Nursing Homes: A Financial Review

January 1991

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Program Evaluation Division

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JAMES R. NOBLES, LEGISLATIVE AUDITOR

January 24, 1991

Members
Legislative Audit Commission

Dear Commission Members:

Legislators requested this study in May 1990 because they were concerned about the financial condition of nursing homes in Minnesota. Industry representatives claimed that more than half the nursing homes were operating at a loss, and residents' care was in jeopardy.

In general, we found that the nursing home industry has experienced considerable financial stress, but only a few homes are in serious financial condition. In addition, we found that residents face little or no danger from the state's reimbursement system. However, because of the industry's weak condition, we think that the Legislature needs to give careful consideration before cutting state support for nursing homes.

We are grateful for the assistance of the Departments of Health and Human Services, the Minnesota Association of Homes for the Aging, and Care Providers of Minnesota. We also thank numerous nursing home administrators for their cooperation.

The report was researched and written by Marilyn Jackson-Beeck (project manager), Jan Sandberg, and Jo Vos. Assistance was provided by Jay Kroshus.

Sincerely yours,

James R. Nobles
Legislative Auditor

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NURSING HOMES: A FINANCIAL REVIEW

Executive Summary

Minnesota state government is strongly linked to the nursing home industry. State policy tries to ensure that citizens have access to nursing homes when needed, without regard to ability to pay. Using state and federal funds, the state pays for most nursing home care, and it is expensive.

During the late 1970s and early 1980s, nursing home costs rose so much that the Legislature decided that strong action was needed. The state developed a reimbursement system that was specifically designed to limit and control payments to nursing homes.[1] Also, legislation put an effective moratorium on the construction of additional nursing homes, while state grants helped to develop less expensive, community-based health care systems.

The Legislature's actions have brought nursing homes' annual cost increases down. However, nursing home trade associations argue that, as a result, their industry is on the verge of financial ruin. Further, some industry representatives claim that financial problems are jeopardizing nursing home residents' care.

Because of these claims, in May 1990, the Legislative Audit Commission asked us to study the nursing home industry and focus on these key questions:

- **What is the general financial condition of nursing homes in Minnesota?**

- **Has the state's method of reimbursement caused serious statewide problems in nursing home operations, administration, and resident care?**

In general, we found that the nursing home industry is under considerable stress—financially and otherwise—but the situation is not critical for most facilities, and residents are in little or no danger from the reimbursement system itself. However, we found evidence which suggests that the reimbursement system and other policy measures may have contributed to nursing homes' physical deterioration and some undesirable cost-cutting.

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1 *Minn. Laws* (1983), Chapter 199.

INDUSTRY CHANGES

Although the moratorium and reimbursement system limit nursing home construction, major remodeling, and other physical changes in nursing homes, the industry has become more professional in management, administration, operations, and service delivery. Despite a statewide labor shortage, health care services have improved and now are delivered with greater emphasis on efficiency.

Residents

Residents are older and sicker.

One result of government efforts to contain health care costs is that:

- **Nursing home residents are older and more debilitated than they were in the 1970s.**

In part, this reflects federal policies which have had the effect of moving Medicare patients out of acute-care hospitals and into nursing homes for recuperation as soon as possible. The change also may reflect state efforts to divert nursing home candidates to less costly alternatives when appropriate, plus medical advances and the general increase in the human life span.

Statewide, about 43,000 individuals receive care annually in Medicaid-certified Minnesota nursing homes. Most of the nursing home residents are women, and their average age is 83. Most residents are not acutely ill, but they have greater care needs, more medical diagnoses, and fewer abilities today than they did ten years ago. On the average, they live in nursing homes three to four years.

Nursing Homes

Only about 40 percent of Minnesota nursing homes are for-profit.

Despite Medicaid restrictions and the accompanying paperwork, we found that:

- **Almost all nursing homes (96 percent) participate in the Medicaid program and agree to accept payment at the rates established by the Department of Human Services.**

The number of nursing homes receiving Medicaid payments from the department has not changed significantly since 1985; during 1989, 448 homes participated in Medicaid.

However, there has been a slight shift in ownership. About the same percentage has remained for-profit (41 percent), but cities and counties have sold some of their homes, often to hospitals or other nonprofit organizations. As a result, we found an increase in hospital-affiliated nursing homes over the past few years. Nearly half (48 percent) of all Minnesota hospitals operated nursing home units in 1989.

REIMBURSEMENT SYSTEM

The state's current method for reimbursing nursing homes has three distinctive features. First, the system sets payment rates "prospectively" for one-year periods, based on nursing homes' previous, allowable expenses plus the projected amount of inflation. Second, rates are tied to the nursing homes' "case mix" or level of services which are actually needed and used by individual residents. Third, reimbursement limits vary by geographic region.

The property payment subsystem is in flux.

Rates for specific nursing homes are determined mainly on the basis of expenses in four categories: care-related, other operating, pass-through costs (such as licensing fees), and property. Currently, the Legislature is scheduled to hear recommendations which may fundamentally change the property payment method. For this reason, our study focused on other aspects of the reimbursement system, particularly those relating to administration, operations, and resident care.

We learned that:

- **The only direct opportunity for nursing homes to earn operating revenues in excess of expenses (or profit) is an efficiency incentive payment of up to $2 per resident day.**

All nursing homes—for-profit, nonprofit, and city/county—are eligible to earn incentive payments by controlling the costs of non-nursing services. These include dietary services (but not raw food), laundry, linen, housekeeping, plant operations, maintenance, general costs, and administration. Most nursing homes (77 percent) earn some incentive payments; 40 percent earn the maximum amount.

Conversely, nursing homes typically spend some money which is ineligible for reimbursement under state law or rules. On the average, we found:

- **About five percent of nursing home expenses were ineligible for reimbursement.**

Some expenses are disallowed by auditors at the Department of Human Services. It is their job to review cost reports and determine whether expenses are documented, related to resident care, and in keeping with laws and rules. A computer system disallows other expenses if they are above certain limits.

In our survey, 61 percent of administrators acknowledged that they made some expenditures with advance knowledge that they were ineligible for reimbursement through the state's reimbursement system. They explained that, in their opinion, some unreimbursed expenses made good business sense and would help nursing homes in the long run (for example, employee recognition programs and marketing).

FINANCIAL REVIEW

We emphasize that our evaluation dealt with the state's reimbursement system and the nursing home industry in general. We did not study the manner in which the Department of Human Services establishes payment rates for specific nursing homes nor the adequacy of the rates with respect to individual residents' care needs. Neither did we evaluate the auditors' work or develop detailed financial statistics which would be important to investors.

Methods

To answer legislators' concern about the financial health of the nursing home industry, we examined audited financial statements and hired an accounting firm with specialized knowledge of the health care industry.

Given the limitations of the best available data, we supplemented our financial analysis with information from nursing homes' cost reports and rate notices and obtained supplementary financial data on hospitals which operate nursing homes. Also, we surveyed administrators and spoke with nursing home owners, industry experts, and residents' representatives.

Nevertheless, it was difficult to evaluate the financial condition of nursing homes. Business practices vary significantly among the homes. There were no specifically identified accounting standards for the industry during the period of our study, nor has the state established a uniform standard for reporting financial results.

Criteria

We tracked financial results over the most recent four-year period for which data were available. Our most important criteria of financial stress were based on the *total margin* and *operating margin*. The total margin equals net income (after taxes, if any) from all sources divided by total revenues. The operating margin is calculated before taxes and equals operating income divided by operating revenues. Generally speaking, when these margins were recently highly negative or slightly negative for several years, we judged that nursing homes were highly stressed.

Business owners, investors, and nonprofit organizations are especially mindful of margins (and many more detailed financial ratios) because they standardize performance comparisons over time and across nursing homes. These indicators describe organizations' performance in clear, simple terms and indicate whether resources are at least sufficient to meet expenses.

Financial Stress

The results of our analysis showed that:

- **Forty to 43 percent of Medicaid-certified nursing homes were subject to some financial stress, but the situation was serious for only a few.**

Financial stress was serious in only a few cases.

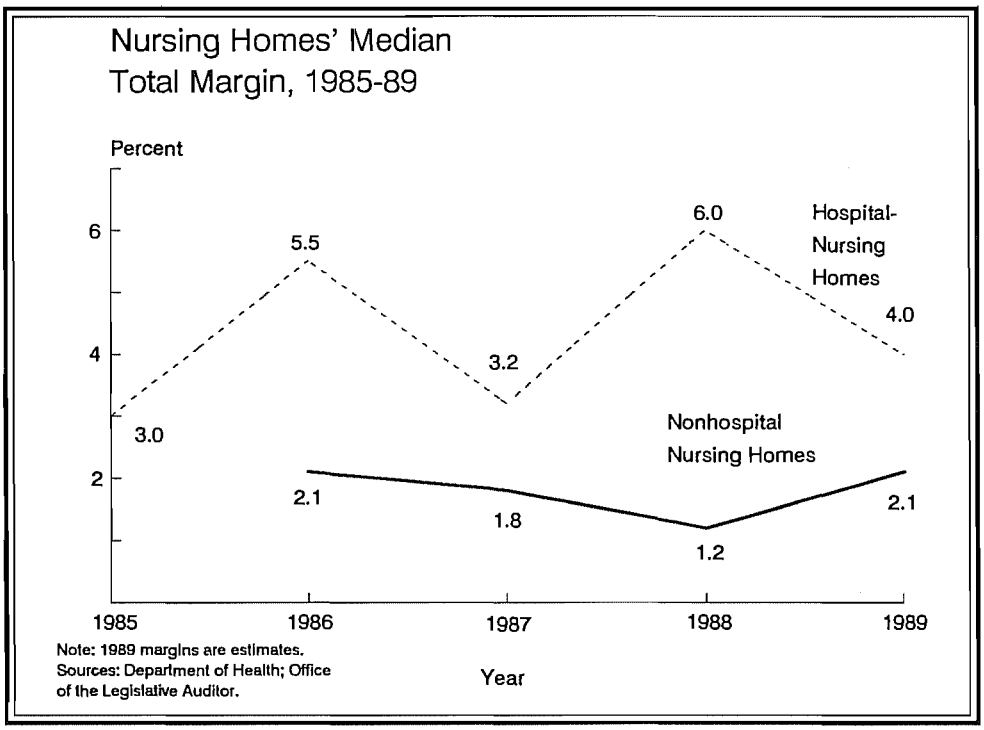
The most serious situation existed where nursing homes operated as part of hospitals. Overall, 43 percent of the hospital-nursing homes experienced some financial stress over the period 1985 through 1988. Sixteen of these hospitals had serious financial problems and were being monitored by the Department of Health. In general, we found that the nursing home part of the operation helped rather than hurt. Nine of the 16 hospital-nursing home combinations are in northern Minnesota where health care services tend to be in short supply; none are in the seven-county Twin Cities area.

Among nonhospital nursing homes experiencing difficulty, 40 percent operated under some financial stress over the period 1986 through 1989, but the situation was serious for only six percent. These homes are not concentrated in northern Minnesota. They are scattered throughout the state and represent all three industry sectors: for-profit, nonprofit, and city/county.

Financial Trends

Financial data from audited statements showed that:

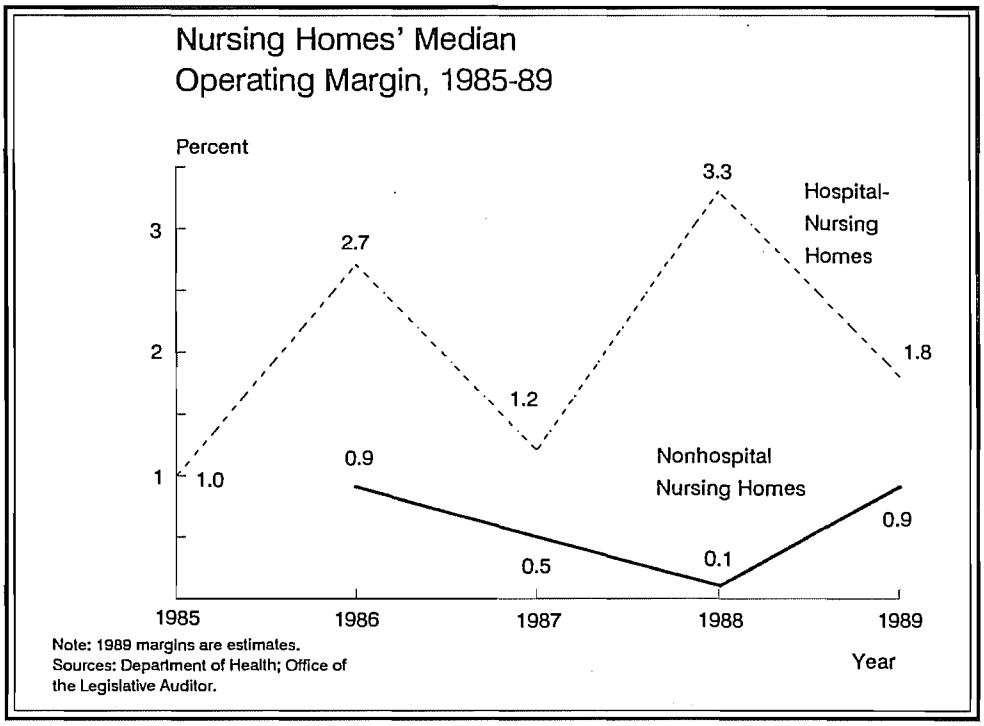
- **Sixty to 75 percent of nursing homes broke even or made some profit, overall, between 1986 and 1989.**



Based on operating margins, 54 to 62 percent earned excess revenues on nursing home operations or at least covered their expenses.

Most nursing homes had enough money to cover operating expenses.

These results are somewhat different from those which were widely publicized last year by a nursing home trade association. The association stated that an unspecified percentage representing more than half of Minnesota's nursing homes had operating losses in 1988. However, we learned that the association based its report on only 54 percent of all nursing homes, and most of them (73 percent) were nonprofit or operated by cities and counties. Also, when the trade association added some of the missing data last fall, its results changed and came into closer agreement with ours.



Adequacy of Performance

Not only does the state lack uniform standards for reporting nursing homes' financial condition, it also lacks guidelines to help determine whether nursing homes' financial performance is adequate. There is no question, however, that at a minimum, nursing homes must at least break even. Beyond that, it is difficult for us to say what is necessary or desirable. In part, the answer depends on nursing homes' mission, the degree of business risk, state policy, and community standards.

Generally speaking, financial risk is low in the nursing home industry because: (1) the moratorium limits competition; (2) high occupancy provides steady revenue; and (3) most payments are from guaranteed (public) sources. Accordingly, we spoke with some owners and administrators who said they would be satisfied with almost any positive margin. Others, representing many of Minnesota's nonprofit nursing homes, told us that they strived for three or

four percent. In their opinion, this is the minimum needed for routine, daily operations, maintenance, repairs, unexpected costs, and temporary changes in their residents and staff. Among for-profit nursing homes, we learned that desirable margins are five to six percent.

A recent study showed that Wisconsin's for-profit nursing homes achieved average total margins of 3.3 to 4.1 percent and nonprofit nursing homes, 2.4 to 3.7 percent. We found that in Minnesota:

- **In each of the past four years, at least one-fourth of the state's nursing homes were operating at or above a total margin of three to four percent.**

However, most nursing homes had smaller margins. Not surprisingly, our survey showed that:

- **Eighty-five percent of administrators said that their nursing homes' net income from all sources was insufficient to meet the goals established by owners or controlling organizations.**

There is no agreement on a minimum standard for nursing homes' financial performance.

Our analysis suggested that for-profit nursing home administrators were most disappointed, but they were not alone. Ninety-two percent of the for-profit group said that their nursing homes' net income was insufficient, and 80 percent of the administrators from nonprofit and city/county nursing homes agreed.

Part of the reason for for-profit nursing home administrators' concern stems from a paradoxical situation. That is:

- **Most of the for-profit nursing homes in Minnesota have operated for the past several years with similar or smaller margins than nonprofit nursing homes.**

For the profit-making and nonprofit nursing homes alike, we found that operating margins were near zero or about one percent. However, the total margin for most nonprofit nursing homes was higher each year than for for-profit nursing homes. Several factors help to explain the anomaly. First, the for-profit nursing homes are taxed. Second, we found that for-profit nursing homes were more likely than others to spend money which the Department of Human Services subsequently disallowed. Third, the for-profit nursing homes may be more likely to embark upon new, risky lines of business such as apartment complexes and home health services. Fourth, the for-profit facilities less often receive contributions which would positively affect their total margins.

However:

- **Financial performance was more often negative among nursing homes which were operated by cities and counties.**

Our study showed that administrators at city/county nursing homes were less likely to strive for efficiency incentive (bonus) payments. Instead, many relied upon local governments for added support.

Recent Failures

Our study showed that 47 nursing homes have changed hands since 1985, and nine of the changes in ownership were the result of financial failure. In addition, one nursing home has gone bankrupt but has not yet been sold. However, most (7 of 10) of the financial failures occurred in two nursing home chains.

Since 1985, ten nursing homes failed financially but continued to care for residents.

While none of the ownership changes caused nursing homes to cease operations, seven of the ten financial failures involved bankruptcy. Another was a case of garnishment, and two nursing homes went into receivership.

In our opinion, nursing homes' recent financial failures can be explained mainly by a few unusual situations. However, we are concerned because most of the cases of financial failure have occurred since 1988. In our opinion, the difficulty of managing successfully under Minnesota's reimbursement system may have caught up with some nursing homes.

Financial Outlook

Our survey corroborated what we concluded from our financial analysis and provided subjective information about nursing homes' future in light of their financial condition. Results showed that:

- **Over half of the nursing home administrators (58 percent) described their financial condition and outlook as fair to good in Fall 1990.**

Although 34 percent of nursing home administrators said their facility was in poor financial condition, they indicated at the same time that they could probably continue operating for several more years. Only two percent said their condition was so poor or critical that their nursing home was clearly in danger of closing. One of these was already bankrupt and for sale. Others gave conditional responses, often saying that their future depended on changes in the state's method of reimbursement for property-related costs. None chose to describe the nursing home's financial condition as "very good."

Explanations for Financial Stress

Two related factors best explain why some nursing homes are in financial distress: a shortage of bonus money from efficiency incentive payments and a higher level of unreimbursed expenses.

We believe that nursing homes' disappointing financial performance can be explained partly by the state's limited, flat efficiency incentive payment.

While the reimbursement system provides inflationary increases in most cost categories, the maximum possible bonus has been fixed at $2 since the state's reimbursement system was implemented in 1985.

EFFECTS OF THE REIMBURSEMENT SYSTEM

Efficiency incentive payments are key to financial health.

We found no major crisis in care as a result of the state's reimbursement system. However, some cost-cutting techniques may be detrimental to nursing homes' infrastructure and are unpleasant for residents, their families, staff, and administrators.

In certain respects, the reimbursement system may have contributed to nursing homes' physical deterioration. Our survey showed that:

- **Twenty-eight percent of administrators said their nursing home was in poor structural and mechanical condition or needed to be entirely replaced, compared with ten percent in 1988.**

- **More than 60 percent of the administrators reported that building upkeep, maintenance, decorating, and furnishings had changed for the worse since 1985.**

The administrators attributed the latter changes directly to the reimbursement system. We noted that this type of response was consistent with the efficiency incentive which is built into the state's reimbursement system, the specific limit of $325 per bed for building repairs and maintenance, the moratorium which generally precludes major remodeling or construction projects, and problems related to the state's method of reimbursing for property-related costs.

We are particularly concerned that:

- **Routine maintenance and repairs have been postponed in favor of earning bonus payments.**

In our opinion, this may lead to future problems as even more debilitated, elderly people enter nursing homes which may be ill-equipped and in need of repairs. On the other hand, we found that:

- **In some ways, nursing homes are operating more efficiently without directly affecting residents' care.**

Our survey showed that most administrators pursued a variety of techniques to minimize unnecessary expenses for items which have little or no direct bearing on residents' health status. For example, they increased their reliance on

convenience foods and decreased their attention to cleaning some areas of nursing homes.

We observed that the administrators' cost-cutting activities caused considerable anxiety for nursing home staff. Moreover:

- **Consumers were more likely to complain when homes were in poor structural and mechanical condition.**

Our study revealed that complaints were significantly more likely to be filed on behalf of nursing home residents when administrators rated their nursing homes' physical condition as poor or very poor. Furthermore, complaints in these instances were not confined to physical maintenance problems but covered all aspects of the facilities' operations.

There was no relationship between nursing homes' financial condition and consumer complaints or violations of state regulations.

There was no direct relationship between nursing homes' financial condition and consumer complaints or violations of state regulations. However, our results showed that:

- **Nursing homes in financial distress were more likely to be fined than nursing homes in better financial condition.**

In general, fines are the Department of Health's last resort when nursing homes fail to make changes which regulations require. While 70 percent of the nursing homes were ordered to make various corrections during fiscal years 1988 or 1989, only 17 percent were fined.

Furthermore, some cost-cutting techniques used by administrators to earn bonus payments may be backfiring in that:

- **Nursing homes had a higher than average chance of being fined for violating regulations in areas of operation where administrators said they used cost-cutting techniques to earn efficiency incentive payments.**

On the average, about five percent of all correction orders resulted in fines. However, nine percent of all correction orders in each of two areas—laundry/linen and housekeeping—resulted in fines.

We noted that nursing homes in financial distress tended to receive less efficiency incentive money than other nursing homes. Taken together, these findings suggest that:

- **Financially distressed nursing homes sometimes may have lacked working capital to quickly correct violations uncovered by the Department of Health.**

RECOMMENDATIONS

Legislators requested our study in May 1990 because they were concerned about the financial condition of nursing homes. In November, however, they also became concerned about the state's financial condition, when the Commissioner of Finance projected a significant shortfall in revenues. Even though the state's financial problem was officially recognized after most of our study was completed, we tried to take it into account as we finalized our study.

Preliminary Considerations

The state should monitor the nursing home industry's financial performance in the future.

To provide better information in the future, we think that:

- **The state should arrive at a consensus on what constitutes adequate financial performance for nursing homes.**

Currently, there is no standard and, without one, it is hard to evaluate whether nursing homes' revenues need to be increased or costs need to be cut. A general agreement about standards of adequate financial performance should not be considered a guarantee to any specific nursing home but a guideline for monitoring the nursing home industry's general performance. We think the Department of Health is in the best position to monitor nursing homes' financial condition because its Health Economics Program already monitors hospitals' financial performance.

In our opinion, the reimbursement system generally promotes efficient nursing home operations. Administrators can make some additional improvements, but we do not think these would produce significant cost savings to the state. Instead, we suggest that:

- **The Legislature review its policies and state regulations for cost-saving opportunities.**

First, legislators should review the geographic regions which now determine nursing home rates. We think that reimbursement should be tied to real differences in the cost of living and other factors which the currently used groups may not reflect. Changes to the geographic groups might save money.

Second, the state might save money by changing the methods by which the Departments of Health and Human Services monitor and regulate nursing homes. Evidence suggests that some of these activities may be inefficient and unnecessarily expensive for the state and nursing homes as well. In all, nursing homes are subject to visits and inspections by 13 different agencies, each on its own schedule. A broad-based regulatory review may be warranted.

Third, policymakers should continue to question the necessity of expensive nursing home care when there are alternatives which are less expensive and

equally appropriate. Fourth, we believe it is time to review the monetary impact of equalizing public and private nursing home rates. This policy was adopted in the 1970s, primarily to foster social equity, and its economic impact is unclear. The policy may be a savings to the state, or it may be a cost. Because of the uncertainty we think that, especially during this time of state financial stress, the Legislature would be well served by a thorough analysis of the policy's monetary impact.

Financial Future

Even if the state were to take these steps, the financial condition of nursing homes might be in jeopardy within the near future. Our evaluation showed that many nursing homes have been operating uncomfortably close to the break-even point. They have been coping with problems in the state's method of paying for property costs yet have had limited resources with which to operate, much less profit. Since 1985, their primary source of profit has been fixed, but costs have risen. Of course, the nursing homes can relieve themselves of some financial stress by minimizing unreimbursable expenses, but we doubt that this is always advisable.

Therefore, we think the Legislature should give careful consideration before cutting state support for nursing homes. Considering their generally weak condition, we think some additional state money may be appropriate, even in this period of state financial difficulty.

Some additional state money may be appropriate for nursing homes.

Most important:

- **The Legislature should correct previously identified problems in the state's method of paying property costs.**[2]

At this date, the cost of this recommendation is unknown, but we understand that a task force so far has been unable to develop an alternative payment method that would correct existing problems without more money.

To provide nursing homes with the potential for improved financial health while maintaining the elements of cost control which are critical to the state, we think that:

- **The Legislature should consider increasing efficiency incentive payments.**

For the 1990 rate year, the Department of Human Services will pay a total of $19.8 million in efficiency incentives to about three-fourths of the nursing homes. If the incentive payments rose at the same rate as the formula provided to offset inflation in other operating costs, we estimate that the additional expense would be about $2.2 million.

2 KPMG Peat Marwick, *Review of the Long Term Care Property Payment System* (Minneapolis, May 1990).

To monitor nursing homes' financial performance in the future, we recommend that:

- **The Legislature should include nursing homes under the Health Care Cost Information Act of 1984.**[3]

The Department of Health's hospital monitoring program already covers an important part of the nursing home industry, and it can readily be adapted to the rest. We understand that nursing homes and the state would incur some costs to produce and analyze the information, but in our opinion, the data would be more useful and of better quality than that which nursing homes have already purchased.

In our opinion, the Departments of Health and Human Services need financial data on nursing homes so that they can determine whether lack of resources truly threatens residents' care. Thus, we also recommend that:

- **The Department of Human Sevices should help to provide short-term loans to facilities to correct life-threatening conditions within nursing homes, upon recommendation from the Department of Health.**

When nursing homes claim that financial hardship prevents them from making vitally necessary corrections, we suggest that the Department of Health review financial data and determine whether a loan is truly required. The Department of Human Services could make the loans through a special state fund and later recover the costs through the reimbursement system, in the same manner as it now collects occasional overpayments.

Nursing homes should not receive efficiency incentive payments for over-zealous economy measures.

Conversely, in our opinion, nursing homes should not receive bonus payments for over-zealous efficiencies that result in health and safety violations. Thus, we suggest further that:

- **The Department of Human Services should make efficiency incentive payments contingent upon nursing homes' compliance with important regulations, as determined by the Department of Health.**

In these cases, nursing homes could be compelled to use their bonus money to correct problems which may have been caused by excessive pursuit of profit. In other cases, the Department of Health could recommend that efficiency incentive payments be forfeited.

Finally, we suggest that the Legislature at some future date should consider incentives for nursing homes to develop innovative programs. Assuming that the incentives were modest and in keeping with the state's interests, we believe that the investment would be cost-effective. Specifically, we recommend:

3 *Minn. Stat.* §§ 144.695 to 144.703.

- **Small, one-time grants should be available to help selected nursing homes develop unique, cost-effective programs.**

When the state's budget allows, we believe that $250,000 for such grants would help to stimulate and encourage the nursing home industry while ultimately benefiting the state.

In conclusion, since the number of Minnesotans over 85 years of age is projected to increase 32 percent by the year 2000, the Legislature also should examine whether and how to continue the current moratorium on nursing home construction. While considerable interest has been focused lately on developing alternatives, we believe that the industry has a legitimate role within the continuum of health care services. In our opinion, the state needs a formal plan to guide decisions to add, subtract, and redistribute nursing home beds in response to local needs. Thus, we encourage the Legislature, nursing home providers, and the Departments of Health and Human Services to take additional steps to ensure that long term care is available, affordable, and appropriate to Minnesotans' current and future needs.

INTRODUCTION

Today, the odds of nursing home residency for Minnesotans 85 years and older are one in three. Furthermore, projections indicate that the number of citizens 85 and older will grow by 32 percent between 1990 and 2000. Thus, nursing homes—and the vitality of the industry—have become increasingly important to policymakers as well as citizens throughout the state.

The 1980 U.S. Census showed that nine percent of Minnesota's elderly population lived in nursing homes compared with the national average of five percent. In 1990, the total cost to government for nursing homes was more than $507 million. The federal government's share was 53 percent, and state government alone spent $215 million. Of all the state's Medical Assistance (MA) spending, 36 percent went to nursing homes.

State government spent $215 million on nursing homes in 1990.

In the late 1970s and early 1980s, nursing home payments consumed so much of the MA budget and were rising so fast that the Legislature was forced to take several strong actions. Most important, it developed a reimbursement system that is designed to pay just for the care each resident receives. Laws also inhibited the nursing home industry's further growth and required many residents to be screened before admission.

The Legislative Audit Commission asked us to study nursing homes' financial condition and report on problems which may have emerged. In our evaluation, we asked:

- **What is the general financial condition of nursing homes in Minnesota?**
- **To what extent has the state's method of reimbursement contributed to problems in nursing home administration, operations, and resident care?**

To answer these questions, we gathered and analyzed financial data about Minnesota nursing homes. We surveyed administrators and spoke with nursing home owners, industry experts, and residents' representatives. Working with the Departments of Human Services and Health, we examined cost reports, ownership changes, complaints, correction orders, and fines issued against nursing homes. In addition, we visited facilities of all sizes and types across the state.

Our evaluation suggests that a considerable number of nursing homes are financially stressed and physically deteriorating. However, most are at least breaking even, and administrators generally believe that they can continue this way for at least the next few years. Further, our evaluation reveals only an indirect connection between the industry's financial condition and resident care problems.

Our evaluation is presented in the following four chapters. Chapter 1 presents an overview of the nursing home industry. In Chapter 2, we review legislation and regulations which have brought the nursing home industry under state control. Chapter 3 documents financial trends and identifies some reasons for stress. Finally, Chapter 4 examines the relationship between nursing homes' financial condition and management practices.

MINNESOTA'S NURSING HOME INDUSTRY

Chapter 1

Nursing home costs have been a major concern to the Legislature throughout the past decade. Problems were evident when, during the late 1970s and early 1980s, nursing home payments consumed nearly half of the Medical Assistance (MA) budget and continued to rise. Each year between 1976 and 1982, the cost increased at least 12 percent, from an average monthly rate of $410 to $1,013 per resident.

In response, the 1983 Legislature developed a reimbursement system which was specifically designed to control cost increases and pay only for the care needed by individual nursing home residents. Other new laws curtailed industry growth, while courts upheld earlier legislation which prohibited Minnesota nursing homes from charging private-pay residents more than publicly supported residents in multi-bed rooms.[1]

In combination, these and other measures brought nursing homes' annual cost increases down, as shown in Table 1.1. Also, nursing homes last year accounted for 36 percent of the MA budget (Figure 1.1). However, policymakers, providers, and consumers have an opposite concern: Is the reimbursement system now too strict?

Legislative actions brought nursing homes' annual cost increases under control.

As part of our evaluation of nursing homes' financial condition, we studied the industry and asked the following questions:

- **Why are nursing homes subject to financial restrictions and other regulations?**
- **How have nursing homes and their residents changed since the current reimbursement system took effect in 1985? How many residents use nursing homes, and under what conditions?**
- **What issues are of general concern within Minnesota's nursing home industry?**

In this chapter, we describe nursing homes as an important part of the health care industry. Our conclusions are based mainly on documents from state agencies, state and national studies, and the collective opinions of Minnesota

1 In early 1990, North Dakota also began to require equal public and private rates. Chapter 2 details Minnesota's reimbursement system and the moratorium on industry growth.

Table 1.1: Medical Assistance Payments for Nursing Home Residents, 1976-89

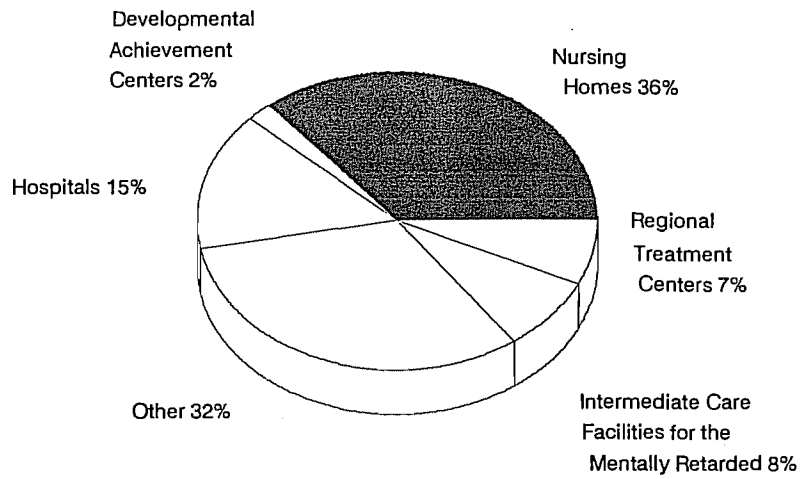
Fiscal Year	Average Monthly $ Per Recipient	Annual Percent Increase	General Inflation Increase[a]
1976	$409.99		
1977	489.77	19.5%	6.5%
1978	572.23	16.8	8.5
1979	648.09	13.3	10.8
1980	759.28	17.2	13.7
1981	902.82	18.9	8.8
1982	1,013.26	12.2	12.7
1983	1,091.37	7.7	3.7
1984	1,192.29	9.2	2.8
1985	1,252.82	5.1	2.5
1986	1,267.77	1.2	.9
1987	1,331.16	5.0	2.5
1988	1,371.50	3.0	5.1
1989	1,511.68	10.2	3.8

Source: House Research; Bureau of the Census, U.S. Department of Commerce.

[a]Based on the Minneapolis-St. Paul Consumer Price Index for April of each year until 1987 (then first six months).

Nursing homes accounted for the largest portion of the $1.4 billion Medical Assistance budget.

Figure 1.1: Medical Assistance Spending, Fiscal Year 1990



Source: Department of Human Services.

nursing home representatives. As described in Appendix A, a representative group of 310 nursing home administrators completed a survey at our request in Fall 1990.

RESTRICTIONS AND REGULATIONS

There are three main reasons for Minnesota's current approach to nursing home reimbursement and regulation. First, the state wanted to avoid large, unpredictable cost increases year after year. Second, there was some evidence of financial fraud and illegal activities which may have endangered nursing home residents. Third, the federal government requires all states to ensure that Medicaid funds are spent prudently for nursing home care.

Need for Cost Control

After the Great Depression, the federal government took responsibility for seeing that indigent and elderly citizens have access to health care services. Congress fostered the development of hospitals and nursing homes and later enacted the Medicare and Medicaid programs to pay much of the cost. These programs have proven to be expensive and hard to control.

In 1990, state government spent $215 million on nursing homes, but the federal government paid even more.

Medicaid is now the primary source of payment for Minnesota nursing homes. Through the joint contribution of federal, state, and county governments, the program paid Minnesota nursing homes $507 million in 1990. The federal share was $268 million (53 percent), the state share $215 million (42 percent), and the county share $24 million (5 percent).[2]

As primary payer, the federal government sets general policy but allows each state some flexibility in determining payment rates and methods for reimbursing nursing homes. States also must inspect nursing homes, enforce compliance with health and safety standards, audit expenditures, prosecute cases of fraud and abuse, and see that administrators are trained and licensed.

The federal government further requires each state to demonstrate, in a formal document, that it is acting as a prudent buyer of nursing home services.[3] In 1990, the Department of Human Services told the federal government:

> The purpose of the Minnesota Medicaid methods and standards for determining payment rates . . . is to provide rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards. [4]

2 Medical Assistance or MA is Minnesota's counterpart to the federal Medicaid program.

3 Department of Human Services, *Methods and Standards for Determining Payment Rates for Services Provided by Skilled Nursing and Intermediate Facilities*, Transmittal IM-90-01 (March 1990).

4 Department of Human Services, *Methods for Determining Payment Rates*, 6.

Representatives of the nursing home industry generally maintain that Medicaid rates are inadequate, but until recently they lacked legal standing to effectively sue states for relief. However, in June 1990, the U.S. Supreme Court decided that nursing homes were legitimate protectors of Medicaid recipients' rights and could sue states over the adequacy of payment rates.[5] In July 1990, nursing home rate suits were on the docket in eight states.

Besides controlling payment rates, the federal government and some states, including Minnesota, have taken steps to reduce unnecessary use of hospitals and nursing homes. These institutions involve the most expensive, intensive health care services, with hospital stays the more costly of the two.

The federal government has contained Medicare costs primarily through a reimbursement system which encourages hospitals to send elderly patients to nursing homes or back to their own homes as soon as possible. Since implementation in 1984, this payment system has limited hospital reimbursement to fixed amounts depending mostly on individual patients' diagnosis-related group (DRG).

Minnesotans tend to rely heavily on nursing homes for long term care.

Industry representatives often comment that the Medicare DRG payment system causes hospitals to discharge elderly patients "quicker and sicker." Nevertheless, the federal government wishes to pay the lowest possible amount for health care services appropriate to individual needs. During a long, uncomplicated process of recuperation, nursing homes can be more cost-effective than hospitals, which maintain advanced technology and highly trained medical staff.

When the DRG payment system was being implemented, Minnesota led the nation in nursing home expenditures per capita and had the fifth highest number of beds per elderly person.[6] Almost all of the nursing home beds were already occupied. The 1980 U.S. Census indicated that:

- **Nine percent of Minnesota's elderly population lived in nursing homes compared with the national average of five percent.**

In addition, projections from the census suggested that in 25 to 35 years:

- **The "baby boom" generation of the late 1940s, 1950s, and early 1960s would dramatically increase both the proportion and total number of elderly Minnesotans.**[7]

As shown in Figure 1.2, the State Planning Agency has projected that the number of Minnesotans 85 and older will grow by 32 percent between 1990 and the year 2000. In this age group, census figures put the odds of nursing home residency at about one in three, compared with one in twenty for Minnesotans between the ages of 65 and 84.

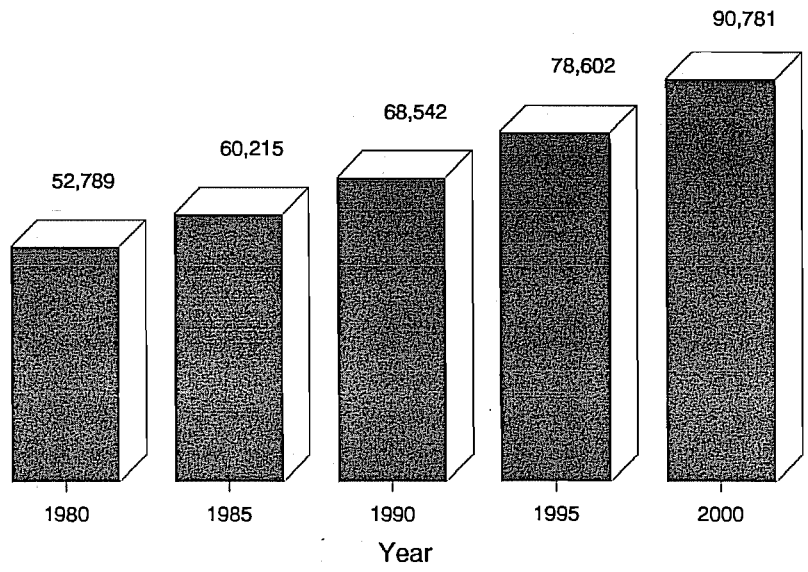
5 *Wilder v. Virginia Hospital Association*, described in *Medicine and Health Perspectives* (July 9, 1990).

6 *Minn. Laws* (1983), Chapter 199, Section 1, Subdivision 1.

7 State Planning Agency, *Long-Term Care for the Elderly* (November 1987).

The "baby boom" will increase demand for nursing home services, but alternatives are growing.

Figure 1.2: Projected Number of Minnesotans 85 and Over



Source: State Planning Agency.

Citizens, planners, and policymakers were alert to the state's changing demographics and agreed that reliance on nursing homes was not only expensive but, in some ways, undesirable. For example, a committee of the Citizens League concluded that residential care was being used indiscriminately, yet:

> In human terms, life in a residential facility is often accompanied by an unhealthy degree of dependence on caregivers. Such relationships sap both residents and caregivers of their energy and spirit. What is worse, they often deprive residents of the will to regain their independence. . . .too much "help" can hurt.[8]

A state government executive branch task force likewise concluded that Minnesota was over-reliant on nursing homes. The group recommended programs and incentives which would encourage independent or semi-independent living.[9]

At the time, the Legislature already was developing strategies to discourage nursing home admissions when less expensive delivery systems could serve the needs of elderly citizens at home or in the community. State grants, along with a moratorium which has stopped all but minor increases in the number of nursing home beds, helped the new systems to develop. In addition, new laws required many nursing home residents to be screened before admission and

8 Citizens League, *Meeting the Crisis in Institutional Care* (Minneapolis, 1984), 73.

9 Executive Branch Policy Development Program, *Strategy on Aging Task Force Executive Summary 1984-85*. More recently, see Minnesota Board on Aging and the Interagency Board for Quality Assurance, *Seniors Agenda for Independent Living (SAIL) for the State of Minnesota* (October 1990).

advised of cost-effective alternatives. These initiatives are discussed in a forthcoming review of the alternative care grant program and preadmission screening.[10]

Need for Regulation

Besides facing an obvious need to control nursing home cost increases, citizens, planners, and policymakers reached general agreement on the principle that nursing homes should operate under strict regulations.

Out of concern for nursing home residents' health and well-being, the 1976 Legislature directed the Department of Health to develop a system of daily fines for violation of state regulations. For various reasons, the fines did not become effective until 1983—seven years later than the Legislature mandated.[11]

Meanwhile, legislators remained concerned about court cases and other widely publicized reports of nursing home fraud and abuse. For example, a St. Paul newspaper indicated that city and county authorities raided one nursing home, arrested the administrator, and confiscated drugs and a gun.[12] In 1980, according to the newspaper, the owner pled guilty to possession of a sawed-off shotgun, possession of a controlled substance, misuse of corporate funds, and filing a false personal income tax return.[13]

In 1986, after two years of study, a strike force from the Attorney General's Office found that some nursing homes had become "money mills" for physical and occupational therapists. The Attorney General identified these problems:

- **The nursing homes' books and receipts were infrequently audited on site.**
- **Nursing homes were earning unreasonable profits through (1) kickbacks for referring residents to outside service agencies or (2) renting their own space, equipment, and staff to outside agencies at substantial rates.**
- **Physicians were providing unnecessary consultations to justify residents' physical therapy.**
- **Nursing home residents were given undocumented or unnecessary services which yielded psychologists as much as $55 per hour.**[14]

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10 The study was mandated under *Minn. Laws* (1990), Chapter 568, Article 3, Section 56, Subdivision 8.

11 In Chapter 4, we describe the number and type of complaints, correction orders, and corresponding fines against Minnesota nursing homes.

12 H.G. Bissinger, Cindy Boyd, and Virginia Rybin, "Police Raid Bethel Center, Mordh Home," *St. Paul Pioneer Press*, November 17, 1979, 1, 8.

13 Staff Writer, "Minnesota Health Department Reconvenes Bethel Care Center Hearing," *St. Paul Dispatch*, November 18, 1981, 1C, 2C.

14 Minnesota Attorney General's Office, *Medicaid Fraud Strike Force Report* (February 1986).

Nursing homes have had some problems with fraud and abuse.

After the Attorney General's report, the 1987 Legislature enacted special restrictions on reimbursement for therapy. However, the strike force investigation did not result in criminal charges.

Records show that since 1985, the Attorney General's Office has prosecuted only a few cases each year involving nursing homes. These fall into one of three categories: (1) cost report fraud issues, (2) patient abuse cases, and (3) patient trust account cases.[15]

INDUSTRY CHANGES

Although the nursing home industry has been contained under the moratorium, it has become more professional in management, administration, operations, and service delivery. Also, health care services have improved and now are delivered with greater emphasis on efficiency.

Nursing Home Residents

As the state's regulations and controls took effect, nursing home residents changed. In general:

- **Nursing home residents have become older and more debilitated.**

According to the Department of Health, residents' average age rose from 80 in 1977 to 83 in 1989. Also, as shown in Table 1.2, residents of skilled nursing facilities stayed for about three years in 1989 compared with four years in 1976.[16] Earlier, about half of the residents in skilled nursing facilities had four

Table 1.2: Nursing Home Residents, 1976 vs. 1989

	Skilled Nursing Facilities		Intermediate Care Facilities	
Average	1976	1989	1976	1989
Age	80	83	78	81
Number of medical diagnoses	3.9	4.1	3.3	3.8
Length of stay (months)	48	35	50	48
Percent with four or more disabilities	55	72	16	47

Source: Department of Health.

15 Minnesota Attorney General's Office, *Annual Reports to the Office of the Inspector General of the U.S. Department of Health and Human Services*, 1986-90.

16 Most nursing homes have been "skilled," and the rest, "intermediate." Only the skilled facilities could provide the highest possible level of nursing home care, but both types of nursing homes served residents with lesser needs. Beginning in October 1990, federal regulations changed so that the same level of care exists in all facilities.

or more disabilities, but in 1989, the figure was 72 percent. The average length of stay in intermediate care facilities remained about four years, but residents of those facilities also were more disabled in 1989 than they had been in 1976.

There are several reasons why such changes occurred. First, residents' increased age can be explained by preadmission screening, the growth of community-based care services, advances in medicine, and the general increase in human life span. Second, shorter lengths of stay may result from skilled nursing facilities being used increasingly for convalescence after hospitalization. Conversely, to the extent that nursing home residents are older and weaker when admitted, death may come sooner than before.

Nursing homes, after all, are homes, but residents now are older and sicker.

During each of the past several years, about 43,000 individuals received care in Medicaid-certified Minnesota nursing homes. Generally, nursing home residents are not acutely ill, but they typically have chronic medical conditions and physical limitations which mean that they need help or supervision with routine activities. Life in a nursing home typically includes worship, outings, games, social activities, family visits, TV, and the day's news. For residents, nursing homes, after all, are homes where they plan to live for an extended period. New residents often move in with some of their own furniture, mementoes, and room decorations.

The majority (71 percent) of nursing home residents are women. As shown in Table 1.3, many have problems bathing, dressing, moving about, and tending to bodily functions. Assistants often must help residents with toileting and transferring from beds to chairs or bathtubs. About half are confused or dis-

Table 1.3: Minnesota Nursing Home Residents Compared with the Nation, 1989

Percent of Residents	MN	U.S.
Requiring some or total assistance with:		
Bathing	85%	82%
Dressing	80	84
Toileting	69	75
Transferring (moving from bed to chair or to tub or toilet)	70	77
Continence problems:		
Catheterized or partial-total loss of bowel or bladder control	65	69
Bowel and bladder retraining program	2	4
Receiving tube feedings or assistance with eating	31	39
Completely bedfast	1	3
Confined to chairs	41	52
Requiring restraints	38	40
Confused or disoriented	52	59
With bed sores	4	8
Receiving special skin care	29	31

Source: U.S. Department of Health and Human Services.

oriented, and many cannot move unassisted from their chairs. In other cases, nursing home residents may wander or be violent. Nevertheless, compared with nursing home residents elsewhere in the United States, the table shows that Minnesotans in 1989 were in somewhat better condition.

Payment Sources

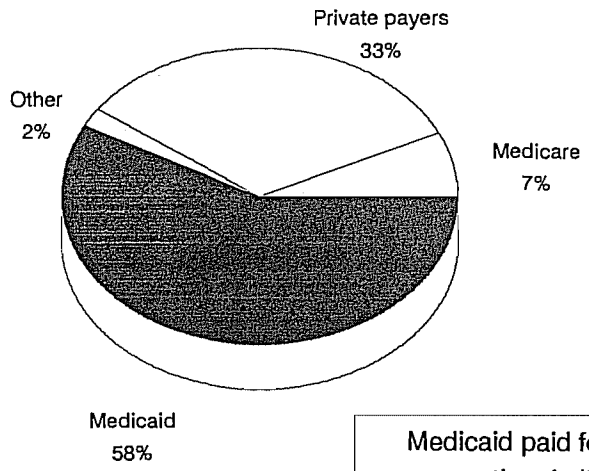
The current average daily rate for nursing home care in Minnesota is about $70. At roughly $25,000 a year for an average of three years, this is beyond most citizens' personal resources. As a result:

- **Government pays for most nursing home residents' care.**

As shown in Figure 1.3, in 1989, the Medicaid program covered 58 percent of Minnesota nursing home residents, and Medicare, 7 percent. One-third of nursing home residents (or their families) paid for their own care, while others, including insurance companies and health maintenance organizations, covered the remaining few.

Recent years have been atypical, however. Medicaid previously had paid nursing home costs for about 65 percent of residents, while the Medicare program applied only to about one percent. The recent Medicare increase reflects the

Figure 1.3: Sources of Payment for Nursing Home Residents, 1989



Source: Department of Human Services.

movement of hospital patients into nursing homes for convalescence plus the temporary addition of catastrophic health care benefits.[17]

Nursing Homes

With the assurance of government support through Medicare and Medicaid, nursing homes generally were pleased to reduce their dependence on private resources and philanthropy. At the time of our study, only 16 Minnesota nursing homes (4 percent of the total) chose to reject Medicaid reimbursement and its accompanying paperwork and special restrictions. Thus:

- **Almost all nursing homes (96 percent) participated in the Medicaid program and agreed to accept payment at the rates established by the Department of Human Services.**

We contacted representatives of all the nonparticipating, private nursing homes and learned that only two were dissatisfied with their status. Representatives of the two dissatisfied facilities told us they would like to accept payment from Medicaid but cannot join the program now because of the moratorium (described in Chapter 2).

We also learned that Minnesota's private nursing homes charged daily rates between $40 and $185. Compared with the state's average daily rate, we estimated that:

- **Private nursing home rates were at least 20 percent higher, on the average, than Medicaid provided.**

We emphasize that this is an approximation because these nursing homes often charge several different rates for various levels of service and may not charge for some items (such as cable television) that the state would require residents to buy for themselves. Also, we excluded two very expensive hospital-affiliated nursing homes along with a nonhospital nursing home which charges no daily fees.

About the same number of nursing homes were in the Medicaid program between 1985 and 1989.

Since 1985, about the same number of nursing homes (between 445 and 448) have accepted Medicaid payments from the Department of Human Services.[18] Where ownership has changed hands, we found that hospitals often were responsible. In several cases, they have taken control of Minnesota nursing homes from cities, counties, and other nonprofit groups. We found that the number of hospital-affiliated nursing homes rose from 66 in 1985 to 77 in 1989. As a result:

17 A year after enactment, Congress repealed most provisions of the 1988 Medicare Catastrophic Coverage Act. Nursing home reimbursement under the Medicare program is further complicated by federal regulations which provide less money than does Medicaid. The difference is rooted in a federal-state conflict which the Legislature has directed to Minnesota's Congressional delegation and the Department of Human Services. Results are reported by the Department of Human Services, *Report on Medicare/Medical Assistance Payment Differentials* (November 1989), and by letter from Commissioner Ann Wynia to The Honorable Dave Durenberger (May 22, 1990).

18 Three Medicaid-certified facilities function almost entirely as private facilities. They stopped accepting Medicaid residents in 1985 and will stop receiving state reimbursement when the remaining Medicaid residents depart.

- **Nearly half (48 percent) of Minnesota's 160 hospitals were affiliated with or attached to a nursing home in 1989.**

Most of these were small, rural, nonprofit facilities with less than 50 hospital beds. Typically, these hospitals operated more nursing home beds than they did hospital beds. According to the Department of Health, nursing home residents have helped some rural Minnesota hospitals to remain open.[19]

Small, rural hospitals commonly run nursing homes in Minnesota.

In other cases, nursing homes have become somewhat like hospitals. Some now have specialized units for Alzheimer's disease, rehabilitation, geriatric chemical dependency, and children or young adults who depend on medical technology for their lives (for example, mechanical respirators). Nursing homes also resemble hospitals as they compete for health care workers with similar training, particularly nurses and aides.

However, most nursing homes are unlike hospitals in several important respects. First, they have run at near-capacity for the past five years. Second, they provide years—not days—of care to fairly stable groups of people. Third, medical staff are minimally involved. In fact, until the federal government required it last October, nursing homes sometimes operated without the physical presence of even one registered nurse.[20]

Also unlike hospitals, Minnesota nursing homes commonly are intended to make a profit. As shown in Appendix A, 41 percent of Minnesota nursing homes in our study were for-profit in 1989.[21] These included partnerships, limited partnerships, and various corporations. Nonprofit corporations or associations were responsible for 43 percent of the nursing homes, while Minnesota cities and counties ran the remainder. In two cases, counties operated more than one nursing home.

Based on the nursing homes' annual reports to the Department of Human Services, we determined that between October 1988 and September 1989:

- **Almost half (45 percent) of Minnesota nursing homes were affiliated with others in a chain.**

Table 1.4 lists Minnesota's largest for-profit and nonprofit chains. Several of these chains operate nursing homes in states besides Minnesota. Of these, Beverly Enterprises and the Evangelical Lutheran Good Samaritan Society are notable examples.

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19 Department of Health, *Access to Hospital Services in Rural Minnesota* (March 1989).

20 The federal government's Omnibus Budget Reconciliation Act of 1987 (OBRA) caused this and other ongoing reforms in nursing home staff, administration, and operations.

21 We used the most recent available data which are for the reporting year beginning October 1, 1988, and ending September 30, 1989. The data from this period produced rates for the year beginning July 1, 1990.

Table 1.4: Minnesota's Major Nursing Home Chains, 1989

	Homes		Beds	
Top Five	Number	Percent	Number	Percent
For-Profit				
Beverly Enterprises	44	10%	4,357	9%
Good Neighbor	14	3	1,026	2
Fair Oaks	12	3	1,682	4
Unicare	6	1	980	2
The Thro Company	6	1	622	1
Nonprofit				
Evangelical Lutheran Good Samaritan Society	23	5	1,927	4
Board of Social Ministry	12	3	1,539	3
Ebenezer Society	4	1	791	2
Volunteers of America	4	1	615	1
American Baptist Homes of the Midwest	4	1	255	1

Note: In 1990, Beverly Enterprises slightly reduced its number of Minnesota nursing homes, and other changes may have occurred.

Source: Department of Human Services.

Despite the moratorium on construction, Minnesota has no shortage of nursing home beds and few access problems.

Because Minnesota's population is concentrated in the Twin Cities area, about a third of all nursing homes and 42 percent of all nursing home beds are in the seven-county metropolitan area. However, according to a recent study of the state's distribution of nursing home beds, there is no shortage of beds anywhere in the state.[22] In addition, a recent study by the U.S. Government Accounting Office concluded that Medicaid recipients in Minnesota generally do not have problems getting into nursing homes.[23]

INDUSTRY ISSUES

In light of their responsibilities to residents, providers are understandably concerned about their ability to operate successfully and provide continuous, good quality care in Minnesota's regulatory environment. We found that they have six overriding concerns.

22 Interagency Board for Quality Assurance, *An Analysis of the 1987 Distribution of Nursing Home Beds in Minnesota* (January 1989).

23 U.S. General Accounting Office, *Nursing Homes: Admission Problems for Medicaid Recipients and Attempts to Solve Them* (Washington, September 1990), 25. However, the report noted that those with very heavy care needs had some access problems.

Property Payments

First, of all the issues facing the industry, the most important, in our opinion, is the property reimbursement subsystem. In 1989, the Legislature also was concerned about this aspect of reimbursement and mandated an independent study of nursing homes' property-related finances and potential need for capital asset replacement funds.[24] The study suggested that the property reimbursement system needs to be changed.

Results showed that, for a substantial number of homes, the subsystem would have been inadequate to cover debt service and replace capital assets such as equipment, furniture, and buildings. Eighty-six facilities (19 percent) could not have paid their property debt service if the state implemented its previously planned rental reimbursement system. [25] This rental system would have paid facilities allowable interest (that is, interest on allowable property debt) and a rental payment of 5.66 percent on allowable equity (appraised value minus allowable property debt).

The main reason for the problem was that 34 of the 86 nursing homes incurred debt after May 22, 1983, for sales and refinancing although this particular type of debt was specifically disallowed.[26] More than half of the net deficit was accounted for by the disallowed sales ($2.0 million) and refinancing ($2.4 million). Other reasons for property payment problems are shown in Table 1.5.

Table 1.5: Nursing Homes Projected to Lack Property Revenue Adequate to Cover Debt Service

	Nursing Homes		Net Deficit	
Underlying Reason	Number	Percent	Dollars	Percent
Principal exceeded rental rate times base	23	27%	$1,405,595	17%
New debt from sales	20	23	1,999,332	25
New debt from refinancing	14	16	2,394,702	30
Interest on debt submitted for study, not reported to DHS	8	9	177,725	2
Debt above investment/bed limit	6	7	982,409	12
Disputed allocation of non-directly identified debt	5	6	199,690	2
Related party debt	3	4	383,391	5
Inadequately documented debt	3	4	225,311	3
Debt above appraised value	2	2	23,452	< 1
Operating debt	1	1	199,209	2
Debt unrelated to resident care	1	1	120,258	1
	86	100%	$8,111,074	100%

Source: KPMG Peat Marwick.

24 *Minn. Laws* (1989), Chapter 282, Article 3, Section 94.

25 KPMG Peat Marwick, *Review of the Long Term Care Property Payment System* (Minneapolis, 1990).

26 *Minn. Rules* Chapter 9549.0060.

KPMG Peat Marwick found that nursing homes' need for capital asset replacement funds varies with their access to revenue for capital improvements and replacement of items such as furnaces, roofs, kitchens, laundries, whirlpool bathtubs, and other large pieces of equipment used in residents' care. Under the planned rental reimbursement system, rental revenue in excess of debt service would have been the primary source for such funds. The study indicated that nursing homes generally spent about 1.5 percent of their appraised value each year on capital improvement items. Further:

The property payment subsystem is under review.

- **About one-fourth of the nursing homes would not have received enough rental revenue to spend 1.5 percent for capital improvement and replacement.**

However, at least half of the nursing homes would have received rental revenue in excess of four percent, more than enough for these purposes. The remaining one-fourth of homes would have had some excess of rental revenue over debt service, sufficient to continue paying at the level of 1.5 percent for capital improvement and replacement.

In response to concerns about property payments, the Legislature requested recommendations from a task force which addressed property-related payment rates for nursing homes during 1990.[27] The recommendations were due to the Legislature on January 15, 1991.

Public-Private Rate-Setting

About half of the nursing home administrators in our survey said that their operating rates were inadequate (Table 1.6). We did not study specific rates or details of the rate-setting process, but we learned that operating rates are a general issue because:

- **The state determines the rate of pay for almost all nursing home residents—not just for Medicaid recipients.**

Of course, nursing homes need not accept payment through the state's reimbursement system, but otherwise they would limit themselves to private payers. By choosing to participate in the Medicaid program, nursing homes can expand their market and increase the certainty of payment, but the price is to operate within the state's system of control.

In 1984, the Eighth Circuit Court of Appeals upheld Minnesota's law that nursing homes cannot charge higher rates to private residents than they receive for similar Medicaid patients.[28] In other states, nursing homes typi-

27 *Minn. Laws* (1990), Chapter 568, Article 3, Section 101.

28 The law is *Minn. Stat.* §256B.48, upheld by *Minnesota Association of Health Care Facilities, Inc. v. Minnesota Department of Public Welfare*, App. 1984, 742 F.2d 442.

Table 1.6: Administrators' Perceptions of Reimbursement Issues

Percent Who Said the Statement was True:	Rarely/ Never	Sometimes	Always/ Usually
We know which costs are allowable	2%	30%	67%
We have enough information to complete our cost reports correctly	4	22	66
The Department of Human Services does an acceptable job administering the reimbursement system	22	58	13
Per diems adequately cover our facility's operating costs	47	37	13
Per diems adequately cover our facililty's property costs	63	23	10

Source: Nursing Home Administrator Survey (n = 310). Percentages do not total 100 because up to 27 administrators could not say or skipped the item.

State law requires equal rates for Medicaid and private residents.

cally charge private residents a higher daily rate than Medicaid recipients. One recent national study estimated a 22 percent difference between nursing home rates for Medicaid and private residents.[29] In Wisconsin, the difference was 35 percent in 1987.[30]

Administrative Difficulties

In our opinion, the state's authority to require equal Medicaid and private rates would be a lesser issue if the Department of Human Services smoothly administered the reimbursement system. However, the system is complex, and it has been difficult for the department to keep up with legislative changes and providers' needs.

For example, when nursing home rates are calculated incorrectly, it can take several years to rectify the error through the appeal process. Providers can file an appeal, but in the meantime they must accept payment at the state's rate both for Medicaid and private payers (that is, individual residents or their families). It is especially difficult for nursing homes to recover the difference due from private payers when residents die before appeals are settled.

Appeals can be complicated and time-consuming. For example, we visited one nursing home where the administrator said he had recently received

29 Joe R. Roberts and Eric Roberts, "Nursing Homes: Government Influence," *The Appraisal Journal* (July 1989): 308-316.

30 Wisconsin Legislative Audit Bureau, *A Review of Nursing Home Reimbursement Formula* (Madison, 1988), 30.

money from an appeal made nine years earlier. Records from the Department of Human Services showed that there was a backlog of more than 500 appeals between 1987 and 1989, but the number dropped to 240 in 1990, despite 231 new appeals during 1990.[31]

In addition, the Department of Human Services instituted a new claims processing system (Residential Services Invoice or RSI billing system) in late 1988, and it presented its own difficulties and delays. However, department records show that most claims (96 percent) recently were resolved within 30 days, suggesting that the system has improved.[32] Provider groups have worked with the department to help resolve the system's problems.

Cost Containment

Nursing homes naturally resist restrictions which are necessary to control cost increases.

The Department of Human Services' administrative problems not only present day-to-day difficulties but aggravate nursing homes' natural resistance to the manner in which Minnesota sets rates. This is because:

- **Minnesota's reimbursement system is specifically designed to limit annual cost increases.**

As we explained earlier, the Legislature and federal government were forced to take control of nursing home expenses under the Medicaid program. One way they have chosen to do this is to discourage new, additional costs.

Thus, the current reimbursement system is in keeping with the goal of cost containment. It is not designed to maximize services to residents, regardless of cost. Under this system, nursing home administrators can make some changes but must do so with existing resources, within limited cost categories. Otherwise, they may divert money from inflationary increases, reduce their level of profit, borrow money temporarily, or raise money from their own sources. As we explain in Chapter 2, rates may eventually catch up to new costs 21 months later.

As a result, nursing homes may have cash flow problems if they add costly services or make big, unexpected purchases. For example, workers' compensation insurance costs have varied unpredictably from year to year, but must be paid. The preliminary results of a recent study suggest that, because these costs have risen significantly in recent years, they should be covered by a separate inflation factor.[33] Likewise, utility costs can vary with weather conditions, but nursing homes must maintain warm temperatures. In addition, the Department of Health may order improvements without regard for nursing homes' payment rates. The Departments of Health and Human Services generally deal with nursing homes separately and independently.

31 Memo from Elaine DuFresne, Provider Appeals Division, to Commissioner Ann Wynia, Department of Human Services (December 20, 1990).

32 Letter from Commissioner Ann Wynia, Department of Human Services, to David Kiely, Association of Residential Resources in Minnesota (October 3, 1990) and memo from Jayne Draves, Department of Human Services, to Kathleen Vanderwall, Office of the Legislative Auditor (September 19, 1990).

33 Department of Human Services, *Draft Report to the Legislature on Workers' Compensation Costs in Nursing Homes* (December 1990).

Industry Pay Scales

The increasing cost of staff is a related issue. Because there is a shortage of health care workers, especially outside the Twin Cities area, some nursing homes would like the freedom to compete with hospitals by raising salaries and benefits, but:

- **The reimbursement system assumes that nursing home salaries and benefits are based on the industry's own norms.**[34]

The nursing home industry pays employees less than they might earn at hospitals.

Nationwide, hospital workers traditionally have earned higher wages and received better employee benefit packages than comparable nursing home workers. In Minnesota, hospital wages likewise have been higher than nursing home wages both for nurses and aides. For example, in 1989, median pay for nurse aides, licensed practical nurses, and registered nurses was 19 percent, 7 percent, and 18 percent higher, respectively, in hospitals than in nursing homes.

Recently, the Legislature authorized some additional money specifically to help reduce the wage gap between hospitals and nursing homes.[35] Although most nursing homes passed the money on to staff, the Department of Human Services could not find evidence that this occurred in 27 facilities.[36]

The reimbursement system regularly inflates payment rates to anticipate economic pressures including scarce labor. The system also provides increasing payments for employee benefits, but we found:

- **About 10 percent of nursing home administrators said they did not contribute toward any kind of health insurance benefits for full-time workers.**

Working Relationships

Minnesota's nursing home industry is not only regulated but also closely monitored. In general:

- **Nursing homes must adhere to precise, predetermined standards and procedures.**

For example, auditors at the Department of Human Services last year reviewed and disallowed millions of dollars in nursing home expenditures,

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34 Department of Jobs and Training, *Minnesota Labor Market Review* (February, June, and September 1990) and *Minnesota Salary Survey of Hospitals and Nursing Homes by Hospital District* (October 1989).

35 *Minn. Laws* (1988), Chapter 689, Article 2, Section 155, Subdivision 2.

36 Department of Human Services, *A Report to the Legislature on the 3.5 Percent Nursing Homes Salary Adjustment of 1988* (December 1990).

including items which cost less than $10. State and federal laws require the Department of Health to conduct surprise inspections of nursing homes, and these have been highly detailed.[37] In all, nursing homes are subject to visits and inspections by 13 different agencies, each on its own schedule.[38]

Nursing homes are subject to close scrutiny.

Of all the agencies involved with nursing homes, we found that administrators objected most to the Department of Human Services. We found that:

- **The relationship between many nursing homes and the Department of Human Services is decidedly tense.**

Although we did not evaluate the relationship in depth, friction was obvious and, to some extent, unavoidable. Nursing home administrators, owners, trade associations, and staff at the Department of Human Services told us stories of inefficiency and misunderstanding on both sides. According to our survey of nursing home administrators (Table 1.6), many found fault last fall with the Department of Human Services' administration of the reimbursement system. Only 13 percent said that the department's performance was usually acceptable. However, at the same time, about a third of the administrators questioned their own knowledge of allowable costs, and 26 percent said they sometimes lacked information which would allow them to complete their cost reports correctly.

SUMMARY

Minnesota's nursing home industry is tightly controlled by state government for several reasons. First, cost increases previously exceeded the state's ability to pay. Second, there was some evidence of financial fraud and illegal activities which could have hurt nursing home residents. Third, the federal government gives states no alternative but to ensure that reimbursement is limited under its Medicaid program.

In 1983, the Legislature developed a new reimbursement system which, along with other measures, brought nursing home cost increases under control. Legislators also placed a moratorium on industry growth and encouraged the development of community-based care systems. Subsequently, the industry changed, residents became older and sicker, and policymakers grew concerned about nursing homes' financial condition.

Nursing homes' financial condition is one of several major concerns.

Our study showed that nursing home administrators have several general concerns. First, property payment rates are in flux. Second, some administrators object to the state's rate-setting authority which extends to private payers as well as residents on Medicaid. Third, the Department of Human Services has had difficulty processing claims and appeals. Fourth, administrators naturally object to control mechanisms which limit their annual cost increases. Fifth,

37 In late 1990, the department began new inspection procedures.

38 Department of Health, *A Review of the Inspection Activity in Hospitals and Nursing Homes: Recommendations for the Coordination of Inspections in Hospitals and Nursing Homes* (March 1990).

they are reimbursed for staff at the nursing home industry's lower pay rates but face a labor shortage and often must compete with higher-paying hospitals. Finally, the nursing home industry is subject to scrutiny by numerous government agencies and has a tense relationship with the Department of Human Services.

In Chapter 2, we explain in detail how the reimbursement system and the moratorium have operated to control nursing homes' cost increases. Also, we present evidence which is consistent with administrators' concern that nursing home operations and maintenance, among other things, may have suffered as a result of the state's cost-containment efforts.

THE NURSING HOME REIMBURSEMENT SYSTEM

Chapter 2

As we discussed in Chapter 1, Minnesota's nursing home industry was in serious trouble in the early 1980s. There were several cases of fraud, and state costs were spiraling upward. By 1983, Medical Assistance (MA) payments were increasing faster than the state could afford to pay, and nearly half the money went to nursing homes. In addition, Minnesota led the nation in state nursing home expenditures per capita and had the fifth highest number of nursing home beds per elderly person.

Facing growing pressure to prudently manage all aspects of the state's budget, the 1983 Legislature significantly changed Minnesota's system of regulating the nursing home industry.[1] It imposed a moratorium on the number of nursing home beds which could be reimbursed and adopted a new rate-setting system based on individual residents' needs. Two of the legislation's goals were simple: (1) to control annual cost increases and (2) to suppress further growth of the nursing home industry.

The 1983 Legislature significantly changed the way nursing homes are regulated.

This chapter examines the general operation of the 1983 cost-containment measures. We asked the following questions:

- **How has the state managed to control increases in the number of certified beds in nursing homes?**
- **How does the state's reimbursement system currently work? What effect has it had on cost increases?**

This chapter is divided into four sections. First, we define licensure and certification. Second, we show the effects of the moratorium on the number of nursing homes reimbursed by the Department of Human Services. Third, we examine the cost containment features of Minnesota's reimbursement system. Fourth, we look at how average spending has changed under this system statewide.

As we show in the following sections, the state's efforts to bring nursing home costs under control have generally succeeded. While the reimbursement system permits costs to grow, increases are deliberate and orderly.

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1 *Minn. Laws* (1983), Chapter 199.

DEFINITIONS

To be reimbursed through the Medicaid program, nursing homes must be federally certified and meet state licensing standards. As we discussed in Chapter 1, almost all nursing homes (96 percent) participate in the Medicaid progam and so are reimbursed by the Department of Human Services. However, the Department of Health is responsible for certifying which homes can participate in Medicaid.

All nursing homes must first be state-licensed, regardless of their decision to accept state reimbursement. The Minnesota Department of Health licenses them either as "nursing" or "boarding care" homes.

Minnesota law defines a nursing home as (1) a facility providing nursing care to at least five persons and (2) not a hospital, clinic, treatment center, or facility for the mentally retarded.[2] Nursing care is further defined as evaluating and treating individuals who do not need an acute-care facility (such as a hospital) but may require nursing supervision on an inpatient basis. In contrast, a boarding care home is a facility which generally provides personal or custodial care to aged or infirm individuals.[3]

In 1990, the Department of Health issued a total of 447 nursing home licenses and 108 boarding care licenses. It certified that 446 of these 555 homes were eligible to receive Medicaid reimbursement from the Department of Human Services as nursing homes.[4]

NURSING HOME MORATORIUM

The Legislature adopted a nursing home moratorium in 1983.

In 1983, the Legislature stopped the Department of Health from (1) certifying new nursing home beds or (2) recertifying beds to higher levels of care. The moratorium required that the total number of certified beds in the state should remain at or decrease from the number of beds certified at each level of care as of July 1, 1983.[5] In 1985, the Legislature expanded the moratorium to include licensed as well as certified beds.[6]

Under the moratorium, construction was defined broadly to include any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with nursing home licensure rules. Originally, the Commissioner of Health, in coordination with the Commissioner of Human Services, could allow six general exemptions. First, additional beds could be

2 *Minn. Stat.* §144A.01, Subd. 5 and 6.

3 Except where otherwise noted, we use the term "nursing home" to include both nursing homes and boarding care homes.

4 As we discuss in Appendix A, two facilities serving both nursing home and severely impaired residents are also certified under Rule 80. For payment and reporting purposes, the Department of Human Services treats them separately, bringing the total number of homes eligible for reimbursement to 448.

5 *Minn. Laws* (1983), Chapter 199, Section 1.

6 *Minn. Laws* (1985), First Special Session, Chapter 3, Section 12.

certified to replace decertified beds if the total number added did not exceed the total number of decertified beds in the state. Second, certified beds could be added to address extreme hardships in particular counties. Third, beds could be certified if nursing homes began construction before July 1, 1983. Fourth, beds could be certified if they would help meet residents' special dietary needs. Fifth, beds could be upgraded from a lower certification status if reimbursement decreased. Sixth, new beds could be licensed in homes which applied for licenses before March 1, 1985, and either started construction or received permission for construction from the Commissioner of Health before May 1, 1985.

In 1986, the Legislature, concerned over nursing homes' inability to remodel, renovate, or replace outdated buildings, created a task force to review the moratorium and make recommendations for change.[7] The task force recommended continuing the moratorium but permitting exceptions for needed physical plant improvements.[8] Consequently, the 1987 Legislature established a moratorium exception process which permits nursing homes to make costly physical plant changes upon review by the Interagency Board for Quality Assurance and approval by the Commissioner of Health.[9] In addition, the Legislature authorized a $600,000 increase in the Medicaid budget for fiscal years 1988 and 1989 to cover resulting cost increases from the approved building projects.[10]

We examined the impact of the moratorium on the overall number of certified nursing home facilities and beds. Despite exemptions and exceptions, we found that:

The overall number of homes and beds has not changed significantly since 1985.

- **The total number of nursing homes and beds covered by the state's reimbursement system did not grow significantly between 1985 and 1989.**

There was an increase of only three Medicaid-certified nursing homes from 1985 to 1989 while the number of certified beds decreased by 44 beds. As Table 2.1 shows, the number of Medicaid-certified nursing homes was 445 in 1985 compared with 448 in 1989. The number of certified beds was 45,496 in 1985 and 45,452 in 1989.

However, nursing home beds today are more likely to be certified at the highest possible level. We found that:

7 *Minn. Laws* (1986), Chapter 420, Section 15.

8 State Planning Agency, *Recommendations for Changes to Minnesota's Nursing Home Moratorium Law from the Governor's Task Force on Long-term Care Health Planning* (1987).

9 *Minn. Laws* (1987) Chapter 403, Article 4, Section 4. The Interagency Board for Quality Assurance was created by the 1983 Legislature to identify and analyze long-term care issues that require coordinated policies between the Departments of Human Services and Health.

10 In addition, numerous other exceptions have been added over the past five years.

Table 2.1: Nursing Homes Reimbursed by the Department of Human Services, 1985-89

	1985	1986	1987	1988	1989	Percent Difference 1985-89
HOMES						
Total number of homes	445	447	448	448	448	1%
Hospital-nursing homes[a]	66	66	71	73	77	17
Short length of stay[b]	11	12	11	12	12	9
Rule 80[c]	4	4	4	4	4	0
BEDS						
Total number of certified beds[d]	45,496	45,547	45,315	45,235	45,452	<-1%
SNF	31,222	33,886	34,921	35,677	36,782	18
ICFI	11,069	8,512	7,219	6,478	5,479	-50
ICFII	3,205	3,149	3,175	3,080	3,191	<-1
Total number of licensed beds	45,914	46,011	46,098	45,864	46,013	<1%
Nursing home	42,665	42,838	43,174	42,865	42,892	1
Boarding care	3,249	3,173	2,924	2,999	3,121	-4
RESIDENTS						
Percent of occupied beds	95.2%	94.7%	94.5%	94.4%	94.5%	-1%
Percent covered by:						
Medicaid	64.6%	64.3%	63.8%	61.8%	58.4%	-10%
Medicare	.4	.4	.5	1.7	7.1	1,675
Private	34.2	34.5	34.8	35.6	33.1	-3
Other	.8	.8	.9	.9	1.5	87

Source: Department of Human Services.

[a]Hospital-nursing homes are facilities attached to hospitals, also referred to as convalescent and nursing care facilities (C&NCs).
[b]Short length of stay facilities care for residents who stay for an average of 180 days or less.
[c]Rule 80 facilities are for severely impaired residents.
[d]Until 1990, the federal government classified nursing homes into two categories: skilled nursing facilities (SNFs) and intermediate care facilities (ICF-Is or ICF-IIs). Skilled nursing facilities could provide 24-hour nursing care which was prescribed by a doctor and administered by a registered nurse. Such facilities provided the highest possible level of nursing home care. In contrast, intermediate care facilities generally were required to have only one registered nurse on duty.

- **Since 1985, the number of intermediate-level beds fell 39 percent while the number of skilled beds rose 18 percent.**

This is because since 1987, the state has required all Medicaid-certified homes also to participate in Medicare. In 1989, the Legislature specified that 50 percent of all eligible beds in nursing homes be Medicare-certified.[11]

After a few years of experience with the moratorium, the Legislature directed the Interagency Board for Quality Assurance to review the state's supply of

11 Minn. Laws (1989), Chapter 282, Section 81. This legislation required all beds to be Medicare-certified after June 30, 1991; however, this requirement was repealed in 1990 when the federal government repealed most provisions of the 1988 Medicare Catastrophic Coverage Act.

nursing home beds.[12] In 1989, the board reported that there was no shortage of beds anywhere in the state, and the supply should be adequate for five to seven more years. It recommended continuing the moratorium for the present, but expanding alternative care programs to ensure a more comprehensive continuum of care.[13]

However, we believe that:

- **The nursing home industry may be unable to meet the future needs of the elderly, both in amount and adequacy of service.**

There are three principal reasons for our concern. First, as we discussed in Chapter 1, the elderly population is not only growing rapidly but entering nursing homes later in life. The current array of nursing homes may not be well equipped to care for a sicker, frailer population. Second, as we show later in this chapter, some nursing homes may have postponed structural improvements and replacement of capital assets. As we discussed in Chapter 1, some nursing homes have not received enough revenue to make capital improvements or replace such items as furnaces, roofs, or large pieces of equipment. Third, some small nursing homes have had difficulty complying with the federal government's new staffing requirements, and this may reduce the number of certified nursing home beds in the state.[14]

COST CONTAINMENT

Although the Legislature's immediate concerns were financial, policymakers also were concerned about the efficiency and appropriateness of nursing home payments. In 1983, there was no apparent connection between costs, services, and quality of care. The reimbursement system at that time (Rule 49) was outdated and cumbersome to administer and gave nursing homes a financial incentive to appeal most of the state's decisions.[15] Also, nursing home owners stood to benefit by selling their facilities (although such sales could disrupt residents' care while increasing the costs of care).[16]

Under Rule 49, annual reimbursement rates were based on two main components: historical costs and future known cost changes. Historical costs were the allowable direct and indirect costs of care delivered in the previous year. Known cost changes were projected cost increases for the coming year. Although the state determined the latter based on reasonable cost principles, known cost changes could occur generally at nursing homes' discretion.

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12 *Minn. Laws* (1987), Chapter 403, Article 4, Section 13.

13 Interagency Board for Quality Assurance, *An Analysis of the 1987 Distribution of Nursing Home Beds in Minnesota* (1989).

14 We discuss staffing issues in Chapter 4.

15 For an examination of Rule 49, see Office of the Legislative Auditor, *Evaluation Report on Nursing Home Rates* (1979).

16 Sales led to higher reimbursement for real estate costs when assets were rebased and new debt amortized.

Consequently, the 1983 Legislature adopted a new reimbursement system that took form administratively as Department of Human Services' Rule 50. It differed from the previous system in three important ways.

- **First, the new system was entirely "prospective," with rates set in advance and based on the previous year's allowable operating expenses adjusted for inflation.**
- **Second, reimbursement was based generally on allowable expenses in four separate categories, the most important of which was based on "case mix," which indicated the level of service actually needed and used by residents.**
- **Third, reimbursement was limited by geographic location.**

Together these characteristics gave Minnesota a very complex reimbursement system. Although it continued to produce widely varying rates for individual nursing homes, these now occurred by design rather than happenstance.

Prospective System

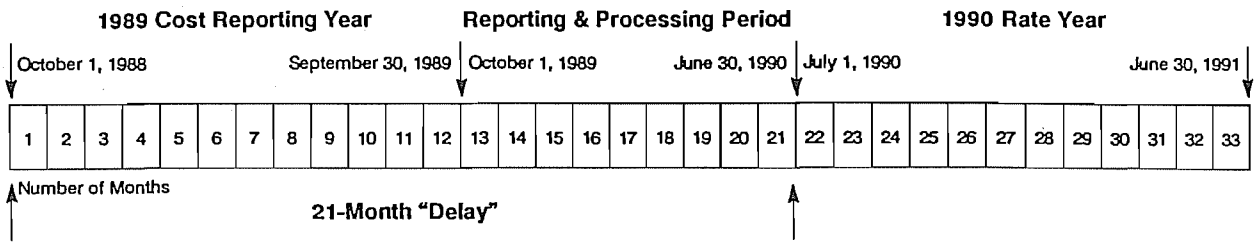
Nationwide, health care reimbursement systems are typically classified either as "retrospective" or "prospective." In a "retrospective" system, reimbursement is closely tied to actual expenses soon after they occur. In a "prospective" system, reimbursement rates are set in advance and may not match current spending.

Minnesota uses a "prospective" reimbursement system.

Under Minnesota's prospective rate-setting system, individual nursing home rates are established for each rate year (July 1 through June 30), based on allowable expenses incurred during the previous reporting year (October 1 to September 30). Nursing homes must submit detailed cost reports to the Department of Human Services each reporting year. After reviewing the reports and adjusting the payment system to incorporate legislative changes, the department sets an overall reimbursement rate per facility for the coming rate year, which begins each year on July 1. The basis for the new rate is primarily the allowable costs for the previous reporting year plus the amount of inflation which is expected during the period between the midpoint of the reporting year and the midpoint of the rate year.

By design, prospective systems effectively preclude cost overruns and major new expenditures. Unlike retrospective systems, prospective systems have a built-in time lag (or other type of gap) between spending and reimbursement. As Figure 2.1 shows, the total time between the beginning of a cost year and the beginning of a rate year for nursing homes is 21 months. Administrators often refer to this time period as the 21-month "delay" or "disallowance."

Figure 2.1: Time Delay Between Spending Data and Establishment of 1990 Reimbursement Rates



Source: Office of the Legislative Auditor.

Rate Components

Rates for specific nursing homes are determined generally on the basis of allowable expenses in four categories outlined in Figure 2.2: care-related, other operating, pass-through, and property. Of these, care-related costs are the most important to administrators, residents, and families. As Figure 2.3 shows, these costs make up over one-third of a nursing home's reimbursement rate.

Care-related operating costs are subdivided into (1) nursing costs and (2) other care-related costs. Nursing costs include nursing equipment and supplies and the salaries, wages, fringe benefits, and payroll taxes of nursing staff. Other care-related costs involve social services, activities, therapies, fringe benefits and payroll taxes of staff providing these services, raw food costs, and dietary consultant fees. Nursing costs, but not other care-related costs, are reimbursed on the basis of residents' care needs.

Other operating costs include dietary services (but not raw food or consultant fees), laundry, linen, housekeeping, plant operations, maintenance, and general and administrative services, including relevant payroll taxes and fringe benefits.

Depending on expenditures in this cost category, nursing homes enjoy their only direct opportunity to earn excess revenue or a "profit" on overall operating costs. This is awarded through so-called "efficiency incentive" payments.[17] Facilities are eligible to earn the difference between their daily costs for other operating expenses and the limit of their geographic group, up to a maximum of $2.00 per resident per day. Each year, administrators can earn these bonuses and use them as profit or in any other way.

17 Other states have similar bonuses which may be called return on equity, interest, management fees, incentive allowance, or owners' costs.

Figure 2.2: Components of the Nursing Home Reimbursement System

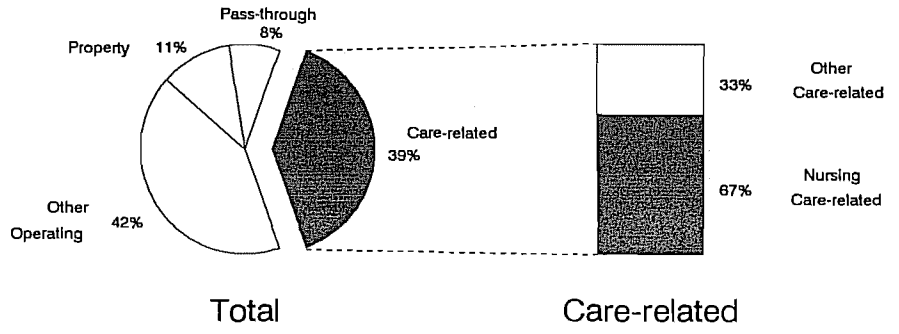
Category	Reimbursement Limit on Allowable Costs	Adjustments
CARE-RELATED		
Nursing Costs		
• Nursing equipment and supplies • Nursing salaries • Related fringe benefits and payroll taxes	• 125 percent of median for geographic group	• Varies with case-mix • Annually for expected inflation
Other Care-related Costs		
• Social services, activities, and therapies • Raw food • Dietary consultant fees	• 125 percent of median for geographic group	• Annually for expected inflation
OTHER OPERATING		
• Dietary services, other than raw food, and dietary consultant costs • Laundry and linen • Housekeeping	• 110 percent of median for geographic group	• Annually for expected inflation
• Plant operations and maintenance	• $325 per licensed bed	
• General and administrative costs, including relevant payroll taxes and fringe benefits	• 15 percent of operating expenses, including associated fringe benefits and taxes • Efficiency incentive allowed	
PASS-THROUGH • Property taxes • Special assessments • Licensing fees • PERA contributions • Preadmission screening fees	• No limits	• No adjustments
PROPERTY • Determined on the basis of a "rental formula"	• Appraised value subject to investment per bed limit	

Pass-through costs are reimbursed in full by the state. These include property taxes, special assessments, licensing fees, Public Employee Retirement Association contributions, and preadmission screening costs.

Finally, ***property reimbursement*** has been determined on the basis of a "rental formula" which had been phasing in from a prior cost-based system since 1985.[18] Generally, property-related reimbursement would be the sum of allowable interest on allowable debt, a rental factor times appraised value less allowable debt, and an equipment allowance.

18 Recommendations for changing this aspect of the reimbursement system are scheduled for review by the 1991 Legislature.

Figure 2.3: Components of Nursing Home Reimbursement Rates, Level "A", 1989



Source: Department of Human Services.

Procedures

The Department of Human Services reviews each nursing home's cost report to ensure that state reimbursements are based on allowable costs only. Both state statutes and department regulations define in detail which costs are ineligible for reimbursement. In addition, the system subtracts some other costs when they are above certain spending limits.

Nursing home administrators often criticize this aspect of Minnesota's reimbursement system. A forthcoming national study suggests that Minnesota has a more narrow and less generous definition of allowable costs than many other states.[19]

About four percent of nursing home costs were disallowed in 1989.

We found that:

- **Almost all (98 percent) cost reports for the 1989 reporting year failed to fully meet the state's specific rules and procedural requirements.**

Subsequently, the Department of Human Services disallowed about four percent of total nursing home expenditures because they represented unallowable spending.[20] As shown in Table 2.2, some costs were disallowed because they were not properly documented. Other costs were disallowed because auditors found them unrelated to nursing home operations or simply excessive. For-profit nursing homes were most affected by these procedures.

19 Robert J. Buchanan, Dan Persons, and R. P. Madel, "Medicaid Coverage of Nursing Home Care: 1988 Reimbursement Policies," *Health Care Financing Review* (forthcoming).

20 These adjustments are subject to appeals and other possible changes.

Table 2.2: Common Reasons for Desk Audit Adjustments by Ownership Type, 1989

Ownership Type	Lacking Documentation	Failure to Capitalize Items	Central Office Allocation	Unrelated/ Personal Expenses	Excessive, Unnecessary Expenses
For-profit	69%	72%	43%	63%	56%
Nonprofit	27	64	19	24	16
City/county	19	43	4	9	6
Statewide Total	43%	64%	27%	38%	31%

Source: Department of Human Services.

About one percent of nursing home costs were disallowed for exceeding limits in 1989.

On the average, desk-level adjustments made by Department of Human Services' auditors amounted to $10.8 million annually between 1986 and 1989.[21] This is in addition to (1) disallowances, if any, for pass-through expenses and property-related costs and (2) limits which may be imposed on the level of allowable costs.

Once cost reports are adjusted for nonallowable spending, the reimbursement system disallows additional expenses that statistically exceed spending limits. These adjustments represented about one percent of total nursing home expenditures. As Table 2.3 shows, only five percent of nursing homes spent more for direct nursing care than they were reimbursed by the state during the 1989 cost year. On the other hand, about one-third spent more for physical plant maintenance.

Table 2.3: Percent of Nursing Homes Exceeding Major Spending Limits by Ownership Type, 1989

	Over Limits for:					
Ownership Type	Nursing Care[a]	Other Care-Related[a]	Other Operating	General/ Administrative	Disallowed Fringe Benefits/ Payroll Taxes[b]	Physical Plant/ Maintenance
For-profit	4%	8%	15%	23%	23%	31%
Nonprofit	6	16	23	20	19	36
City/county	9	14	26	17	17	19
Statewide Total	5%	12%	20%	21%	20%	31%

Source: Department of Human Services.

[a]For purposes of rate setting, these two limits are combined and trade-offs between them are permitted.
[b]Associated with general/administrative expenses over limits.

21 Annual adjustments varied widely, ranging from $2.9 million in 1988 to $17.2 million in 1989.

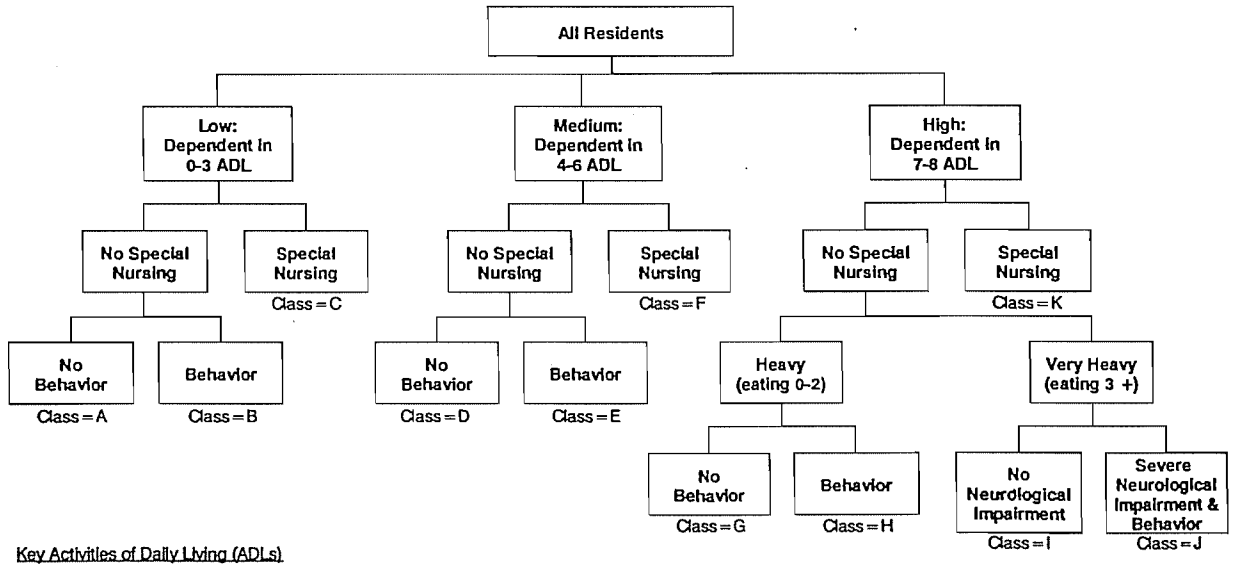
In addition to annual desk audits, the department reviews some nursing homes' records on site. These field audits cover the four most recent annual cost reports. According to the federal government, such audits nationally disallow, on the average, an estimated 2.4 percent of reported costs.[22] The federal government believes that Minnesota does not conduct enough field audits, which would result in further disallowances to nursing homes.

Case Mix

Reimbursement for care-related nursing costs varies with the care needs of residents, as reflected by case-mix indicators. This is one of the most important cost items for nursing homes, comprising almost 40 percent of total expenses.

A case-mix assignment is first determined for each resident through the Preadmission Screening Program. Shortly before or after admission, nursing home residents are classified into one of 11 groups, "A" through "K." Figure 2.4 shows how residents' care needs are determined by their ability to perform eight key activities of daily living (ADLs): dressing, grooming, bathing, eating,

Figure 2.4: Case-mix Classification System



Key Activities of Daily Living (ADLs)

	Not Dependent	Dependent
Dressing	0-1	2-4
Grooming	0-1	2-3
Bathing	0-3	4-5
Eating	0-1	2-4
Bed Mobility	0-1	2-3
Transferring	0-1	2-4
Walking	0-1	2-4
Toileting	0	1-6

Source: Department of Health.

Classification		Relative Resource Use
A	Low ADL	1.00
B	Low ADL and behavior problems	1.30
C	Low ADL and special nursing needs	1.64
D	Medium ADL	1.95
E	Medium ADL and behavior needs	2.27
F	Medium ADL and special nursing needs	2.29
G	High ADL	2.56
H	High ADL and behavior needs	3.07
I	Very High ADL (eating 3-4)	3.25
J	High ADL and severe neurological impairment and behavior	3.53
K	High ADL and special nursing	4.12

22 Health Care Financing Administration, *Review of the Minnesota Medicaid Reimbursement System for Nursing Homes, July 1, 1985 through June 30, 1987* (Washington, 1988).

bed mobility, transferring, walking, and toileting. In addition, the need for clinical monitoring and behavioral intervention is considered.

Each category carries with it an estimate of the number of staff hours needed to care for individual residents (resource use). In general, residents classified at the "A" level require considerably less nursing care than residents at the "G" level or above.

Five studies suggest that the case-mix classification system has some technical shortcomings. First, a recent national study compared seven different case-mix classification systems and found that Minnesota's system could be improved in two ways: (1) if groupings were adjusted to better identify heavy-care residents; and (2) if case-mix indices were adjusted for some groups.[23] This study indicated that residents assigned to groups "F" and "I" use more resources than the case-mix system assigns to them (especially Group "F"), while residents classified as "E" and "H" use less nursing care than the system assumes.

Case mix may require some fine-tuning.

Second, the Department of Health established a case mix technical advisory committee in 1988. It recommended raising residents' classifications to the next higher behavior level when residents have frequent behavior problems that require continuous intervention by nursing staff.[24]

Third, the Department of Health has shown elsewhere that it is difficult to assign residents with behavior problems to proper case-mix classifications.[25] This study compared how often central office staff at the department agreed with field office staff when classifying residents' care needs. While the study generally showed a high level of agreement, the area of "behavior" was a problem. Raters agreed only 81 percent of the time. With the exception of "eating" (86 percent agreement), all other categories showed agreement levels of at least 90 percent.

Fourth, the Department of Health has shown that, since 1986, nursing homes' own assessments of residents' needs have resulted consistently in higher case-mix scores than Department of Health assessments.[26] Nursing home staff must reassess all residents six months after admission. In addition, the Minnesota Department of Health assesses all residents once more during the year. During 1988 and 1989, average case-mix scores resulting from nursing home staff assessments were 2.34 compared with the Department of Health's scores of 2.31.

Nursing home staff may assign higher case-mix levels because they are more familiar with residents and their specific needs. However, they may assign

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23 Brant E. Fries, "Comparing Case-Mix Systems for Nursing Home Payments," *Health Care Financing Review 11* (Summer 1990), 103-119.

24 Department of Health, *Recommendations for Modifications of the Case Mix System for Minnesota Nursing Homes* (1989).

25 Department of Health, *The Quality Assurance and Review Resident Assessment System: An Inter-Rater Reliability Study, 1988-89* (1989).

26 Minnesota Department of Health, *Case Mix Classification Distribution Frequencies* (undated).

higher levels also because their reimbursement is related directly to their case-mix score.

Finally, in our survey of nursing home administrators, 41 percent said case mix was a problem. Several administrators commented that behavior problems were inadequately reflected in the weightings. According to these administrators, some residents with behavior problems are inappropriately classified at the low end of the scale despite their need for more staff time.

Geographic Limits

Figure 2.2 shows that reimbursement for care-related and other operating costs are determined on the basis of limits. To be reimbursed for all allowable spending, care-related costs must fall within 125 percent and other operating costs within 110 percent of median spending for nursing homes in certain geographic groups. These groups, shown in Figure 2.5, are based on 1983 nursing salaries and are presumed to reflect local cost variations.

However, we found:

- **Geographic groups do not adequately reflect local costs of living.**

Some northern Minnesota counties are reimbursed as metropolitan counties.

This is especially true for those northeastern Minnesota counties classified in group 3 or "metro" (Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, and St. Louis), where we found that the average cost of living was only 89 percent of what it was in the seven-county Twin Cities area.[27] Furthermore, our study suggests that the cost of living in the northern Minnesota counties classified "metro" was actually the same as that of group 2 "semi-metro" counties. However, cost of living in group 1 "deep rural" counties was less than that of the "metro" or "semi-metro" groups.

The 1986 Legislature, responding to criticisms of the geographic groups, directed the State Planning Agency to examine other ways to recognize regional cost differences.[28] However, its study found that inequities in the present groups could not be addressed without creating other inequities. Therefore, it recommended no changes in the present geographic groups.[29]

As we discuss later, the 1987 Legislature permitted "deep rural" or group 1 nursing homes to be reimbursed at their own rate or at the rate of "semi-metro" or group 2 homes, whichever was greater. Accordingly, the Department of Human Services has used group 2 rates for group 1 homes since 1987.

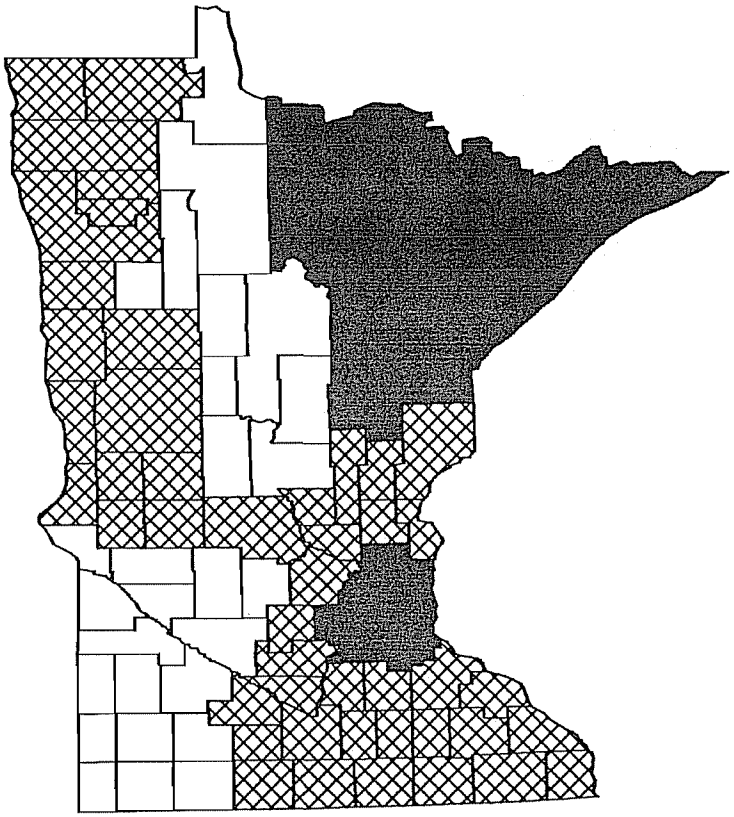
Beginning in 1989, care-related costs were capped at 125 percent of the median for the nursing home's particular geographic group; other operating costs were capped at 110 percent. Homes whose costs for these categories were less than the median cost are reimbursed for their total allowable costs.

27 See Office of the Legislative Auditor, *Statewide Cost of Living Differences* (1989).

28 *Minn. Laws* (1986), Chapter 420, Section 14.

29 State Planning Agency, *Appropriateness Study: Minnesota's Geographic Groups for Nursing Home Reimbursement* (1987).

Figure 2.5: Nursing Home Reimbursement Geographic Groups



DEEP RURAL
Beltrami, Big Stone, Cass, Chippewa, Clearwater, Cottonwood, Crow Wing, Hubbard, Jackson, Kandiyohi, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Wadena, and Yellow Medicine counties

SEMI-METRO
Becker, Benton, Blue Earth, Brown, Chisago, Clay, Dodge, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Houston, Isanti, Kanabec, Kittson, LeSueur, McLeod, Marshall, Martin, Mille Lacs, Mower, Nicollet, Norman, Olmsted, Otter Tail, Pennington, Pine, Polk, Pope, Red Lake, Rice, Roseau, Sherburne, Sibley, Stearns, Steele, Stevens, Traverse, Wabasha, Waseca, Watonwan, Wilkin, Winona, and Wright counties

METRO
Aitkin, Anoka, Carlton, Carver, Cook, Dakota, Hennepin, Itasca, Koochiching, Lake, Ramsey, St. Louis, Scott, and Washington counties

Geographic Groups

Group 1: Deep rural

Group 2: Semi–metro

Group 3: Metro

Source: Department of Human Services.

Homes at or exceeding the geographic median are reimbursed for allowable expenses up to the geographic limit.

Other limits also apply within some cost categories—most notably, general and administrative expenses within the other operating cost category. Reimbursement for these expenses is capped at 15 percent of operating expenses while any associated fringe benefits above this are disallowed as well.

Finally, the reimbursement system limits expenses for many small items. These are most commonly expressed in terms of dollars rather than percent-

ages. For example, allowable costs for yellow page advertising are limited to a maximum of $2,000, and allowable plant and maintenance costs are fully reimbursed only up to $325 per licensed bed annually.

Combining geographic limits with case-mix levels produces wide variations in individual nursing home rates. As Table 2.4 shows, the average reimbursement rate for the 1990 rate year may range from $44.71 to $106.31, depending on residents' location and condition.

There are wide variations in individual nursing home rates.

Table 2.4: Nursing Homes' Average 1990 Daily Payment Rate by Geographic Group and Case-mix Level

Case-mix Level	Group 1 Deep Rural	Group 2 Semi-Metro	Group 3 Metro
A	$44.71	$47.29	$55.46
B	48.30	51.18	60.36
C	52.37	55.59	65.90
D	56.09	59.61	70.96
E	59.92	63.76	76.17
F	60.16	64.02	76.50
G	64.40	67.52	80.90
H	69.51	74.13	89.21
I	71.66	76.47	92.14
J	75.02	80.10	96.70
K	82.08	87.74	106.31

Source: Department of Human Services.

Exceptions

Three types of nursing homes are reimbursed in a slightly different way: (1) hospital-nursing homes (referred to as convalescent and nursing care facilities or C&NCs); (2) facilities caring for severely impaired residents (known as Rule 80 facilities); and (3) nursing homes where residents stay for an average of 180 days or less. In general, reimbursement limits for these facilities are calculated separately. In addition, hospital-nursing homes do not have to submit all the cost information required of other nursing homes.

System Changes

Adding to its inherent complexity, Minnesota's reimbursement system has been fine-tuned and modified by the Legislature each year since implementation in 1985. As Figure 2.6 shows:

- **Many changes to the reimbursement system have increased payments to nursing homes.**

Figure 2.6: Major Legislation Affecting Nursing Home Reimbursement Cost Components, 1985-90

Year	Care-related	Other Operating	Pass-through	General
1985	Established rates and need determination for MA residents in private rooms.	Established 3-year phase-in efficiency plan to assist homes 5% or more above the limits.		Set temporary, retroactive rate adjustments for operating costs. Set operating cost reimbursement schedule with 2 month delay after rate notice.
1986	Created eligibility standards for a one-time adjustment for homes significantly below care-related minimum standards.	Defined general and administrative costs. Clarified that gifts, bad debts, and communications service were not allowable costs.		Established distribution method for private-pay and MA differentials.
1987	Made six changes to curb therapy costs: • Expanded utilization review board activities • Limited maximum rental charges to independent contractors • State to recover therapy revenue over 108% of defined costs • Established method to determine costs • Triple damages for violations • Established advisory committee to study alternative reimbursement methods	Enacted a $325 cap on allowable plant and maintenance costs. Excluded liability and property insurance from disallowed costs for G&A.	Clarified rates when homes have changes in real estate taxes that occur between rate years.	Allowed Group 1 homes to be reimbursed at Group 2 rates. Established cost accounting requirements for payroll taxes, fringe benefits, and contracted services. Clarified responsibility for overpayments when home is sold.
1988	Increased spending limit from 115 to 125% of geographic median.	Increased spending limit from 105 to 110% of geographic median.	Pass-through pension costs for staff. Limited real estate tax pass-through.	Provided a 3.5% salary and fringe benefit adjustment, excluding administrative salaries.
1989	Established upper limit for reimbursing highest case mix category, "K."	Permitted interest for demand call loans as allowable expense.	Narrowed 1988 pension pass-through provision to PERA contributions only.	Established a plan to Medicare-certify all Medicaid-certified beds. Provided additional money to offset OBRA costs.
1990		Distinguished between consultant contracts and management agreements when allocating other operating costs.		Extended provisions permitting Group 1 homes to be reimbursed at Group 2 levels. Repealed requirements that all Medicaid-beds be Medicare-certified.

For example, in 1987, the Legislature permitted nursing homes in geographic group 1 to be reimbursed either at their own rate or at the rate of homes in group 2, whichever was higher.[30] Now, the Department of Human Services uses the higher rate figures.

The 1988 Legislature made several other changes which increased nursing home payments.[31] Three changes were paramount. First, the care-related limit rose from 115 to 125 percent of median costs for geographic groups, and the other operating limit rose from 105 to 110 percent. Second, the Legislature provided nursing homes with money for a 3.5 percent salary, payroll tax, and fringe benefit adjustment. (Management fees, administrative and central office salaries, and related payroll taxes and fringe benefits were specifically excluded.) Third, nursing homes could begin to pass through allowable employee pension contributions and payments made in lieu of real estate taxes directly to the state.

The reimbursement system has been constantly fine-tuned and modified.

In 1989, the Legislature revised the reimbursement system and thereby increased payments to nursing homes again.[32] First, the Legislature provided some money to help offset the costs of complying with new federal requirements which began in October 1990. The change was expected to increase the nursing home industry's total revenues by $2.8 million in fiscal year 1990 and $5.1 million in fiscal year 1991. Second, the Legislature required the Department of Human Services to base reimbursement on current statistical norms for the 1989 and 1990 reporting years. Previously, the 1984 reporting year was used, with the effect of compressing payment limits over time.

However, during the same years:

- **Other major changes to the system curbed rather than raised nursing home reimbursement.**

First, the 1987 Legislature changed the department's method of reimbursing for therapy costs to reduce unnecessary services, kickbacks, and fee-splitting.[33] Second, 1987 legislation established that new or current nursing home owners were responsible for repaying any overpayments which may have been made to previous owners.[34] It also required the Department of Human Services to conduct field audits upon request within 15 months of nursing home sales to advise owners of any overpayment liability. Third, the 1987 Legislature adopted a limit on allowable plant and maintenance costs of $325 per licensed bed for uncapitalized expenses.[35] Fourth, the 1989 Legislature amended employee retirement pass-through provisions adopted the pre-

30 *Minn. Laws* (1987), Chapter 403, Article 2, Section 89.

31 *Minn. Laws* (1988), Chapter 689, Article 2.

32 *Minn. Laws* (1989), Chapter 282.

33 Chapter 1 outlines problems related to therapy expenses.

34 *Minn. Laws* (1987), Chapter 133.

35 *Minn. Laws* (1987), Chapter 403, Article 4, Section 10.

vious year to include only Public Employee Retirement Association contributions.[36]

Allowable Spending by Category

Although the state's reimbursement system provides money for growth in all cost categories, we found that allowable spending in some categories has not grown as much as the Minneapolis-St.Paul Consumer Price Index (CPI).[37] Table 2.5 shows how daily allowable spending in each major category has changed since 1985. As these data show, care-related expenses easily kept pace with inflation (exceeding both local inflation rates and national indices for skilled nursing homes), but laundry, housekeeping, and maintenance spending did not.

- **Allowable maintenance spending increased by only seven percent since 1985, and laundry/linen and housekeeping increased by about 10 percent each. At the same time, local inflation increased 14 percent.**

Table 2.5: Average Daily Spending, 1985-89

	1985	1986	1987	1988	1989	Percent Difference 1985-89
Care-related						
Nursing[a]	$8.72	$7.66	$9.39	$10.06	$11.25	29%
Other care-related	1.94	1.81	2.26	2.23	2.45	26
Other Operating						
Dietary	6.77	6.25	7.03	7.53	8.05	19
Laundry/linen	1.38	1.27	1.41	1.44	1.52	10
Housekeeping	2.16	1.75	2.17	2.24	2.39	11
Maintenance	3.63	3.35	3.35	3.69	3.87	7
General and administrative	4.46	4.13	5.35	5.66	5.90	32
Fringe benefits and payroll taxes	4.84	4.49	5.34	5.93	6.40	32
Statewide Total[b]	$33.90	$30.71	$36.30	$38.78	$41.83	23%
SNF Input Price Index	1.768	1.808	1.887	1.998	2.122	20%
Minneapolis-St. Paul Consumer Price Index-W(1967 = 100)	336.0	334.6	350.0	366.9	382.2	14%

Sources: Department of Human Services; SNF price index based on costs for skilled nursing care nationwide, as developed by the Health Care Financing Administration, U.S. Department of Health and Human Services; and Minneapolis-St. Paul CPI from the Bureau of the Census, U.S. Department of Commerce.

[a]These costs reflect level "A" services, the largest classification level of nursing home residents.
[b]Costs reflect allowable spending in each category.

36 *Minn. Laws* (1989), Chapter 282, Article 3, Sections 66 and 68.

37 The federal government produces the CPI for Minneapolis-St. Paul and not for the rest of Minnesota.

Some spending has not kept pace with inflation.

We believe that these small increases are due largely to nursing homes' efforts to earn efficiency incentive payments. To earn these bonuses, homes must limit their spending in the other operating cost category. Furthermore, most nursing homes (75 percent) received at least some bonus payment in 1989. As discussed earlier, the efficiency incentive offers facilities the only direct opportunity for excess revenue or "profit" from residents' overall care.[38]

However, reduced spending to earn efficiency incentive payments may cause problems in the future. Nursing home administrators told us that they have deferred routine maintenance and repairs, and this may exacerbate problems associated with aging buildings and a shortage of capital asset replacement funds, especially under the moratorium. While homes have maintained high occupancy levels (above 90 percent) throughout the past decade, some may not have been improved or redecorated for years. We found evidence that:

- **Nursing homes may have physically deteriorated during the past few years.**

In our survey, we asked administrators to describe the general structural and mechanical condition of their nursing home. By asking almost the identical question which was asked in a 1988 survey by Senate Research, we were able to indirectly estimate the extent of deterioration.[39]

As Table 2.6 shows, only 10 percent of administrators said their nursing home was in poor condition or needed to be replaced in 1988, but 28 percent said this in Fall 1990. Conversely, we found that few (6 percent) administrators

Table 2.6: Administrators' Judgment of Nursing Homes' General Structural and Mechanical Condition, 1988 vs. 1990

Condition	1988	1990
Excellent: No need for upgrading, remodeling, major repairs, or replacement	28%	6%
Fair to Good: Need moderate upgrading, remodeling, or repairs	62	66
Poor: Significant need for upgrading, remodeling, or repairs[a]	10	25
Poor: Needs to be entirely replaced[a]		3

Sources: 1988—Senate Counsel and Research (n=327); 1990—Administrator Survey (n = 310).

[a]These two categories were combined in Senate Counsel and Research's survey.

38 In Chapter 4, we discuss the implications of such cost-cutting measures.

39 Michael Scandrett, *Air Conditioning in Minnesota Nursing Homes* (St. Paul: Senate Counsel and Research, 1989).

rated their nursing home's condition as excellent, but 28 percent did so in 1988. However, only three percent of the administrators in our survey said that their entire nursing home needed to be replaced.

Nursing homes' physical plants may have deteriorated.

The 1988 survey by Senate Research indicated that about half the nursing home administrators found the lack of air conditioning a problem for residents and/or staff. Most administrators (62 percent) said their facility was only partially air-conditioned, usually in resident dining rooms, activity areas, administrative areas, and kitchens. Resident rooms were least likely to be air-conditioned, although this may partially reflect the preferences of elderly residents or their physical need for warmer temperatures. Twenty-nine percent of the administrators indicated that air conditioning was available throughout their nursing home.[40]

Our 1990 survey provided other evidence which suggests that Minnesota nursing homes have grown less comfortable and attractive over the past few years. As shown in Table 2.7, 65 percent of nursing home administrators said that building upkeep and maintenance have suffered. Sixty-three percent said decorating and furnishings have changed for the worse. In addition, 42 percent of the administrators indicated that housekeeping and cleaning were worse in 1990 than they had been in the mid-1980s.

Table 2.7: Administrators' Perceptions of Operational Changes, 1989

	Percent Who Said:	
Areas of Operation	Changed for the Better	Changed for the Worse
Salaries and benefits	11%	57%
Building upkeep/maintenance	2	65
Decorating/furnishing	3	63
Heating/cooling	4	21
Management and administration	8	30
Laundry/linen	4	29
Meals/snacks	5	8
Housekeeping/cleaning	2	42
Patient care	16	28
Activities/outings	9	21
Social services	14	12

Source: Nursing Home Admininstrator Survey (n = 310). The question was: "Have these aspects of your operation changed as a result of the state's reimbursement system?"

Furthermore, as we discussed in Chapter 1, some nursing homes have not received enough revenue to make capital improvements or replace items such as furnaces, roofs, or large pieces of equipment. As a result, the 1991 Legisla-

40 Minn. Laws (1988), Chapter 689, Article 2, Section 40 requires all nursing homes constructed after June 30, 1988, to be fully air conditioned.

ture is reviewing recommendations to change the reimbursement method for property-related costs.

While spending for many activities indirectly related to resident care has not kept up with inflation, allowable care-related costs in Minnesota increased over 25 percent since 1985. As shown earlier in Table 2.5, allowable spending for direct resident care in Minnesota rose faster than nursing home costs nationally.

Part of the reason allowable care-related costs increased faster than inflation may be attributed to residents' needs. Since residents are increasingly debilitated, nursing home staff expenses have increased to provide additional care. As Table 2.8 shows, the average case-mix score statewide has increased somewhat.

- **Since 1985, nursing homes' average case-mix score rose from 2.21 to 2.30 on a scale from 1 to 4.12.**

Table 2.8: Percentage of Residents by Case-mix Level, 1985-89

Case-mix Level	1985	1986	1987	1988	1989	Percent Difference 1985-89
A	26.2%	24.0%	23.7%	24.1%	23.5%	-10.3%
B	9.3	9.1	8.6	8.0	8.2	-11.8
C	1.4	1.3	0.9	0.6	0.5	-64.3
D	9.9	9.5	9.5	10.0	9.8	-1.0
E	7.8	8.0	7.3	6.8	6.8	-12.8
F	1.6	1.6	1.1	0.7	0.7	-56.2
G	11.2	11.5	13.3	15.1	15.3	36.6
H	7.2	7.8	8.1	8.0	8.5	18.1
I	8.6	8.6	6.7	6.7	6.2	-27.9
J	9.7	10.8	13.2	14.2	15.0	54.6
K	7.0	8.7	7.5	5.7	5.4	-22.9
Statewide Average Case-mix Score	2.21	2.28	2.30	2.29	2.30	4.1%

Note: Percentages may not total 100 due to rounding.

Source: Department of Human Services.

Case-mix scores have increased since 1985.

While most case-mix levels experienced a drop in their relative share of the population, the percent classified at the higher levels of "G," "H," and "J" increased substantially. Looked at another way, the average nursing home resident in 1985 had a case-mix level midway between levels "D" and "E," dependent in four to six key activities of daily living with some behavior problems. In 1989, the average resident was classified slightly above level "F," still dependent in four to six activities, but now also requiring special nursing care.

Correspondingly, over the past few years, nursing homes have increased the number of nursing staff employed, especially licensed staff. Statewide, we found that:

Average nursing levels have increased since 1985.

- **Nursing homes have been staffed above the minimum levels required by regulations.**

The Department of Health's regulations require at least two nursing hours per resident day and .95 nursing hours per case-mix point. Table 2.9 shows how homes tended to exceed these requirements over time. As is shown:

- **Since 1985, the average number of nursing hours per resident day increased 10 percent, from 2.39 to 2.64 hours, and the average number of nursing hours per standardized day increased from 1.09 to 1.15 hours.**

Table 2.9: Average Nursing Levels, 1985-89

	1985	1986	1987	1988	1989	Percent Difference 1985-89
Nursing hours per resident day	2.39	2.45	2.52	2.57	2.64	10%
Nursing hours per standardized day[a]	1.09	1.08	1.10	1.13	1.15	5
Licensed nursing hours per standardized day	.30	.31	.32	.33	.35	17
Nurse aide hours per standardized day	.79	.77	.78	.80	.80	1
Nursing hours per case-mix point	1.08	1.07	1.10	1.12	1.15	6
Licensed nurses per nursing aide	.43	.43	.45	.47	.47	9

Source: Department of Human Services.

[a]Standardized days is the sum of the total number of resident days in each case mix classification multiplied by its corresponding case mix weight.

Most of these increases were for licensed staff, not lower-paid aides. Licensed hours per standardized day increased 17 percent since 1985, while aide hours increased only 1 percent. Furthermore, the ratio of licensed nurses to aides increased nine percent since 1985.

Also, the table shows that:

- **Since 1985, nursing hours per case-mix point increased from 1.08 to 1.15 statewide.**

Despite a general shortage of health care workers, relatively low wages, and administrators' complaints about payment rates, we conclude that most Minnesota nursing homes have been able to meet state staffing requirements.

SUMMARY

Reforms made by the 1983 Legislature produced a very complex reimbursement system which has controlled nursing home payments by (1) tightly defining allowable costs, (2) basing payments on residents' needs, (3) discouraging new expenses, and (4) offering financial incentives for cutting certain types of spending. While state spending for nursing homes continues to increase, the rate of increase and total costs now can be better anticipated.

However, the reimbursement system and moratorium together may have contributed to the physical deterioration of some nursing homes. We found evidence that routine maintenance and repairs have been postponed in favor of earning efficiency incentive payments. Under the moratorium and Rule 50, nursing homes generally are deterred from undertaking major remodeling or construction projects. Some nursing homes have not received enough revenue under the property reimbursement subsystem to make capital improvements or replace such items as furnaces, roofs, or large pieces of equipment needed for resident care. We believe this may lead to future problems as more debilitated, elderly people enter nursing homes which may be ill-equipped, uncomfortable, timeworn, and in need of repairs.

The following two chapters examine the specific impact of the reimbursement system on individual nursing homes. In Chapter 3, we describe the effect of the reimbursement system on nursing homes' financial condition and the reasons why some are profitable and others not. In Chapter 4, we evaluate the effect of the reimbursement system on nursing home administration, operations, and resident services.

FINANCIAL CONDITION OF NURSING HOMES

Chapter 3

As Chapters 1 and 2 showed, the Legislature developed a complex system to control nursing homes' annual cost increases and discourage most new construction, remodeling, and building improvements. These measures were effective but may have contributed to physical deterioration at some facilities. In this chapter, we ask whether nursing homes' financial condition also has deteriorated.

Our evaluation addressed the following questions:

- **What is the recent trend in nursing homes' financial performance? What is the outlook for the industry in the next few years?**
- **How many nursing homes are in serious financial distress, if any? Do these nursing homes share certain characteristics?**
- **Why are some nursing homes more profitable than others?**

In general, we found that:

- **The nursing home industry's financial performance has recovered from a downward slump, and more than half of the Medicaid-certified nursing homes have had at least a small amount of excess revenue or profit in each of the past four years.**

For our evaluation, we reviewed financial statements and applied standard formulas to develop key indicators of financial health for a statewide sample of 96 nursing homes in each of four years, 1986 through 1989. The Department of Health provided similar financial data for all (66) hospitals which operated nursing homes in Minnesota between 1985 and 1988. The Departments of Health and Human Services also provided data which we used to describe nursing homes and some reasons for their financial status. Finally, we asked nursing home administrators about the financial outlook for their homes in a survey which they completed at our request.

We emphasize that our financial review was limited and focused on policymakers' concern about the nursing home industry's overall condition. We did not attempt to develop the type of financial data which would be

needed to evaluate the industry's investment potential or manage specific nursing homes.

FINANCIAL INDICATORS

Industry experts have developed scores of indicators to help them describe specific aspects of hospitals' financial performance. In recent years, the same indicators also have been applied to nursing homes.

All standard financial indicators come from audited financial statements. To produce the indicators, service bureaus and trade associations extract basic data from the statements, enter the data into fixed formulas, and present the results in ratio form. The effect is to summarize and standardize information which would otherwise be difficult to present quickly and comparatively on a large scale.

Business owners and investors are particularly attuned to financial ratios because these make it easy to compare performance from year to year, across companies, and among industries. At the same time, many of the same indicators are equally useful to nonprofit organizations because they express organizations' performance in clear, simple terms. Of course, nonprofit organizations do not strive for the same financial performance as for-profit enterprises, but they too must record some net income, or excess revenues over expenses, to pay their bills on time, make major purchases occasionally, and withstand temporary changes in their operating environment. For them, the term "profit" means at least enough money to cover expenses.

Measures of Financial Health

To describe the nursing home industry's general financial condition, we considered various indicators but finally focused on two which we believe are the most complete, appropriate, and accurate. We also chose these two indicators because they are the backbone of the financial monitoring program which already applies to Minnesota hospitals. As shown in Chapter 1, nearly half of all Minnesota hospitals operated in combination with a nursing home in 1989. On the average, only 38 percent of the beds operated by these hospitals were for hospital patients; the majority were for nursing home residents.[1]

Our first indicator of nursing homes' financial health is the ***total margin*** (also called "overall," "institutional," or "profit" margin). When multiplied by 100, this presents net after-tax income as a percentage of total revenues from all activities and all sources, including contributions. Our second indicator is the ***operating margin***, which is similar but uses pre-tax income and is based on the primary business of resident care. Figure 3.1 shows the formulas which produce these two indicators.

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1 The nursing home portion of these hospitals receives Medicaid reimbursement as a convalescent and nursing care unit or "C&NC," also referred to as a hospital-attached nursing home. We refer to them as hospital-nursing homes.

Figure 3.1: Definitions of Financial Performance Indicators

Net Income	=	Total Revenues - Total Expenses
Operating Income	=	Operating Revenues - Operating Expenses
Total Margin	=	Net Income / Total Revenues
Operating Margin	=	Operating Income / Operating Revenues

Although the operating margin is a basic indicator of financial health, we learned that even it can be difficult or impossible to calculate for some nursing homes. The greatest problem is that:

- **Minnesota nursing homes may provide services to nonresidents as well as residents, and the costs and benefits of nonresident services can be intermixed with resident services.**

When the two types of services are interdependent, audited financial statements do not show the results as though they were separate.

As a result:

- **Audited financial statements are sometimes insufficient to determine nursing homes' financial condition.**

Nursing homes' operating margin sometimes is less useful as an indicator of financial health than the total margin.

For example, some nursing homes operate apartment complexes where seniors live independently but take meals and other services at the nursing home. Other nursing homes offer community-wide home health services since trained staff are available, and the activity could ultimately attract residents. Nursing homes often produce and deliver meals to private homes, and at the same time may reduce their cost per meal. We found that nursing homes' other significant lines of business (besides resident care) include adult day care, physical therapy, construction, housekeeping services, gift stores, pharmacies, and barber/beauty shops, among other things.

When nursing homes provide extensive nonresident services, resident care actually may not be their primary business. Thus, in some cases, the operating margin is less useful as an indicator of financial health than the total margin. Similarly, when hospitals run nursing homes or when nonprofit nursing homes are heavily involved in fundraising, the total margin is often a better indicator of financial performance than the operating margin would be alone.

METHODS

We reviewed audited financial statements which must be filed with the Department of Human Services by or on behalf of nursing homes and learned that some of these fail to yield even the most basic financial indicators. The most significant problem was the overlap between resident and nonresident business activities. Also, statements from nursing home chains did not always include detailed data on each of their specific nursing homes, and the statements categorized revenues and expenses differently.

Unlike hospitals, nursing homes lacked professionally agreed-upon accounting standards until 1990. In the meantime, including our study period, we learned that many accountants voluntarily used hospital accounting standards for nursing homes. The hospital accounting procedures were well established but, unfortunately, were not required and not always adopted.[2]

To address the shortcomings of financial statements, we obtained expert accounting assistance and used supplementary financial data from the Departments of Health and Human Services.[3] We were particularly concerned about the accuracy of financial indicators which were recently derived from nursing homes' financial statements and widely reported by Care Providers of Minnesota, a nursing home trade association.[4]

The Care Providers report was based on an analysis of financial data and indicators by a national firm, the HealthCare Financial Management Association (HFMA). HFMA subcontracted most of the job to a professor and a data processing firm at Ohio State University. Over the past few years, the professor, his students, and staff have generated financial indicators for fiscal years 1986 through 1989, for a total of 182 Minnesota nursing homes. The data processing firm has computerized the information, combined it with descriptive information, and sent installments of data and results to Care Providers.

To do our own assessment, we selected 96 of the 182 nursing homes, creating a sample which reflected the state's nonhospital nursing homes geographically and in terms of ownership.[5] The sample also represents nonhospital nursing homes accurately in terms of size, case mix, and religious affiliation, if any, but under-represents nursing homes without facility-specific financial statements (often the case with chain affiliates).

Before using the data, our accounting experts checked the 96 nursing homes' total revenues, total expenses, operating revenues, operating expenses, and fund balances for four years (1986 through 1989) against the audited financial statements which are on file at the Department of Human Services. We asked

2 See the American Institute of Certified Public Accountants, *Hospital Audit Guide,* and *Audits of Providers of Health Care Services* (New York, 1972 and 1990).

3 The Minneapolis office of the Deloitte & Touche accounting firm consulted on this part of our evaluation.

4 See Care Providers of Minnesota, *Compromise on Quality* (Bloomington, 1990).

5 We eliminated 11 hospital-nursing homes and categorized the remainder by ownership and geographic region, then randomly discarded homes which were over-represented.

our accountants to change the existing figures if necessary to correct errors and ensure that margins could be calculated accurately and consistently.

Expert analysis of previously existing financial data showed that:

- **In most cases (74 of 96 nursing homes), some data elements were incorrect and needed to be changed.**

We found that the magnitude of error was small, but some figures had been compiled inconsistently across nursing homes and, in eight cases, the 1989 data came from unaudited financial statements. Our accountants told us that the financial statements varied in their categorization and definition of operating expenses, bad debt expenses, income tax expenses, ancillary revenues, and interest income. They recommended that we discard items from unaudited statements and also fund balances in nine cases where owners had withdrawn capital and reduced equity. In addition, we avoided analyzing return on equity since this financial indicator requires sound information on fund balance.[6]

Accountants made nursing homes' financial data consistent, although audited statements usually were not.

In all but a few cases, our accountants ultimately could determine total margins and operating margins for nursing homes' primary business of resident care. However, the information needed to determine operating margins was missing for some years and other times had to be pieced together from supplementary material and financial notes. In a few cases, when financial information on resident care was not segregated completely from nonresident care, the accountants could preserve information needed to calculate operating margins only by allowing a small amount of nonresident business to inflate operating revenues. However, this was limited to a maximum of ten percent of total revenues.

To evaluate hospital-nursing homes' financial condition, we obtained the results of a financial monitoring program which was recently refined by the Department of Health.[7] The program begins with financial data and indicators which the Minnesota Hospital Association derives each year from audited financial statements plus standardized revenue and expense reports.[8] Analysts at the department compare the financial indicators against criteria which are designed to detect financial stress and then screen the results to determine whether hospitals' degree of financial stress is low, medium, or high.

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6 Results for 1989 are estimated because of the missing data for eight nursing homes and because, for hospital-nursing homes during our study period, the Department of Health had financial data only for six months of the year.

7 *Minn. Laws* (1988), Chapter 689, Article 2, Section 255, required the department to develop methods to identify financially distressed rural hospitals. Since then, the department has elaborated and extended its financial monitoring activities to all Minnesota hospitals.

8 The Health Care Cost Information Act of 1984 (*Minn. Stat.* §§144.695 to 144.703) requires each Minnesota hospital to provide audited statements and a standardized financial report each year. Under an agreement with the Department of Health, the hospital association administers most of the reporting requirements. The association has produced financial indicators for the Minnesota hospital industry consistently since the 1970s.

For our sample of nonhospital nursing homes, we adapted the criteria which the Department of Health used in October 1990 to identify hospitals in financial distress.[9] Figures 3.2 and 3.3 describe the criteria and show how they identified hospital-nursing homes and nonhospital nursing homes which experienced financial difficulty over the most recent years for which data were available.

Figure 3.2: Criteria for Financial Stress

Description	Hospital-Nursing Homes	Nonhospital Nursing Homes
Continuing losses 1. Total margin 2. Operating margin	In at least three out of four years, 1985-88	In at least three out of four years, 1986-89
Recent large losses (-10% or more) 3. Total margin 4. Operating margin	In at least one of the last two years for which data were available, 1985-88	In at least one of the last two years for which data were available, 1986-89
Declining fund balance 5. 85% or less remaining of the previous amount	Most recent balance compared with 1985	Most recent balance compared with 1986
Negative cash flow 6. Total 7. Hospital only	In at least one of the last two years for which data were available, 1985-88	No data

Figure 3.3: Levels of Financial Stress

	Hospital-Nursing Homes	Nonhospital Nursing Homes
High	Continuing losses and either or both large recent losses and negative cash flow	Continuing losses and large recent losses
Medium	Continuing losses or large recent losses plus negative fund balance, excluding those selected as highly stressed	Continuing losses or large recent losses, excluding those selected as highly stressed
Low	Large recent losses, negative cash flow, or declining fund balance, excluding those selected at the medium or high level	Large recent losses or declining fund balance excluding those selected at the medium or high level

9 As we explained earlier, our accounting experts advised against using some of the nursing home data which otherwise could have been used as criteria for financial stress.

As shown, the most important criteria were those reflecting large recent losses or a continued pattern of loss, based on total and operating margins. In the case of hospital-nursing homes, the operating margin relates to hospital patients' care, and the total margin emphasizes the nursing home services which tend to predominate. In the case of nonhospital nursing homes, the operating margin refers primarily to resident care and the total margin, to all revenues from all sources.

In addition, we conducted a survey of all nursing home administrators, as described in Appendix A. This provided subjective information on the outlook for continued operations despite the possibility of financial stress, and identified threatening financial conditions as recently as last fall. Survey questions further revealed which of many possible supplementary sources of revenue were actually being used to enhance or support nursing homes around the state.

Finally, we studied each change in nonhospital nursing home ownership which has occurred since 1985 and determined which of these involved financial failures.[10] To do this, we contacted bankruptcy courts, searched newspaper clippings, reviewed records at the Departments of Health and Human Services, and checked our results with auditors and industry experts.

FINANCIAL REVIEW

For several reasons, we analyzed the results for hospitals with nursing homes separately from our sample of other nursing homes. First, as indicated above, it is impossible to separate nursing home results from hospital performance when these two activities are conducted by the same institution. Second, the Department of Health maintains financial information on all hospitals with nursing homes (not just a sample). Third, almost all hospitals with nursing homes are small, rural, and nonprofit or government-run. Finally, as Chapter 2 explains, the state uses special methods to pay hospitals for providing nursing home services.

However, for both types of facilities, we looked at trends in financial performance over the most recent years for which data were available. Next, we identified and described which ones were in serious financial distress. Finally, we examined supplementary financial information and identified the most important explanations for financial health.

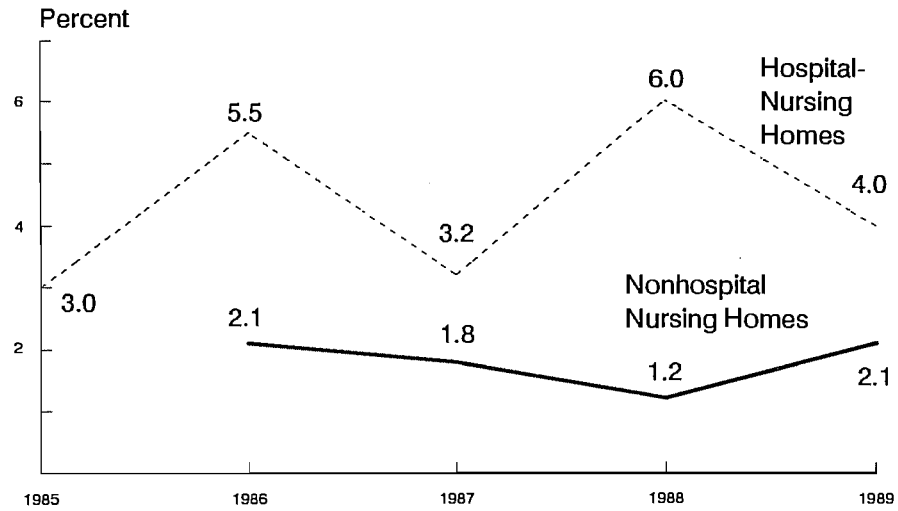
Trends

In general, hospital-nursing homes have experienced much better overall financial performance than nonhospital nursing homes in the past several years. As shown in Figure 3.4, at least half the hospitals with nursing homes had a total margin of three percent or more each year between 1985 and

10 The Department of Health tracks hospital ownership and, in August 1990, reported 11 closures and 3 mergers since 1985. Our study period ended in October 1990.

More than half of the nursing homes had positive margins in each of the past few years.

Figure 3.4: Nursing Homes' Median Total Margin, 1985-89



Note: 1989 margins are estimates.
Sources: Department of Health; Office of the Legislative Auditor.

1989. In contrast, the total margin for half the nonhospital nursing homes fell to little more than one percent in 1988 and only recently regained its previous (1986) level. Further, hospital-nursing homes' median total margin was better each year than it had been in 1985. However, the pattern of performance was erratic.[11]

However, regardless of hospital affiliation:

- **More than half of the nursing homes had positive total and operating margins each year since the state's reimbursement system took effect.**

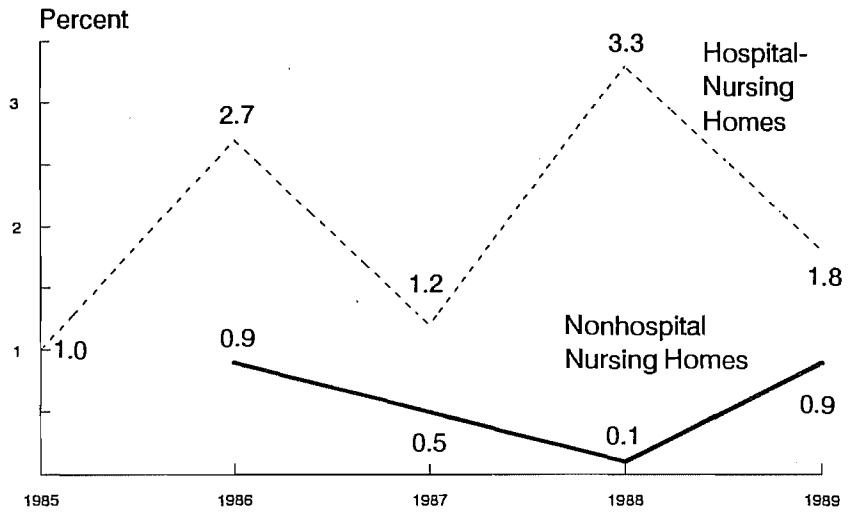
The total margin reflects all income from all sources, and results on this measure were better than for the operating margin alone. Figure 3.5 shows that operating margins for both types of nursing homes followed the same general performance pattern as total margins but were generally lower by one to three percentage points.

Our nonhospital nursing home results are somewhat different from those which were widely publicized last year by a nursing home trade association. We found that:

- **Sixty to 75 percent of nonhospital nursing homes broke even or made some profit, overall, between 1986 and 1989, while 54 to 62 percent broke even or showed a profit specifically on resident care.**

11 As in other evaluations of financial performance, we refer mainly to medians (the 50th percentile). We avoid averages (arithmetic means) because they are easily distorted by only a few cases of unusually good or bad performance.

Figure 3.5: Nursing Homes' Median Operating Margin, 1985-89



Note: 1989 margins are estimates.
Sources: Department of Health; Office of the Legislative Auditor.

In contrast, the association stated that an unspecified percentage representing more than half of Minnesota's nursing homes had operating losses and critical financial problems in 1988. Also, based on what appeared to be a consistent downward trend, the association said that financial problems were serious and threatened nursing homes' ability to deliver an acceptable level of health care.[12]

We believe there are three main reasons for the difference in our results. First, as we explained, there were numerous inconsistencies in the financial data which the trade association used. Second, the trade association used data from an unrepresentative group of nursing homes. Specifically:

- **Care Providers' negative results for 1988 were based on only 54 percent of the state's nursing homes, most of which (73 percent) were nonprofit or operated by cities and counties.**

The association's report did not mention that its 1988 results were based on a subset of nursing homes, excluding most but not all hospital-nursing homes, many chain-affiliated nursing homes, and nursing homes whose fiscal years fell after a certain date.

Third, we believe that the trade association extrapolated the trend line downward too soon, based on partial data for 1988. About six months after its report was published, the association received additional data from Ohio State University and sent us revised results. These unpublished figures indicated that nursing homes' median operating margin was zero (not negative) in

12 Care Providers, *Compromise on Quality*, 1.

1988 while median total margins were above zero each year, 1986 through 1988.[13]

In addition, we believe that 1988 was an unusually poor year for nursing homes' financial performance because significant new restrictions came into effect. As we explained in Chapter 2, these limited nursing homes' revenues from therapy services.

Furthermore, we believe that Care Providers' findings were exaggerated by omission. Its report, based on others' data analysis, focused primarily on nursing homes' operating margin. The report presented more than a dozen other financial indicators but did not include nursing homes' total margin. The total margin reflects all business activities and revenue sources and tends to be higher than the operating margin alone. For one nursing home, Care Providers' data showed that the operating margin was a negative 31 percent, but we found that dues, interest, and contributions boosted the home's total margin to a positive 23 percent.

Performance Standards

Generally speaking, nursing homes face little financial risk.

The state has no standard for determining whether nursing homes' financial performance is adequate. There is no question that, at a minimum, organizations must at least break even, but it is hard to say how much beyond that is necessary or desirable. In part, the answer depends on the organizations' mission, state policy, degree of business risk, and community standards.

Generally speaking, risk is low in the nursing home industry because: (1) the moratorium limits competition; (2) high occupancy provides steady revenue; and (3) most payments are from guaranteed (public) sources. Accordingly, we spoke with some owners and administrators who said they would be satisfied with almost any positive margin. Others, representing many of Minnesota's nonprofit nursing homes, told us that they strived for three or four percent. In their opinion, this is the minimum needed for routine, daily operations, maintenance, repairs, unexpected costs, and temporary changes in their residents and staff. Among for-profit nursing homes, we learned that desirable margins are five to six percent.

In Wisconsin, according to a study by the Legislative Audit Bureau, for-profit nursing homes' total margins averaged 3.3 to 4.1 percent, overall, between 1983 and 1986. Nonprofit homes' average total margins ranged from 2.4 to 3.7 percent during the same period. However, city/county nursing homes lost 8.4 percent or more, overall.

The Wisconsin researchers determined that an excess of revenues over expenses of 3 to 4 percent could be considered reasonable for nursing homes. This amount of profit represented an average of $1.84 per resident per day.[14]

13 Letter from Janet L. Bull, Care Providers of Minnesota, to the Office of the Legislative Auditor, September 5, 1990. The letter further stated that the added data changed the association's results for earlier years as well as 1988.

14 Legislative Audit Bureau, *A Review of Nursing Home Reimbursement Formula* (Madison, Wisconsin: September 1988).

For further comparison, we reviewed Minnesota hospitals' historical levels of profitability (that is, before the federal government implemented its diagnosis-related group or DRG payment system specifically to control cost increases). Hospitals of course run some nursing homes, operate in similar communities, and provide many of the same services. However, they are almost totally (97 percent) nonprofit, so standards of reasonable financial performance are lower.

We found that during the late 1970s and early 1980s:

- **The median operating margin for Minnesota hospitals—including those with nursing homes—was usually one percent, and the median total margin was two to three percent.**[15]

We also learned that Minnesota's nonprofit nursing homes performed about like hospitals during the late 1970s. At that time, financial indicators showed that:

Historically, margins were small but positive for most nursing homes.

- **Nonprofit nursing homes in Minnesota had a median operating margin of one percent and a total margin of two or three percent.**[16]

Since the mid-1980s, the federal government's DRG payment system has sorely tested hospital administrators, but the industry's performance has improved in Minnesota. As shown in Table 3.1, the median for all Minnesota hospitals' operating margin recently has ranged from 1.3 to 3.5 percent and the total margin, from 3.3 to 5.4 percent.

Nationally, for-profit hospital and nursing home chains had a margin of about four percent in 1989 and 1990. However, the nursing home chains (especially Beverly Enterprises) underperformed and pulled down the group average.[17] Recently, a health care investment group reported that the national average for nursing homes' total margin was just 1.2 percent in 1987 and 1988.[18]

Adequacy of Results

Table 3.1 further indicates that most hospital-nursing homes recently have performed as well as or better than they did in the late 1970s and early 1980s. In addition:

- **Hospitals' affiliation with a nursing home generally helped rather than hurt the institutions' overall financial performance.**

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15 David A. Lee and Jane E. Nystul, *Hospital Financial Ratios, 1978-1985* (Minneapolis: Minnesota Hospital Association, September 1986).

16 Paul Olson, *Financial Ratio Analysis of the Nonprofit, Freestanding Nursing Homes in Minnesota, 1978-1979* (Minneapolis: Minnesota Association of Homes for the Aging, September 1981).

17 Robert Mims (ed.), "Corporate Scoreboard," *Business Week*, May 14, 1990, 78. In this publication, margins are defined as net income before extraordinary items as a percent of sales.

18 Health Care Investment Analysts, Inc., "Nursing Home Industry on Marginal Financial Footing," News Release (October 31, 1990).

Table 3.1: Minnesota Hospitals' Financial Performance, 1985-89

Median	With Affiliated Nursing Home	Without Nursing Home	All
Operating Margin			
1985	.010	.016	.013
1986	.027	.022	.024
1987	.012	.021	.019
1988	.033	.035	.035
1989	.018	.019	.018
Total Margin			
1985	.030	.036	.033
1986	.055	.039	.042
1987	.032	.039	.035
1988	.060	.052	.054
1989	.040	.034	.034

Source: Department of Health.

Note: Data for 1989 are estimated.

In each of the past five years, as Table 3.2 shows, one-fourth of the hospitals with nursing homes had operating margins of at least 4.8 percent and total margins of 7.2 percent or more. At least one-fourth of other hospital-nursing homes operated at a loss, but the nursing home business apparently helped to improve results. As shown, 25 percent of these hospitals lost 3.9 percent or more on their hospital operations each year, but the extent of their total losses was consistently smaller.

Table 3.3 indicates that nonhospital nursing homes' median operating and total margins ranged from 0.1 to 2.1 percent during the period 1986 through 1989. Thus, the industry has performed at or below the levels which were achieved by nonprofit, freestanding nursing homes during the late 1970s, and:

- **Nonhospital nursing homes' overall performance generally failed to reach margins in the three to four percent range.**

The table further shows that at least one-fourth of the nonhospital nursing homes had margins of 3.3 percent or more on operations and 4.2 percent or more in total. However, another fourth of the group had losses of 1.4 percent or more on operations and 0.1 percent overall.

Not surprisingly, in our survey:

- **Eighty-five percent of administrators reported that their nursing homes' net income from all sources was insufficient to meet the goals established by owners or controlling organizations.**

Table 3.2: Financial Performance of Hospital-Nursing Homes, 1985-89

	1985	1986	1987	1988	1989
Median					
Operating margin	.010	.027	.012	.033	.018
Total margin	.030	.055	.032	.060	.040
25th Percentile					
Operating margin	-.042	-.056	-.050	-.105	-.039
Total margin	-.016	-.032	-.041	-.064	-.024
75th Percentile					
Operating margin	.048	.065	.071	.078	.055
Total margin	.072	.090	.095	.099	.073

Note: Date for 1989 are estimated.

Source: Department of Health.

Some nursing homes had losses, but most earned excess revenues or profit.

Table 3.3: Financial Performance of Nonhospital Nursing Homes, 1986-89

	1986	1987	1988	1989
Median				
Operating Margin	.009	.005	.001	.009
Total Margin	.021	.018	.012	.021
25th Percentile				
Operating Margin	-.021	-.020	-.039	-.014
Total Margin	-.007	-.005	-.025	-.001
75th Percentile				
Operating Margin	.043	.037	.033	.034
Total Margin	.049	.046	.042	.057

Note: Data for 1989 are estimated.

Source: Statewide sample of 96 nursing homes.

In general, we found that industry representatives were disappointed with the financial performance of nursing homes in Minnesota. Survey results further indicated that for-profit nursing home administrators faced the greatest pressure to improve performance, but they were not alone, for:

- **Ninety-two percent of the for-profit group said that their nursing homes' net income was insufficient, and 80 percent of the administrators from nonprofit and city/county nursing homes agreed.**

Performance by Sector

Table 3.4 suggests that for-profit nursing home administrators face a paradoxical situation. That is:

- **Most of the for-profit nursing homes in Minnesota have operated for the past several years with similar or smaller margins than nonprofit nursing homes.**

Table 3.4: Nonhospital Nursing Homes' Financial Performance by Ownership Type, 1986-89

	Median	
	Operating Margin	Total Margin
For-profit		
1986	.007	.010
1987	.010	.012
1988	.003	.007
1989	.003	.017
Nonprofit		
1986	.008	.031
1987	.004	.022
1988	.003	.021
1989	.011	.018
City/County		
1986	.017	.028
1987	-.005	.014
1988	-.026	-.009
1989	.028	.042
All (Nonhospital)		
1986	.009	.021
1987	.005	.018
1988	.001	.012
1989	.009	.021

Note: Data for 1989 are estimated.

Source: Statewide sample of 96 nursing homes.

For the for-profit and nonprofit nursing homes alike, median operating margins were near zero or about one percent. However, the median total margin for most nonprofit nursing homes was higher each year than for for-profit nursing homes. In our opinion, several factors help to explain the anomaly. First, the for-profit nursing homes are taxed.[19] Second, as shown in Chapter 2, we found that for-profit nursing homes were more likely than others to spend money which the Department of Human Services subsequently disallowed. Third, the for-profit nursing homes may be more likely to embark upon new, risky lines of business such as apartment complexes and home

19 The total margin reflects tax deductions while the operating margin was calculated on a pre-tax basis.

health services. Fourth, as we show below, the for-profit facilities are less likely to receive contributions which would positively affect their total margins.

As we would expect from the Wisconsin study, city/county nursing homes had negative median margins in some years. However, Table 3.5 indicates that about a third of these nursing homes received financial support from local governments.

Table 3.5: Nursing Homes' Revenue Sources Aside from Reimbursement for Residents' Care

Nursing homes' revenue sources vary significantly.

	Percent with This Type of Revenue During Last Fiscal Year			
	For-profit	Nonprofit	City/County	Statewide
Business loans from local lenders	22%	9%	6%	13%
Business loans from controlling (parent) organization	21	8	0	11
Personal loans	8	2	0	4
Public fundraisers	2	15	19	11
Donations/grants	10	66	64	46
Endowment/reserves	3	15	11	10
Lawful gambling	0	4	0	2
Other lines of business	10	9	13	10
Local government	3	1	32	7
Interest/investment income	26	52	51	43
Sales of assets	6	6	2	5
Other	4	6	11	6

Source: Nursing Home Administrator Survey, based on 278 respondents to this series.

In total:

- **About half (48 percent) of Minnesota's nursing homes were supported to some extent or enhanced by charitable donations, grants, or public fundraisers during the last fiscal year.**

For half of the nursing homes statewide, donations and grants provided at least $5,000 and accounted for 0.4 percent or more of total revenues during the last fiscal year. Public fundraisers yielded at least $3,000 for half of the nursing homes or 0.2 percent of total revenues.

However, charity even in modest amounts is generally not available to for-profit administrators. In our survey, only ten percent of the for-profit nursing home administrators said that donations and grants helped them operate. But nearly two-thirds of the nonprofit and city/county nursing home administrators said that donations and grants helped them. Similarly, public fundraisers helped 16 to 19 percent of nonprofit or city/county nursing home administrators, but only two percent of for-profit administrators. In addition, we found

that a few nonprofit nursing homes greatly benefited from lawful gambling. From our survey, we learned that, in four nursing homes, lawful gambling supplied an average of more than $120,000, or three percent of total revenues.

Sources of revenue, other than Medicaid, helped to enhance or support nursing homes.

For-profit nursing home admininistrators indicated that they relied upon business or personal loans to supplement public and private reimbursement for residents' care.[20] We estimate that, during the last fiscal year:

- **Loans or transfers helped about 40 percent of the for-profit administrators to enhance or support their nursing homes.**

The for-profit administrators said their nursing homes got business loans from local lenders (22 percent) or relied upon money loaned or transferred to them by parent companies or controlling organizations (21 percent). Eight percent indicated that personal loans had been taken. Statewide, most of the loans or transfers were in the $60,000 to $100,000 range, and they provided three to eight percent of total revenues.

Overall, the for-profit nursing home administrators had access to fewer additional sources of revenue than nonprofit or city/county administrators. The average number of supplemental revenue sources was close to two for nonprofit and city/county administrators but only one for for-profit administrators. However, the nursing homes' cost reports at the Department of Human Services showed that:

- **For-profit nursing homes paid more than $5 million statewide to owners during the 1989 reporting year.**

Fifty-six percent of the for-profit nursing homes reported that they gave their owners no direct compensation for any kind of work. However, among the other 44 percent, half of the owners received at least $45,000 for the year. We found that the owners' pay rate ranged from less than $10 an hour to more than $200.

FINANCIAL OUTLOOK

Financial statements do not provide all of the information policymakers need for decision making. One reason is that nursing homes can refocus their business activities and gain support from sources other than the state. For example, nursing homes and hospitals have diversified into lines of business besides resident and patient care. Owners of for-profit nursing homes have latitude in setting their own wages and determining whether they will distribute dividends to themselves and others. Nonprofit nursing homes can and do raise money from donations, fundraisers, lawful gambling, and other charitable sources. The city/county nursing homes can be supported by local levies.

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20 As explained in Appendix A, administrators use the term "loans" loosely to include inter-company transfers which may not require interest or repayment.

A related problem with financial statements is that they do not portend the future. They report past performance months after the end of a fiscal year and usually compare results only to the previous year. As a result, the perspective from nursing homes' financial statements can be stale and limited.

Although we did not develop financial indicators for investment purposes, security analysts carefully follow the national nursing home industry and regularly forecast its future. We checked an investment data base for recent reports and learned that:

- **In September 1990, one major investment house reported that the nursing home industry generally had bright prospects and was on the mend.**[21]

The investment firm noted these favorable signs: (1) a weak economy, signalling the end of the nursing shortage, making it easier for nursing homes to attract less-skilled workers, (2) continuously increasing demand, which is impervious to the economy, combined with limited bed supply, (3) higher Medicaid rates in light of the Supreme Court's decision allowing nursing homes to sue states, and (4) moderation in labor cost increases. Among other nursing home chains, Salomon Brothers recommended investment in Beverly Enterprises, which controls about ten percent of the Medicaid-certified nursing home beds in Minnesota.

Most administrators said their nursing homes could continue operating for at least the next several years.

Similarly, in contrast to the disappointing financial performance which we found between 1985 and 1989:

- **Over half of the administrators (58 percent) in Fall 1990 said that their current financial condition and outlook was fair to good.**

As shown by Table 3.6, 17 percent of the administrators described their condition as good and their future as sound. Forty-one percent said their condition was fair, and they had no doubt about their ability to operate in the foreseeable future. Further, our survey showed that:

- **Thirty-four percent of administrators said that their nursing home was in poor financial condition but probably could continue operating for at least several more years.**

Overall, three percent of the nursing home administrators said their condition in Fall 1990 was so poor or critical that they were clearly in danger of closing. Others (five percent) gave conditional responses, often because they were uncertain about the impact of potential changes in the property reimbursement subsystem. None chose to describe nursing homes' financial condition and outlook as "very good."

Among those administrators whose nursing homes were randomly included in our sample and who responded to our survey (73 of 96), we compared the

21 M. L. Vignola, *Long Term Care Industry: Quarterly Review* (Salomon Brothers, Inc., September 10, 1990), InvesText No. 1030326, summary and investment opinion.

Table 3.6: Administrators' Assessment of Their Nursing Homes' Financial Condition and Outlook

	For-profit	Nonprofit	City/County	Statewide
Good and expecting to maintain a sound financial condition	13%	23%	8%	17%
Fair, without doubt about ability to operate in the foreseeable future	37	42	48	41
Poor, but probably can continue operating at least several years	36	32	35	34
Very poor, likely to close under duress within a year	6	0	0	2
Critical, in imminent danger of closing under duress[a]	1	0	0	<1
Other circumstances	7	3	8	5

Note: Percentages do not total 100 due to rounding.

Source: Nursing Home Administrator Survey (n=310). The question was: "Which of these best describes the current financial condition and outlook for this nursing home."

[a]Filed Chapter 11 and trying to sell.

administrators' perceptions to our objective criteria for determining financial stress. In most cases, the nursing home administrators' perception of their financial future was reasonably consistent with objective measures of past financial performance.

For example, the administrators' assessment of their own financial condition (Table 3.6) was consistent with our finding that for-profit nursing homes' performance has been more disappointing than nonprofit nursing homes'. As shown:

- **All of the nursing homes whose administrators said were in imminent danger of closing were for-profit.**

Although financial statements showed that city/county nursing homes sometimes performed worse, we believe that the public administrators were realistically optimistic. Given the nursing homes' important contribution to local communities, there is little reason to expect such facilities suddenly to close for lack of money. However, as we discussed in Chapter 1, cities and counties increasingly have sold nursing homes in the past few years.

We analyzed the characteristics of the for-profit nursing homes whose administrators said were in very poor or critical financial condition last fall. There were only eight nursing homes in this category, but results suggested that:

- **The financially endangered nursing homes had low occupancy and were in the midst of transition.**

One of the nursing homes had declared bankruptcy and was for sale. In the meantime, it was operating with the financial support of its parent company. Two were under new management, and the administrators had little information about past problems. In response to our open-ended questions, two of the other administrators attributed their financial problems to unfairness in the reimbursement system, and two blamed the property reimbursement subsystem. Overall, like other administrators, this group said that payment delays, paperwork, and excessive regulations contributed to financial difficulties.

FINANCIAL STRESS

Most nursing homes were not seriously financially stressed.

To determine the specific percentage of nursing homes which were in serious, persistent financial trouble, we tracked their performance over a four-year period and applied the criteria as shown in Figures 3.2 and 3.3. Combined with information from the Department of Health, results indicate that:

- **The majority of hospital-nursing homes (57 percent) and nonhospital nursing homes (60 percent) did not show signs of serious financial difficulty.**

Our study also suggested that nonhospital nursing homes generally experienced lower levels of financial stress than hospitals which were affiliated with nursing homes. As shown in Table 3.7:

- **Only six percent of Minnesota's nonhospital nursing homes registered the highest level of financial stress, but this was true for 25 percent of hospital-nursing homes.**

The Department of Health told us that, in all, 16 hospitals operated nursing homes and were highly stressed between 1985 and 1988.[22] We analyzed the characteristics of these hospital-nursing homes and found that half were run by city or county governments and half by nonprofit groups. Nine were in northern Minnesota, and none were in the seven-county Twin Cities area. Further:

22 Recently, the department updated its analysis to include 1989 results and found that 14 of the 16 hospital-nursing homes remained highly stressed. Further information on the department's findings is forthcoming in a report on rural health care professionals, mandated by *Minn. Laws* (1990), Chapter 568, Article 2, Section 98.

Table 3.7: Financially Stressed Nursing Homes

	Hospital[a]	Nonhospital[b]
Degree of Stress		
None	57%	60%
Low	11	13
Medium	6	21
High	25	6
Total Stressed	43%	40%

Source: [a]Department of Health, October 1990. Percentages do not total due to rounding.
[b]Statewide sample of 96 nursing homes.

Nursing homes affiliated with hospitals experienced the most financial stress.

- **All of the highly stressed hospital-nursing homes were previously identified and monitored by the Department of Health, in light of longstanding, serious financial problems.**

As we discussed earlier, the hospitals with nursing homes tend to be small and rural. Over the past several years, policymakers have been concerned about the rural hospitals' general distress and its potential to disrupt health care access, not only in northern Minnesota but throughout the nation. Last year, the U.S. General Accounting Office found that rural hospitals are especially vulnerable to financial problems because of their small size, low patient volume, and other factors—not their location in itself.[23]

In 1987, the Legislature mandated a study to determine how many rural hospitals might close in Minnesota because of financial problems. The results indicated that 33 rural hospitals showed some signs of stress, and 12 were in serious financial condition. However, although financial statements and other objective indicators were used to make this determination, the Department of Health told us that by year-end 1990:

- **Only 2 of the 12 seriously distressed rural hospitals had actually closed.**

The Department of Health has noted that distressed rural hospitals commonly are subsidized by a city, county, tax district, or an attached nursing home.[24] More recently, in our survey, one of the administrators said that his hospital has turned to a professional fundraiser in its search for financial improvement.

Of the nonhospital nursing homes, we focused on those which operated under the greatest stress. Unlike troubled hospitals, the most troubled nursing homes were scattered throughout the state, including the Twin Cities area, and represented all three industry sectors: for-profit, nonprofit, and city/county. Most of them (5 of 6) were affiliated with a nursing home chain.

23 See U.S. General Accounting Office, *Rural Hospitals: Factors that Affect Risk of Closure* (Washington, 1990).

24 Department of Health, *Access to Hospital Services in Rural Minnesota* (Minneapolis, 1989), 29.

Records at the Department of Human Services also showed that, despite serious financial difficulties, one of the highly stressed for-profit nursing homes paid $68,000 to an owner in 1989.[25] The owner worked full-time as the nursing home's administrator and received $50,000 for that job plus $18,000 for service as a director. A second owner worked 520 hours at the facility and received $18,000 in director's fees. The other for-profit, highly stressed nursing home paid two owners a total of $26,196 for 920 hours of work and also retained an administrator at $42,640. In addition, one of the highly stressed nonprofit facilities paid directors $3,423 for the year.

Even highly stressed facilities may provide significant return to owners.

Explanations for Financial Stress

As shown in Figure 3.6, our study reviewed the relationship between nursing homes' financial status and several potential explanatory factors. First, we considered the most direct explanations: efficiency incentive or bonus payments and unreimbursed expenses. Second, we considered indirect explanations involving characteristics of the nursing home, its residents, and its administrator. Our statistical study included the nursing home's size, type of ownership, region, workforce, chain affiliation if any, and the percentage of residents who paid for their own care.[26] We also tested the relationship between financial health and residents' average length of stay and case-mix scores as well as administrators' knowledge and experience (the latter, to the extent that survey data permitted).

Based on our sample of nonhospital nursing homes, results showed that the simplest, most direct explanations were the best. Thus:

- **Nursing homes suffered financially when they failed to receive high bonus payments for efficiency.**

Figure 3.7 shows that the least profitable nursing homes received only about thirty-five cents per resident as an efficiency incentive. The ones with little or no financial stress earned most of the maximum $2 which is possible under the state's reimbursement system.

Looking at the data in another way, we found that the nursing homes which earned the full $2 bonus payment achieved a median operating margin of 2.6 percent and a total margin of 3.7 percent. This result is not surprising because, as we explained in Chapter 2:

- **The efficiency incentive is the only direct means by which the reimbursement system provides excess revenue or profit on nursing home residents' care.**

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25 These figures include wages, bonuses, and the value of stock options, unreimbursed company vehicle use, and facility-supplied residences, if any. They exclude fringe benefits, vacation, and sick leave if similar benefits are available to most of the nursing home's employees.

26 A recent study explains that, although Minnesota requires equal nursing home rates for Medicaid and private payers, payment flows more quickly from private sources. See Lisa M. Abicht-Swensen, "The Factors Affecting Operating Margins of Minnesota Nursing Homes," (Master's Thesis, University of Minnesota, June 1990). Progress toward resolving problems with the state's billing system was mentioned in Chapter 1.

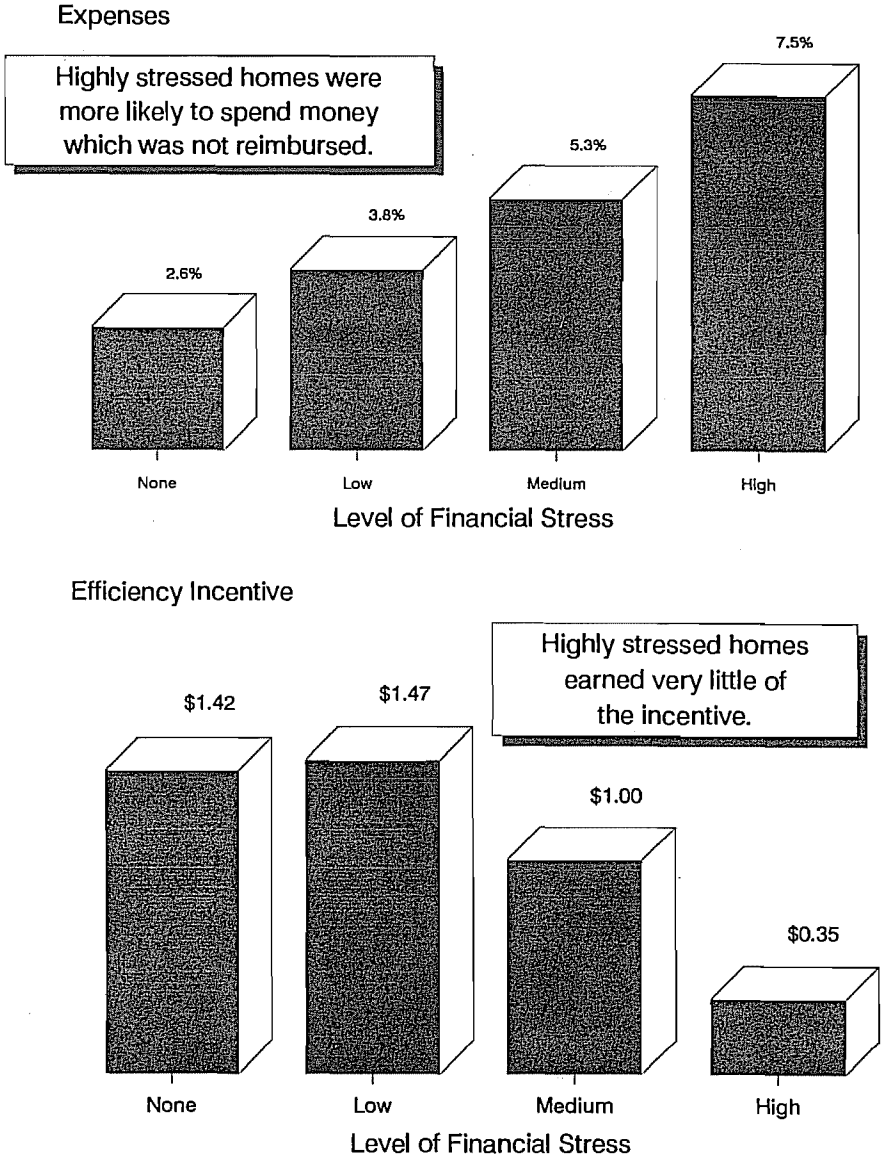
Figure 3.6: Factors Which Might Explain Nursing Homes' Financial Condition

Factor	Description	Data Source
DIRECT		
Efficiency incentive payments	Up to $2 per diem bonus based on other operating costs.	Department of Human Services
Percentage of reimbursable expenses	The difference between nursing homes' actual total expenses and the amount after disallowances, adjustments, and deductions.	Department of Human Services
INDIRECT		
Reimbursement region	Geographic regions shown in Figure 2.5.	Department of Human Services
Ownership type	For-profit, nonprofit, city/county.	Department of Human Services
Chain affiliation	One of at least two nursing homes controlled or operated by a common party.	Office of the Legislative Auditor, based on cost reports from nursing homes
Unionized workforce	Employees represented by an organized labor union.	Office of the Legislative Auditor
Average length of stay	Average number of days between residents' admission and discharge.	Department of Health
Average case mix	Average of scores reflecting residents' care needs.	Department of Human Services
Facility size	Total number of beds licensed for nursing home residents' use.	Department of Human Services
Private pay residents	Percentage of residents who pay for their own care.	Department of Human Services
Administrators' knowledge and experience	Self-assessed knowledge of allowable costs; years of experience with Minnesota nursing homes.	Office of the Legislative Auditor, Administrator Survey

About three-fourths of the nursing homes have received at least some efficiency incentive payments in the past few years. However, it can be difficult for nursing home administrators to control housekeeping, dietary, laundry, maintenance, operations, general, and administrative costs simultaneously, as is required to earn the maximum. Another problem is that:

- **The efficiency incentive has remained at $2 since its inception in 1985.**

Figure 3.7: Major Explanations for Financial Stress



Note: Results above apply only to a sample of 96 nonhospital nursing homes.

We believe that nursing homes' financial performance over the past few years can be explained partly by the flat efficiency incentive payment. While the reimbursement system provides inflationary increases in most cost categories, the nursing homes' ability to cover expenses and earn a profit, if applicable, has been effectively capped.

Besides earning the efficiency incentive, we found that:

- **Financially healthy nursing homes did a better job of avoiding unreimbursable expenses.**

When nursing homes were reimbursed for at least 99 percent of their expenses, we found that their 1989 median operating and total margins were about three percent (3.4 and 2.8, respectively). However, the median operating margin was negative 1.8 percent and the total margin only 0.3 percent when unreimbursed expenses were more than 5 percent of the nursing homes' total.

Similarly, Figure 3.7 indicates that 7.5 percent of the highly stressed nursing homes' expenses were not reimbursed (pending appeals and subject to other possible disallowances). Statewide, about 5 percent of nursing homes' expenses were unreimbursed during the 1989 cost reporting year, after the Department of Human Services subtracted spending which exceeded limits or was otherwise ineligible for inclusion in payment rates.

Our analysis showed that the highly stressed nursing homes had other operating costs which were above the state's limits. These made the nursing homes ineligible for efficiency incentive payments and were associated with disallowances, particularly for general and administrative expenses.

As shown, unreimbursed expenses take an obvious toll on nursing homes' financial health, yet we also found that:

Most administrators said they spent money which they knew was ineligible for reimbursement by the state.

- **Most administrators (61 percent) acknowledged in our survey that they made some expenditures with advance knowledge that they were ineligible for reimbursement.**

Some of the administrators told us that they believed their nonreimbursable expenses made good business sense and ultimately helped. We understand this logic for small items, as discussed in Chapter 4. However, the cumulative impact of nonreimbursable expenses could be devastating, depending on the nursing homes' success in gaining supplemental income.

Of the other potential explanatory variables in our study, we found that one was indirectly linked with financial problems, and two missed statistically significance but had practical importance. These secondary factors included the percentage of private-pay residents, residents' average length of stay, and the nursing homes' level of occupancy. When there were more private-paying residents, nursing homes received payment more quickly than through government, and financial performance was somewhat improved. Conversely, shorter lengths of stay and lower levels of occupancy bore negative but statistically insignificant relationships to nursing homes' margins. In addition, we recognize that nursing homes may face specific local conditions, unusual resident populations, and other factors which place them in financial jeopardy.

OWNERSHIP CHANGES

Despite some rural hospitals' serious condition, we showed above that few (2 of 12) have closed because of financial stress. We also asked whether non-hospital nursing homes have been forced to close since 1985, when the state's reimbursement system was implemented.

Although the total number of nursing homes has remained about the same since 1985, and resident care has continued, we learned that:

- **Forty-seven nursing homes changed hands, and nine of the changes in ownership were caused by financial failure.**

In addition, one nursing home went bankrupt but was unsold during our study period. Thus, we found a total of ten financial failures, seven of which involved bankruptcy. Another case involved garnishment, and two nursing homes went into receivership. However:

- **Most (7 of 10) of the financial failures occurred in two nursing home chains.**

Despite financial troubles and ownership changes, no nursing home has closed its doors.

One of the chains, based in another state, owned four nursing homes, and the other owned three. Some of the affected nursing homes had been purchased at high prices despite low occupancy rates. Costly improvements were made, and they quickly became a financial burden to the parent company. The other corporation expanded by purchasing some Minnesota nursing homes, had severe cash flow problems as well as problems with the state's billing system, and ultimately was unable to cover its costs.

One nursing home's parent company, a hospital chain, went bankrupt. Another had problems with the property reimbursement subsystem and low occupancy, while the third had high administrative costs which, in some instances, were disallowed by department auditors.

In our opinion, the recent nursing home bankruptcies can be explained by a few unusual situations. However, we are concerned because most cases of financial failure have occurred since 1988.

Our study showed that there were no Medicaid-certified nursing home bankruptcies or failures in 1985 or 1986. One was recorded in 1987, four in 1988, four in 1989, and one in 1990. In our opinion:

- **The difficulty of managing successfully under Minnesota's reimbursement system may have "caught up" with some nursing homes.**

As shown in Chapter 2, successful nursing home administrators must monitor their expenses not just for the coming year but also with careful attention to previous levels of spending. If management makes a mistake at one point in

time, it can take several years to put things right. In addition, the Department of Human Services can require new owners to return money which was forgiven by bankruptcy courts.

SUMMARY AND RECOMMENDATIONS

Although the nursing home industry has seen only a little excess revenue or profit over the past several years, administrators have indicated that they probably will be able to continue operating for at least several years more. One reason is that nursing homes have various revenue sources and new business opportunities. Thus, we conclude:

- **There is no immediate financial crisis facing Minnesota nursing homes.**

However, we believe that the industry has suffered significantly. First, many nursing homes have had limited resources while being required to change their operations to accommodate older, sicker residents and increased medical technology. Second, evidence suggests that some of the facilities have deteriorated structurally, mechanically, and aesthetically. Third, financial performance has been below expectations.

Nursing homes' long-term financial condition needs to be addressed.

Our evaluation showed that many nursing homes have been operating uncomfortably close to the break-even, zero point. Their primary source of excess revenues or profit, the efficiency incentive, has remained at a flat dollar amount since 1985, while costs have risen. One way they can be better off financially in the future is to reduce their level of unreimbursed expenses. But in Chapter 4, we show that it is not always advisable for nursing homes to eliminate unreimbursed expenses altogether.

To provide nursing homes with the potential for increased margins while maintaining the elements of cost control which are critical to the state, we have several recommendations. First:

- **The Legislature should correct previously identified problems in the state's method of paying property costs.**

In general, we believe that the property payment subsystem has contributed to financial uncertainty and, in some cases, weak financial performance. Assuming the new method of reimbursement is well designed and promptly implemented, we expect that some nursing homes will gain financial relief.

Second, although we recognize the state's current financial difficulties and its continuing need to control nursing home spending, we recommend that:

- **The Legislature should consider increasing efficiency incentive payments.**

For the 1990 rate year, the Department of Human Services will pay a total of $19.8 million in efficiency incentives to about three-fourths of the nursing homes. If the per diem incentive payments rose to $2.20 (reflecting the rate year's 9.8 percent inflationary increase in the other operating category), we estimate that the additional expense would be about $2.2 million.[27]

The state should monitor the nursing home industry's financial performance in the future.

By increasing efficiency incentive payments, we believe that nursing home administrators would be stimulated to identify additional ways in which they can cut costs. As we show in Chapter 4, they have taken numerous steps toward this goal but, in our opinion, additional improvements may be possible. Also, we believe that a small increase in bonus money is reasonable because the nursing homes need resources to be prepared for a growing population. In our opinion, it makes sense to provide a slightly larger measure of financial encouragement.

Also, we recommend that:

- **The state should arrive at a consensus on what constitutes adequate financial performance for nursing homes.**

Currently, there is no standard and, without one, it is hard to evaluate whether nursing homes' revenues need to be increased or costs need to be cut. A general agreement about standards of adequate financial performance should not be considered a guarantee to any specific nursing home but a guideline for monitoring the nursing home industry's general performance. Further:

- **The Legislature should include nursing homes under the Health Care Cost Information Act of 1984.**[28]

Our evaluation showed that the Department of Health's monitoring program already covers an important part of the nursing home industry, and it can readily be adapted to the rest. To implement this provision, we suggest that a few more pages should be added to the cost report which nursing homes already send annually to the Department of Human Services. Of course, nursing homes and the state would incur some costs in exchange for the standardized data, but in our opinion, it would be useful and probably less expensive than financial data nursing homes are already purchasing from a national firm through a trade association. The trade association told us that it has invested more than $150,000 for information which we found was inconsistent and incomplete.

After financial data are obtained by the Department of Human Services:

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27 To estimate the projected increase, we added $.20 to the per diem amount of incentive payments that each nursing home received most recently and gave hypothetical bonuses to a few homes which were slightly above the limit. We emphasize that our calculation was approximate. Any actual increase would depend on inflation, details of the calculation method, and other factors.

28 *Minn. Stat.* §§144.695 to 144.703.

- **The Department of Health, through its Health Economics Program, should analyze the results and report nursing homes' and hospitals' financial condition regularly to the Legislature.**

Possibly, the Health Department could work cooperatively with nursing home trade associations on the financial monitoring project. At the same time, this would give the Departments of Health and Human Services routine access to financial indicators for the nursing home industry. In Chapter 4, we suggest that both of the departments should attend to the potential for real financial difficulties which, if not corrected, could threaten residents' care.

EFFECTS OF THE REIMBURSEMENT SYSTEM

Chapter 4

As discussed in the previous chapters, state costs for nursing home reimbursements have been brought under control. However, evidence suggests that this has had detrimental effects on the physical condition and environment within some nursing homes. In this chapter, we focus on how the reimbursement system has affected nursing home administration, operations, and residents—not just finances. Specifically, we examine the following questions:

- **To what extent has the state's reimbursement system caused problems for nursing home administrators and residents? How have administrators responded to the reimbursement system?**

- **Have administrators' responses had serious, negative statewide effects?**

In general, we found reasons to be concerned that the level of attractiveness and comfort in Minnesota's nursing homes has diminished as a result of the reimbursement system. For example, nursing homes are not being repaired or upgraded to the extent that administrators would prefer. We believe this contributes to consumer dissatisfaction and is incompatible with the future need for adequate homes.

Facility problems are due partly to the $325 per bed limit on repairs and maintenance and to administrators' efforts to maximize efficiency incentive payments. Together with the moratorium and inadequate capital asset replacement funds, which we have explained in Chapters 1 and 2, many nursing home administrators have indicated that nursing homes' structural and mechanical condition has declined along with the residential environment.

On the other hand, we found that:

- **Nursing homes are operating more efficiently without directly affecting residents' care.**

For the most part, our study showed that nursing homes are exceeding state staffing requirements, and residents are not in danger due to the reimbursement system. This makes sense because the payment system is designed to make resident care the least productive or desirable area for cost-cutting.

However, we believe that the general decline in non-nursing areas requires attention, for many related activities are vitally important to administrators, residents, and families. For example, housekeeping and decorating contribute intangibly to residents' well-being and quality of life.

ADMINISTRATIVE RESPONSE

This section examines how nursing home administrators have responded to major features of the reimbursement system which was implemented in 1985. First, we discuss the problems which administrators have identified in connection with the current reimbursement system. Second, we examine the specific cost-cutting techniques which they have adopted. Our findings are based largely on our survey of nursing home administrators and Department of Human Services' rate notices.[1]

For the most part, we found that the problems which nursing home administrators have with the reimbursement system generally fall into one of two categories. First, many of their most pressing concerns are reactions to cost-control mechanisms inherent in a prospective reimbursement system. Second, some problems which administrators have are currently under study or have just recently been studied.

Staffing Issues

Nursing homes have many staffing problems.

Probably the one problem of most concern to nursing home administrators—and the one which can most deeply affect residents—is staffing. Through discussion and review of nursing home industry publications, combined with information from our survey, we identified four major staffing issues besides the general shortage of labor we cited previously. In order of importance these were salaries, turnover, nursing pools, and staff recognition. However, we also found that:

- **Cost-control features of the reimbursement system have not caused nursing homes' staffing problems, although such problems may be exacerbated by reimbursement regulations.**

As we showed in Chapter 2, on the average, nursing homes have consistently staffed at higher levels than are required by regulations. Yet, many administrators reported that low salaries and expensive benefit packages have made it difficult for them to attract and retain nursing staff.

The nursing home industry is labor intensive with salaries comprising about one-half of nursing home operating costs. When residents' care needs change, administrators must add or subtract nursing staff to maintain efficiency and meet regulatory standards. However, because it is hard to attract

1 Appendix A describes the survey and provides a selection of comments directly from nursing home administrators.

and retain high-quality staff, administrators told us that cuts may be unrealistic and short-sighted.

Nursing homes cannot realistically compete with hospitals or government-owned health care facilities on staff wages or benefits. As we discussed in Chapter 1, the nursing home industry currently pays 7 to 19 percent less for nurses and aides, respectively. It would be costly to reimburse nursing homes enough to match hospital wages every year. To the dismay of many nursing home administrators, we found that:

- **The reimbursement system was not designed to equalize nursing home and hospital wages.**

The current inflation factor was intended to increase rates annually and thereby maintain nursing homes' wages at prevailing levels for the nursing home, not hospital, industry. As shown in Figure 4.1, a gap between the two industries' wages existed during the 1970s, disappeared in the early 1980s, and reappeared in the mid-1980s. The 1988 Legislature authorized additional money to reduce this gap. To increase wages or benefits beyond inflation or this one-time adjustment, nursing home administrators have only a few difficult options. They could reduce other expenditures or profits, borrow money, or tap other income sources.

Table 4.1: Median Percentage Turnover of Nurses and Nurse Aides by Ownership Type

Staff turnover was generally higher in the Twin Cities metropolitan area.

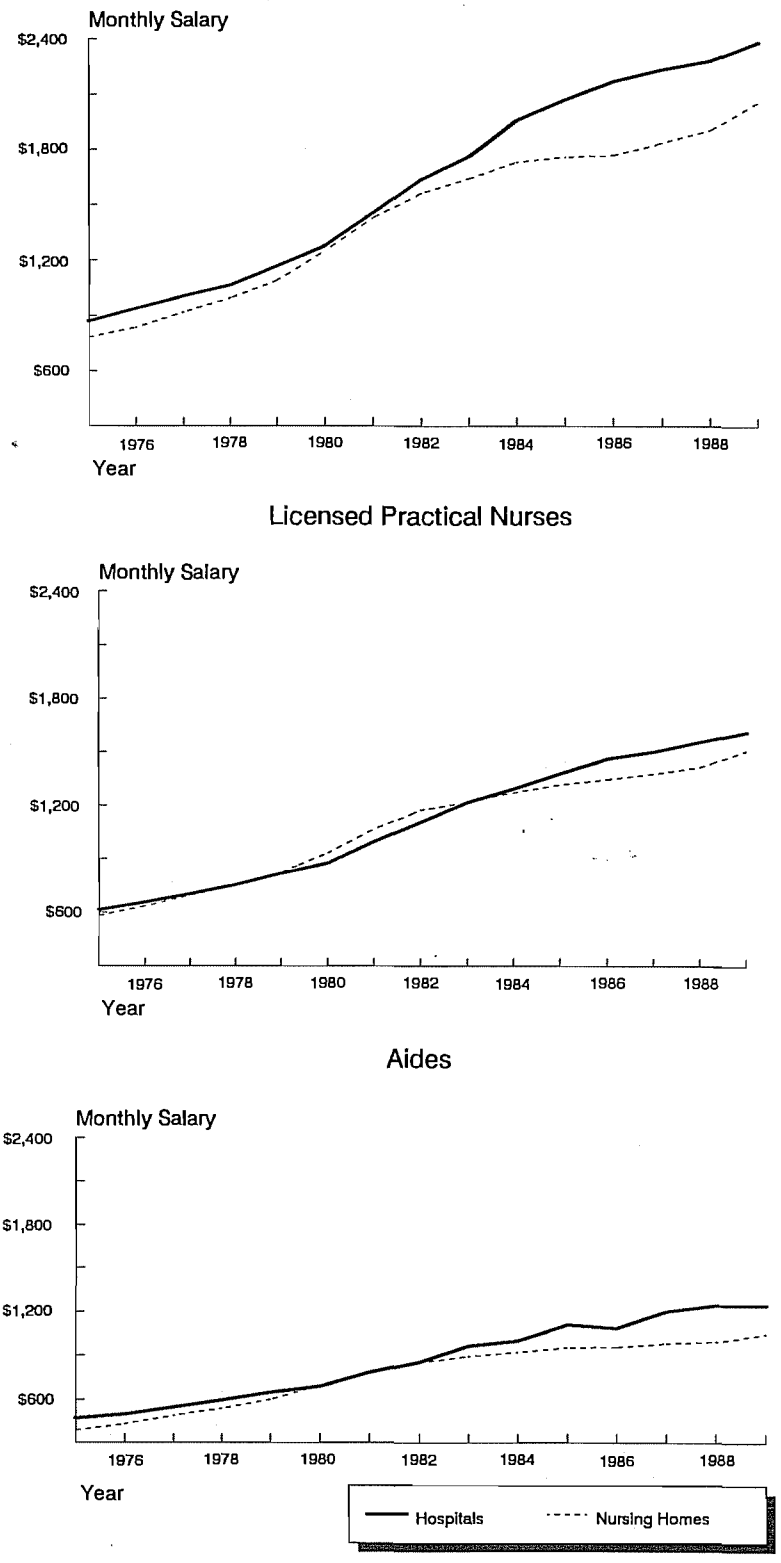
Ownership Type	Nurses	Nurse Aides
For-profit homes	30%	50%
Outstate	25	48
Twin Cities metropolitan area	31	60
Nonprofit homes	15	34
Outstate	12	30
Twin Cities metropolitan area	16	50
City/county homes	17	25
Outstate	17	25
Twin Cities metropolitan area	14	18
Statewide	20%	40%

Source: Nursing Home Administrator Survey (n = 310). The question was: "About what percentage of nurses and nursing aides voluntarily left your employment and needed to be replaced during the 1989 reporting year? Fill in estimated percentages."

Administrators gain some flexibility through high turnover rates. However, the industry's low wages combined with the nursing shortage make staff turnover a serious, ongoing administrative problem. As shown in Table 4.1, we found that:

Since the early 1980s, nursing homes have paid less than hospitals.

Figure 4.1: Wage Differences for Minnesota Nursing Personnel, 1975-89



Source: Department of Jobs and Training.

- **During the 1989 cost reporting year, one-half of the nursing homes in the state lost at least 20 percent of their nurses and 40 percent of their nurse aides.**

Administrators varied widely in their reported turnover, ranging from 0 to 300 percent for aides and 0 to 155 percent for nurses. Ten percent of administrators reported nurse turnover of 50 percent or more and aide turnover in excess of 100 percent during the 1989 reporting year. Policymakers are concerned because staffing problems may have contributed to recent increases in the number of residents' deaths attributable to neglect.[2]

In response to high employee turnover and shortages of regular nursing staff, some nursing homes have turned to nursing pools for help. A recent study by the Department of Human Services revealed that, on an hourly basis, pools received 1.5 to 1.8 times more for aides and nurses than ordinary nursing home staff, before adjustments for benefits and overtime were made. Yet:

- **Nursing pools may be the only way for some administrators to meet the Department of Health's minimum staffing requirements.**

We learned that pools are most often used for weekend-evenings, when it is difficult to schedule regular staff overtime. They are widely used in the Twin Cities metropolitan area and less so outstate, where distance and availability are major considerations. When asked about the impact of nursing pools on their operations, administrators who reported using pools (47 percent) tended to be negative about their usage except as a way to meet staffing requirements.[3]

Spending which might help reduce staff turnover is not always an allowable expense.

To cut nursing pool usage or retain their own staff, nursing home administrators must spend considerable resources (both time and money) recruiting staff and making their home attractive to employees. However, this type of spending does not fit well within the reimbursement system. For example, the costs for programs which might help staff retention, particularly employee recognition, are not allowed. Nevertheless, our survey showed that most administrators (61 percent) said they made ineligible expenditures knowingly, particularly for staff recognition and rewards.

Among other things, they reported spending nonreimbursable money for employee picnics, bonuses, Christmas parties, and scholarships. Administrators told the Department of Human Services that, along with competitive wages and overtime pay, employee recognition is one of their best techniques for attracting and retaining staff.[4]

2 Department of Health, *Report of the Commissioner's Task Force on Nursing Home Mortality Review* (1990).

3 Department of Human Services, *Draft Report to the Legislature on the Impact that Nursing Pools are Having on Nursing Facilities in Minnesota* (January 1991).

4 Department of Human Services, *Draft Report on Nursing Pools* (January 1991).

Administrators' Other Problems with the Reimbursement System

We asked nursing home administrators about their problems with the Rule 50 reimbursement system. Only three percent said they had none. Table 4.2 shows the particular problems administrators had with the reimbursement system during the 1989 cost reporting year. Besides the problems included in our list of possibilities, administrators also filled in many additional items.

Almost all administrators reported reimbursement-related problems.

Table 4.2: Administrator Problems with the Reimbursement System

Problem	Percent Who Said It Was A Problem
21-month delay	84%
OBRA allowance	73
Property-related costs	69
Operating costs	50
Equalization of public and private rates	43
Case-mix system	41
Geographic groupings	27
Other: including RSI billing system, desk audits, workers' compensation, Medicare, and retroactively billing private-pay residents	28

Source: Nursing Home Administrator Survey (n = 310). The question was: "During the last reporting year, have you had any problems working with the state's reimbursement system for nursing homes?"

While almost all administrators (96 percent) reported that they had at least one of the seven problems on our list, these four were most important: the 21-month delay (84 percent), money to comply with the Omnibus Budget Reconciliation Act of 1987 (OBRA) (73 percent), property-related costs (69 percent), and operating costs (50 percent). We found that:

- **Almost one-third of administrators said they had all four major problems with the reimbursement system simultaneously.**

As shown, rate equalization and case mix were each problems for about 40 percent of the administrators. Relatively fewer administrators had problems with the state's geographic groups (27 percent), and 28 percent wrote in other concerns. Most commonly, these involved the state's billing system (Residential Services Invoice or RSI), desk audits, workers' compensation costs, Medicare, and retroactively billing private-pay residents.

In general, we found that nursing home administrators had a host of problems, only some of which were financial. However:

- **Two of the administrators' most pressing concerns (the 21-month delay and determination of operating costs) flow from cost-control mechanisms which the state has deliberately built into the reimbursement system.**

In our opinion, nursing home administrators understandably object to the 21-month delay, both in terms of its length and basic nature.[5] One reason is that large, unanticipated cost increases, most notably workers' compensation, may exceed the projected amount of inflation.[6] Nevertheless, such cost increases must be paid even though homes may not be fully reimbursed until the next rate year. However, some time lag is inherent in a prospective reimbursement system, and is necessary for the state to anticipate future costs. While the 21-month delay is obviously not responsible for large, unanticipated cost increases, it may further exacerbate their effects.

Furthermore, because the reimbursement system closely defines ineligible costs, and most administrators report making such expenditures, it is not surprising that operating costs were a major problem for nursing home administrators. Our survey showed that only 13 percent reported that their operating costs were always or usually covered by their per diem rate. To help make up for the shortfall, the survey further indicated that:

- **Administrators who said their operating rates were inadequate were more likely to report using property reimbursement for operating expenses.**

Sixty-four percent of administrators who said their operating rates were rarely or sometimes adequate said they used property reimbursement for operating costs, in contrast to 20 percent of administrators who said their operating rates were usually adequate.

In addition, as we explained in Chapter 1, the state effectively sets the operating rate for almost all nursing home residents—not just Medicaid recipients. Through equalization requirements, private-pay residents are charged the same as those on Medicaid. While this was a problem for 43 percent of the administrators, the Minnesota Court of Appeals has already upheld the constitutionality of this law.

In addition, we found that:

- **Most of the other problems which nursing home administrators have are either due to federal government actions or have already been addressed in recent studies.**

Concerning the federal Omnibus Budget Reconciliation Act of 1987 (OBRA), the Legislature has provided special funds to meet the new, more demanding

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5 As we explained in Chapter 2, 21 months may elapse between some expenses and rates which would reflect them.

6 As we discussed earlier, the Legislature mandated the Department of Human Services to study the effects of workers' compensation costs on nursing homes.

federal requirements, but some administrators doubt that they can afford to make required changes. The act requires increased staff and other significant changes for some Minnesota nursing homes. This has created problems for nursing home administrators across the nation and may lead to more problems in the future.[7] For example, federal regulations were not yet published when parts of the act were implemented in October 1990, and many administrators were unsure about requirements for compliance. Also, in light of the nursing labor shortage, some homes may not be able to attract or retain the necessary additional staff. In at least one case, we learned that a nursing home in a small Minnesota town has threatened to close specifically because of OBRA requirements.

On the other hand, many of the other problems which administrators reported have already been addressed in legislatively mandated studies. Most important is the issue of property-related costs, which, as shown in Table 4.1, was a problem for many, although not all, administrators. In our opinion, administrators' problems with the property payment subsystem are understandable. The calculation method has not been successful for all homes, and the Legislature is scheduled to hear recommendations for change.

A KPMG Peat Marwick study earlier this year found that 86 facilities could not pay their property debt service if the state implemented the previously planned rental reimbursement subsystem.[8] Further, one-fourth of the nursing homes would not have received sufficient rental revenue to spend 1.5 percent of their appraised value for capital improvement and replacement.

Several other concerns of administrators have been studied, although in most cases recommendations have not yet been implemented. For example, workers' compensation, geographic groups, and Medicare-funding reports were mandated by the Legislature in recent years, and the Department of Health studied the case-mix system and presented recommendations in 1989. Finally, the Department of Human Services has worked actively and successfully with providers to address billing system problems.

COST-CUTTING TECHNIQUES AND EFFICIENCY INCENTIVE PAYMENTS

In Chapters 2 and 3, we discussed the importance of efficiency incentive payments for earning a profit. We found:

- **Most administrators (82 percent) said that they tried to earn efficiency incentive payments and had various strategies to do so.**

7 Toby S. Edelman, "Level of Care for Medicaid Nursing Homes to Be Eliminated by October 1, 1990: What Lies Ahead," *Clearinghouse Review 23* (December 1989), 959-965.

8 KPMG Peat Marwick, *Review of the Long Term Care Property Payment System* (Minneapolis, 1990).

However, nursing home ownership (for-profit, nonprofit, or city/county) affected whether administrators said they tried to earn these payments. We found:

- **Only two-thirds of the administrators in city/county homes said they tried to earn efficiency incentive payments, compared with 85 percent in for-profit and nonprofit homes.**

Subsequently, we learned that only one-third of city/county and 36 percent of nonprofit homes earned the maximum amount. In contrast, almost half of the for-profit homes earned the entire incentive. Furthermore, 30 percent of city/county and 26 percent of nonprofit homes failed to earn any of the bonus money, in comparison with 17 percent of for-profit homes. On the average, city/county homes earned $1.08, nonprofit homes $1.11, and for-profit homes $1.40 of the $2.00 maximum possible per resident day.

Most homes tried to earn efficiency incentive payments.

We believe that some nursing home administrators do not try hard to earn efficiency incentive payments because they can obtain revenue elsewhere. Our survey showed:

- **Administrators from city/county and nonprofit homes which earned no efficiency incentive were significantly more likely to use supplementary revenue sources to enhance or support their nursing homes.**

City/county facilities of course have access to local taxes. We found that 14 government homes actually earned no efficiency incentive payments in 1989. On the average, these administrators indicated in our survey that 11 percent of their revenue ($273,000) came from other sources. In comparison, administrators from 33 government homes which earned efficiency incentive payments averaged 3 percent of revenue ($87,000) from other sources.

Similarly, nonprofit homes may obtain donations or have cash reserves available. Administrators from 33 nonprofit homes earning no efficiency incentive payments reported an average of 6 percent ($220,405) in other revenue. In comparison, administrators from 101 homes which earned at least some efficiency money said about 3 percent ($61,244) came from other sources.

Although most administrators need to earn efficiency incentive payments, we found that their efforts were not always made willingly. Our survey showed that:

- **Administrators were highly ambivalent toward the incentive as an effective means to recognize good management.**

Only 40 percent of the administrators who said they tried to earn efficiency payments in 1989 said it was a positive mechanism, while 34 percent said it was negative. The rest were neutral. Some administrators commented that the incentive would eventually harm residents, whether they tried to earn it or

not. Others stated that the efficiency incentive made them operate in a more business-like way, and it was the only way to make a profit.

Table 4.3 shows how those administrators who said they tried to earn efficiency incentive payments did so. We found that 70 percent indicated that they controlled costs in at least four of the following six areas: salaries in the other operating category, and other costs in dietary, laundry, housekeeping, maintenance, and administration.

Table 4.3: Areas Controlled to Earn the Efficiency Incentive

Area	Percent of Administrators Who Said They Tried to Earn the Efficiency Incentive[a]
Other operating salaries	81%
Non-salary controls	
Plant operation and maintenance	84
General and administrative	83
Laundry and linen	69
Dietary	59
Housekeeping	55

Source: Nursing Home Administrator Survey (n = 310). The question was: "Did this nursing home try to control costs in any of the following areas in an effort to earn efficiency incentive payments during the past reporting year?"

[a]Of the 310 administrators responding to the survey, 56 said that they did not try to earn incentive payments.

Eighty-one percent of the administrators said they tried to control other operating salaries.[9] These results suggest that:

- **Staffing levels and salaries in the other operating category may not have kept pace with nursing staffing and salaries.**

About 42 percent of administrators trying to earn the incentive said they reduced the number of other operating staff during the last reporting year, while another 38 percent reduced the number of hours worked. This contrasts with increased staffing levels and salaries for care-related staff which we discussed in Chapter 2. Many administrators commented that they had been forced to hold down non-nursing salaries, which helped them to earn the efficiency incentive but put them in the position of discriminating between nursing and non-nursing staff.

Building and grounds maintenance was another popular avenue for cost-cutting. For example, almost two-thirds of administrators trying to earn incentive payments (66 percent) said they postponed redecorating. We recognize that decorating has no obvious, direct relationship to the physical health of

9 These salaries include dietary, laundry, housekeeping, maintenance, and administrative staff.

residents, but the nursing home's environment is certainly important to administrators, staff, residents, and families.

Administrators also turned to education as another method to manage more efficiently. Almost two-thirds of these administrators said the efficiency incentive prompted them to pay more attention to financial information, and 47 percent attended training sessions in an effort to control costs. In addition, 26 percent said they have passed on additional paperwork to nursing staff.

Not all cost-cutting techniques were positive.

To help earn efficiency incentive payments, 46 percent of the administrators said they cut laundry expenses by using more disposable diapers and incontinence pads. Since disposable incontinence aids are classified as a nursing expense in Minnesota's reimbursement system, relying more on paper than cloth helps reduce laundry costs which are classified as other operating expenses. The nursing homes' strategy of switching to disposable incontinence products to maximize reimbursement was previously reported to the Legislature in 1987 by the State Planning Agency.[10] In our opinion, the reimbursement system in this case may have contributed to environmental problems and may not necessarily be in residents' best interests.

The administrators reported relatively little cost cutting in the dietary area. Raw food costs are not defined as other operating expenses, but administrators said they saved some dollars through increased use of convenience food (35 percent) and more restricted menu selections (15 percent).

While resident rooms were minimally affected by cost-control techniques, other areas were not. Twenty-one percent of administrators trying to earn bonus payments reported less frequent floor cleaning, and 24 percent reported less frequent cleaning of common areas.

REPORTED CHANGES IN NURSING HOME OPERATIONS

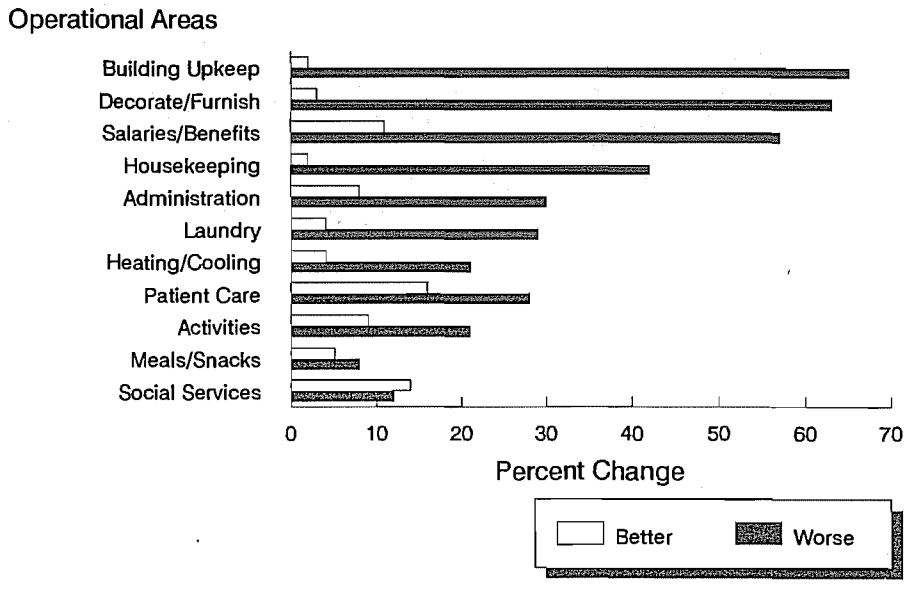
In our survey, administrators said that there had been changes for the worse in several, though not all, operational areas as a result of the reimbursement system. As shown in Figure 4.2, areas most frequently reported as changing for the worse were physical operations, housekeeping, and salaries and benefits. Areas closer to resident care, such as heating/cooling, meals/snacks, and resident services were reported to suffer less. For the most part, these changes are consistent with how administrators reported trying to control costs to earn the efficiency incentive. However, a few administrators reported that conditions had improved nonetheless.

In general, with the increasing care needs of residents, we found that:

10 State Planning Agency, *Appropriateness Study: Minnesota's Geographic Groups for Nursing Home Reimbursement* (1987).

Most indirect-care areas changed for the worse.

Figure 4.2: Administrators' Perceptions of Operational Changes



Source: Nursing Home Administrator Survey (n=310).

- **It has become more challenging for nursing home administrators to maintain an odor-free, clean, attractive environment.**

The dynamics of the efficiency incentive combined with the moratorium and Rule 50 have made it increasingly difficult to maintain a pleasant environment yet earn the incentive. Many administrators told us they have had no real choice but to limit spending on nursing homes' appearance and upkeep in favor of earning the efficiency incentive which, we learned, is a necessity for financial health.

PERFORMANCE INDICATORS

In light of administrators' ambivalence toward cost-cutting measures, we evaluated whether the reimbursement system—and administrators' responses to it—have affected the overall adequacy of care, as defined by state regulations.[11] First, we addressed consumers' satisfaction by looking at all complaints filed against nursing homes with the Office of Health Facility Complaints during the 1989 reporting year (October 1, 1988, through September 30, 1989).[12] Second, we examined violations of state regulations during fiscal years 1988 and 1989. We used a two-year period because the Minnesota

11 Our evaluation did not examine the adequacy, appropriateness, or administration of health and safety regulations.

12 We use the term "consumer satisfaction" even though nursing home residents file very few complaints themselves. Most complaints are filed on their behalf by relatives and facility employees.

Department of Health inspects each nursing home at least once every two years. Third, we reviewed the fines levied against nursing homes by the Department of Health during fiscal years 1988 and 1989. Again, to ensure that all nursing homes had about the same chance of being fined, we used a two-year period.

In general, we found no evidence of an immediate crisis of care in Minnesota's nursing homes. First, we found that:

- **According to the federal government, Minnesota's nursing homes complied with federal health and safety requirements more often than homes in other states.**

There is no immediate crisis of care in Minnesota's nursing homes.

Based on 32 performance indicators, Minnesota's homes rated better overall than the national average on 20 measures, about the same on 9, and worse on 3 during the 1988-89 year. As we show in Table 4.4, Minnesota's nursing homes failed standards more frequently than the national average for these reasons: (1) poor nutritional menus, (2) over-use of drugs or physical restraints, and (3) lack of bowel/bladder self-control programs. We believe that nursing homes' cost-cutting efforts may have contributed to some of these deficiencies, but they are few among many other indicators of high quality.

In general, we found that problems which nursing homes have with consumers or regulatory agencies were not related to their overall financial condition. However, nursing homes in financial distress were more likely to have fines levied against them than homes in acceptable financial condition, perhaps due to their inability to fund the necessary corrections. Also, consumer dissatisfaction was higher when homes were in poor physical condition; subsequently, these nursing homes were more apt to have correction orders issued against them.

Consumer Complaints

Consumers appear to be somewhat satisfied with the overall adequacy of care in most nursing homes. We found:

- **Slightly less than half the homes in the state were the subject of consumer complaints during the 1989 reporting year.**

From October 1, 1988, through September 30, 1989, the Office of Health Facility Complaints received 622 complaints against 204 of Minnesota's 448 Medicaid-certified nursing homes (46 percent).[13] Each of these homes had, on the average, three complaints filed against them.

Each complaint may include more than one problem. During the 1989 reporting year, consumer complaints referred to 962 problems in the 204 nursing

13 In this section, we concentrate on total complaints, not just substantiated ones because we are using them as an overall measure of consumer satisfaction with nursing homes. Later we discuss substantiated complaints which result in corrective action.

Table 4.4: Selected Performance Indicators, 1989

	Percent of Facilities Not Meeting Requirements	
	MN	U.S.
Each resident receives proper care for injections (shots), fluids supplied through tubes, colostomy/ileostomy, respiratory (breathing), and tracheotomy care, suctioning, and tube feeding.	6%	15%
Each resident receives rehabilitative nursing care to promote maximum physical functioning to prevent loss of ability to walk or move freely, deformities, and paralysis.	15	20
Each resident needing assistance in eating or drinking is provided prompt assistance. Specific self-help devices are available when necessary.	10	14
Drugs are administered according to the written orders of the attending physician.	19	24
Menus are planned and followed to meet the nutritional needs of each resident in accordance with physicians' orders, and to the extent medically possible, based on the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.	22	13
Therapy is provided according to orders of the attending physician in accordance with accepted professional practices by qualified therapists or qualified assistants.	6	5
Services are provided to meet the residents' social and emotional needs by the facility or by referral to an appropriate social agency.	7	9
An ongoing program of meaningful activities is provided, based on identified needs and interests of each resident. It is designed to promote opportunities for engaging in normal pursuits, including religious activities of the resident's choice, if any.	5	15
Appropriate staff develop and implement a written health care plan for each resident according to the instructions of the attending physician.	3	13
Toilet and bath facilities are clean, sanitary, and free of odors.	7	11
All common resident areas are clean, sanitary, and free of odors.	9	9
All essential mechanical and electrical equipment is maintained in safe operating condition.	5	14
Resident care equipment is clean and maintained in safe operating condition.	15	14
Isolation techniques to prevent the spread of infection are followed by all personnel.	9	21
The facility has available at all times a quantity of linen essential for proper care and comfort of residents.	1	7
Food is stored, refrigerated, prepared, distributed, and served under sanitary conditions.	36	36
The facility ensures that its written procedures regarding the rights and responsibilities of residents are followed.	<1	2

Table 4.4: Selected Performance Indicators, 1989, continued

	Percent of Facilities Not Meeting Requirements	
	MN	U.S.
The facility uses a system that assures full and complete accounting of residents' personal funds. An accounting report is made to each resident in a skilled nursing facility every three months.	<1%	4%
Each resident is free from mental and physical abuse.	<1	1
Drugs to control behavior and physical restraints are only used when authorized by a physician in writing for a specified period of time or in emergencies.	14	9
Each resident is given privacy during treatment and care of personal needs.	8	15
Each resident is allowed to communicate, associate, and meet privately with individuals of his/her choice unless this infringes upon the rights of another resident.	<1	<1
Each resident is allowed to retain and use his/her personal possessions and clothing as space permits.	0	3
Except in a medical emergency, a resident is not transferred or discharged, nor is treatment changed radically, without consultation with the resident or, if the resident is incompetent, without prior notification of next of kin or sponsor.	0	<1
The facility ensures that the health care of each resident is under the continuing supervision of a physician.	0	1
Emergency services from a physician are available and provided to each resident who requires emergency care.	0	1
Nursing services are provided at all times to meet the needs of residents.	1	6
Each resident receives daily personal hygiene as needed to assure cleanliness, good skin care, good grooming, and oral hygiene taking into account individual preferences. Residents are encouraged to take care of their own self care needs.	5	25
Each resident receives care necessary to prevent skin breakdown.	3	19
Each resident with a bed sore receives care necessary to promote the healing of the bed sore including proper dressing.	4	11
Each resident who has problems with bowel and bladder control is provided with care necessary to encourage self control, including frequent toileting and opportunities for rehabilitative training.	28	17
Each resident with a urinary catheter receives proper routine care, including periodic evaluation.	7	20

Source: U.S. Department of Health Human Services, Health Care Financing Administration, 1988-89.

homes. On the average, complaints contained about five different problems per nursing home.

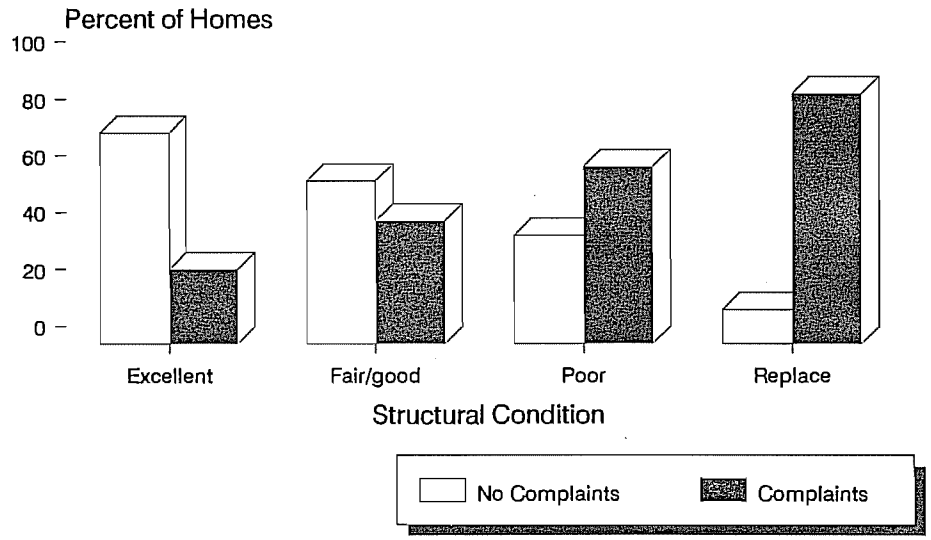
In general, consumers were less satisfied with larger, for-profit nursing homes, especially in the seven-county Twin Cities area. Consumers tended to file about twice as many complaints per resident against these types of facilities, and about twice as many complaints were found to be true.[14] In addition, we found that:

- **The structural and physical condition of nursing homes was an important variable in consumer satisfaction.**

As Figure 4.3 shows, consumers filed more complaints against those nursing homes where administrators rated the facility in poor or very poor physical condition than they did against homes rated in better physical condition. Furthermore, complaints in these instances were not confined to physical maintenance problems, but covered all aspects of facilities' operations.

Homes rated good or excellent were less likely to receive complaints.

Figure 4.3: Consumer Complaints and Administrators' Ratings of Homes' Structural Condition



On the other hand, we found that:

- **Consumer satisfaction was not directly related to nursing homes' financial condition.**

In Chapter 3, we showed that about 40 percent of nursing homes have experienced financial distress over the past several years. However, we found that:

14 The reverse is also true in that these types of homes had twice as many unsubstantiated or undeterminable complaints filed against them.

- **Nursing homes received consumer complaints regardless of their level of financial stress.**

The overall number and type of complaints received by the Office of Health Facility Complaints have increased since Minnesota's new reimbursement system took effect in 1985. As Table 4.5 shows, from fiscal year 1985 through 1989, the number of complaints filed against nursing homes per resident increased by 13 percent. The number of resident-specific complaints filed under vulnerable adult laws rose 41 percent, while the number of facility-specific complaints fell 9 percent.[15]

Table 4.5: Complaints Filed per 10,000 Nursing Home Residents, 1985-89

	1985	1986	1987	1988	1989	Percent Difference 1985-89
Number of Complaints						
Resident-specific	64	78	84	82	90	41%
Facility-specific	80	98	85	69	73	-9
Total[a]	144	176	169	151	163	13%
Number of Problems Cited						
Resident-specific	118	135	125	118	121	3%
Facility-specific	168	231	161	130	141	-16
Total[a]	286	366	286	248	262	-8%

Source: Department of Health.

[a]Data include complaints filed against all facilities licensed by the Department of Health as nursing homes, including state-operated and non-Medicaid-certified nursing homes. They do not include complaints filed against Medicaid-certified boarding care homes. Also, 1985 through 1987 represent calendar years while 1988 and 1989 represent fiscal years.

However, the overall increase in complaints filed does not fluctuate according to changes in total margins which we showed in Chapter 3. As Figure 4.4 shows:

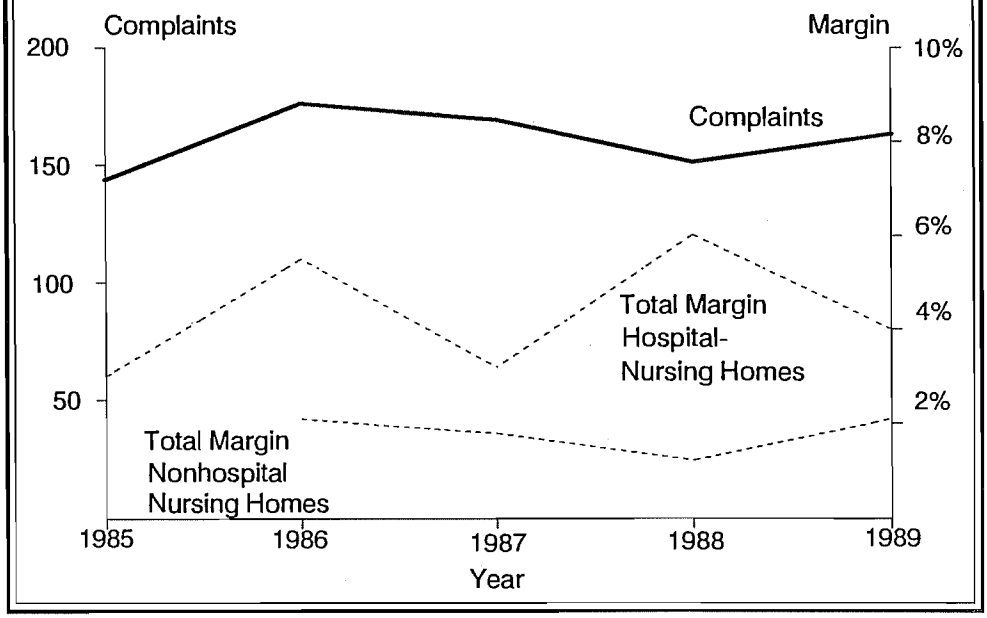
- **Consumers did not file more complaints in those years when the nursing home industry was least profitable.**

In addition, we looked at the substance of complaints and found that:

- **Consumer problems with nursing homes have changed little since 1985, when the state implemented its new reimbursement system.**

15 Resident-specific complaints (vulnerable adult) involve allegations of resident abuse, neglect, or inadequate care. In contrast, facility-specific complaints relate to overall nursing home conditions and do not contain allegations of individual abuse or neglect.

Figure 4.4: Number of Complaints Per 10,000 Residents vs. Total Margin



Complaints were not directly related to nursing homes' financial condition.

Tables 4.6 and 4.7 list the problems most frequently cited in complaints over time. As these data show, resident-specific complaints usually involved allegations of (1) health care neglect, (2) physical abuse, or (3) poor supervision. However, only health care neglect problems increased since 1985.[16] Facility-specific complaints usually made general allegations about (1) inadequate patient care, (2) staff shortages, or (3) violations of resident rights.

Furthermore, the number of consumer complaints filed in areas that nursing home administrators said had changed for the worse since 1985 has not increased. (See Figure 4.2.) We found that:

- **The number of complaints filed about nursing homes' overall physical condition has declined, while complaints about patient care and staffing shortages have increased.**

We believe that the growth in the number and type of complaints filed against nursing homes may be due less to the reimbursement system than to (1) staffing issues, (2) raised expectations, (3) increased access to regulators, and (4) admission of a more frail population.

First, staffing issues—major problems for nursing home administrators—probably contribute to consumer dissatisfaction. To some extent, consumer complaints about staffing shortages and subsequently, inadequate care, are not surprising, since administrators have problems attracting and retaining nursing

16 Complaints in many of these areas resulted in a mortality review task force, which we discuss later in this section.

Table 4.6: Problems Per 10,000 Residents Mentioned in Resident-specific Complaints, 1985-89

Type of Problem	1985	1986	1987	1988	1989	Percent Difference 1985-89
Health care neglect	67	80	78	75	84	25%
Physical abuse	9	14	13	11	9	0
Supervision neglect	17	18	8	6	8	-53
Failure to report	6	9	10	10	7	17
Unexplained injuries	3	4	4	4	5	67
Sexual abuse	-	-	-	4	3	-
Mental/emotional abuse	6	5	7	2	2	-67
Food neglect	5	3	2	2	1	-80
Other	3	3	2	3	3	0

Note: Data include complaints filed against all facilities licensed by the Department of Health as nursing homes, including state-operated and non-Medicaid-certified nursing homes. They do not include complaints filed against Medicaid-certified boarding care homes. Also, 1985 through 1987 represent calendar years while 1988 and 1989 represent fiscal years.

Source: Department of Health.

Table 4.7: Problems per 10,000 Residents Mentioned in Facility-specific Complaints, 1985-89

Type of Problem	1985	1986	1987	1988	1989	Percent Difference 1985-89
Patient care	39	67	48	43	46	18%
Staffing shortage	21	29	26	22	24	14
Resident rights	14	18	10	7	15	7
Poor housekeeping	11	13	6	6	8	-27
Food	8	14	8	5	6	-25
Medication administration	5	8	5	6	6	20
Odors	7	7	7	6	6	-14
Physical plant/maintenance	5	6	6	5	5	0
Smoking	8	3	3	3	2	-75
Inadequate supplies	2	4	2	2	3	50
Infection control	3	4	3	3	3	0
Dietary environment	2	4	3	2	3	50
Linen supplies/procedures	3	5	3	1	4	33
Safety hazards	3	4	4	2	1	-67
Pest control	3	3	3	2	1	-67
Other	32	40	24	15	9	-72

Note: Data include complaints filed against all facilities licensed by the Department of Health as nursing homes, including state-operated and non-Medicaid-certified nursing homes. They do not include complaints filed against Medicaid-certified boarding care homes. Also, 1985 through 1987 represent calendar years while 1988 and 1989 represent fiscal years.

Source: Department of Health.

staff. However, it should be noted that staffing has consistently been a problem for consumers and, thus, is more likely related to the overall nursing shortage than to the state's reimbursement system.

Second, consumers may expect more of nursing homes than laws and regulations require. What may seem to be too few staff to the public may actually be above state or federal minimums. Consumers may also expect more medical treatment from nursing homes than they actually provide.

Third, as nursing home problems surfaced in the 1970s and early 1980s, consumers and their advocates have become increasingly more organized and vocal. Partially as a result of their reform efforts, residents now have definitive rights and nursing homes definitive obligations. For example, the 1973 Legislature adopted the Patients and Residents of Health Care Facilities Bill of Rights to ensure that residents' interests are protected during their stay in a health care facility.[17] In 1980, the Legislature passed the Vulnerable Adults Act to protect residents of health care facilities from abuse or neglect.[18] Also, more channels exist to receive complaints. Numerous local ombudsman programs were developed throughout Minnesota in the 1970s a result of the federal Older Americans Act.[19] On the state level, the 1976 Legislature created the Office of Health Facility Complaints to receive, investigate, and resolve complaints from any source about services provided by health care facilities, health care providers, and administrative agencies.[20] That same year, the Legislature also directed the Board of Aging to recommend state policies which ensured residents a voice in determining which long term care services and programs were available to them.[21]

Finally, some increase in complaints, especially resident-specific complaints, may be expected since residents are older, sicker, and more debilitated than in previous years. We found that:

- **Consumers were more likely to file complaints against nursing homes with higher average case-mix scores and lower average lengths of stay than other homes.**

Residents with higher case-mix classifications and those in homes for short, intensive stays require more staff time than other residents. This creates more opportunities for consumer dissatisfaction and disruptions in the continuity of care, especially when nursing homes may be suffering from high staff turnover.

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17 *Minn. Laws* (1973), Chapter 688.

18 *Minn. Laws* (1980), Chapter 542, Section 1.

19 *Public Laws* 98-456, United States Code, Title 42, Section 3027(a)(12).

20 *Minn. Laws* (1976), Chapter 325.

21 *Minn. Laws* (1976), Chapter 275.

Correction Orders

After investigating each complaint, the Office of Health Facility Complaints concludes that the problems contained in them are either (1) substantiated, (2) false, (3) or undeterminable.[22] We found that:

- **About one-third of all problems investigated by the Office of Health Facility Complaints in Medicaid-certified nursing homes during the 1989 reporting year were true, one-third false, and the other third undeterminable.**

When problems or violations of regulations are substantiated, the Office of Health Facility Complaints may issue correction orders directly to the nursing homes involved.[23] Another section of the Department of Health also may issue correction orders to nursing homes when violations of state regulations are uncovered during biennial licensing inspections or follow-up visits.[24]

State licensing visits usually result in correction orders.

Table 4.8 shows the number of state correction orders issued to Medicaid-certified nursing homes by the Office of Health Facility Complaints and the Department of Health. We found that:

- **Seventy percent of the Medicaid-certified nursing homes in the state were ordered to make corrections in their administration, operations, or care of residents.**

Most correction orders were issued as a result of the licensing process. As these data indicate, inspections in fiscal years 1988 and 1989 led to 1,775 correction orders issued against 314 nursing homes. These facilities averaged about 6 orders each, although 53 homes each received at least 10 correction orders. On the other hand, consumer complaints resulted in 345 correction orders issued to 122 different nursing homes, or about 3 orders each.

We found that:

- **Nursing homes violated many different state regulations; no singular type of problem was pronounced.**

As Table 4.8 shows, services/staffing violations accounted for 22 percent of all correction orders issued, dietary violations for 16 percent, medication administration 12 percent, and resident care 11 percent. Other types of violations were less frequent.

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22 The Office of Health Facility Complaints cannot always determine whether complaints are valid. For example, a complaint might be filed about an uncooperative employee who no longer works at the nursing home by the time the complaint is investigated. These complaints tend to be classified as undeterminable.

23 Correction orders are not always issued because problems may have already been taken care of by the time a complaint is filed or investigated.

24 The Department of Health also conducts annual Medicaid-certification inspections for the federal government. When these inspections reveal that nursing homes violated state regulations which are not covered by federal regulations, state correction orders are issued.

Table 4:8: Correction Orders and Fines Issued Against Nursing Homes

	Correction Orders				Fines		Fines as a Percent of Total
Type of Problem	OHFC[a]	MDH[b]	Total	Percent	Total[b]	Percent	Correction Orders
Administration	19	52	71	3%	2	2%	3%
Records	37	141	178	8	5	5	3
Services and staffing	74	389	463	22	28	26	6
Resident care	76	163	239	11	9	8	4
Medication	28	229	257	12	21	19	8
Laundry and linen	1	85	86	4	8	7	9
Dietary services	11	334	345	16	11	10	3
Housekeeping	7	133	140	7	13	12	9
Physical plant	5	165	170	8	7	6	4
Bill of rights	50	83	133	6	4	4	3
Pets	0	1	1	0	0	0	0
Vulnerable Adults Act	34	0	34	2	0	0	0
Other	3	0	3	0	0	0	0
Total	345	1,775	2,120	99%	108	99%	5%

Note: Percentages do not total 100 due to rounding.

Source: Department of Health.

[a]Correction orders issued by the Office of Health Facility Complaints as a result of complaints filed from October 1, 1988, through September 30, 1989.
[b]Correction orders and fines issued during fiscal years 1988 and 1989.

We examined the characteristics of homes which received correction orders and found that:

- **Nursing homes' financial condition was not related to state correction orders being issued.**

Nursing homes violating state regulations may still earn efficiency incentive payments.

Correction orders resulting either from consumer complaints or the licensing process were just as likely to be issued against homes in acceptable financial condition as those in financial distress. Furthermore:

- **Nursing homes earned efficiency incentive payments regardless of noncompliance with health and safety regulations.**

On the average, nursing homes which were found in violation of state regulations during licensing visits earned about the same amount of incentive per resident ($1.20) as facilities without violations ($1.28).

In addition, we found that:

- **Correction orders resulting from consumer complaints were related to many factors, including nursing homes' physical condition, location, size, ownership, occupancy, and residents' average length of stay.**

Nursing homes in poor physical condition, facilities in the Twin Cities metropolitan area, homes with many beds, for-profit facilities, homes with low occupancy, and those with short average lengths of stay were more likely to have correction orders issued against them as a result of consumer complaints than other nursing homes. However, these variables were not related to whether nursing homes received correction orders from licensing inspections. This is perhaps because such visits usually uncover some violation of state regulations.

Fines

The Department of Health can impose daily fines on nursing homes which do not comply with correction orders quickly.[25] These fines vary according to the severity of the violation. We examined the number of fines issued by the department during fiscal years 1988 and 1989 and found that:

- **The Department of Health fined almost one-fifth of the state's Medicaid-certified nursing homes for persistent or serious violations of state regulations.**

During fiscal years 1988 and 1989, 17 percent of the Medicaid-certified homes in the state (70) were fined for violating state regulations. The Department of Health issued 76 fines against 56 Medicaid-certified nursing homes in 1988 and 32 fines against 22 homes in 1989. Eight nursing homes had fines for both years.

Seventeen percent of homes were fined for violating state regulations.

Table 4.8 shows the areas of operation for which nursing homes were fined. As these data show:

- **Nursing homes received fines most frequently for violating regulations in two areas: services/staffing and medication administration.**

Together, violations of these regulations accounted for almost half (45 percent) of all fines imposed. The issues involved were not obviously related to cost-cutting techniques which administrators have used. For example, some services/staffing fines related to the overall responsibilities of the director of nursing or not having programs which encouraged residents to reach their highest levels of independence. Some medication-related fines were for unlocked medicine cabinets, not recording when medication was administered, and not reporting medication errors and residents' subsequent reactions.

Table 4.8 shows that, on average, about five percent of all correction orders resulted in fines. The overall low number of fines in relation to correction orders may indicate that (1) nursing homes respond to correction orders quickly, or that (2) violations are not indicative of ongoing, facility-wide problems, but more often are one-time or short-term occurrences.

25 The Office of Health Facility Complaints can also fine nursing homes. However, the office fined only one Medicaid-certified facility during the 1989 reporting year. We did not include this fine in this section.

Looking at these data another way, we found that:

- **Nursing homes had a higher than average chance of being fined for violating regulations in those areas of operation where administrators said they used cost-cutting techniques to earn efficiency incentive payments.**

Although five percent of all correction orders involved fines, nine percent of the correction orders written in each of two areas—laundry/linen and housekeeping—resulted in fines. As we discussed earlier, over two-thirds of the administrators trying to earn incentive payments said that they adopted cost-cutting techniques in one or both of these two areas. In addition, 42 percent reported that housekeeping had gotten worse since 1985, and 29 percent said that laundry/linen had changed for the worse.

We examined factors related to whether nursing homes received fines and found that:

- **Nursing homes in financial distress were more likely to be fined than nursing homes in better financial condition.**

In addition, we found:

- **Nursing homes fined by the Department of Health were more likely to have occupancy problems or shorter than average length of stays than nursing homes not fined.**

Furthermore, nursing homes in financial distress tended to receive less efficiency incentive payments than other nursing homes—about 28 cents less. Taken together, these findings suggest that:

- **These nursing homes may not have had enough working capital to quickly correct violations uncovered by the Department of Health.**

Although the Departments of Health and Human Services each administers its own separate regulations which are distinct at the state level, they are necessarily interconnected at the facility level. Yet, little coordination exists between the two departments to ensure that individual nursing homes have access to the money necessary to make those corrections vital for residents' well-being.

Other Issues

In February 1988, the Department of Health formed a task force to investigate the increase in complaints of neglect in regard to some nursing home deaths. The Office of Health Facility Complaints received 15 such complaints in fiscal year 1988, 37 in 1989, and 81 in 1990. The office determined that

neglect contributed to residents' deaths in almost half of these complaints (47 percent).[26]

The Department of Health's task force issued its report in November 1990.[27] It attributed the sharp increase in nursing home deaths to the overall increase in the elderly population and the greater use of nursing homes instead of hospitals as recovery sites.

The task force made several staffing recommendations to deal both with the overall increase in nursing home deaths and those related to neglect. Recommendations included: (1) regulatory oversight of nursing pools, (2) more definitive policies related to the roles of the director of nursing and medical director, and (3) increased attention to strategies to decrease staff turnover. It further recommended developing policies concerning resident resuscitation and limited treatment plans.

SUMMARY AND RECOMMENDATIONS

Our evaluation showed that nursing homes operate within many complex, restrictive regulations. However, in return, Medicaid-certified nursing homes are protected from most competition and nearly guaranteed a steady flow of residents and revenue. As we have shown, most nursing home administrators have not completely accepted the restrictive nature of the reimbursement system, but many of their concerns have been actively addressed by task forces and studies. We found that the nursing home industry's most serious concern—that residents were being harmed by the industry's financial performance—was not well-founded.

Residents have not been directly affected by the industry's financial performance.

In response to Rule 50, our evaluation showed that nursing homes adopted many cost-efficient practices without making major, apparent sacrifices in residents' direct care. However, as indicated earlier, we believe that:

- **Some cost-cutting activities, such as delaying building repairs and general upkeep, may prove detrimental in the long run to the nursing home industry, residents, and the state.**

For the time being, we found little relationship between the reimbursement policies of the Department of Human Services and violations of the health and safety regulations administered by the Department of Health. However, we observed that:

- **Some nursing homes may not have the money to respond quickly to correction orders.**

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26 The Office of Health Facility Complaints is still investigating five complaints from fiscal year 1990.

27 Department of Health, *Report of the Commissioner's Task Force on Nursing Home Mortality Review* (1990).

On the other hand, nursing homes can and do receive efficiency incentive payments regardless of outstanding correction orders or fines. We believe that nursing homes should not be rewarded for over-zealous efficiencies that result in health and safety violations. Thus, to ensure adequate care for residents, we recommend that:

- **The Department of Human Services should make efficiency incentive payments contingent upon nursing homes' compliance with important regulations, as determined by the Department of Health.**

In these cases, nursing homes could be compelled to use their bonus money to correct problems which may have been caused by excessive pursuit of profit. In other cases, the Department of Health could recommend that efficiency incentive payments be forfeited.

Short-term loans should be available.

In addition, to ensure that it is financially possible for nursing homes to comply with health and safety requirements, the Departments of Health and Human Services need to be better coordinated. This could occur through the Interagency Board for Quality Assurance, which was created by the 1983 Legislature to identify and analyze long-term care issues that require coordinated policies.[28] Therefore, we recommend that:

- **The Department of Human Services should help to provide short-term loans to facilities to correct life-threatening conditions within nursing homes, upon recommendation from the Department of Health.**

When nursing homes claim that financial hardship prevents them from making vitally necessary corrections, we suggest that the Department of Health review financial data and determine whether a short-term loan is necessary. We would not anticipate such a mechanism to routinely approve all nursing homes' requests for loans. However, when residents' safety is in jeopardy, nursing homes should have access to resources if necessary.

This mechanism could cost the state some additional money. However, costly health and safety corrections could be passed through immediately (upon coordinated review) as a state loan and recovered in the same manner as the Department of Human Services collects nursing home overpayments now.

Other reimbursement systems already provide some flexibility in this area. For example, reimbursement regulations for intermediate care facilities for the mentally retarded permit, with Department of Human Services' approval, special rate adjustments once every three years.[29] We believe a similar mechanism should be developed for nursing homes' unanticipated costs of complying with major health and safety regulations.

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28 *Minn. Laws* (1983), Chapter 199, Section 5.

29 Office of the Legislative Auditor, *Administration of Reimbursement to Community Facilities for the Mentally Retarded* (1990).

Other loan options which safeguard residents' well-being could be explored. For example, emergency loans could be made available through the Minnesota Housing Finance Agency. This agency is currently working with the Department of Human Services to provide funding to develop group homes for the developmentally disabled.[30] Another option would be for the state to underwrite nursing home loans with local lenders in those instances where nursing homes are in financial distress and residents' safety is in jeopardy.

Also, we suggest that some flexibility be provided to help develop innovative programs which could save money in the future or significantly improve resident care. We recommend:

- **Small, one-time grants should be available to help selected nursing homes develop unique, cost-effective programs.**

We believe that a small amount of money for this purpose—about $250,000—would stimulate the nursing home industry and ultimately benefit the state. Currently, program innovations are nearly impossible to develop.

We realize that state budget problems make it difficult to fund new programs at this time, no matter how little spending is involved. However, such a program could be funded partly from savings incurred by withholding efficiency incentive payments from nursing homes with outstanding violations of important state regulations.

Applications for development funds should be reviewed and approved both by the Departments of Health and Human Services to ensure that nursing homes' plans fit into the state's long-term strategy for coping with the large number of Minnesotans who are approaching old age. We believe that these grants should be competitive, with only a small number awarded on the basis of merit. This program also could be coordinated by the Interagency Board for Quality Assurance.

Along the same line, quality incentives for nursing homes need to be developed. In our opinion, these are long overdue for the nursing home industry.[31] Currently, the Interagency Board for Quality Assurance is developing some indicators through its Quality Indicators Advisory Committee. Its report calls for developing a resident-centered, outcomes-oriented approach which focuses on the results of services for individual residents.[32]

Because our evaluation concerned only a few aspects of nursing home reimbursement, we did not examine in detail how the Departments of Health and Human Services administer their respective rules. For example, we found that nursing homes' disallowed costs were related directly to financial health, but we did not examine the appropriateness of disallowances or the specific ramifications for resident care. However, during the course of our evaluation,

30 Office of the Legislative Auditor, *Minnesota Housing Finance Agency* (1989).

31 Office of the Legislative Auditor, *Nursing Home Reimbursement* (1979).

32 Interagency Board for Quality Assurance, *Conclusions and Recommendations Regarding Indicators of High Quality Long Term Care Service and the Feasibility of Establishing a Quality Incentive Program for Minnesota Nursing Homes and Boarding Care Homes* (1990).

we found reasons to question the efficiency and cost-effectiveness of current regulatory practices. Therefore, we suggest that:

- **An additional study of nursing home regulation by both the Departments of Health and Human Services is needed.**

In our opinion, the Interagency Board for Quality Assurance would be a logical choice to conduct such a study since its routine responsibilities include analyzing long-term care issues which involve both departments. In our opinion, such a study could identify practices which could help nursing homes spend less money and thus provide some cost savings to the state. In addition, identifying inefficient regulatory practices on the part of state agencies could lead to cost savings.

More work needs to be done to ensure that future needs are met.

With the passage of the Federal Omnibus Reconciliation Act of 1987 and new federal nursing home rules, a broad regulatory study seems particularly appropriate. As part of its 1991 legislative agenda, the Department of Health is recommending a surcharge on nursing home beds to finance a comprehensive review of its licensing laws and regulations. The department believes that such a study is necessary to ensure that state laws and rules complement, not duplicate, federal provisions, thus making the system more efficient and effective to administer. While such a review is warranted, we believe that it is necessary to review Department of Human Services' regulations as well.

Finally, since the number of Minnesotans over 85 years of age is projected to increase 32 percent by the year 2000, the Legislature should examine whether and how to continue the moratorium on nursing home construction. Presently, there is no formal long range plan which addresses how to add, subtract, and redistribute nursing home beds or facilities in response to local needs. In 1986, the Legislature created a task force on long-term health care planning to propose, among other things, a statewide plan for the orderly and rational development of additional long-term care facilities.[33] The task force did not address this issue due to time and data constraints.[34] With new census data becoming available soon, it may be possible to thoroughly address this issue now.

While considerable interest has been focused lately on developing more alternatives to nursing homes, we believe that it is equally necessary to recognize the legitimacy of nursing homes within the continuum of care. We encourage the Legislature, nursing home providers, and the Departments of Human Services and Health to take additional steps to ensure that long term care is available, affordable, and appropriate to Minnesotans' current and future needs.

In summary, we conclude that nursing homes and their residents are not endangered by the reimbursement system itself. The nursing home industry has many legitimate concerns and limited resources, but neither it nor residents face an immediate crisis.

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33 *Minn. Laws* (1986), Chapter 420, Section 15.

34 State Planning Agency, *Recommendations for Changes to Minnesota's Nursing Home Moratorium Law from the Governor's Task Force on Long-term Health Care Planning* (1987).

STUDY POPULATION AND SURVEY OF NURSING HOME ADMINISTRATORS

Appendix A

For our study, we evaluated only those nursing homes which received reimbursement under the state's Medicaid reimbursement system (Rule 50) in 1989. As we explained in Chapter 1, 16 private nursing homes did not participate in Minnesota's Medicaid program during 1989. In addition, state-operated nursing homes were exempt from Rule 50. The information below describes the study population and compares it with the respondents to our survey.

STUDY POPULATION

On August 20, 1990, we sent questionnaires and cover letters to administrators of 446 nursing homes operating during the 1989 cost reporting year (October 1, 1988, through September 30, 1989) and participating in the Medicaid program.[1] Three nursing homes were mainly private facilities with only a few Medicaid residents but were Medicaid-certified and filed cost reports.

State-operated facilities, including Ah Gwah Ching, Oak Terrace, the Minneapolis Veterans Home, the Brainerd and Faribault regional treatment centers, and one licensed boarding care home in Hastings, received Medicaid reimbursement, but were excluded from our survey because they were not reimbursed under Rule 50 during 1989.

SURVEY RESPONSE

We received 310 usable responses, for a response rate of 70 percent. Of the remaining 136 questionnaires, several administrators told us that they did not have sufficient information to complete the questionnaire, ten were received too late for processing, and one was returned without identification. To be included, administrators or other officials were required to sign a statement that the information provided was complete and accurate. An accountant or controller completed the financial information for some of the facilities. In a

1 In all, 448 cost reports were filed, but two were from the same facilities filing separate, additional cost reports under Rule 80. These Rule 80 units serve severely impaired residents and operate without limits on nursing costs.

few cases, an owner or other person with administrative responsibilities completed the questionnaire.

Table A.1 compares our survey respondents' nursing homes to the total population of 448 Medicaid-certified facilities which filed 1989 cost reports and were reimbursed at rates established by the Department of Human Services under Rule 50. As the table shows, there were no major differences, so it was not necessary to weight survey responses.

Table A.1: Minnesota Nursing Homes Paid under Rule 50 and Represented in Administrator Survey

	All Nursing Homes (N = 448)	Nursing Homes Represented by Survey Respondents (n = 310)
PERCENTAGES		
Reimbursement Region[a]		
Deep rural (1)	19%	19%
Semi-metro (2)	40	41
Metro (3)	41	40
Ownership[a]		
For-profit	41	39
Nonprofit	43	45
City/county	15	16
Affiliation, if any		
Hospital	17	16
Religious	28	29
Union	22	23
Chain	45	45
Licensing		
Nursing home	95	97
Boarding care	16	15
AVERAGES		
Percent occupancy	94.5	94.7
Percent private payers	32.3	32.7
Percent Medicaid residents	59.3	58.8
Number of licensed beds	102.7	106.6
Case-mix score	2.30	2.31
Nursing hours per standardized day[b]	1.15	1.15
Efficiency incentive payment per diem	$1.22	$1.18

Note: Some percentages do not total 100.

[a]See Figure 2.5 for a list of counties in these regions.
[b]Standardized resident days means the sum of the number of resident days in each resident class multiplied by the weight of that class. A resident day is a day for which nursing services are rendered and billable, or a day for which a bed is held and billed.

CODING PROCEDURES

We found it necessary to make minor adjustments when answers from the administrators were contradictory or unclear. For example, some neglected to circle "yes" but indicated that this was what they meant. A few gave more than one answer to the same question, so we chose the midpoint of the given range of values or the lower value of two answers.

Several administrators referred to sections of their facility which were of different ages and therefore in different condition. In these cases we used a combined value to rate structural condition. Concerning administrators' perceptions of their nursing homes' financial condition, we usually coded the one rating which was chosen, "excellent" through "critical." In those few cases where the "other" category was chosen in addition to a rating, we assigned the rating. Also, some administrators chose only the "other" category, in which case we assigned a rating based on written comments where possible.

Information on revenue sources was sometimes incomplete, and we noticed that administrators loosely defined this term. If the administrators indicated that they received revenue from some sources but not others on our list, we assumed that the others were not significant. Further, we checked and corrected the percentage of total revenue from each source because some administrators made arithmetic errors. In general, the response to this line of questioning was incomplete and less certain than we had hoped. However, in our opinion, the information can withstand limited, cautious use by policymakers.

Results of the survey are shown on the following questionnaire. Throughout, the value "0.1 percent" includes all nonzero values up to and including 0.1 percent. A selection of administrators' written comments is attached for illustrative purposes on detail pages after the questionnaire.

QUESTIONNAIRE FOR NURSING HOME ADMINISTRATORS

Office of the Legislative Auditor
Program Evaluation Division
August 1990

RESULTS –
Responses received August 20 through October 6, 1990.

Unless otherwise stated, percentages are based on all 310 respondents.

Note: Percentages may not total 100 due to rounding.

Please indicate your fiscal year's ending date:

See detail, page 115.

Month / Date

GENERAL INSTRUCTIONS: This questionnaire should be completed by the administrator who is primarily responsible for managing this nursing home. Please answer only on behalf of your nursing home.

1. How do you define full-time employment for nursing staff (including only the time for which employees are paid)? Fill in the blank:

No Response #	No Response %
7	2

_____ hours/week Mean: 35 Median: 36 Min: 10 Max: 47

a. Check whether this is longer, shorter, or about the same as in 1985, when the current reimbursement system was implemented:

#	%	
6	2	☐ Longer by about _____ minutes
25	8	☐ Shorter by about _____ minutes
269	87	☐ About the same
10	3	No Response

See detail, page 115.

2. What is the minimum overlap, if any, which you routinely schedule for professionals and nonprofessionals as nursing shifts change? Fill in the blank:

No Response #	No Response %
7	2

_____ minutes Mean: 21 Median: 30 Min: 0 Max: 75

a. Check whether this is more, less, or about the same as in 1985:

#	%	
27	9	☐ More by about _____ minutes
38	12	☐ Less by about _____ minutes
234	76	☐ About the same
11	4	No Response

See detail, page 115.

b. In your opinion, is this amount of overlap sufficient to learn about residents' care needs? Check yes or no:

☐ No #	☐ No %	☐ Yes #	☐ Yes %	No Response #	No Response %
110	36	195	63	5	2

If no, how do replacement shifts learn about residents' care needs? Check all that apply:

#	%	
51	17	☐ **Tape recordings**
95	31	☐ **Written notes**
73	24	☐ **Unscheduled communication between employees**
31	10	☐ **Something else (specify):** _____

	#	%
Useful Comments:	27	9
No Useful Comments:	4	1

3. About what percentage of nurses and nursing aides voluntarily left your employment and needed to be replaced during the 1989 reporting year? Fill in *estimated* percentages:

						No Response #	No Response %
a.	_____ percent of nurses turned over.	Mean: 24	Median: 20	Min: 0	Max: 155	23	7
b.	_____ percent of nursing aides turned over.	Mean: 47	Median: 40	Min: 0	Max: 300	21	7

4. To what extent, if any, do you use volunteers to help with residents' care? Estimate the average number of hours volunteers contributed during the 1989 reporting year:

					No Response #	No Response %
_____ average hours per week	Mean: 19	Median: 0	Min: 0	Max: 403	22	7

5. Does your nursing home contribute toward the cost of health insurance of any kind for employees (not counting Workers' Compensation benefits)? Check one:

☐ No (# 24, % 8) ☐ Yes (# 286, % 92)

#	%	If yes, which of the following groups are eligible to participate in your nursing home's health insurance program? Check all that apply:
277	89	☐ a. **Full-time professional**
139	45	☐ b. **Part-time professional**
270	87	☐ c. **Full-time nonprofessional**
137	44	☐ d. **Part-time nonprofessional**

6. Please mark the category that best describes the general **structural and mechanical condition** of your nursing home:

#	%	
19	6	☐ **Excellent condition.** No need for upgrading, remodeling, major repairs, or replacement; just routine repairs and maintenance.
204	66	☐ **Fair to good condition.** Need moderate upgrading, remodeling, or repairs.
78	25	☐ **Poor condition.** Significant need for upgrading, remodeling, or repairs.
8	3	☐ **Needs to be entirely replaced.**
1	<1	No Response

7. Which of these best describes the current **financial condition and outlook** for this nursing home? Check one:

#	%	
0	0	☐ **Very good** and expecting to improve financial condition.
52	17	☐ **Good** and expecting to maintain a sound financial condition.
127	41	☐ **Fair,** without doubt about ability to operate in the foreseeable future.
105	34	☐ **Poor,** but probably can continue operating at least several years.
7	2	☐ **Very poor,** likely to close under duress within a year.
1	<1	☐ **Critical,** in imminent danger of closing under duress.
16	5	☐ **Other** circumstances (describe):_____
2	1	No Response

8. In addition to public and private reimbursement for residents' care, did any of the following potential revenue sources help to enhance or support this nursing home during your last fiscal year? For each, estimate what proportion of your total revenue came from that source and the approximate amount of money, or circle 0 if you received no such revenue:

Note: 32 respondents (10 percent) skipped this item.

		Received No Revenue #	Received No Revenue %	Received some revenue #	Received some revenue %	Of those who received some revenue: Approximate Percent of Total Revenue[a] Mean / Median	Min / Max	#	Estimated Dollar Amount[a] Mean / Median	Min / Max	#
a.	Business loans from local lenders	242	78	37	12	6.7% / 4.0	1.3% / 50.0	28	$107,109 / 75,000	$18,000 / 400,000	32
b.	Business loans from controlling (parent) organization	247	80	31	10	4.2 / 3.3	1.0 / 20.0	23	88,565 / 59,250	10,000 / 337,684	24
c.	Personal loans	268	86	10	3	9.4 / 8.0	4.0 / 25.0	7	120,146 / 100,000	30,000 / 250,000	8
d.	Public fundraisers	247	80	32	10	2.1 / 0.2	0.1 / 25.0	23	23,240 / 3,000	500 / 280,000	25
e.	Donations/grants	150	48	128	41	0.7 / 0.4	0.1 / 7.5	92	19,371 / 5,350	35 / 235,000	110
f.	Endowment/reserves	250	81	28	9	5.6 / 4.5	0.1 / 21.0	22	143,837 / 50,000	2,000 / 1,165,004	23
g.	Lawful gambling	273	88	5	2	2.7 / 3.4	0.2 / 4.5	3	127,300 / 122,000	2,000 / 263,200	4
h.	Other lines of business (specify):	250	81	28	9	2.6 / 0.7	0.1 / 18.0	19	62,375 / 14,239	500 / 302,952	18
i.	Local government	259	84	19	6	9.1 / 3.2	0.5 / 50.0	16	273,649 / 74,250	13,000 / 1,100,000	16
j.	Interest/investment income	159	51	119	38	1.5 / 1.0	0.1 / 6.2	97	34,321 / 21,005	155 / 380,000	104
k.	Sales of assets	263	85	16	5	0.9 / 0.1	0.1 / 6.0	13	26,506 / 1,500	300 / 300,000	16
l.	Something else (specify):	261	84	17	6	3.8 / 0.8	0.1 / 24.0	12	258,960 / 22,450	100 / 1,790,000	16

[a]Of those reporting it as a non-zero revenue source.

9. Did your nursing home use any portion of its property reimbursement to cover operating expenses during your last reporting year?

☐ No		☐ Yes		No Response	
#	%	#	%	#	%
125	40	165	53	20	7

10. During the last reporting year, did your nursing home make some expenditures with advance knowledge that they were ineligible for reimbursement through the state's reimbursement system? Please check yes or no and explain if yes:

☐ No		☐ Yes		No Response	
#	%	#	%	#	%
112	36	188	61	10	3

If yes, why?

	#	%
Useful Comments:	151	49
No Useful Comments:	32	10

See detail, page 115.

11. Have these aspects of your operation changed as a result of the state's reimbursement system? For each, indicate the nature of any change which has occurred or circle 0:

		No Response		(No change)		What is the difference? Better		Worse	
		#	%	#	%	#	%	#	%
a.	Housekeeping/cleaning	21	7	155	50	5	2	129	42
b.	Building upkeep/maintenance	18	6	86	28	5	2	201	65
c.	Decorating/furnishing	19	6	87	28	10	3	194	63
d.	Heating/cooling	24	8	210	68	11	4	65	21
e.	Patient care	24	8	150	48	48	16	88	28
f.	Social services	24	8	207	67	43	14	36	12
g.	Activities/outings	24	8	192	62	28	9	66	21
h.	Meals/snacks	25	8	245	79	15	5	25	8
i.	Laundry/linen	24	8	184	59	12	4	90	29
j.	Salaries/benefits	26	8	75	24	34	11	175	57
k.	Management/administration	30	10	162	52	25	8	93	30
l.	Something else (specify):	250	81	36	12	0	0	24	7

12. Did this nursing home try to control costs in any of the following areas in an effort to earn efficiency incentive payments during the past reporting year? Check yes or no for each area and explain how you tried to control costs. (Or, if you made no attempt to earn efficiency incentive payments, put an X here: # 56, % 18)

a. Salaries for dietary, laundry, housekeeping, maintenance, and/or general and administrative staff.

☐ No (# 43, % 14) ☐ Yes (# 206, % 67) No Response (# 61, % 20)

If yes, how did you try to control costs? Check all that apply:

#	%	
106	34	☐ Reduced number of staff (FTEs)
97	31	☐ Reduced number of work hours per FTE
32	10	☐ Reduced salary levels
65	21	☐ Hired new staff with less training or experience
77	25	☐ Other (specify): _____

	#	%
Useful Comments:	50	16
No Useful Comments:	27	9

12. Continued

b. Dietary (other than salaries, raw food, and consultant costs)

☐ No		☐ Yes		No Response	
#	%	#	%	#	%
94	30	151	49	65	21

#	%	If yes, how did you try to control costs? Check all that apply:
10	3	☐ Reused disposable items
38	12	☐ Restricted menu selections
90	29	☐ Increased use of prepared/convenience foods
65	21	☐ Other (specify):

	#	%
Useful Comments:	54	17
No Useful Comments:	11	4

c. Laundry and linen (other than salaries)

☐ No		☐ Yes		No Response	
#	%	#	%	#	%
70	23	175	57	65	21

#	%	If yes, how did you try to control costs? Check all that apply:
8	3	☐ Fewer linen changes
39	13	☐ Poorer quality linens
117	38	☐ More use of disposable diapers, incontinence pads
49	16	☐ Larger laundry loads
67	22	☐ Other (specify):

	#	%
Useful Comments:	55	18
No Useful Comments:	12	4

d. Housekeeping (other than salaries)

☐ No		☐ Yes		No Response	
#	%	#	%	#	%
103	33	140	45	67	22

#	%	If yes, how did you try to control costs? Check all that apply:
39	13	☐ Less thorough dusting
54	17	☐ Less frequent floor-cleaning
22	7	☐ Reduced frequency of cleaning residents' rooms
62	20	☐ Reduced frequency of cleaning common areas
61	20	☐ Other (specify):

	#	%
Useful Comments:	50	16
No Useful Comments:	11	4

e. Plant operations and maintenance (other than salaries)

☐ No		☐ Yes		No Response	
#	%	#	%	#	%
33	11	213	69	64	21

#	%	If yes, how did you try to control costs? Check all that apply:
167	54	☐ Postponed repainting/redecorating
160	52	☐ Partial rather than complete building repairs
98	32	☐ Reduced attention to lawn and grounds
69	22	☐ Other (specify):

	#	%
Useful Comments:	62	20
No Useful Comments:	7	2

12. Continued

f. General and administrative (other than salaries)

☐ No		☐ Yes		No Response	
#	%	#	%	#	%
34	11	210	68	66	21

If yes, how did you try to control costs? Check all that apply:

#	%	
65	21	☐ Assigned additional paperwork to nursing staff
166	54	☐ Increased attention to financial data
73	24	☐ Obtained outside assistance
120	39	☐ Attended training sessions
71	23	☐ Other (specify):

	#	%
Useful Comments:	59	19
No Useful Comments:	12	4

13. In your opinion, is the efficiency incentive a positive, neutral, or negative means to recognize management control over nursing home expenses? Check the one best answer and comment if you wish:

#	%	
104	34	☐ Positive
87	28	☐ Neutral
104	34	☐ Negative
15	5	No Response

Comments:

	#	%
Useful Comments:	139	45
No Useful Comments:	13	4

See detail, page 116.

14. During the last reporting year, have you had any problems working with the state's reimbursement system for nursing homes? Please check yes or no and indicate which aspects of the reimbursement system pose problems:

☐ No		☐ Yes		No Response	
#	%	#	%	#	%
8	3	298	96	4	1

If yes, which aspects? Check all that apply:

#	%	
214	69	☐ a. Property-related costs
154	50	☐ b. Operating costs
259	84	☐ c. 21-month delay
128	41	☐ d. Case-mix system
132	43	☐ e. Equalization of public and private rates
225	73	☐ f. OBRA allowance
83	27	☐ g. Geographic groupings
86	28	☐ h. Other (specify):

	#	%
Useful Comments:	76	25
No Useful Comments:	10	3

See detail, page 118.

15. How true is each of these statements, in your experience? Please circle the response that best matches your nursing home's experience during the last reporting year:

		Rarely/Never True		Sometimes True		Always/Usually True		(Can't Say) or No Response	
		#	%	#	%	#	%	#	%
a.	We know which costs are allowable.	5	2	92	30	206	67	7	2
b.	We have enough information to complete our cost reports correctly.	11	4	67	22	205	66	27	9

15. Continued

	Rarely/Never True		Sometimes True		Always/Usually True		(Can't Say)	
	#	%	#	%	#	%	#	%
c. The Department of Human Services does an acceptable job administering the reimbursement system.	68	22	181	58	39	13	22	7
d. Per diems adequately cover our facility's operating costs.	147	47	113	37	41	13	9	3
e. Per diems adequately cover our facility's property costs.	194	63	70	23	32	10	14	5

16. Since the current reimbursement system was implemented, has the net income from all sources for this nursing home generally been sufficient to meet the goals established by the owner(s) or controlling organization? Please check yes or no and explain if not:

☐ No		☐ Yes		No Response	
#	%	#	%	#	%
256	83	46	15	8	3

If no, why?

	#	%
Useful Comments:	229	74
No Useful Comments:	6	2

See detail, page 118.

17. In your opinion, how could the reimbursement system be improved yet costs controlled?

	#	%
Useful Comments:	244	79
No Useful Comments:	3	1
No Response:	63	20

See detail, page 120.

Finally, please supply some information about yourself and certify the accuracy of information you have provided:

18. Number of years you have administered this nursing home:

_____years Mean: 7 Median: 4 Min: 1 Max: 46

No Response	
#	%
9	3

19. Total number of years you have administered any Minnesota nursing home:

_____years Mean: 9 Median: 7 Min: 1 Max: 32

No Response	
#	%
12	4

20. In what year were you first licensed as a nursing home administrator in Minnesota?

19_____

	#	%
1970-1975	76	25
1976-1980	44	14
1981-1985	79	25
1986-1990	94	30
No Response	17	6

Certification: I certify that to the best of my knowledge, the information above is complete and accurate.

Your name and title _____ **Phone number** _____

Signature _____ **Date** _____

Check here if you would like a copy of our final report: ☐

Thank you for your participation.

Please return in the enclosed envelope by August 31 to:

Office of the Legislative Auditor
122 Veterans Service Building
St. Paul, Minnesota 55155

Telephone: (612) 296-4708

DETAIL

Questionnaire Page 1, Fiscal Year Ending Month:

Code	#	%
January	2	1%
February	2	1
March	1	0
April	5	2
May	2	1
June	26	8
July	0	0
August	7	2
September	128	41
October	4	1
November	1	0
December	90	29
No Response	42	14

Question 1. a. Minutes by which full time employment differed from 1985:

	Mean	Median	Minimum	Maximum	#
Longer	339	480	15	480	5
Shorter	344	300	30	960	23

Question 2. a. Minutes by which overlap differed from 1985:

	Mean	Median	Minimum	Maximum	#
Longer	20	15	5	30	23
Shorter	21	15	10	30	37

Question 10. Categorization of comments from administrators who said they made some expenditures knowing they were ineligible for reimbursement:

	#	% of Total Comments
Employee recognition/scholarships	63	22%
Expenditures beyond cost of living/exceeded limits	38	13
Marketing/PR	32	11
Capital purchases	25	9
Remodeling	19	7
Repairs	16	6
Contribution to community/outreach	16	6
Equipment	13	5
Administrative	15	5
Employee benefits/salary	8	3
Physical and occupational therapy	3	1
Employee recruitment	3	1
Coffee and gift shop, extended services	3	1
Correction orders	2	1
Interest, overdrafts, OBRA, apartments, fund-raising costs, payments in lieu of taxes, lost resident items, pay equity, utility costs	9	3
Other (difficult to categorize)	17	6
Total	282	

Note: Some administrators who said they made ineligible expenditures listed several items and others, none.

Question 13. Selected administrator comments on whether the efficiency incentive was a positive, negative or neutral means to recognize management control over nursing home expenses:

POSITIVE

It's forced me to manage better.

However other incentives for excellence need to be developed.

Energy costs need to be taken out of other operating. We are limited in controlling fuel prices or how we can realistically conserve energy. Garbage collection is another growing cost and problem we have little control over.

It has been my entire bottom line.

Generally positive as it promotes more attention to actual resident care. Negative in that it penalizes us for purchasing equipment, etc., in an effort to become more efficient. Unfair in that we are forced to spend more $ to meet state and federal mandates (e.g., OBRA, Medicare, etc.).

It's one of the only incentives to stay in this business.

Positive way to *stay in business*, negative in terms of quality of patient care and flexibility of management.

An efficiency incentive is very positive to the extent that it is attainable by the facility. However, in smaller homes or in homes with occupancy problems, the current incentive is very difficult to earn, even with good management controls.

It ought to apply to more categories of expenses.

In theory. However, inflation has eroded its value. Also, certain costs are less controllable, such as workers' compensation, health insurance, competition for labor, utilities.

Makes us operate a business instead of a community center.

It isn't reimbursement for operating expenses that is the problem but rather reimbursement for property.

We are far below limits. Quality is not always directly proportional to cost. There are homes that need to get costs down.

NEGATIVE

So many of the costs in other operating category we have no control over, i.e., workers' compensation, insurance premiums, employee group health insurance premiums. Utilities: we are told they will raise 10-12% a year for the next 3 years. We will be paying out an estimated $66-$70,000 in Sept. 30, 1991 cost report. Comparable worth: with 100 employees of which 96-97 are female, we are forced to increase our wages dramatically in next year to be in compliance with the rest of county employees. This raises our contributions for PERA and FICA, etc.

It is based on industry averages, therefore some facilities will lose.

Especially when viewed under OBRA, when environment is recognized as a component of resident outcomes.

The incentive theory is probably sound but not realistic given the dollar limits set, state and federal regulations mandated, and ever higher expectations from the public.

Question 13. Negative, continued

It penalizes nursing homes with long term employees (higher salaries).

If one concentrates on a few departments such as dietary, housekeeping, and laundry, the morale of those departments dips. They begin to feel they are not an important part of the team.

In theory it is positive, management should be rewarded for efficient use of resources. In practice, it is restrictive, punitive, and bad business policy. In order to get the incentive a facility has to cut back on supplies and services that help make the facilities pleasant and safe for the residents and staff. Over a period of time the facility is forced to give up on the incentive or risk having the facilities deteriorate to an unsafe condition.

One must be paid at cost plus profit before efficiency incentive works. Incentive should be added after profit.

Results in lower quality, trimmed down environment and requires a person to demand too much from subsistence wage level employees.

It promotes cutting back on building maintenance and repair. It is a short-sighted control and potentially leads to disastrous results for the future. As costs are held, it lowers reimbursement to even more difficult limits.

There are too many costs which are difficult to control such as fuel costs/utilities included in the criteria for the efficiency incentive.

1) It does not recognize the tremendous increase in administrative paperwork and record keeping. 2) It has not increased with inflation. 3) It does not recognize unique costs due to building age and configuration. 4) It rewards inefficiency in some cases, example, medivan (medical van) services vs. private hauling.

It makes the statement that "non-care-related" staff are not as important to a facility. It encourages the hiring of a less expensive, less qualified labor force.

NEUTRAL

The efficiency incentive could quickly turn negative depending on how expenses are controlled/reduced, both on human resources and quality of life and quality of care provided to residents.

We watch all costs. We use efficiency allowance to cover 21 month delay and non-reimburseable expenses, etc. We have never used the efficiency allowance as a windfall.

It has very little to do with efficiency. Some buildings are designed to be more efficient than others, some labor markets allow for stringent controls on wages, some operations had a head start in these costs, etc.

If the nursing home has already cut costs to the bone but wages are high due to union activity, then some allowance must be made for that.

A 50 bed facility does not have a base large enough to spread costs.

Varies with facility. In some cases staff do not receive needed salary increase to insure an efficiency incentive. It is the only area of the system to make money and sometimes done at all costs.

Question 14. **Other problems administrators reported that they had with the state's reimbursement system during the past year:**

	#	% of Total Other Problems
RSI (Residential Services Invoice)	34	43%
Audits (desk)	7	9
Medicare	7	9
Workers' Compensation	6	8
Retroactively billing private patients	4	5
Administrative cost limits for ICF II	2	3
Mandated expenditures	2	3
Nonallowable interest	2	3
No profit	2	3
Eligibility	2	3
Wage gap (compared to hospitals)	2	3
Owners dividends, unions, property taxes, attached facilities, too much regulation, physical therapy, appeals, timely field audits, pay equity, paperwork	10	13
Total	80	

Note: Some administrators who said they had problems with the system listed several items and others, none.

Question 16. **Selected administrator comments on whether net income from all sources has generally been sufficient to meet the organization/owners' goals:**

YES – income is sufficient to meet goals.

Only due to some significant community fund raising.

We have been able to meet the organization's goals only because there are endowment funds available.

NO – income is not sufficient to meet goals.

System is too tight to allow much, if any, net income. As an investment, the money would be better off in a savings account. There is no incentive, financially, to operating a nursing home. That leaves only "charitable" incentives.

We do not have a cash flow to generate money to spend now and be reimbursed 21 months later. There should be an allowance for those facilities to project large expenditures and get paid as they occur instead of waiting 21 months.

Twice we have taken rate reductions because of efficiency and the lag in the system (21 months). If we weren't part of a chain we would not be able to remain open.

We continue to struggle to match reimbursement with cost of operation. Demands by licensing agencies to meet increasing regulations, expectations by public, staff, families, continue to make operating a long term care facility an ongoing financial struggle.

For this home and for all of our original homes acquired before 1989, the financial goals have been elusive. In terms of patient care, we also believe that our goals could have been achieved more quickly and easily under the reimbursement system that existed in 1984. Under that system, we rarely had to be concerned about obtaining reimbursement for dollars expended to care for our residents.

Question 16. No, continued:

Since 1/1/89 through 7/31/90 this facility has lost $363,000. The first 7 months of 1990 I have lost $165,000. I get the $2 efficiency incentive so I run an efficient facility. Does this look like the reimbursement system is adequate to you?

Generally yes, but there have been some fiscal years during this reimbursement program that even our modest goals have been missed by a significant margin.

One of our goals is to offer our employees a decent wage package—we are not doing this. One of our goals is to maintain our buildings and grounds in good repair—we are not doing this. One of our goals is to be financially viable in the future; on a cash flow basis, we are viable for about 16 days; on an equity basis, we could not sell this facility at a price that would pay off our debt.

After Rule 50, income deteriorated and entered a loss situation in 1988. Since 1988, we have been in the red a total of approximately $100,000—that after cutting staffing, holding salaries below inflation and deferring maintenance.

Unable to reach a margin of profitability in order to reinvest back into our facility.

We don't have any money in the bank—our checking account is overdrawn by $50,000. We need a new roof, new laundry equipment, new beds for resident rooms, new patient room furniture. NO MONEY.

No profit at all since 1973.

Unable to provide quality care consistently—unable to repair and replace. Unable to initiate new programs in care-related and community service of health.

Lack of understanding of how the Rule 50 reimbursement system worked so they (the owners) made unintelligent decisions and lost revenue.

This county-owned facility's goal is to break even while maintaining high quality standards. We are not able to continue our current level of operations without substantial subsidies from taxpayers.

This facility has lost money on operations each year since this reimbursement system began. The only way we have been able to provide the special care and extras we provide for our residents is because of gifts, memorials, and investment income.

Even with all sources of income, we are still operating on a cash basis. We are unable to establish any operating cash reserves and no depreciation cash reserve.

We want to offer health insurance to our employees but can't afford to do it for 21 months before it gets into our rates. We had spent many thousands of dollars on property projects (air conditioning) anticipating full implementation of the rental concept of property reimbursement.

Despite controlling costs and realizing more efficiency incentive, the years since Rule 50 have not provided adequate income to replace capital items, improve staffing and salaries. We have not hired an RN for other than administrative positions in 3 years because of hospital competition.

The property system doesn't allow for capital improvements, and this building is now 25 years old.

Many reasons—first, the system is *very* complex and it took some time to understand how it works. With the 21 month delay, cash flow has been a problem. Workers' compensation increases and nurse wage increases have escalated these cash concerns. The property payment addresses debt, but not remodeling and rebuilding costs. There is little incentive to manage costs, within limits of course.

Question 16. No, continued:

The restricted reimburesment framework and the state control of every nursing home dollar does not allow for an incentive for creativity or a reward for excellence in services.

It is insufficient in that were unable to have adequate return on investment for future capital improvements and expenditures.

We have had substantial financial problems under this sytem. At this point we are finally making some headway.

Why? Should have 7% bottom line to build adequate reserves, repair, etc. Reasonable business expenses not all allowed. Last several years much work added by new regulations—never recognized.

You could pay $1,000 a day—it is basically money in, money out if there were no limits on care related. Limits on property and efficiency incentive are proving to be defeating. My pain is great, I will not go away, I will stay to change the system.

Because we belong to a health services organization, some creative management has saved our nursing home. However, we were surely looking forward to implementation of rental concept to the tune of $125,000 per year. We need that to fix up an aging structure.

Continued borrowing on a monthly basis is necessary to keep this facility open. Money is being borrowed from the controlling organization and hence goals are not being met.

Not able to build the reserve fund. This fund is necessary in order to build a new/replacement facility.

Our goal of providing quality care through quality staff has been limited by our inability to maintain wages and benefits competitive in the health care industry.

The only area that is adequate is care related as the limits are high. The problem is you have the 21 month disallowance to work with if you want to increase staffing. All other areas are not sufficient to meet the increasing demands—dietary, housekeeping, maintenance, administrative.

Never will stockholders/owners find satisfactory balance between their return on the dollar, and requests from facilities.

Audited financial statements show for the three years ending in 1989 a cumulative net loss of $316,535.

It is the goal of our corporation to have a 3% operating margin of profit on an on-going basis and our facility has not always experienced this.

Revenues have barely covered expenses to say nothing of needed capital improvements or a legitimate return on investment.

We have never been able to set money aside for a rainy day. This past year we borrowed $50,000 to meet expenses.

Question 17. Administrator comments on how the reimbursement system could be improved:

The state billing system costs lots of time and money for many homes. We have less admissions and discharges, therefore less problems. The twenty-one month delay is unfair. Many of us simply do not have the up-front money that this requires.

Question 17. Selected comments, continued:

Philosophical Comments: When you think the whole building, that is the whole unit of LTC/DHS/MDH, is rotten and ready to fall, it's difficult to talk about which boards to replace. We simply need more money to take care of old people. Where is it going to come from? I wonder if the legislature, in the little time they have, could possibly look at the big picture . . . I wonder how much money it costs Minnesota to fight the small stuff that is different than Federal—we keep adding the new things on top of what we already have and never eliminate anything. Could we settle on ONE assessment form that would satisfy everyone. We still talk about Boarding Care, Intermediate and Skilled and OBRA talks about only a "nursing facility", we have to do the lengthy OBRA assessment form AND case mix, we're surveyed for State Rules as well as Federal Rules—all of this lengthy, time consuming, frustrating and COSTLY.

We are always the object of cost cutting. Perhaps the whole bureaucracy tree could stand a good shake!

Ultimately, the only way to control costs and yet provide adequate reimbursement is to control the *inputs*—salaries, etc. And this will mean controlling them across the board (e.g., hospitals and clinics). Otherwise you will perpetuate the inequity between sectors of the health care industry—and the less skilled/competent will end up in the lowest paid sector.

The State of Minnesota has no long term plan for health care. By making nursing homes competitive with hospitals in attracting nurses, in physical plant, in technology, the State could save money through the reduction of unnecessary transfers from nursing homes to hospitals of patients more cheaply cared for in the nursing home.

A number of changes need to be made to make the reimbursement system work for the provider. These include:

1. Recognition of extraordinary cost increases to eliminate the 21-month delay problem.
2. Indexing of efficiency incentive to adjust for inflation.
3. Provision of a DHS manual for cost reporting so that both providers and DHS auditors can have firm guidelines.
4. Revise the appeals system so math errors and oversights can be fixed rather than appealed, and allowance of charges of the disputed amount while the appeal is pending.

As to the question of controlling costs, there will be no workable system until the State and Federal government focus fiscal restraint efforts on the costs faced by the industry rather than the rate paid to the industry. The present Rule 50 only squeezes the rates paid to facilities at a time when homes are facing rapidly rising costs on several fronts. The result is a bankrupt industry. My suggestion then, is to reduce the paperwork and resident assessment and monitoring load on the industry. Costs will slow down and care quality will improve. (Example: the last 3 staff positions added, at an annual cost of $50,000, have all been to do paperwork. Prior to 1987 they weren't needed. They have no impact on resident care other than to divert dollars away from resident care.)

Cut down 21-month delay. Allow for competitive wages and benefits with hospitals. As far as controlling costs, remember—you get what you pay for. We have difficulty getting our claims out of a suspended condition.

(1) Reallocation of funds. (2) Improvement costs allowed, at a reasonable rate. (3) Case levels re-evaluated. Behavior needs heavier weight.

(1) Eliminate 21 month disallowance, reimburse legitimate expenses immediately as a pass-through—like the old Rule 49. (2) Identify known cost changes as reported on Cost Report—like the old Rule 49. (3) Reimburse actual costs for OBRA implementation, especially in ICF IIs.

For hospital attached facilities, more recognition should be given to the fact that costs allocated to the nursing home were "lost" in the middle of all the different reimbursement mechanisms.

Question 17. Selected comments, continued:

(1) When the state system makes any type of changes there should be more educational sessions available. (2) State employees should have a better knowledge of their areas so when one calls you don't end up feeling like your questions were not answered. (3) I believe the system should take a closer look at what they consider necessary and unnecessary allowable costs for nursing home care. (4) I do feel the criteria should be broadened to include behavioral type problems in individual case mix classifications.

(1) Allow different rates for non-medicaid residents. (2) Be more responsive to appeals. In many cases, appeals are taking months to be resolved when the issues are straightforward. We end up losing. (3) Reduce the paperwork burden. (4) Be reasonable.

New groupings or eliminate Deep Rural class (in light of nursing shortage, it doesn't make sense).

Retain efficiency incentive. Do not change rules all the time. Give us some consistency to do long range planning. Example: property reimbursement—I think rental concept is fair. I have planned around its implementation. *What's the status of Rental?* How do we plan our future?

(1) Modify private pay equalization statutes. (2) More incentives for efficiency and cost control. (3) More modern plans and equipment to promote capital investment for operating efficiencies (new methods and procedures).

We need more money for staff salaries, employee recognition programs, and a higher minimum staffing hour ratio. The .95 ratio is too low for care and also for retaining staff. If I averaged .95 daily or even .98 daily, I wouldn't have a stable staff—I'd have pool help. Dietary is becoming more important with possibilities of offering selective menus, meal time choices, etc. for resident autonomy. We need more staffing hours and dollars recognizing cost control needs to stay in place.

The two goals are conflicting and it is difficult to balance the concerns. The Case Mix system of reimbursement has been an improvement but the property reimbursement mechanism seems to be inequitable and arbitrary at times. When the state promises to "phase-in" to one standard approach/level over a period of years, they should stand by their promises, regardless of budgetary concerns. N.H. buildings must be maintained. We have an aging population and the N.H. beds are going to be needed in the future and we have to adequately prepare for that financially today!

Cut down on paper work. RNs are getting tired of all this nonsense!

We have been unable to maintain the building adequately. Maintenance is being deferred. Will eventually "overwhelm" us.

Capitalize at $1,000 vs. present $500. Provide incentive for refinancing of high interest bonds used to finance construction. Increase $325 limit per bed for repairs/maintenance to at least $500 per bed. Index for inflation! Include dietary staff in the "other care related" category.

Allow for a property system which: 1) includes capital asset improvements, 2) gives owners a return on equity.

The realities of the competitive marketplace for staff need to be addressed. The expectation that people who work in a nursing home will be paid below other health care workers doing the same job is not reasonable.

(1) Move away from the "shoebox" approach to cost categories. It forces providers to game the system because of the limits. (2) Remove expenses from the cost categories over which the provider has no control, e.g., workers' compensation premiums, health insurance premiums, malpractice insurance, all other. (3) Index the efficiency incentive. (4) Compensate or redesign system to eliminate the 21-month delay which is one of the most serious problems with the system. (5) The RSI system is a mess!

Question 17. Selected comments, continued:

Limit legislative action to "deletions only" for five years . . . Pay them to stay home. Get DPW and HHS and MDH and HCFA commission to invest in a nursing home.

What does the state want – quality nursing homes or cheap homes who don't care about quality? Money is important and sometimes that is all the state is concerned about. They say they are concerned about the lives of residents but are they really? Funding is needed to provide quality care as well as maintaining the facilities in a liveable condition. Allow nursing homes to charge private pay more to make up for the state's lack of concern to provide adequate funding. I'm not really in favor of that but somewhere along the line we have to become more concerned about the elderly than some of Perpich's pet projects. Revamp the workers' compensation program. Our premium for this year was $84,000. It has increased 164 percent over the last two years.

(1) Property reimbursement needs improvement for older homes so that money can be set aside for major repair and replacement. Rental concept is an appropriate method. (2) 21 month delay must be changed to allow for expenses that are beyond the control of the facility that have statewide cost increases over a certain inflation factor. Some examples of these are: workers' compensation, liability and health insurances; utilities, license fees, food, etc. These increases now have to be absorbed at the expense of other controllable costs.

SELECTED PROGRAM EVALUATIONS

Board of Electricity, January 1980	80-01
Twin Cities Metropolitan Transit Commission, February 1980	80-02
Information Services Bureau, February 1980	80-03
Department of Economic Security, February 1980	80-04
Statewide Bicycle Registration Program, November 1980	80-05
State Arts Board: Individual Artists Grants Program, November 1980	80-06
Department of Human Rights, January 1981	81-01
Hospital Regulation, February 1981	81-02
Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill, February 1981	81-03
State Designer Selection Board, February 1981	81-04
Corporate Income Tax Processing, March 1981	81-05
Computer Support for Tax Processing, April 1981	81-06
State-sponsored Chemical Dependency Programs: Follow-up Study, April 1981	81-07
Construction Cost Overrun at the Minnesota Correctional Facility - Oak Park Heights, April 1981	81-08
Individual Income Tax Processing and Auditing, July 1981	81-09
State Office Space Management and Leasing, November 1981	81-10
Procurement Set-Asides, February 1982	82-01
State Timber Sales, February 1982	82-02
Department of Education Information System, March 1982	82-03
State Purchasing, April 1982	82-04
Fire Safety in Residential Facilities for Disabled Persons, June 1982	82-05
State Mineral Leasing, June 1982	82-06
Direct Property Tax Relief Programs, February 1983	83-01
Post-Secondary Vocational Education at Minnesota's Area Vocational-Technical Institutes, February 1983	83-02
Community Residential Programs for Mentally Retarded Persons, February 1983	83-03
State Land Acquisition and Disposal, March 1983	83-04
The State Land Exchange Program, July 1983	83-05
Department of Human Rights: Follow-up Study, August 1983	83-06
Minnesota Braille and Sight-Saving School and Minnesota School for the Deaf, January 1984	84-01
The Administration of Minnesota's Medical Assistance Program, March 1984	84-02
Special Education, February 1984	84-03
Sheltered Employment Programs, February 1984	84-04
State Human Service Block Grants, June 1984	84-05
Energy Assistance and Weatherization, January 1985	85-01
Highway Maintenance, January 1985	85-02
Metropolitan Council, January 1985	85-03
Economic Development, March 1985	85-04
Post Secondary Vocational Education: Follow-Up Study, March 1985	85-05
County State Aid Highway System, April 1985	85-06
Procurement Set-Asides: Follow-Up Study, April 1985	85-07

Insurance Regulation, January 1986	86-01
Tax Increment Financing, January 1986	86-02
Fish Management, February 1986	86-03
Deinstitutionalization of Mentally Ill People, February 1986	86-04
Deinstitutionalization of Mentally Retarded People, February 1986	86-05
Management of Public Employee Pension Funds, May 1986	86-06
Aid to Families with Dependent Children, January 1987	87-01
Water Quality Monitoring, February 1987	87-02
Financing County Human Services, February 1987	87-03
Employment and Training Programs, March 1987	87-04
County State Aid Highway System: Follow-Up, July 1987	87-05
Minnesota State High School League, December 1987	87-06
Metropolitan Transit Planning, January 1988	88-01
Farm Interest Buydown Program, January 1988	88-02
Workers' Compensation, February 1988	88-03
Health Plan Regulation, February 1988	88-04
Trends in Education Expenditures, March 1988	88-05
Remodeling of University of Minnesota President's House and Office, March 1988	88-06
University of Minnesota Physical Plant, August 1988	88-07
Medicaid: Prepayment and Postpayment Review - Follow-Up, August 1988	88-08
High School Education, December 1988	88-09
High School Education: Report Summary, December 1988	88-10
Statewide Cost of Living Differences, January 1989	89-01
Access to Medicaid Services, February 1989	89-02
Use of Public Assistance Programs by AFDC Recipients, February 1989	89-03
Minnesota Housing Finance Agency, March 1989	89-04
Community Residences for Adults with Mental Illness, December 1989	89-05
Lawful Gambling, January 1990	90-01
Local Government Lobbying, February 1990	90-02
School District Spending, February 1990	90-03
Local Government Spending, March 1990	90-04
Administration of Reimbursement to Community Facilities for the Mentally Retarded, December 1990	90-05
Pollution Control Agency, January 1991	91-01
Nursing Homes: A Financial Review, January 1991	91-02
Teacher Compensation, forthcoming	
State Investment Performance, forthcoming	
Corrections Policy, forthcoming	
Game and Fish Fund, forthcoming	
Greater Minnesota Corporation: Organizational Structure and Accountability, forthcoming	
State Contracting, forthcoming	

Evaluation reports can be obtained free of charge from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-4708.