thus impacting negatively on the curtailment of state expenditures.

- The availability of adult day care and respite care alternative placement options within the various counties on a statewide basis are for the most part unknown. Through efforts to obtain such data, MDH learned that counties do not routinely supply such information to DPW and some counties did not maintain such data.

- The Minnesota Preadmission Screening Program only became effective on a statewide basis in September, 1983. The statistical data in Exhibit D covers the period of January 1982 through June 1983 for only a portion of the state. During that period of time slightly over one half of the persons seeking nursing home admission were actually placed in a nursing home while the remainder were referred to other programs for necessary services.

- The majority of CON approvals or waivers for nursing homes and certified boarding care homes granted from January 1, 1982 through May 22, 1983 were related to the upward reclassification of existing beds rather than to the construction of new facilities (See Table VI, Appendix, page A-9 and Table VIII, Appendix, page A-11). For the same period of time 517 beds were denied reclassification upward through the CON process (See Table VI). However, as a result of the moratorium not all of the beds approved through the CON process will be eligible for Medicaid certification.

- Although some facilities submitted requests prior to the moratorium, waiver approval was not received until after the moratorium was in effect. As a result, the required Medicaid certification procedures to reclassify the beds to a higher level of care could not be conducted prior to the law's enactment, thus resulting in the Department's denial for the change in level of care. Other projects which had received CON or waiver approval prior to the date of enactment of the moratorium, had to be denied their requested change due to facility problems or MDH resource limitations. These projects also did not meet any of the exception provisions in subdivision 3 of the law and, therefore, Medicaid certification of new beds or for an upward change was denied.

- Some projects for which CON approval was received prior to the moratorium were, as of November 30, 1983, neither licensed nor certified. These facilities met the "commenced construction" exception provided for in the law and will be Medicaid certified at the completion of the project. These beds, in addition to those already approved between May 23, 1983 and November 30, 1983 will, when added into the system at a future date, increase the total number of added MA beds from the number certified at each level of care on the effective date of the law (See Table IV, Appendix, page A-7).

- A review of OHFC complaint investigations identified that, of the 17 facilities denied reclassification upward of existing certified beds, only 3 had complaints registered against them since the effective date of the moratorium. An analysis of those complaints revealed that the allegations in one facility were not substantiated and those substantiated in the second facility had no relationship to the denial of reclassification. The third facility, without MDH's authorization of the reclassification, had notified patients and families of impending transfers based upon their assumption of the necessary MDH approval, which was, in fact, denied.

- Survey and Compliance activities conducted subsequent to the effective date of the moratorium for 9 of the facilities denied upward reclassification revealed that the deficiencies cited had no relationship to the denial of the reclassification request.

Discussion

A number of issues surfaced in attempting to evaluate the impact of the moratorium which will require continued review. Some of these issues are as follows:

The United States General Accounting Office (GAO) recently released its July, 1982 report titled "Preliminary Findings on Patient Characteristics and State Medicaid Expenditures for Nursing Home Care" (GAO/IPE-82-4). In this report, the GAO presented preliminary findings on the increasing disability and dependence of nursing home patients and the increasing difficulties states are experiencing in meeting Medicaid expenditures. This report was prepared in response to the Health Care Financing Administration's (HCFA) proposed revisions to the certification survey procedures. The preliminary findings of the GAO raises issues which are relevant to the imposition and continuation of the moratorium. GAO's analysis of the characteristics of nursing home patients and the trends relating to nursing home expenditures lead to the following considerations:

- survey data indicate that patients entering nursing homes over the past several years are increasingly dependent or disabled; this trend is likely to continue. A more disabled nursing home population may imply a need for more extensive, and potentially more costly care.

- at the same time, States are finding it difficult to pay the escalating cost of this care and are taking steps to reduce their nursing home expenditures. Since more than half of the increases in expenditures are a result of inflation, States are cutting reimbursement rates, freezing bed supply, and taking other actions that may change both the quality of nursing home care and patients' access to it.

GAO's finding of the increasing dependency of nursing home residents was based on national surveys as well as their analysis of all institutionalized Medicaid recipients

in Minnesota in 1976 through 1979. GAO concluded that, "the number of potential users of nursing home care will increase and so will their dependence". This conclusion was also suggested by the fact that the elderly population is increasing and that the oldest age grouping (85 years and older) is growing the fastest. GAO also pointed out that another factor contributing to increasing dependence among nursing home residents is the development of Medicaid pre-admission screening programs, which assess less disabled MA applicants or recipients to avoid institutionalization when appropriate services are available in the community.

Statistics for Minnesota also show a significant increase in the number of the elderly. In April, 1983, Commissioner of Health, Sister Mary Madonna Ashton, addressed a gathering of long term care professionals and discussed the increase in our elderly population and future implications for health care. Portions of the speech were subsequently published in a report issued by the Minnesota Center for Health Statistics of the Minnesota Department of Health.[1] The following comments highlight portions of this report:

- °Minnesota had 32,000 people who were aged 85 or over in 1970 and 58,000 similarly aged people in 1980. By 1990, it is projected that this population group will increase to 69,000 and to 112,000 by the year 2010.

- °In 1980, approximately 9% of the elderly population were living in institutional settings (40,490). By the year 2010 and if the same institutionalization patterns hold, approximately 2 1/3% of 65-74 year olds (8,020) will be receiving institutional care and 16 1/3% of the over 75 age category (54,230) will receive institutional care.

- °If it can be assumed that the life expectancy of Minnesotans will continue to increase, it cannot be assumed that population will be disability free. It can be expected that more skilled levels of care will be required since greater proportions of the institutional population will be advanced age (over 75) and will suffer proportionately greater degrees of disability.

As noted in the GAO report, the growing and potential demand for services resulting from the increase in the number of aged individuals conflicts with the state's ability to pay for MA services. The moratorium was one of the Minnesota Legislature's response to the escalating costs of the Medical Assistance Program. As a short term measure, the moratorium will provide the time to see some stabilization in the growth of certified beds, especially the SNF beds. However, any leveling off of the bed increase will not be attained until all the beds meeting the exception provisions have entered the system. The long range effects of the moratorium will have to be more carefully and critically evaluated. The mission of institutional services for the elderly has to be more clearly identified. A number of factors that will have to be considered include:

- °The impact of the pre-admission screening program and the increase in the aged population. Will the pre-admission screening program provide an alternative to institutional care or will it merely delay a person's admission to the nursing home? If the latter situation develops, the nursing home population may become increasingly dependent and will most likely require skilled nursing care. Will the necessary beds and services be available in nursing homes to meet the needs of these individuals?

1. MCHS Report, volume 4, number 2, Spring, 1983, Minnesota Center for Health Statistics, Minnesota Department of Health

- What criteria or considerations will govern the location of a facility or the ability of an existing facility to change certification status or increase its capacity? Will state policy promote community based facilities or will the emphasis shift to providing a regional facility designed to service several communities? Will the state be willing to pay for services to be located within the community or will there be an expectation that admission to a nursing home will require some separation from the resident's home community?

- Will nursing home care become synonymous with skilled care? Will community based alternatives reduce or eliminate the need for noncertified long term care facilities or for ICF's. Or will it be more appropriate to require that long term care facilities offer and maintain a continuum of care with various levels within or adjacent to the facility to hopefully reduce the possibility of resident relocation?

- If the moratorium is lifted what, if any, controls will be developed to take its place? Will long term care planning efforts continue to be initiated at the local level or will the State take a more direct role in assigning and deciding bed numbers, size of facility, and level of care determinations?

- Will the implementation of the case mix reimbursement mechanism eliminate the need for a moratorium by calculating the MA reimbursement on resident needs and not on the certification level?

Until enough time has elapsed to ascertain the status of admissions and transfers of residents in facilities denied SNF beds and the effect of the state-wide implementation of the pre-admission screening program and the availability of alternatives in each county for residents requiring less than nursing home care, it will not be possible to analyze the moratorium's impact on the provision of services to the elderly.

The restriction of the moratorium to only Medicaid beds allows both newly licensed nursing home beds and Medicare certified beds to continue to be added to the total network. As pointed out in the GAO findings, patients now entering nursing homes are more dependent and, with the elderly population increasing, will undoubtedly be more disabled and require more intensive services in a nursing home. Some of these patients will be admitted from hospitals to nursing home beds certified for only Medicare but will continue to require skilled nursing care after their Medicare benefits have been exhausted. The moratorium provision brings into play a number of situations affecting resident relocation. Examples are as follows:

- A licensed nursing home has new beds which were certified only for Medicare; the other facility beds are Medicaid certified. A hospital patient is admitted into the Medicare bed. The resident continues to require skilled nursing home care after the Medicare benefits have been exhausted. The lack of private resources requires the resident to become

a MA recipient. However, in order for the MA benefits to be paid, the resident must reside in that portion of the facility that is Medicaid certified as a SNF. Limited options are available. A private pay resident in a Medicaid SNF multi-bed room could be relocated to a bed in the Medicare Unit which would allow the MA recipient to be admitted into the vacated bed in the MA certified portion. If a MA SNF bed cannot be made available but an ICF bed becomes available, the resident could be transferred into the ICF bed. State licensing rules would require that the facility meet the skilled nursing needs of the resident but Medicaid would only reimburse at the ICF level. Even if the facility attempted to rectify the problem by upgrading some of its ICF beds to SNF, the moratorium would require that the request be denied. The facility, under these circumstances, may elect to relocate the resident to another facility. Of course, such relocation would also be necessary if no in-facility transfers could be made to facilitate an empty bed in either the Medicaid SNF or ICF portion.

- Elderly persons may be appropriately admitted to a non-certified nursing home as private pay residents. When their private funds become exhausted and MA is necessary, these residents must automatically be relocated to an appropriate MA certified facility since reimbursement cannot be made for eligible MA recipients cared for in a non-certified MA facility.

- A facility's licensed nursing home beds are certified as MA ICF beds but, under the law, were denied SNF reclassification. The residents' conditions changes through the normal aging process, thus requiring skilled services. Since the facility cannot be reimbursed for SNF care, the options open to the facility are to retain the residents and continue to meet their needs as required under nursing home licensure rules, but be reimbursed only for the amount allowed by DPW for the ICF level of care or, relocate the residents to other facilities certified to be reimbursed for the higher level of care required. This may mean relocation to a facility far removed from the resident's family and home community.

- In all cases, however, the danger of relocation trauma becomes a serious concern.

Currently, as noted in QA&R and S&C data, there are facilities which have elected to retain SNF residents in ICF beds. For the most part, these are limited numbers in each facility thus reducing the negative cost impact upon the facility in the provision of a higher level of care. As the residents become more dependent and disabled however, this picture will undoubtedly require facilities unable to upgrade their certification status to reconsider retention of these intensive care residents with only ICF reimbursement and perhaps require them to relocate to other facilities. If such facilities are not available, the danger exists that the needs of the elderly will be unmet.

Another issue relates to the ability of a Supervised Living Facility (SLF) to become certified as an ICF. This would increase the number of MA beds brought into the system after the effective date of the moratorium which may be contrary to the policy inherent in the moratorium. Since the enactment of the moratorium, 3 SLF's have requested ICF certification. Upon satisfactory completion of the certification process, an increase of 70 new beds will be added to the system.

Another issue relates to the effect of the interpretations of the exception provisions in the law. As has been noted in the report, challenges to MDH interpretation of the law have generated considerable provider activity. For example, providers have requested an increase in skilled beds which were decertified by another facility. Their rationale is that this does not consitute additional certified beds but merely replaces certified beds which were previously in the system. Such an interpretation would make it possible for a metropolitan facility to request additional certified beds to "replace" beds decertified in northern Minnesota. The department has characterized this as a "bed banking" proposal and inconsistent with the law. A number of facilities have made such requests which to date have been denied.

Recommendations for Corrective Action

°The sixth month period covered by this report is insufficient to fully assess the impact of the moratorium. As has been noted, continued monitoring of the moratorium is essential. It will be critical to analyze the availablity and opportunities of alternatives to institutional care and to monitor occupancy rates and care level determinations in nursing homes and boarding care homes. It is anticipated that sufficient data will be available for a more detailed report in the areas in the Department's next annual report.

°Since 726 SNF beds and 422 ICF beds will enter the long term care system, the final impact of the moratorium as it relates to bed availability is still unknown. The Department recommends that the moratorium remain unchanged and that any additional exceptions not be considered by the 1984 Legislature. The continued prohibition on additional Medicaid certified beds or on changes to a higher level of care will provide an opportunity for the increased development and utilization of alternatives and for an assessment of the effectiveness of these resources.

°The Department recommends that the Legislature appropriate funds to provide sufficient resources to monitor the impact of the moratorium so that future legislative decisions may be made in the light of a more complete data base.

GLOSSARY OF TERMS

1. Licensure - Licensure is a state mandated, directed and administered process. Licensure of health care facilities is required by the provisions of Minn. Stat. §§144.50 - .58 (hospitals, boarding care homes, supervised living facilities and outpatient surgical centers) and by the provisions of Minn. Stat. §§144A.01 - .16 (nursing homes).

   a. Boarding Care Home (BCH) - A "boarding care home" is a state licensure classification denoting a facility or part of a facility which provides "care for aged or infirm persons who require only personal or custodial care and related services..." (7 MCAR §1.044 C.). A Boarding Care Home can be certified as an intermediate care facility. (For reimbursement purposes, the Department of Public Welfare designates a certified boarding care home as an ICF II facility.)

   b. Nursing Home (NH) - A "nursing home" is a state licensure classification denoting a facility or part of a facility which provides "care for aged or infirm persons who require nursing care and related services." (7 MCAR §1.044 A.). "Nursing care" is defined in Minn. Stat. §1.044A.01, subd. 6 as "health evaluation and treatment of patients and residents who are not in need of an acute care facility but who require nursing supervision on an inpatient basis". A nursing home can be certified as either a skilled nursing facility or as an intermediate care facility. (For reimbursement purposes, the Department of Public Welfare designates a nursing home certified as an intermediate care facility as an ICF I facility.)

   c. Supervised Living Facility (SLF) - A "supervised living facility" is a state licensure classification denoting a facility or part of a facility which provides services to the adult mentally ill, mentally retarded, chemically dependent, or physically handicapped. A supervised living facility is also issued a program license by the Department of Public Welfare. A supervised living facility can be certified as an intermediate care facility for the mentally retarded or in specific limited cases as an intermediate care facility.

2. Certification - "Certification" is a federally mandated and directed program. The certification program governs the determination as to a health care facility's eligibility to participate in the Medicare or Medicaid program or both. The federal provisions governing the certification of health care facilities are found in 42 NSCA 1395 and 1396.

   a. Medicare - "Medicare" is the federal health insurance program and is governed by Title 18 of the Social Security Act. The moratorium does not preclude a nursing home's participation in Medicare certification as a SNF.

   b. Medicaid - "Medicaid" is a federally aided, state operated and administered program authorized by Title 19 of the Social Security Act. Its Purpose is to provide medical services to persons receiving public assistance under the Social Security Act, and at the State's option, other needy persons. The program is jointly funded by the Federal, State and county governments but is administered by the State. Federal regulations set forth State plan

requirements, standards, procedures and conditions for obtaining Federal financial participation (FFP). The Medicaid law requires that there be a single State agency responsible for the overall management of the Medicaid Program with the agency ultimately responsible to the Health Care Financing Administration (HCFA) for program administration. In Minnesota, the single State agency is the Department of Public Welfare (DPW). The State Plan must also designate as the State authority responsible for establishing and maintaining health standards for facilities providing services to Medicaid recipients the same agency that is used by the Secretary of Health and Human Services (HHS) to determine qualifications of providers and suppliers of services participating in Medicare. (42 CFR 405.1902.) In Minnesota, the survey agency is the Minnesota Department of Health (MDH).

c. Levels of Care

1. Skilled Nursing Facility (SNF) - A "skilled nursing facility" is a federal certification classification denoting a facility or part of a facility which provides "skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled or sick persons." (42 NSCA §1395 x.) A SNF can be certified under both the Medicaid and Medicare programs.

2. Intermediate Care Facility (ICF) - An "intermediate care facility" is a federal certification classification denoting a facility or part of a facility which meets the requirements for a state license to provide, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services that are above the level of room and board and can be made available only through institutional facilities. (42 CFR 440.150.)

3. Intermediate Care Facility for the Mentally Retarded (ICF/MR) - An "intermediate care facility for the mentally retarded" is a federal certification classification denoting a facility or part of a facility which provides services to the mentally retarded or persons with related conditions if the primary purpose of the facility is to provide health or rehabilitative services to those individuals. (42 CFR 405.150.) The moratorium contained in Minn. Stat. §144A.071 does not prohibit the certification of ICF/MR beds, however, a moratorium on ICF/MR beds is contained in Laws 1983, Chapter 312, Article 9, §3.

3. Home Health Agency (HHA) - A "home health agency" is a public or private agency primarily engaged in providing home based health care and other services to the elderly and adult physically impaired persons. In Minnesota these agencies are not required to be licensed, but may be certified as a Medicare provider in accordance with section 1861(o) of the Social Security Act.

4. Adult Day Care - A program of services provided under health leadership in an ambulatory setting for adults who do not require 24 hour institutional care but due to physical and/or mental impairment, are not capable of full-time independent living.

5. Respite Care - Services provided on a short-term basis to a dependent individual due to the absence of or need for relief for those persons normally providing the care to that person.

6. Office of Health Facility Complaints (OHFC) - The Office of Health Facility Complaints was established by Minn. Stat. §§144A.51 - .55 in 1976. The office is a part of the Minnesota Department of Health and is directly responsible to the commissioner of health. The office investigates and acts upon complaints from both identified and anonymous sources made against licensed health care facilities, health care providers or administrative agencies of the state. OHFC may order the correction of any violation of state or federal laws or regulations.

7. Quality Assurance and Review Section (QA&R) - The Quality Assurance and Review is a federally mandated program, established in accordance with 42 CFR §456.600 et. seq., which reviews quality, quantity and level of care for Medicaid patients in long term care facilities in Minnesota. Teams of professionals including nurses and social workers, in consultation with physicians, conduct annual on-site evaluations of the care received by each Medicaid patient residing in a long term care facility. These evaluations provide an indication that in accordance with federal regulations appropriate levels of services are being received.

8. Survey and Compliance Section (S&C) - Survey and Compliance is a Section of the Health Systems Division of the Minnesota Department of Health. This Section is responsible for the licensure and certification of health care facilities in accordance with the state licensure laws, Minn. Stat. §§144.50 - .58 and §§144A.01 - .16, and the federal certification requirements, 42 U.S.C. 1395 and 1396. The Section conducts on-site inspections of health care facilities throughout the state for initial state licensure or federal certification and on a routine basis to assess compliance with state and federal laws and regulations. Surveys are conducted on an unannounced basis by teams of health professionals, e.g., nurses and sanitarians, who review facilities for sanitation, equipment, services provided and administration. These teams evaluate the facilities' performance and effectiveness in providing quality health care.

TABLE I

Number of Medicaid Certified Beds - January 1, 1978 - May 22, 1983*

Facility Type	1978	1979	1980	1981	1982	1983	Bed Change	% of Change
SNF Beds	23,366	24,646	26,332	26,557	27,895	28,839	+5,473	+23.4
ICF Beds	20,561	20,157	19,305	18,643	17,845	17,368	-3,193	-15.5
TOTAL Certified Beds	43,927	44,803	45,637	45,200	45,740	46,207		+5.2
(% SNF)	(53.2%)	(55%)	(57.7%)	(58.8%)	(61%)	(62.4%)		

*Source: Certificate of Need Review in Minnesota: Past Effectiveness and Issues for the Future, unpublished MDH report.

TABLE II

Number of Bed Certification Changes Approved Through CON Process January 1, 1978 – September 30, 1983*

Facility Type	Bed Numbers
New SNF Beds	2,025
New ICF Beds	675
ICF to SNF	1,628
ICF II to ICF I	586

*Source: Certificate of Need Review In Minnesota: Past Effectiveness and Issues for the Future, unpublished MDH report.

TABLE III

Number of Certified Beds as of May 23, 1983 and November 30, 1983
Listed By Health Systems Agency

Health Systems Agency	SNF 5/23/83	SNF 11/30/83	Difference	ICF I 5/23/83	ICF I 11/30/83	Difference	ICF II 5/23/83	ICF II 11/30/83	Difference
Agassiz Health Systems Agency	1,086	1,086	0	1,109	1,124	+15	185	172	-13
Health Systems Agency of Western Lake Superior	2,604	2,625	+21	880	876	-4	222	222	0
Min-Dak Health Systems Agency	1,381	1,381	0	1,551	1,551	0	153	153	0
Central Minnesota Health Systems Agency	3,661	3673	+12	1,217	1,241	+24	240	200	-40
Metropolitan Health Planning Board	12,948	13,273	1. +325	4,278	4,374	2. +96	2,301	2,238	-63
Minnesota Health Systems Agency Six	3,591	3,591	0	3,356	3,356	0	327	327	0
Southeastern *(Energy, Planning & Development)	3,911	3,911	0	1,142	1,142	0	162	162	0
STATE TOTALS	29,182	29,540	SNF +358	13,533	13,664	ICF I +131	3,590	3,474	ICF II -116

1. 327 new SNF beds were actually certified, however 2 SNF beds were decertified.

2. 108 new ICF I beds were actually certified, however, 12 ICF I beds were decertified.

*The Department of Energy, Planning and Development serves as the HSA for southeastern Minnesota.

TABLE IV

Number of Beds By Health Systems Agency Which Have Been Certified or Will be Certified Subsequent to May 22, 1983 Based on the Exception Provisions of Subdivision 3, of Chapter 199

Health Systems Agency	SNF Beds Certified Between 5/23 - 11/30/83	SNF Beds to be Certified	ICF I Beds Certified Between 5/23 - 11/30/83	ICF I Beds to be Certified	ICF II Beds Certified Between 5/23 - 11/30/83	ICF II Beds to be Certified
Agassiz Health Systems Agency	0	38	15	38	0	0
Health Systems Agency of Western Lake Superior	21	0	0	20	0	0
Min-Dak Health Systems Agency	0	50	0	99	0	58
Central Minnesota Health Systems Agency	12	133	24	46	0	0
Metropolitan Health Planning Board	327	382	108	128	0	0
Minnesota Health Systems Agency Six	0	88	0	22	0	0
Southeastern **(Energy, Planning & Development)	0	35	0	11	0	0
*STATE TOTAL	360	726	147	364	0	58

Note: All of the above beds (24 facilities) with the exception of 38 SNF and 38 ICF I (one facility) to be certified have been approved based on Subd. 3(b). The one exception meets Subd. 3(a).

*It is anticipated that additional beds may be approved based on Subd. 3(b) - met commenced construction.

**The Department of Energy, Planning and Development serves as the HSA for southeastern Minnesota.

TABLE V

ICF Beds Reclassified to SNF From January 1, 1982 Through May 22, 1983

Time Period	# of Facility Requests	# of Facility Requests of 10 Beds or Less	# of Beds Certified	% of Change From Previous Six Month Period
January 1 - June 30, 1982	22	18	274	-
July 1 - December 31, 1982	12	5	251	-9.2%
January 1 - May 22, 1983	37	27	463	+45.8%
TOTAL	71	50	988	-

Facility Requests for Changes from ICF to SNF
January 1, 1982 - May 22, 1983

Average # of Facility Requests Per Month	Number of Facility Requests for March, 1983	Number of Facility Requests for April, 1983	Average # of Beds Reclassified Per Month	Number of Beds Reclassified March, 1983	Number of Beds Reclassified April, 1983
4.2	12	11	58.1	184	158

TABLE VI

Certificate of Need Approvals or Waivers Granted for ICF to SNF Beds

Time Period	Number of Facilities	Number of Beds
January 1, 1982 - June 30, 1982	7	186
July 1, 1982 - December 31, 1982	11	228
January 1, 1983 - May 22, 1983	14	374
TOTAL	32	788

Certificate of Need Denials for ICF to SNF Beds

Time Period	Number of Facilities	Number of Beds
January 1, 1982 - June 30, 1982	0	0
July 1, 1982 - December 31, 1982	13	443
January 1, 1983 - May 22, 1983	2	74
TOTAL	15	517

TABLE VII

Quality Assurance and Review Section Recommendations for Facilities Denied Certification Requests

	Number of Recommendations 1982 Visit	Number of Recommendations 1983 Visit
ICF I to SNF	132	123
ICF II to ICF I	0	6
SNF to ICF I	39	18
ICF I to ICF/MR	0	2
ICF I to ICF II	0	16
ICF II to Independent Living	1	1
ICF II to Semi Independent Living	6	0

TABLE VIII

Certificate of Need Granted to Nursing Homes, and Boarding Care Homes - January 1, 1982 Through May 22, 1983

Type of Change	Number of Facilities	Number and Classification of Beds Licensure	Certification
ICF to SNF	4	-	121 SNF
Additional Beds to Existing Nursing Homes	6	413 NH	252 SNF 161 ICF I
New Nursing Homes	3	360 NH	335 SNF 25 ICF I
Replacement of All or Part of a Nursing Home	4	+31 NH -42 BCH	+64 SNF -33 ICF I -42 ICF II
Reclassification of Boarding Care Home Beds to Nursing Home Beds	3	+52 NH -54 BCH	10 SNF 42 ICF I
TOTAL	20	+856 NH -96 BCH	+782 SNF +195 ICF I -42 ICF II

CHAPTER 199 — S.F.No. 695

An act relating to public welfare; requiring new procedures for determining nursing home payment rates; requiring a moratorium on certification or welfare licensure of new beds with certain exceptions; providing for an interagency board for quality assurance; appropriating money; amending Minnesota Statutes 1982, sections 144A.10, subdivisions 4, 6, and by adding a subdivision; 256B.091, subdivisions 1, 2, 4, and 8; 256B.41; 256B.47; and 256B.48; proposing new law coded in Minnesota Statutes 1982, chapters 144A and 256B; repealing Minnesota Statutes 1982, sections 256B.42; 256B.43; 256B.44; 256B.45; and 256B.46; and 12 MCAR 2.049.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[144A.071] MORATORIUM ON CERTIFICATION OF NURSING HOME BEDS.**

Subdivision 1. **FINDINGS.** The legislature finds that medical assistance expenditures are increasing at a much faster rate than the state's ability to pay them; that reimbursement for nursing home care and ancillary services comprises over half of medical assistance costs, and, therefore, controlling expenditures for nursing home care is essential to prudent management of the state's budget; that construction of new nursing homes, the addition of more nursing home beds to the state's long-term care resources, and increased conversion of beds to skilled nursing facility bed status inhibits the ability to control expenditures; that Minnesota already leads the nation in nursing home expenditures per capita, has the fifth highest number of beds per capita elderly, and that private paying individuals and medical assistance recipients have equivalent access to nursing home care; and that in the absence of a moratorium the increased numbers of nursing homes and nursing home beds will consume resources that would otherwise be available to develop a comprehensive long-term care system that includes a continuum of care. Unless action is taken, this expansion of bed capacity and changes of beds to a higher classification of care are likely to accelerate with the repeal of the certificate of need program effective March 15, 1984. The legislature also finds that Minnesota's dependence on institutional care for elderly persons is due in part to the dearth of alternative services in the home and community.

The legislature declares that a moratorium on medical assistance certification of new nursing home beds and on changes in certification to a higher level of care is necessary to control nursing home expenditure growth and enable the state to meet the needs of its elderly by providing high quality services in the most appropriate manner along a continuum of care.

Subd. 2. **MORATORIUM.** Notwithstanding the provisions of the Certificate of Need Act, sections 145.832 to 145.845, or any other law to the contrary, the commissioner of health, in coordination with the commissioner of public welfare, shall deny each request by a nursing home or boarding care home, except an intermediate care facility for the mentally retarded, for addition of new certified beds or for a change or changes in the certification status of existing beds except as provided in subdivision 3. The total number of certified beds in the state in the skilled level and in the intermediate levels of care shall remain at or decrease from the number of beds certified at each level of care on the effective date of this section, except as allowed under subdivision 3. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq.

The commissioner of public welfare, in coordination with the commissioner of health, shall deny any request to issue a license under sections 245.781 to 245.812 and 252.28 to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

Subd. 3. **EXCEPTIONS.** The commissioner of health, in coordination with the commissioner of welfare, may approve the addition of a new certified bed or change in the certification status of an existing bed under the following conditions:

(a) To replace a bed decertified after the effective date of this section or to address an extreme hardship situation, in a particular county that, together with all contiguous Minnesota counties, has fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than the national average of nursing home beds per 1,000 elderly individuals. For the purposes of this section, the national average of nursing home beds shall be the most recent figure that can be supplied by the federal health care financing administration and the number of elderly in the county or the nation shall be determined by the most recent federal census or the most recent estimate of the state demographer as of July 1, of each year of persons age 65 and older, whichever is the most recent at the time of the request for replacement. In allowing replacement of a decertified bed, the commissioners shall ensure that the number of added or recertified beds does not exceed the total number of decertified beds in the state in that level of care. An extreme hardship situation can only be found after the county documents the existence of unmet medical needs that cannot be addressed by any other alternatives;

(b) To certify a new bed in a facility that commenced construction before the effective date of this section. For the purposes of this section, "commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were secured;

(c) To certify beds in a new nursing home that is needed in order to meet the special dietary needs of its residents, if: the nursing home proves to the commissioner's satisfaction that the needs of its residents cannot otherwise be met; elements of the special diet are not available through most food distributors; and proper preparation of the special diet requires incurring various operating expenses, including extra food preparation or serving items, not incurred to a similar extent by most nursing homes; or

(d) When the change in certification status results in a decrease in the reimbursement amount.

Subd. 4. **MONITORING.** The commissioner of health, in coordination with the commissioner of public welfare, shall implement mechanisms to monitor and analyze the effect of the moratorium in the different geographic areas of the state. The commissioner of health shall submit to the legislature, no later than January 15, 1984, and annually thereafter, an assessment of the impact of the moratorium by geographic area, with particular attention to service deficits or problems and a corrective action plan.

Subd. 5. **REPORT.** The commissioner of energy, planning, and development, in consultation with the commissioners of health and public welfare, shall report to the senate health and human services committee and the house health and welfare committee by January 15, 1986 and biennially thereafter regarding:

projections on the number of elderly Minnesota residents including medical assistance recipients;

the number of residents most at risk for nursing home placement;

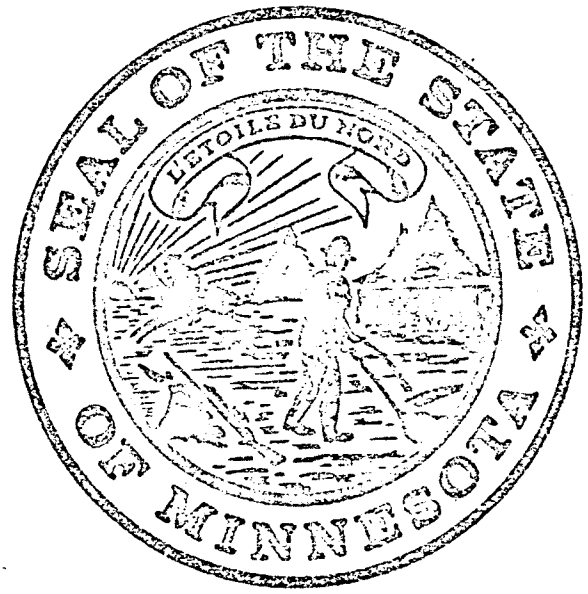
the needs for long-term care and alternative home and noninstitutional services;

availability of and access to alternative services by geographic region; and

the necessity or desirability of continuing, modifying, or repealing the moratorium in relation to the availability and development of the continuum of long-term care services.

EXHIBIT B

MINNESOTA STATE HEALTH PLAN



September, 1982

Statewide Health Coordinating Council
State Health Planning and Development Agency
Department of Energy, Planning and Development

INSTITUTIONAL LONG TERM CARE

DEFINITION

For purposes of this section, long term care services includes services in nursing homes and boarding care homes. These services are provided in a long-stay, inpatient setting and focus on the elderly. Nursing home beds are skilled and intermediate care beds.

A. ANALYSIS OF REGIONAL HEALTH SERVICE AREAS

Estimate of Need

Occupancy rate is used as an indicator of service requirements. This assumes that the majority of long-term care facility residents are appropriately placed. This assumption is verified by the Quality Assurance and Review Section of the Minnesota Department of Health. But problems with this review include (1) it generally does not review admissions until several months after they occur, and (2) it can consider only those alternatives to institutional living which currently exist in the particular community. The Minnesota Statewide Health Coordinating Council approved guideline for minimum long-term care facility occupancy is:

> **Guideline:** The minimum average occupancy rate in each long-term care service area should exceed 93%.

The Central Minnesota HSA and Southeastern Minnesota HSA used this occupancy guideline in their HSP. The other five HSAs raised this minimum rate to 95%.

Another bed need indicator used in the HSPs is the bed-to-population ratio.

Inventory and Use

With 41,259 nursing home beds and 5,917 boarding care beds, Minnesota has 86 nursing home beds per 1,000 residents 65 and over and 12.3 boarding care beds per 1,000 residents 65 and over. Occupancy of nursing homes averages 92.4% and exceeds 90% in all HSAs (see Figure 35).

From 1976-1980 the supply of nursing home beds to the number of persons aged 65 and older remained fairly steady.

Agassiz Health Systems Agency: The area has 90 nursing home beds per 1,000 population 65 and over with an average occupancy rate of 97.5.

FIGURE 35. 1980 FACILITIES INVENTORY AND USE FOR LONG-TERM CARE

Area	No. and Type of Unit	No. of Licensed Beds	Average Daily Census	Occupancy Rate (licensed)	Licensed ICF-1 & SNF Beds/1,000 Persons 65+
Agassiz	30 NH 13 B/C	2,102 NH 429 B/C	2,048.4 NH 504.3 B/C	97.5% NH 117.5% B/C	90.0
Western Lake Superior	36 NH 6 B/C	3,360 NH 222 B/C	3,053.6 NH 235.6 B/C	90.9% NH 106.1% B/C	73.2
Min-Dak	31 NH 12 B/C	2,548 NH 197 B/C	2,373.9 NH 167.0 B/C	93.2% NH 84.8% B/C	82.8
Central	50 NH 15 B/C	4,684 NH 277 B/C	4,404.7 NH 234.5 B/C	94.0% NH 84.7% B/C	83.7
Metro	140 NH 63 B/C	16,928 NH 3,810 B/C	15,345.1 NH 3,147.5 B/C	90.6% NH 82.6% B/C	90.0
Six	98 NH 28 B/C	6,849 NH 565 B/C	6,445.0 NY 494.7 B/C	94.1% NH 87.6% B/C	84.4
Southeastern Minnesota	56 NH 24 B/C	4,788 NH 417 B/C	4,460.5 NH 404.2 B/C	93.2% NH 96.9% B/C	89.6
STATE	441 NH 161 B/C	41,259 NH 5,917 B/C	38,131.3 NH 5,187.7 B/C	92.4% NH 87.7% B/C	86.0

NH = Nursing Home
B/C = Boarding Care Facility

SOURCE: Health Facilities Detail Report, Minnesota Department of Health, Fiscal Year 1980.

FIGURE 36

MINNESOTA
NURSING HOME BEDS AND POPULATION 1976-1980

	1976	1977	1978	1979	1980
No. of Licensed Nursing Home Beds	38,139	38,994	40,061	40,949	41,259
Population 65+	445,557	451,940	461,208	470,477	479,746
Bed-to-Population Ratio	85.6	86.3	86.7	87.0	86.0
No. Patients 65+	32,806	33,859	34,887	35,684	36,115

SOURCE: Health Facilities Detail Report, Minnesota Department of Health, Fiscal Years 1976-1980. Population figures taken from U.S. Census, 1980, and Office of State Demographer, Minnesota Age Estimates, April 1977 (December, 1978), p. 4. Population figures for 1976, 1978 and 1979 estimated by SHPDA staff.

The current number of nursing home beds exceeds the HSA's bed-to-population goal and they are not evenly distributed by county. An excess of beds is projected to continue beyond 1995. Data from a 1981 regionwide survey revealed that (1) average age of nursing home residents was 84, (2) 61% of nursing home residents use Medicaid, (3) more than one-third were hospitalized immediately prior to admission, and (4) inadequate incentives to develop various alternatives to long-term institutional care and lack of coordinated long-range planning among area facilities were problems. The HSP recommends that (1) the number of long-term care beds be limited to no more than 80 beds per 1,000 population aged 65 and over, and (2) each long-term care facility establish a long-range plan in conjunction with the HSA which addresses alternatives to institutional long term care services.

Health Systems Agency of Western Lake Superior: The area has 73.2 nursing home beds per 1,000 population 65 and over with an average occupancy rate of 90.9. The HSP goal calls for no more than 70.0 long-term care beds per 1,000 population 65 and over. The HSA identifies a maldistribution of long-term care beds. The agency, therefore, recommends that (1) no new beds be added in planning areas with adequate or surplus service, and (2) that additional beds be added only to areas below the desired bed ratio.

Min-Dak Health Systems Agency: The area has 82.8 nursing home beds per 1,000 population 65 and over with an average occupancy rate of 93.2. The HSA has identified an excess number of long term care beds in the area, and projects the elderly population to decline somewhat in the next 20 years. No data is available concerning the appropriateness of current distribution of facilities or the adequacy of service options for the area.

Central Minnesota Health System Agency: The area has 83.7 nursing home beds per 1,000 population 65 and over with an average occupancy rate of 94.0. The HSA experienced a larger percentage increase in the number of persons aged 65 and over than did the state as a whole, and the HSA projects this segment of the population to increase further by 1985. The HSA notes that there are inadequate incentives to develop all the various alternatives for long-term care and that up to 397 additional beds may be needed by 1985. Currently a maldistribution of beds exists in the region, and counties which may need more beds have been identifed. The HSP goal calls for limiting the number of nursing home beds to 83.9 per 1,000 population 65 and over.

Metropolitan Health Board: The area has 16,928 nursing home beds or 90.0 beds per 1,000 population 65 and over with an average occupancy rate of 90.6. The metropolitan area institutionalizes its elderly at almost twice the national rate. Projected demand for 1985 indicates that approximately 17,443 long-term care beds are needed. The HSP goals call for (1) the long-term care bed ratio to be reduced from the current 100.1 beds per 1,000 population age 65 and over to 95 beds per 1,000 population age 65 and over*, and (2) beds to operate at 95% occupancy before more are added. The HSA noted that one of the most significant problems to long term care service is lack of alternative services and stressed development of incentives to explore and implement options to institutionalization of the elderly.

Health Systems Agency Six: The area has 84.4 nursing home beds per 1,000 population 65 and over with an average occupancy rate of 94.1. The distribution of beds in the area is imbalanced which will result in county excesses and shortages by county by 1985. Total area bed need for 1985 is 15 additional beds.

Southeastern Minnesota Health Systems Agency: The area has 89.6 nursing home beds per 1,000 population 65 and over with an average occupancy rate of 93.2. These facilities are well-distributed throughout the region. There are no availability problems. The HSA identifies five counties which need additional beds by 1987, based on projections of 93 beds per 1,000 population 65 and over at a 95% occupancy level.

B. STATE ANALYSIS

Availability/Accessibility

The state has an adequate supply of nursing home beds in all health service areas. The range of bed-to-population ratios targeted by HSAs for their areas varies widely, from 70 to 95 beds per 1,000 persons aged 65 and over. The Agassiz HSA, Western Lake Superior HSA and HSA Six report an imbalance in the distribution of beds and recommend additions of future beds only to those counties below the desired supply and occupancy. Southeastern Minnesota HSA reports adequate bed distribution and additional beds to selected counties below 1987 need. The average occupancy rate statewide is 92.4% for nursing home beds, but rates in four HSAs are below their recommended occupancy guideline.

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*HSP goal includes certified (ICF II) boarding care beds, and long stay convalenscent and nursing care beds in its ratio.

Three-fourths of nursing home residents are aged 75 and over (see Figure 37). Seventy-three percent of those are women. Of the total long term care patients, the metropolitan area has the highest percentage (28%) of persons between the age of 65-74 who are institutionalized (see Figure 37).

Of the total state population 75 and older, 15% are in nursing homes.

Cost

Sixty-four percent of nursing home residents are reimbursed through the Medicaid program. The remainder are largely private pay residents. Medicaid recipients in skilled nursing facilities and intermediate care facilities are reimbursed on the basis of allowable costs, up to a point. Minnesota Department of Public Welfare's current daily rates vary by type of ownership and population density but fall within these ranges:

	Daily Rates
Skilled	$37 - $47
ICF (in Nursing Home)	$31 - $39
ICF (in Boarding Care Home)	$22 - $28
Personal or Custodial Care	- $19

Facilities are prohibited from charging private-pay patients more than Minnesota Department of Public Welfare rates.

Equalizing reimbursement for nursing homes and alternative services, i.e., home health care is considered as an important issue by HSAs for cost, quality and acceptability reasons.

Continuity/Quality/Acceptability

Each HSA pointed to the need for a continuum of care or broader range of services to be available to the elderly. More types of and greater distribution of alternative services to inpatient nursing care are called for together with financial incentives to use them rather than nursing homes.

Policy changes and greater emphasis to expand home health care services and to develop and implement methods to remove financial barriers to the use of alternatives to institutionalized care is necessary.

HSPs also reflect the need for coordinated and long range planning among long term care service providers.

C. CONCLUSION

Minnesota has a sufficient number of nursing home beds available but perhaps not suitably distributed in certain counties. With the exception of the Central Minnesota HSA and selected counties in other HSAs, further expansion of inpatient nursing home beds is unnecessary at this time.

Even though most HSAs cite a more than adequate number of long term care beds, bed supply and utilization do not seem to be as important a concern as the often noted lack of alternative care. A related concern to third party payors, which are primarily state and federal governments, is the rising costs of inpatient care together with the increasing number of elderly. This means greater share of state (and federal) budgets will be required to support these persons. While practices to promote a healthier elderly population are desired, the cost of needed care can be examined and options to expensive inpatient care made available and used.

A shift toward increasing the type, amount and distribution of acceptable, alternative services to inpatient beds is needed statewide. Planning efforts and resource monies should be directed to support such development. Changes in reimbursement mechanisms are also required.

Coordinated efforts between long-term care service providers on a regional basis should be encouraged so that a patient might receive all the care needed but not more than is necessary.

FIGURE 37. LONG TERM CARE PATIENT PROFILE, 1980

	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	STATE
Patients 65+								
TOTAL	2,278	3,170	2,470	4,374	16,615	6,685	4,616	40,208
(percentage of patients 65-74)	(27%)	(24%)	(20%)	(20%)	(28%)	(18%)	(20%)	(25%)
Nursing Home	1,935	2,916	2,298	4,161	14,295	6,263	4,247	36,115
Boarding Care	343	254	172	213	2,320	422	369	4,093
Patients 75+								
TOTAL	1,944	2,631	2,102	3,707	13,884	5,832	4,032	34,132
(percentage of all patients)	(73%)	(76%)	(80%)	(80%)	(72%)	(82%)	(80%)	(75%)
TOTAL - Nursing Home	1,663	2,415	1,979	3,518	12,075	5,488	3,721	30,859
Nursing Home - Male	536	663	617	1,120	2,793	1,677	1,018	8,424
Nursing Home - Female	1,127	1,752	1,362	2,398	9,282	3,811	2,703	22,435
TOTAL - Boarding Care	281	216	123	189	1,809	344	311	3,273
Boarding Care - Male	113	61	46	66	401	115	91	893
Boarding Care - Female	168	155	77	123	1,408	229	220	2,380

SOURCE: Health Facilities Detail Report, Minnesota Department of Health, Fiscal Year 1980.

EXHIBIT C

Calculations by Each HSA of LTC Beds Per 1,000 Persons Over 65

HSA - Metro Health Planning Board

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Anoka	80.52	107.35
Carver	60.07	110.35
Dakota	94.40	108.79
Hennepin	114.58	106.77
Ramsey	96.82	105.80
Scott	144.00	110.40
Washington	93.85	95.39

HSA - of Western Lake Superior

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Aitkin	59.12	82.52
Carlton	86.49	81.24
Cook	77.18	73.25
Itasca	68.91	85.54
Koochiching	88.95	83.15
Lake	71.62	83.83
St. Louis	84.56	81.20

HSA - Min-Dak

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Becker	96.26	98.14
Clay	86.11	99.71
Douglas	108.38	81.80
Grant	121.82	104.24

HSA - Min-Dak (Continued)

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Otter Tail	101.10	96.44
Pope	109.16	81.61
Stevens	90.28	104.74
Traverse	111.50	107.45
Wilkin	94.30	98.94

HSA - Central

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Benton	172.56	96.22
Cass	128.03	81.17
Chisago	117.17	92.40
Crow Wing	67.27	89.73
Isanti	100.08	104.75
Kanabec	57.38	96.08
Mille Lacs	111.37	101.60
Morrison	92.15	82.87
Pine	60.25	82.30
Sherburne	194.26	108.91
Stearns	50.72	93.94
Todd	54.52	88.29
Wadena	131.44	96.03
Wright	92.11	105.51

HSA - Agassiz

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Beltrami	89.41	85.11

HSA - Agassiz (Continued)

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Clearwater	109.14	98.25
Hubbard	56.37	102.51
Kittson	131.33	86.49
Lake of the Woods	83.87	89.45
Mahnomen	55.24	116.67
Marshall	52.23	102.36
Norman	139.16	108.63
Pennington	74.90	101.11
Polk	136.94	106.11
Red Lake	87.68	115.74
Roseau	91.92	87.40

HSA - Southeastern (State Planning)

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Dodge	82.98	96.88
Fillmore	115.88	93.73
Freeborn	85.54	82.58
Goodhue	134.17	98.73
Houston	109.68	103.57
Mower	82.61	88.33
Olmsted	87.12	97.68
Rice	116.72	103.56
Steele	78.45	98.19
Wabasha	80.08	99.82
Winona	93.05	94.96

HSA - Six

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Big Stone	118.84	102.50
Blue Earth	88.13	81.63
Brown	88.98	93.15
Chippewa	80.74	96.03
Cottonwood	98.99	87.80
Faribault	84.05	83.46
Jackson	95.00	81.76
Kandiyohi	97.82	81.22
Lac Qui Parle	120.84	94.74
LeSueur	77.58	95.02
Lincoln	104.13	96.46
Lyon	108.22	100.84
McLeod	72.44	85.97
Martin	75.55	86.04
Meeker	108.09	80.44
Murray	69.57	95.67
Nicollet	71.30	85.44
Nobles	75.68	86.87
Pipestone	105.19	90.28
Redwood	115.55	98.62
Renville	107.66	90.94
Rock	73.72	81.15
Sibley	68.06	86.30
Swift	78.62	98.07
Waseca	79.86	89.12

HSA - Six (Continued)

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Watonwan	77.74	86.97
Yellow Medicine	87.67	103.92

EXHIBIT D

PREADMISSION SCREENING AND ALTERNATIVE CARE GRANTS PROGRAM

STATISTICAL UPDATE FOR 82-83 BIENNIUM

January 1982 through June 1983 (18 months)

1. Preadmission Screening

   a. Total people screened: 2,323

   b. Results:

Nursing home placements	1,172
Community placements	1,108
(of these, 790 received services funded by the alternative care grants program)	
Not indicated	43

   c. Eligibility:

Medical Assistance (MA) eligible	938
90-day eligible	1,118
Private pay	224

   d. Cost for screenings:

$204,196	state reimbursement to counties
51,590	estimate for PHN under MA

2. Alternative Care Grants Program

   a. Total people served: 790

   b. Services provided (reported on quarterly basis):

Day care	119
Respite Care	42
Homemaker	1,074
Home health aid	419
Foster care	0
Personal care	75
Case management	727

   c. Cost:

Services		$722,029.82
Administrative		221,557.43
	TOTAL	$943,587.25

   d. Funding:

State		$666,796.95
Federal		202,701.86
County		74,088.44
	TOTAL	$943,587.25

   e. Average cost of services per client: $914
   (the average length of time on ACG is estimated at 3 months therefore the average cost per month is about $305)