REPORT TO THE MINNESOTA STATE LEGISLATURE

AN ASSESSMENT OF THE IMPACT OF THE MORATORIUM ON THE MEDICAL ASSISTANCE CERTIFICATION OF NURSING HOME AND BOARDING CARE HOME BEDS

Prepared Pursuant to Minnesota Statute 144A.071

Minnesota Department of Health
717 Delaware Street, S.E.
Minneapolis, Minnesota 55440

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PREFACE

This report is prepared in response to the legislative mandate that the Commissioner of Health monitor and assess the impact of the moratorium in order to determine its effect on the provision of long-term care services throughout the State. The report contains the findings, implications, and recommendations regarding the moratorium for the period between November 30, 1983 (the date of the last report) and November 30, 1984. This report was prepared by Cynthia L. Polich, Polich and Associates, under contract with the Minnesota Department of Health.

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EXECUTIVE SUMMARY

The 1983 Minnesota legislature enacted Minnesota Statute 144.A071 which imposed a moratorium on the addition of Title XIX (Medicaid) skilled nursing facility (SNF) beds or intermediate care facility (ICF) beds and prohibited the upgrading of the certification status of any existing certified beds. This law became effective on May 23, 1983. As of that date, the Commissioner of Health was required to deny the certification of new beds or the upward certification status of existing beds unless the request for certification qualified under one of the exceptions provided for in subdivision 3 of the law. The exceptions include the following:

1) Certification of beds is allowed in a facility that "commenced construction" prior to the effective date of the law.
2) Certification of beds is allowed in areas of the State where there is an "extreme hardship situation". This is defined as having fewer beds per 1,000 persons over age 65 than the national average.
3) Certification of beds is allowed in a new nursing home when needed to meet special dietary needs of residents.
4) A change in the certification of existing beds is allowed when it will result in a decrease in the amount of Medicaid reimbursement.

This report was prepared in response to the legislative mandate that the Commissioner of Health monitor and assess the impact of the moratorium in order to determine its effect on the provision of long-term care services throughout the State. The report contains the findings, implications, and recommendations regarding the moratorium for the period between November 30, 1983 (the date of the last report) and November 30, 1984.

Findings

1) The number of certified nursing home and boarding care home beds increased from 46,647 in November 1983 to 47,433 in November 1984. This was an increase of 786 beds or 1.7%.

2) There was an increase in the proportion of SNF beds during this period. In 1983 there was a ratio of 1.72 SNF beds for every 1 ICF bed. In 1984, this had increased to 1.74 SNF beds for every 1 ICF bed.

3) The number of uncertified beds increased from 1,967 to 1,995. This was an increase of 1.4%.

4) Adequate data were not available to analyze the impact of the moratorium on occupancy rates in nursing homes. Data collected for 1983 show statewide occupancy rates of 90%. However, nursing home occupancy rates were higher in St. Paul (96.3%) and outside of the metropolitan area (95.2%).

5) Data on the number of nursing home beds per 1,000 persons over age 65 showed that the rates had increased in 13 counties, decreased in 2 counties and stayed the same in the remaining 72 counties. The national average is 63.19 beds per 1,000. In most Minnesota counties, the rate is significantly higher. Hennepin County's rate is 116.38 per 1,000. Ramsey County's rate is 98.65 beds per 1,000.

However, county rates vary tremendously -- from a high of 194.26 beds per 1,000 in Sherburne County to a low of 51.93 beds per 1,000 in Todd County. There are currently eight counties (Carver, Aitkin, Kanabec, Stearns, Todd, Hubbard, Mahnomen, and Marshall) that have a lower rate of beds per 1,000 than the national average. This is down from 13 counties in 1983. However, as was true last year, none of these counties meet the "hardship provision" exception when contiguous counties are considered.

6) Level of care recommendations made by the Quality Assurance and Review program show that in 1,730 cases, the QA & R team recommended moving the resident to a higher level of care. In 1,143 cases, the team recommended moving the resident to a lower level of care. These recommendations were implemented in 20% of the cases when a higher level of care was needed, and 21% of the cases when a lower level of care was needed. More importantly, the recommendation was more likely to be implemented when a facility had both SNF and ICF beds compared to those facilities that had only one level of care.

7) Since the moratorium went into effect, 27 facilities have made certification requests. All of these were denied. Seven of these were for new certifications, twenty were for upward re-certifications.

8) Since the moratorium went into effect, 21 homes added new beds that have been certified under the exceptions to the moratorium. This amounted to 954 SNF beds and 312 ICF beds. In addition, five facilities were allowed to reclassify beds. This resulted in a change of 39 ICF-II beds to 41 ICF-I beds, 30 ICF-I beds to 30 SNF beds, and 6 ICF-II beds to 6 SNF beds.

9) The Long-Term Care Ombudsman and the Office of Health Facility Complaints both handle consumer complaints about nursing homes. Neither office reported any complaints about the inability of consumers to locate or be admitted to a suitable nursing home.

10) Surveys conducted with county pre-admission screening teams, hospital discharge planners, and nursing home administrators revealed the following:

- -There have been no major differences in the ability to place elderly in nursing homes since the moratorium took effect.
- -In the vast majority of cases, elderly individuals in need of nursing home care could find suitable beds.
- -There was difficulty in placing elderly individuals into their preferred homes. However, this was no more difficult than it was prior to the moratorium.
- -The majority of homes were targeting their vacant beds to clients in greatest need, in spite of having a long waiting list. Most homes gave hospital discharges top priority.

Conclusions and Recommendations

1) Available data show no evidence of negative impact from the moratorium on meeting the long-term care needs of the elderly. While there are some problems with placing elderly in their preferred homes, this is not appreciably different from before the implementation of the moratorium.

2) The Department recommends that the moratorium be continued for another year.

3) In order for the moratorium to continue to have no negative impact on care, the State must continue to adequately fund home care services. These services must be used to substitute for the nursing home care that would otherwise be provided.

4) The Legislature should consider changing the norm for determining "hardship situations" from beds per 1,000 persons over age 65. The largest number of nursing home beds are used and needed by those over age 85. Demographic projections show a slowing in the rate of growth of those over age 65 -- suggesting a reduced need for nursing home beds. This does not adequately reflect the large growth in the number of people who need that care the most -- those over age 85.

5) Additional data analysis is needed regarding the implications of DRGs on the need for nursing home beds and higher level of care certification.

6) Additional analysis is needed regarding the implications of case mix reimbursement on the moratorium. It is likely that the implementation of case mix reimbursement will render the moratorium limitation on upward certification irrelevant since the State will no longer reimburse homes based upon their SNF and ICF certification.

INTRODUCTION

The 1983 Minnesota legislature enacted Minnesota Statute 144.A071 which imposed a moratorium on the addition of Title XIX (Medicaid) skilled nursing facility (SNF) beds or intermediate care facility (ICF) beds and prohibited the upgrading of the certification status of any existing certified beds. This law became effective on May 23, 1983. As of that date, the Commissioner of Health was required to deny the certification of new beds or the upward re-certification status of existing beds unless the request for certification qualified under one of the exceptions provided for in subdivision 3 of the law.
The exceptions include the following:

1) Certification of beds is allowed in a facility that "commenced construction" prior to the effective date of the law.

2) Certification of beds is allowed in areas of the state where there is an "extreme hardship situation". This is defined as having fewer beds per 1,000 persons over age 65 than the national average.

3) Certification of beds is allowed in a new nursing home when needed to meet special dietary needs of residents.

4) A change in the certification of existing beds is allowed when it will result in a decrease in the amount of Medicaid reimbursement.

Copies of the moratorium law and the proposed temporary rule are included in the Appendix.

The enactment of the moratorium was one of the major elements of the 1983 Legislature's initiatives to contain increasing Medicaid expenditures. It was the Legislature's finding that "a moratorium on Medical Assistance certification of new nursing home beds and on changes in certification to a higher level of care is necessary to control nursing home expenditure growth and enable the state to meet the needs of its elderly by providing high quality services in the most appropriate manner along a continuum of care."

The moratorium was intended to accomplish two objectives:

1) to stop the growth in the number of nursing home beds that receive reimbursement from Medicaid, and

2) to stop the increases in the upward certification of nursing home beds from ICF to SNF.

The first objective resulted from large increases in the number of nursing home beds in Minnesota in previous years. Between 1978 and 1983, the number of Medicaid certified beds increased from 43,927 to 46,207, an increase of 5.2%. This was a concern because of the increased costs each new bed adds to the Medicaid program. At an average nursing home cost of approximately $15,000 per year, the budgetary implications of these additional beds amounts to over $34 million annually.

In addition to this growth, Minnesota has a very high rate of nursing home beds per 1,000 elderly (among the top seven states in the country) and a high rate of institutionalizaton (fifth in the country). Minnesota data show approximately nine percent of those over age 65 in nursing homes compared to approximately five percent for the entire United States. (Minnesota Center for Health Statistics, 1983) Given these data, and the fact that past Certificate-of-Need policies did not adequately control the growth in the number of nursing home beds, the Legislature felt that a key step in controlling Medicaid nursing home costs was to place a moratorium on the certification of nursing home beds.

The second objective is related to concerns about large increases in the proportion of SNF beds in Minnesota. Between 1978 and 1983, the proportion of SNF beds increased from 53.2% to 62.4%. This is important because SNF beds are more

expensive. The increasing proportion of SNF beds further adds to the costs of the Medicaid program.

Minnesota's moratorium was implemented with the assumption that the State had an adequate number of nursing home beds, and an adequate number of SNF beds. In order to ensure that the elderly in need of long-term care received adequate long-term care services, the Legislature increased funding for alternative long-term care services (i.e., home care) to offset the possible effects of the moratorium.

SUMMARY OF 1984 MORATORIUM REPORT

The 1984 moratorium report, which was presented to the Minnesota Legislature by the Minnesota Department of Health, examined the impact of the moratorium between May and November of 1983. The report found that:

*Between May and November of 1983, the number of certified nursing home beds increased from 46,207 to 46,678. This was an increase of 471 certified beds. The mixture of beds went from 28,839 SNF beds and 17,368 ICF beds to 29,540 SNF beds and 17,138 ICF beds. Thus, during this period the ratio of SNF to ICF beds increased from 1.66 SNF/1 ICF to 1.72 SNF/1 ICF. (The proportion of SNF beds increased from 62.4% to 63.3%).

*During the six-month period immediately preceding the implementation of the moratorium, 37 facilities requested an upward change in the level of care for ten beds or less, thus requiring no Certificate of Need approval. This resulted in an addition of 463 SNF beds between January 1, 1983 and May 23, 1983, an increase of 45.8% over the preceding six-month period of July 1, 1982 through December 31, 1982.

* The Department's analysis of the "hardship provision" indicated that no county met this criterion. The "hardship provision" is defined as having fewer beds per 1,000 persons over age 65 than the national average (63.19 beds per 1,000). While 13 counties met the hardship provision, the consideration of contiguous counties found that all geographic areas of the State were at least 10% above the national average for beds.

*An additional 1,148 beds (726 SNF and 422 ICF) were expected to be certified subsequent to November 1983 due to the moratorium exception provisions.

*The six-month period from the effective date of the law to the November 30, 1983 cutoff date for the data used in the 1984 report did not provide a sufficient time period for full and comprehensive analysis of the impact of the moratorium or for identification of potential service deficits or problems.

*The Department recommended that the moratorium continue and that additional exceptions to the moratorium not be considered by the 1984 Legislature.

DEMOGRAPHICS OF MINNESOTA'S ELDERLY POPULATION

The moratorium was enacted to control the growth in certified nursing home beds. In spite of accompanying increases in funding for alternative long-term care services, opponents of the moratorium have been concerned about the State's

capacity to meet the long-term care needs of the impaired elderly population. This concern is partly based upon the demographic trends that show an increasing size and changing characteristics of that part of our population most likely to need nursing home care.

The elderly population is the group most likely to need long-term care services. Approximately 91% of residents in nursing homes are over age 65 and almost half are over age 85. (Quality Assurance and Review, 1983) As the number of people in these age groups increase, so will the need for long-term care services. This section provides data on the number of elderly in Minnesota today and in the future. More detailed data tables are provided in the Appendix.

Between 1970 and 1980 the number of Minnesotans over age 65 increased from approximately 408,000 to almost 480,000 -- an increase of 17 percent. In comparison, the total Minnesota population increased by only 14 percent. The increase in the number of elderly, however, was not evenly distributed among the age groups. The lowest rate -- 12.5 percent -- occurred in the youngest age group (those aged 65 to 74) and the largest increase -- a dramatic 56.5 percent -- occurred in the oldest age group (those over age 85). (Health Futures Institute, 1984)

Projections for the next twenty years show that the growth in the number of elderly will begin to slow. While the number of elderly in Minnesota increased 17 percent between 1970 and 1980, there will only be a 14.5 percent increase between 1980 and 1990 and a 9 percent increase between 1990 and 2000. However, the number of those over age 85 will continue to increase at a rapid rate -- from 52,789 in 1980 to 68,542 in 1990 to 90,781 in 2000. These large increases in the number of elderly over age 85 is due in part to increasing life expectancy. Minnesotans at age 65 can expect to live an additional 17 years -- 15 years for men and 19 years for women. This is one of the highest life expectancy rates in the country. (Minnesota Center for Health Statistics, 1982)

Data show that up to 50% of people in this age group need some level of long-term care (either home care or nursing home care). Assuming the status quo, the number of individuals in this age group needing long-term care could increase from 26,000 in 1980 to 45,000 in 2000. (Health Futures Institute, 1984) However, this does not automatically translate into a need for additional nursing home beds. First, individuals over age 85 are increasingly leading more independent lives for longer periods of time. In the future, a lower proportion of people in this age group may require long-term care services. Second, a need for long-term care does not necessarily mean a need for nursing home beds. An increase in the availability of alternative services may adequately substitute for the use of nursing homes.

However, one issue that should be examined is the appropriateness of using the number of nursing home beds per 1,000 persons over age 65 as a indication of the need for additional nursing home beds. The largest number of nursing home beds are used and needed by those over age 85. Demographic projections show a slowing in the rate of growth of those over age 65 -- suggesting a reduced need for nursing home beds. This does not adequately reflect the large growth in the number of people who need that care the most -- those over age 85. Thus, it may be appropriate to use the number of nursing home beds per 1,000 persons over age 85 as the indicator of whether a given geogaphic area is in a "hardship situation" regarding their need for nursing home beds.

ESTIMATE OF THE NEED FOR LONG-TERM CARE IN MINNESOTA

The previous section has stated that the elderly are the largest users of nursing home care -- and that those over age 85 use almost half of the nursing

home beds in Minnesota. However, this does not necessarily describe the total need for long-term care in Minnesota.

People need long-term care when they have a chronic disease or condition which causes both functional impairment and physical dependence on others. This situation is referred to as "functional disability." The presence of chronic disease is often viewed as a primary indicator of a person's risk of long term care placement. About 40 percent of the U.S. population suffers from one or more chronic ailments. (U.S. Senate, 1983) For many of these individuals, illness does not result in any demonstrable functional impairment. Thus, presence of a chronic condition per se is too broad a measure to serve as a proxy for functional disability. The limitation of activity due to chronic condition more closely approximates functional limitation than does the presence of a chronic condition. The following table shows the percentage of elderly with varying limitations.

TABLE 1

Limitation of Activity Due to Chronic Conditions, By Type of Limitation and Age, U.S., 1981

Category	Percent 65-74	Percent 75+
No Limitation of Activity	59%	47%
Limited, but not in major Activity	6%	7%
Limited in Kind or Amount of Major Activity	20%	24%
Unable to Conduct Major Activity	15%	22%

Source: U.S. Senate Special Committee on Aging and the American Association of Retired Persons, Aging America: Trends and Projections , Washington, D.C., 1983.

It may be surprising that such a large proportion of elderly have no limitation of activity due to chronic condition. However, for those 22% of the 75 and over population who are unable to carry on major activity, some type and amount of support is vital.

Many organizations and agencies have attempted to estimate the need for long-term care. Those estimates range from 5.3% to 18.7% of the elderly population needing some level of long-term care (ranging from home care to nursing home care). (MDH, 1981) The Minnesota State Long-Term Care Plan, published by the Minnesota Department of Health in 1981 used estimates developed by the Congressional Budget Office (CBO). The CBO estimated that between 12% and 17% of the older population have disability levels such that they are either bedridden or need help in most basic functions of daily living. Applying these percentages to Minnesota results in the following estimates of need.

TABLE 2

Estimates of the Need for Long-Term Care in Minnesota, 1985

	Estimated 1985 Population
Minnesota 65+ Population	512,467
Estimate of Disabled 65+ (12%)	61,496
Estimate of Disabled 65+ (17%)	87,119

Source: Polich and Associates, 1985.

The above table shows that between 60,000 and 90,000 elderly require some level of long-term care. Currently, approximately 41,000 elderly are in nursing homes or boarding care homes. (MDH, 1984) The remaining elderly still reside in the community. Estimates indicate that the majority of care (60-80%) needed by impaired elderly who live in the community is provided by family and friends. (Minnesota Gerontological Society, 1984) Given this, the estimated number of elderly individuals who still need some level of long-term care is reduced to between 11,000 and 32,000.

This does not suggest that Minnesota needs another 11,000 to 32,000 nursing home beds. Many of those elderly individuals are receiving home care services. A recent report on home care showed that over 32,000 Minnesota elderly currently receive some type of home care services. (Center for Health Services Research, 1985) The following sections further explore the use of both nursing homes and home care by the elderly to determine the extent of unmet need.

CHANGES IN THE INSTITUTIONAL LONG-TERM CARE SYSTEM: NOVEMBER 1983 - NOVEMBER 1984

This section describes the major changes that have occurred in the nursing home system over the past year. The 1984 moratorium report indicated that the number of certified beds increased by 471 between May and November 1983. In addition, the ratio of SNF to ICF beds increased from 1.66/1 to 1.72/1 during this same period.

Number of Certified Nursing Home Beds

The number of certified nursing home and boarding care home beds increased from 46,647 in November 1983 to 47,433 in November 1984. This is an increase of 786 or 1.7%. The following table shows the distribution of SNF, ICF-I and ICF-II beds.

TABLE 3

Number of Certified Beds in Minnesota, November 1983-November 1984

	November 1983	November 1984	Rate of Increase
SNF	29,538	30,174	+2.2%
ICF-I	13,628	13,841	+1.6%
ICF-II	3,481	3,418	(-1.8%)

Source: Minnesota Department of Health, 1984.

The ratio of SNF to ICF beds also changed from 1.72/1 in November 1983 to 1.74/1. This was a much smaller increase in this ratio than occurred between May 1983 and November 1983. (See Appendix for a listing of the number of certified beds by Minnesota county.)

Number of Uncertified Beds

In November 1983 there were 1,967 uncertified beds in Minnesota (646 nursing home beds, 1,279 boarding care home beds, and 42 Medicare only beds). In November 1984 this had increased to 1,995 uncertified beds (652 nursing home, 1,300 boarding care home, and 43 Medicare only beds). This is an increase of 1.4% This is about the same rate of increase that occurred with certified beds. This relatively low rate of increase does not support the suggestion that the moratorium would result in a large increase in the number of uncertified beds. However, it is possible that the construction of more uncertified beds will occur in the future. (See Appendix for a listing of uncertified beds by Minnesota county.)

Occupancy Rates of Nursing Homes

Adequate data are not presently available to analyze the impact of the moratorium on occupancy rates of nursing homes in Minnesota. The most recent data

from the Minnesota Department of Health is for the period October 1982 to September 1983. This is because the State requires nursing homes to report their previous year's occupancy rates. The rates for 1983-1984 had not been reported in time for this report. Since the moratorium took effect in May 1983, these data are not current enough to reflect any changes due the the moratorium. However, it can be used as baseline data for future reports.

TABLE 4

Occupancy Rates of Minnesota Long-Term Care Facilities, October 1982-September 1983

Type of Facility and Geographic Area	Occupancy Rate
Nursing Home - Minneapolis	89.3%
Nursing Home - Outstate	95.2%
Nursing Home - St. Paul	96.3%
Nursing Home - Suburban	92.3%
C & NC - Metropolitan Area	79.0%
C & NC - Outstate	95.1%
Boarding Care Home - Minneapolis	82.7%
Boarding Care Home - Outstate	88.7%
Boarding Care Home - St. Paul	95.8%
Boarding Care Home - Suburban	77.1%

Source: Minnesota Department of Health, 1983.

TABLE 5

Occupancy Rates in Minnesota Nursing Homes, 1978-1984

Geographic Area	1978	1984	% Change
1 Agassiz	95.9%	95.8%	-0.1%
2 Western Lake Superior	97.1%	94.9%	-2.2%
3 MIN-DAK	95.8%	95.9%	+0.1%
4 Central Minnesota	91.6%	96.0%	+4.4%
5 Metropolitan	90.0%	95.3%	+5.3%
6 Region Six (SW)	92.2%	95.4%	+3.2%
7 Southeastern	92.0%	97.3%	+5.5%
Entire State	92.0%	95.8%	+3.8%

Source: Ruth Stryker-Gordon. A Study of Public Policy and Availability of Nursing Home Beds in Minnesota, University of Minnesota, Minneapolis, 1984.

Statewide occupancy for all long-term care facilities was 90% for this period. It was 93.8% for nursing homes, 85.1% for boarding care homes, and 94.3% for convalescent and nursing care (C & NC) units. However, the occupancy rates varied by geographic area, as is shown in the following table.

These data indicate that, as of October 1983, occupancy rates in many areas were low enough to reflect availability of nursing home and boarding care home beds. However, certain geographic areas, particularly outside of the metropolitan area and in St. Paul, showed high occupancy rates. In St. Paul, nursing home and boarding care home occupancy rates of 96% may suggest difficulty in obtaining a nursing home bed in that area.

A report completed by Ruth Stryker-Gordon of the University of Minnesota provided the following data on occupancy rates. These data were obtained from a statewide sample of 321 nursing homes (75% of the nursing homes in Minnesota).

More recent data from the Quality Assurance and Review program show that, for a statewide sample of nursing homes in July, August, September, and October of 1984, occupancy rates were 93.4%.

Changes in the Number of Beds per 1,000 Elderly

The appendix provides data on the number of beds per 1,000 persons over age 65 in each Minnesota county for November 1984. Comparing these rates with data from November 1983 shows that in 13 counties (five of which were metro counties), the number of beds per 1,000 increased over the past year. In only two counties did the number of beds per 1,000 decrease. The remaining counties stayed the same.

The number of beds per 1,000 elderly persons has often been considered a proxy for the appropriate number of nursing homes needed in a geographic area. The moratorium legislation has established the national average of the number of beds per 1,000 persons over age 65 as the norm by which Minnesota will be judged. The national average is 63.19 beds per 1,000. In most Minnesota counties, this rate is significantly higher. Hennepin County's rate is 116.38 beds per 1,000. Ramsey County's rate is 98.65 beds per 1,000. However, county rates vary tremendously -- from a high of 194.26 beds per 1,000 in Sherburne county to a low of 51.93 beds per 1,000 in Todd County.

There are currently eight counties (Carver, Aitkin, Kanabec, Stearns, Todd, Hubbard, Mahnomen, and Marshall) that have a lower rate of beds per 1,000 than the national average. This is down from 13 counties in 1983. However, as was true last year, none of these counties meet the "hardship" exception when contiguous counties are considered.

This again raises the issue of whether "the number of beds per 1,000 persons over age 65" is the appropriate number to use as the norm for adequate numbers of nursing home beds. Since the largest number of people using nursing homes are over age 85, using the number of beds per 1,000 persons over age 85 may not only be more appropriate but may better capture future needs due to population changes than would using age 65 as the variable.

Changes in Level of Care

It has been suggested that the level of care needed by people entering nursing homes has increased -- that is, that nursing homes are caring for more disabled individuals than they have in the past. This statement would support the need for a larger number of skilled nursing beds compared to the number of ICF beds. Since the moratorium prohibits recertifying beds to a higher level of care, there is concern that residents are not able to obtain the care that they need.

The Quality Assurance and Review Section of the Minnesota Department of Health annually assesses the level of care needs of nursing home residents. Recent data are not available for level of care recommendations made to facilities by the QA & R teams. However, the following table shows level of care recommendations made by QA & R in 1983.

TABLE 6

Quality Assurance Review's Recommendations for Changes in Level of Care, 1983

Recommendation	Number of Cases	Number Changed	Percent Changed
SNF to ICF-I	796	208	26.1%
SNF to ICF-II	15	4	26.7%
ICF-I to SNF	1,623	320	19.7%
ICF-I to ICF-II	332	32	9.6%
ICF-II to SNF	39	13	33.3%
ICF-II to ICF-I	68	14	20.6%
Total	2,873	591	20.6%

Source: Minnesota Department of Health, 1983.

The above table shows that in 1,730 cases, the QAR team recommended moving the resident to a higher level of care. In 1,143 cases, the QAR team recommended moving the resident to a lower level of care. These recommendations were implemented in 20% of the cases when a higher level of care was needed, and 21% of the cases when a lower level of care was needed. More importantly, the recommendation was more likely to be implemented when a facility had both SNF and ICF beds compared to those facilities that had only one level of care. What this may suggest is a greater need for facilities to have a mixture of levels of care. Currently, however, facilities are more likely to request an increase in level of care certification even though there appears to be a comparable need for lower care levels (according to the QA & R).

Aggregately the profile of nursing home residents is changing. In 1982, the average age of SNF residents was 81.6 compared to 81.9 in 1983. For ICF residents, the average age increased from 80.7 to 80.8. More residents are being admitted from the hospital (possibly suggesting greater disability levels). However, there are no major differences reported in the physician's statement of general condition. Approximately the same percentage of residents have an unstable or declining condition (13% of SNF residents and 6% of ICF residents).

The available data does not show that the moratorium has had major negative effects on the availability of nursing home beds. There are more certified beds and slightly more uncertified beds available now compared to a year ago. The occupancy rates are high in some areas, but not so high as to suggest extreme difficulty in finding a nursing home bed. The number of beds per 1,000 persons over age 65 has increased compared to a year ago. However, as stated above, this may not adequately reflect the need for nursing home beds. Level of care recommendations from QA & R show that 1,730 residents needed higher levels of care. However, 1,143 residents needed lower levels of care. While this may suggest a need to allow facilities to change their certification levels, it does not suggest a need to change them only to higher levels of care.

DESCRIPTION OF CHANGES IN THE NON-INSTITUTIONAL LONG-TERM CARE SYSTEM

An integral part of the long-term care system is the non-institutional or home care service system. The moratorium was created in part to reduce Minnesota's reliance on nursing home care. A second part of this strategy, however, is to increase the availability of home care services in order to create alternatives to nursing home placement. Past studies have indicated that home care services can substitute for nursing home care in certain circumstances. Thus, if a moratorium on nursing home bed certification is to have no major negative effects, other services must be available to care for those individuals who would have otherwise gone into a nursing home. This is particularly true if the moratorium is maintained for a long period of time. This section describes the availability of these alternative long-term care services -- or home care.

Earlier estimates of the need for long-term care showed that between 11,000 and 32,000 elderly individuals reside at home but need some level of long-term care. One of the primary programs providing these services is the Pre-Admission Screening/Alternative Care Grant program.

The Minnesota legislature first established a pilot pre-admission screening program in 1980. It was implemented in two counties (Blue Earth and St. Louis). It was an attempt to reduce the costs of long-term care in Minnesota, reduce inappropriate nursing home and boarding care home placement, and provide alternatives to institutionalization for the elderly. In 1981 the legislature funded the pre-admission screening (PAS) program for statewide implementation, although the program was not mandated (that is, the counties were not required to participate). It was also expanded to include funds for alternative care grants (ACG). These grants could be used by counties with approved pre-admission screening programs to provide services to the elderly. As of July 1, 1983, the program was required in all counties in Minnesota.

While the program has undergone many changes in the past four years, the basic concept and objectives remain the same. The program is divided into two components: Pre-Admission Screening and Alternative Care Grants. The Pre-Admission Screening Progam requires that all elderly applicants to nursing homes (those 65 and over) who are eligible for Medicaid, or will be eligible within 180 days if they enter the nursing home, be screened by the county's pre-admission screening program. In addition, the pre-admission screening program can assess elderly individuals who are at risk of nursing home placement -- even if they have not made an application to be admitted to a nursing home.

The Alternative Care Grant Program (ACG) can fund services to individuals screened which will allow them to be maintained at home rather than enter a nursing home. The services allowed by the program include: adult day care, homemaker, home health aide, adult foster care, respite care, case management, and personal care. In order to receive ACG services the elderly individual must be at risk of nursing home placement -- that is, they must either have applied for nursing home placement, be seriously considering it as an option, or meet ICF-I or SNF level of care criteria. It is important to note that, while the screening team makes a recommendation regarding the appropriate placement for the elderly individual, the client has the final choice of placement. If, for example, the screening team recommends that the client remain at home but the client chooses to enter a nursing home, that is permitted. The program emphasizes client choice and the right to self-determination.

The following provides information on the program operations for fiscal year 1984 (July 1983 to July 1984). (DHS, 1984)

1) There were 5,236 individuals screened in Minnesota between July 1983 and June

1984. Over the four quarters of this year the number of screenings went from 1,222 in the first quarter to 1,141 in the second quarter to 1,336 in the third quarter to 1,537 in the fourth quarter.
2) The average age of clients screened was 80.7 years, which is about the same as the average age of nursing home residents.
3) The majority of clients were 180-day eligibles (66%). Only 27% were currently Medicaid-eligible.
4) The screening teams recommended that over 51% of the clients stay at home with services. Four percent of clients were recommended to stay at home without services and 41% were recommended to enter a nursing home or boarding care home.
5) There has been a trend toward an increasing proportion of clients being placed in the community and a decreasing proportion placed in nursing homes.
6) The counties differ tremendously in the proportion of clients recommended to nursing home versus community placement (from 100% recommended to nursing homes to 86% placed in the community) and with the rate of screening (from 0% to 5.7%), that is, the percentage of the county's elderly population that was screened last year.
7) The cost of the pre-admission screening program was $559,750 for fiscal year 1984. The cost of providing alternative care services was $4,233,451. The total number of clients who received services in fiscal year 1984 was approximately 2,500.

Other public programs also provide services to the elderly, including Medicaid, Title III of the Older Americans Act, the Community Social Services Program, the Community Health Services Program and Medicare. Together with the Alternative Care Grant program, approximately $40 million in public funds are spent for home care serving over 30,000 elderly clients. (Center for Health Services Research, 1985) However, there is likely some duplication of clients across programs. Unduplicated numbers across programs are not available. In addition, this does not include services that are purchased from private providers.

Anecdotally, practitioners in the field state that they are able to provide services to most elderly who require them. It is a rare circumstance when services cannot be provided to a functionally impaired elderly person, at least in the metropolitan area of the State. Given this, it appears that our current system is doing an adequate job in the metropolitan area of providing care to those in need. However, rural areas of the state are still plagued with problems of an insufficient supply of services and providers. In addition, given expected increases in the size of the "at risk" elderly population, current service levels will not likely meet future needs.

Finally, a survey was made of a seven county pre-admission screening programs in Minnesota to determine whether the screening teams had any difficulty finding suitable nursing home beds for their clients. The teams interviewed indicated that they did not have any greater difficulty now than a year ago finding suitable beds for clients. The consensus was that screening teams were able to find a nursing bed at the proper level of care whenever one was needed. However, there were some problems obtaining a bed in the client's preferred nursing home, or in the preferred geographic area. It was also stated that this was no different from the difficulty that was experienced before the moratorium was in effect. It has always been difficult to find beds in preferred homes.

One suggestion by screeners was that the Pre-Admission Screening/Alternative Care Grant program was providing additional competition for the nursing home industry. Prior to the implementation of PAS/ACG, if an impaired elderly person needed long-term care and could not be admitted to the preferred home, that person would have to enter whatever home had beds available. Today, that person can remain at home with alternative services until the preferred bed becomes available.

OTHER SYSTEM CHANGES AND ISSUES

Certification Denials

In spite of the moratorium, many facilities have made requests for certification changes or additions. Since the moratorium went into effect in May 1983, 27 facilities have made certification requests. All of these were denied. Seven of these were for new certifications, twenty were for upward re-certifications. (See Appendix for a listing of these facilities.)

Moratorium Exceptions

Since May, 1983, 21 homes added new beds that have been certified. This amounted to 954 SNF beds and 312 ICF beds. In addition, five facilities were allowed to reclassify beds. This resulted in a change of 39 ICF-II beds to 41 ICF-I beds, 30 ICF-I beds to 30 SNF beds, and 6 ICF-II beds to 6 SNF beds. (See Appendix for a listing of these facilities.)

Consumer Complaints Related to the Moratorium

The Long-Term Care Ombudsman and the Office for Health Facility Complaints both handle consumer complaints about nursing homes. Neither office reports any complaints about the inability of consumers to locate or be admitted to a suitable nursing home.

Provider Reactions to the Moratorium

A survey was conducted of both a sample of nursing homes and a sample of discharge planners in Minnesota hospitals. (See Appendix for a list of nursing homes and hospitals surveyed.) The facilities were asked whether they had any difficulty in the past year (and since the moratorium) placing elderly clients in suitable nursing homes. Both the nursing home administrators and the hospital discharge planners echoed the findings of the pre-admission screeners. Both felt that there were no major differences since the moratorium went into effect. All the nursing homes kept a waiting list but none felt that elderly individuals in need of placement could not find suitable beds. None of the homes surveyed had any plans to expand their homes prior to the moratorium. In addition, none felt that their placement situations had changed in the past year (i.e., their waiting list had not gotten longer, and the length of time of waiting before admission had not gotten significantly longer). The discharge planners indicated that they did have problems placing people in their preferred homes but did not have problems finding a bed with a suitable level of care. And again, this was no different than before the moratorium.

Provider reaction to the moratorium is mixed. The predominant negative feelings are from those homes (or potential homes) that had plans to expand or change certification of beds prior to the implementation of the moratorium. Others believe that the moratorium effectively eliminates competition from the nursing home industry. Few seem to believe that the moratorium has resulted in a negative impact on the care (or lack of care) being provided to the elderly. In fact, many of the nursing homes are now diversifying into alternative services and housing in order to expand their continuum of care and continue to serve their constituency without new nursing home beds. However, their major concern is with the inability to recertify to higher levels of care. Most of the homes surveyed

did believe that the acuity or disability level of their residents was increasing (even though they had no data to support this). It was thought that this increase in acuity was due primarily to DRGs (Diagnostic Related Groups) in hospitals. DRGs is a new reimbursement system which pays hospitals for treatment of elderly patients by diagnosis, not according to total costs. Some believe this has resulted in elderly patients being discharged earlier from hospital stays. Thus, they are admitted to nursing homes with higher care needs. Again, no data exist to either support or refute this argument.

Ruth Stryker-Gordon's report entitled A Study of Public Policy and Availability of Nursing Home Beds in Minnesota, showed somewhat similar findings. She surveyed a sample of 321 nursing homes in Minnesota (75% of the nursing homes in the State). Of this group, 74% had waiting lists. In addition, the survey found that the greatest wait time was for persons needing skilled nursing care. Twenty-two percent of the homes with SNF beds had a waiting time of two or more years. However, 66% of those homes with waiting lists provide services to clients between the time they apply for admission and a bed opens. This indicates that in many cases, in spite of the fact a nursing home bed is not available in the preferred home, the client's long-term care needs are nonetheless met.

Stryker-Gordon's report also found that hospitalized persons have an admission priority in over half the homes and is second priority for 22 percent of the homes. Only seventeen percent of the homes reported calling the people at the top of their waiting list, regardless of client status. This reflects a tendency on the part of most nursing homes to target their vacant beds to those elderly most in need. This targeting is extremely important in order to ensure that the moratorium has minimal negative implications on the availability of care for those most in need.

Impact of Case Mix Reimbursement

Another element of the State's strategy to contain Medicaid costs is a revision of the nursing home reimbursement system. This new system, referred to as Case Mix Reimbursement, is expected to be implemented later this year.

It is unclear what impact case mix reimbursement will have on the moratorium, or vice versa. Case mix reimbursement will move the State away from payment based on SNF and ICF levels of care. Instead, residents will be classified within eleven different categories based upon the intensity of care they require. Given this, the ratio of SNF to ICF certified beds will no longer be as important for analyzing the implications for the Medicaid budget. Rather, the important variable will be the relative proportions of the eleven resident classification groups and the reimbursement rates for each grouping.

This foes not mean, however, that SNF and ICF Certificate will not continue to be an important factor in Minnesota's nursing home system. Unless federal certification requirements are changed, nursing home beds will still be required to be certified as SNF or ICF, and meet those standards. The eleven classification groups will in some way need to correspond with the SNF and ICF certification. The result may be that a nursing home with all ICF certified beds, for example, would not be allowed to care for residents who are assessed to be in the highest care mix groupings.

The restrictions of the moratorium on upward certification may need to be revised with the implementation of case mix reimbursement. The important issue will no longer be how many SNF beds the State has, but how residents are assessed, and in what case mix group they are placed. Currently, the State can control reimbursement by limiting the number of beds (and thus, the number of residents) at each level of care through the moratorium. It is unclear how much discretion the State will have to limit the number of residents assigned to each of the eleven level of care categories after case mix reimbursement is implemented. As a

result, it may be more difficult to control the Medicaid budget through limits on the higher levels of care. Rather, cost containment may need to be accomplished through limitations on rates and on continued limitations on the total number of beds. Limitations on upward certification will likely no longer be relevant.

Impact of Increasing Numbers of Uncertified Beds

One concern that was expressed during the debate on the passage of the moratorium was whether it would result in an increase in the number of uncertified beds. As was shown earlier, the first year and a half of data do not show a significant increase in the number of uncertified beds. While it may be too early to draw conclusions on the impact of the moratorium in this area, it is important to continue to monitor the potential increase in the number of uncertified beds.

Three types of nursing home beds have the greatest potential for significantly increasing the number of uncertified beds: private-pay beds, Medicare swing beds, and Veterans Homes. The potential of a significant increase in private-pay beds is limited by the number of elderly with required resources. Medicare swing beds and Veterans Homes are not limited by the potential market as there will likely be an adequate demand for these beds from the elderly population.

On the surface, it does not appear that the addition of a large number of uncertified beds would have a negative impact on the Medicaid budget (since the Medicaid program will not pay for care provided in these beds). However, the addition of these beds may have indirect negative implications in two ways. First, the addition of these beds will add capacity to the nursing home system. If those beds are filled, it will free space in certified beds. The result is that the State will not be reducing its reliance on nursing homes to provide long-term care, but perpetuating that reliance. The institutionalization rate and the number of beds per 1,000 in Minnesota will continue to grow. Second, once the moratorium is lifted, it is likely that many of these nursing homes will request certification for their uncertified beds. If the certification is granted, it will result in large increases in the Medicaid budget. The moratorium will have only been a short-term interruption in the increasing costs of nursing home care to the State.

Medicare swing beds are hospital beds that have been "converted" to nursing home use. A hospital can apply to the Minnesota Department of Health to use some of their beds for nursing home care. They are intended to be used for short-term rehabilitation after a hospitalization or until another nursing home bed or appropriate non-institutional placement becomes available. No patient can stay in a swing bed for longer than 100 days unless there are no other available nursing home beds within a 25 mile distance from the patient's home that can provide the services needed by the patient. There are currently approximately 70 hospital beds that have been allowed to "convert" to Medicare swing beds. However, it is estimated that the potential number of Medicare swing beds that are eligible for approval is approximately 1,500 statewide. Again, this is important because, while swing beds can serve as an important precaution against negative consequences of the moratorium (i.e., when a nursing bed is not available to a hospitalized patient upon discharge), a large increase in the number of swing beds can also serve to undermine the intent of the moratorium.

This also holds true for the construction of new beds in Veterans Homes. The Minnesota Department of Veterans Affairs recently completed a report intended to determine the need for long-term care services for elderly veterans in Minnesota. While the report recommended that no new nursing home beds be added to the veterans long-term care system, there is considerable interest on the part of veterans groups to construct Veterans Homes throughout the State. While, these beds would not be certified for Medicaid reimbursement, they would require a State

appropriation to supplement federal reimbursement and payments from veterans for this care. In addition, since the majority of veterans who require nursing home care currently use private nursing homes, the addition of beds specifically designated for veterans would have a major impact on both the nursing home industry and the objectives of the moratorium.

In the remaining years of the moratorium it will be extremely important to monitor and analyze the impact of the potential growth in uncertified beds in order to ensure that the moratorium results in its intended outcome.

Adjustments to the Moratorium Exceptions

The initial moratorium legislation stipulated four exceptions under which new nursing home beds could be certified (or existing beds re-certified). It may be necessary in the future to re-examine these exceptions and make adjustments. This report has already discussed two possible adjustments that may be needed.

1) Change the definition of "extreme hardship situation."

Currently, the "extreme hardship" is defined as having fewer nursing home beds than the national average of the number of beds per 1,000 individuals over age 65. Data have shown that the largest number of nursing home residents are over age 85 and that it is at this higher age that the need for nursing home care increases. Age 65 is not an adequate proxy for the need for nursing home care. In addition, demographic trends show a decreasing growth in the over age 65 population, but a dramatic increase in the number of people over age 85. Using age 65 as the variable to determine the need for more nursing home beds will underestimate the actual need as the population changes.

2) Change the limitations on upward certification of nursing home beds after the implementation of case mix reimbursement.

Further analysis is needed to determine how case mix reimbursement will interact with the moratorium. In particular, the implementation of case mix reimbursement will likely make the limitations on upward certification of nursing home beds irrelevant since nursing homes will no longer be reimbursed based upon their SNF and ICF certification. Nursing homes will be reimbursed according to which of the eleven case mix groupings the residents are assigned. In addition, the assignment of residents to these groupings will not be as easily controlled (in order to control the Medicaid budget) as the proportion of SNF beds.

3) Extend the moratorium to licensed beds.

In order to prevent the potential increases in the number of uncertified beds and the indirect negative consequences that might result, some suggest extending the moratorium to all nursing home beds in Minnesota -- not just certified beds. One concern regarding the moratorium was that it would result in a large increase in the number of uncertified beds. Current data show little evidence of this potential increase.

4) Allow the selective replacement of nursing home beds.

Currently, the exceptions for the moratorium are interpreted to not allow for the construction of new certified beds, even when that construction will replace existing beds at the same level of certification. It may be necessary to revise the exceptions to allow for selective replacement when there will be no new beds added and no upward certification required. This may be necessary for nursing

homes that are out-dated. Some nursing homes in Minnesota are very old. While new construction of these facilities may add somewhat to the Medicaid budget, it may be appropriate in certain circumstances in order to ensure an acceptable quality of life for all nursing home residents in Minnesota.

CONCLUSIONS AND RECOMMENDATIONS

The primary conclusion of this report is that available data show no evidence of negative impact from the moratorium on meeting the long-term care needs of the elderly. This is due to a continued growth in the number of nursing home beds due to exceptions to the moratorium and an increase in the availability of alternative long-term care services. Thus, the Department recommends that the moratorium be continued for another year.

However, special attention is needed to certain issues. First, in order for the moratorium to continue to have no negative impact on care, the State must continue to adequately fund home care services. These services must be used to substitute for the nursing home care that would otherwise be provided. Second, the Legislature should consider changing the norm for determining "hardship situations" from beds per 1,000 persons over age 65. This is needed in order to adequately assess increasing needs for long-term care. Third, additional data and analysis is needed regarding the implications of DRGs on the need for nursing home beds and higher level of care certification.

It is still too early to adequately assess the impact of the moratorium. Once those beds that are exceptions to the moratorium are all certified, and the population continues to increase, the "beds per 1,000" rate should begin to decline. At that point, it may be possible to detect a greater impact of the moratorium. It is essential that adequate data be gathered (and that sufficient funds be allocated for analysis) in order to fully understand the changes that will occur. The data needed include:

1) the number of certified beds, by level of care and by county,
2) the number of uncertified beds, by level of care and by county,
3) occupancy rates by facility and by county,
4) beds per 1,000 person over age 65 (or 85), by county,
5) number of clients served by home care services, by county,
6) extent of consumer complaints about the moratorium,
7) the number of admissions to nursing homes, by level of care and by county, including whether the admission was a new admission or a re-admission after hospitalization,
8) the level of disability of nursing home residents, including the case mix grouping in which the residents are placed, and
9) QAR level of care recommendations and resident characteristics.

APPENDIX

APPENDIX A

GLOSSARY OF TERMS

GLOSSARY OF TERMS

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

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

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

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

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

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

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

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

c. Levels of Care

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

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

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

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

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

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

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

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

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

APPENDIX B

DEMOGRAPHIC DATA ON THE ELDERLY POPULATION

DEMOGRAPHIC DATA ON THE ELDERLY POPULATION

TABLE ONE

NUMBER OF ELDERLY AND AGE DISTRIBUTION, MINNESOTA, 1970-2000

AGE	1970	1980	1990	2000
65+	408,919	479,564	548,933	599,959
65-74	240,406	270,148	295,969	292,412
75-84	134,773	156,627	184,422	216,766
85+	33,740	52,789	68,542	90,781

TABLE TWO

GROWTH RATES OF THE ELDERLY POPULATION, MINNESOTA, 1970-2000

AGE	1970-1980	1980-1990	1990-2000
65+	+17.0%	+14.5%	+ 9.3%
65-74	+12.5%	+ 9.6%	(-1.2%)
75-84	+16.0%	+17.7%	+17.5%
85+	+56.5%	+29.8%	+32.4%
TOTAL POP.	+14.0%	+ 5.3%	+ 3.4%

SOURCE: HEALTH FUTURES INSTITUTE, 1984.

APPENDIX C

NUMBER OF CERTIFIED BEDS, BY COUNTY

MINNESOTA DEPARTMENT OF HEALTH
HEALTH RESOURCES DIVISION
NUMBER OF CERTIFIED BEDS

County	November 1, 1983 T. 19 SNF	ICF I	ICF II	November 1, 1984 T. 19 SNF	ICF I	ICF II
Aitkin	68	86	0	68	86	0
Anoka	525	135	0	560	135	0
Becker	283	129	0	280	129	0
Beltrami	123	160	20	123	160	20
Benton	458	20	0	458	20	0
Big Stone	37	151	0	37	151	0
Blue Earth	340	163	28	340	163	28
Brown	212	175	11	212	175	11
Carlton	275	3	51	275	3	51
Carver	90	80	28	90	80	28
Cass	298	204	0	298	204	0
Chippewa	65	150	0	65	150	0
Chisago	269	70	24	269	70	24
Clay	235	191	0	235	191	0
Clearwater	70	96	0	70	96	0
Cook	47	0	0	47	0	0
Cottonwood	0	275	0	0	272	0
Crow Wing	312	94	32	312	94	32
Dakota	932	148	8	932	148	8
Dodge	156	0	0	156	0	0
Douglas	249	231	0	249	231	0
Faribault	212	90	0	212	90	0
Fillmore	262	200	0	283	211	0
Freeborn	339	129	0	339	129	0

County	November 1, 1983 T. 19 SNF	ICF I	ICF II	November 1, 1984 T. 19 SNF	ICF I	ICF II
Goodhue	641	153	25	641	153	25
Grant	107	80	0	107	80	0
Hennepin	7,054	2,786	1,818	7,435	2,939	1,777
Houston	176	122	0	176	122	0
Hubbard	130	0	0	130	0	0
Isanti	150	40	63	163	80	63
Itasca	291	18	58	291	18	58
Jackson	71	140	0	71	140	0
Kanabec	58	29	20	58	29	20
Kandiyohi	332	107	58	332	107	58
Kittson	91	75	0	91	75	0
Koochiching	110	72	0	110	72	0
Lac Qui Parle	115	95	37	115	95	37
Lake	50	55	0	50	55	0
Lake of the Woods	0	52	0	0	52	0
LeSueur	229	22	12	229	22	12
Lincoln	120	30	14	120	30	14
Lyon	194	164	8	194	164	8
McLeod	185	116	0	218	116	0
Mahnomen	48	0	0	48	0	0
Marshall	0	102	0	0	102	0
Martin	225	70	18	225	70	18
Meeker	194	112	52	194	112	52
Mille Lacs	319	20	0	319	20	0
Morrison	309	69	0	309	69	0
Mower	447	79	0	447	79	0
Murray	32	94	0	32	94	0
Nicollet	141	60	0	141	60	0

	November 1, 1983			November 1, 1984		
County	T. 19 SNF	ICF I	ICF II	T. 19 SNF	ICF I	ICF II
Nobles	67	191	0	67	191	0
Norman	93	176	0	93	176	0
Olmsted	601	137	9	601	137	9
Otter Tail	225	618	100	225	618	100
Pennington	90	75	0	90	75	0
Pine	139	42	0	179	42	0
Pipestone	40	157	30	40	157	30
Polk	351	251	132	351	251	132
Pope	99	92	51	99	92	51
Ramsey	3,911	891	361	3,981	891	361
Red Lake	0	74	0	0	74	0
Redwood	238	155	0	238	155	0
Renville	110	247	24	110	247	24
Rice	440	140	40	440	140	40
Rock	0	118	4	0	118	4
Roseau	90	63	20	90	63	20
St. Louis	1,784	642	113	1,784	642	113
Scott	296	170	0	296	170	0
Sherburne	333	121	20	333	121	20
Sibley	81	92	0	81	92	0
Stearns	425	62	48	425	62	48
Steele	266	34	0	266	34	0
Stevens	98	46	0	98	46	0
Swift	72	75	31	72	75	31
Todd	162	49	0	162	49	0
Traverse	0	125	2	0	125	2
Wabasha	176	52	10	176	52	10

	November 1, 1983			November 1, 1984		
County	T. 19 SNF	ICF I	ICF II	T. 19 SNF	ICF I	ICF II
Wadena	70	236	0	70	236	0
Waseca	188	11	0	188	11	0
Washington	465	128	23	465	128	23
Watonwan	0	168	0	0	168	0
Wilkin	86	39	0	85	38	0
Winona	407	96	78	451	109	56
Wright	368	185	0	371	185	0
Yellow Medicine	91	128	0	91	128	0
TOTALS	29,538	13,628	3,481	30,174	13,841	3,418

APPENDIX D

NUMBER OF UNCERTIFIED BEDS, BY COUNTY

MINNESOTA DEPARTMENT OF HEALTH
HEALTH RESOURCES DIVISION
NUMBER OF UNCERTIFIED BEDS

	November 1, 1983			November 1, 1984		
County	NH	BCH	T. 18 Only	NH	BCH	T. 18 Only
Aitkin		6			6	
Anoka						
Becker						
Beltrami		20			20	
Benton						
Big Stone						
Blue Earth						
Brown		12			12	
Carlton						
Carver		22			22	
Cass						
Chippewa						
Chisago						
Clay						
Clearwater						
Cottonwood						
Crow Wing						
Dakota	3	200		3	200	
Dodge						
Douglas						
Faribault		27			27	
Fillmore						
Freeborn		41			41	
Goodhue				2		

County	November 1, 1983 NH	BCH	T. 18 Only	November 1, 1984 NH	BCH	T. 18 Only
Grant	5			5		
Hennepin	574	339	42	574	360	42
Houstin						
Hubbard						
Isanti		23			23	
Itasca						
Jackson						
Kanabec						
Kandiyohi						
Kittson						
Koochiching						
Lac Qui Parle						
Lake						
Lake of the Woods						
LeSueur						
Lincoln						
Lyon						
McLeod						
Mahnomen						
Marshall						
Martin		11			11	
Meeker						
Mille Lacs						
Morrison						
Mower						
Murray						
Nicollet						

County	November 1, 1983 NH	BCH	T. 18 Only	November 1, 1984 NH	BCH	T. 18 Only
Nobles						
Norman						
Olmsted		75			75	
Otter Tail						
Pennington		150			150	
Pine						
Pipestone						
Polk		19		4	19	
Pope						
Ramsey	40	175		40	175	
Red Lake						
Redwood		22			22	
Renville						
Rice						
Rock						
Roseau		26			26	
St. Louis						
Scott						
Sherburne						
Sibley						
Stearns	5	12		5	12	
Steele		13			13	
Stevens						
Swift						
Todd						
Traverse						
Wabasha	19	17		19	17	

County	November 1, 1983 NH	BCH	T. 18 Only	November 1, 1984 NH	BCH	T. 18 Only
Wadena						
Waseca						
Washington		58			58	
Wilkin						1
Winona		11			11	
Wright						
Yellow Medicine						
TOTAL	646	1,279	42	652	1,300	43

APPENDIX E

NURSING HOME BEDS PER 1,000 ELDERLY IN MINNESOTA, BY COUNTY

Minnesota Department of Health
Health Resources Division
November 1, 1984

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

HSA-Metro Health Planning Board

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Anoka	84.78	109.55
Carver	60.07	112.18
Dakota	95.69	110.57
Hennepin	116.38	108.52
Ramsey	98.65	107.84
Scott	144.00	111.91
Washington	99.63	97.64

HSA-of Western Lake Superior

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Aitkin	59.12	83.34
Carlton	86.49	82.22
Cook	77.18	73.25
Itasca	68.91	85.54
Koochiching	88.95	83.15
Lake	71.62	83.83
St. Louis	84.56	81.20

HSA-Min-Dak

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Becker	95.56	115.76
Clay	86.11	99.21
Douglas	108.38	81.87
Grant	121.82	103.86

HSA-Min-Dak (Continued)

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Otter Tail	100.24	95.78
Pope	109.16	78.76
Stevens	90.28	104.74
Traverse	111.50	107.45
Wilkin	94.30	98.51

HSA-Central

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Benton	172.56	97.10
Cass	128.03	80.88
Chisago	117.17	93.40
Crow Wing	67.27	89.73
Isanti	120.09	104.21
Kanabec	62.65	93.08
Mille Lacs	111.37	103.93
Morrison	92.15	83.15
Pine	73.57	88.27
Sherburne	194.26	110.02
Stearns	52.61	94.16
Todd	51.93	88.33
Wadena	131.44	95.22
Wright	92.11	107.48

HSA-Agassiz

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

HSA-Agassiz (Continued)

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Clearwater	109.14	98.10
Hubbard	56.37	102.33
Kittson	131.33	86.49
Lake of the Woods	83.87	89.45
Mahnomen	55.24	116.45
Marshall	52.23	102.36
Norman	139.16	108.46
Pennington	74.90	101.11
Polk	136.94	106.11
Red Lake	87.68	115.74
Roseau	91.92	87.40

HSA-Southeastern (State Planning)

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Dodge	82.98	96.88
Fillmore	123.90	96.38
Freeborn	85.54	82.58
Goodhue	134.17	99.10
Houston	109.68	109.28
Mower	82.61	89.39
Olmsted	87.12	99.73
Rice	116.72	103.96
Steele	78.45	98.19
Wabasha	80.08	101.57
Winona	99.77	97.98

HSA-Six

County	# of Beds Per 1,000	# of Beds Per 1,000 Including Contiguous Counties
Big Stone	118.84	102.50
Blue Earth	88.13	81.63
Brown	88.98	93.15
Chippewa	80.74	96.03
Cottonwood	98.99	87.80
Faribault	84.05	83.46
Jackson	95.00	81.76
Kandiyohi	97.82	81.89
Lac Qui Parle	120.84	94.74
LeSueur	77.58	95.02
Lincoln	104.13	96.46
Lyon	108.22	100.84
McLeod	81.58	87.63
Martin	75.55	86.04
Meeker	108.09	82.21
Murray	69.57	95.67
Nicollet	71.30	85.44
Nobles	75.68	86.87
Pipestone	105.19	90.28
Redwood	115.55	98.62
Renville	107.66	92.05
Rock	73.72	81.15
Sibley	68.06	87.96
Swift	78.62	98.07
Waseca	79.86	89.12
Watonwan	77.74	86.97
Yellow Medicine	87.67	103.92

APPENDIX F

LEVEL OF CARE CHANGE RECOMMENDATIONS

LEVEL OF CARE CHANGE RECOMMENDATIONS, MINNESOTA QUALITY ASSURANCE AND REVIEW PROGRAM, MINNESOTA DEPARTMENT OF HEALTH, 1984

Residents Reviewed

SNF	15,754
ICF	11,186
ICF-MR	6,480
Psych.	249
TOTAL	33,669

Level of Care Recommendations

TYPE	MADE	ACCEPTED
ICF to SNF	1,648	348
ICF to ICF-MR Comm.	32	3
ICF to Psych. Care	2	1
ICF to Acute Care	1	0
ICF to Independent Liv.	19	4
ICF to SILS	13	1
Sub Total	1,715	357
SNF to ICF	1,068	306
SNF to ICF-MR Comm.	10	1
SNF to Psych. Care	5	0
SNF to Acute Care	1	1
SNF to Independent Liv.	2	1
SNF to SILS	1	0
Sub Total	1,087	309
Community Group Homes		
ICF-MR to SNF	1	0
ICF-MR to ICF	4	0
ICF-MR to ICF-MR State Hospital	2	0
ICF-MR to Psych. Care	3	0
ICF-MR to Acute Care	0	0
ICF-MR to Independent Liv.	2	1
ICF-MR to SILS	71	26
Sub Total	83	27
State Hospital		
ICF-MR to SNF	2	1
ICF-MR to ICF	1	0
ICF-MR to ICR-MR Comm.	121	35
ICF-MR to Psych Care	0	0
ICF-MR to Acute Care	1	0
ICF-MR to Independent Liv.	0	0
ICF-MR to SILS	5	0
Sub Total	130	36
Psych Care to SNF	2	0
Psych Care to ICF	2	1
Sub Total	4	1
GRAND TOTAL	3,019	730

LEVEL OF CARE RECOMMENDATIONS MADE/ACCEPTED BY FACILITY CERTIFICATION - 1983

FACILITY	NUMBER OF FACILITIES	NUMBER OF FACILITIES BY LEVEL OF CARE	RECOMMENDED CHANGE IN LEVEL OF CARE	NUMBER OF RECOMMENDATIONS MADE	ACCEPTED	PERCENT
SNF	35	22	SNF TO ICFI	100	2	2
		2	SNF TO ICFII	5	1	20
		1	SNF TO ICF-MR(C)	1	0	0
		1	SNF TO PSYCH	1	0	0
SNF/ICF	307	205	SNF TO ICFI	696	206	29
		10	SNF TO ICFII	10	3	30
		10	SNF OF ICF-MR(C)	11	1	9
		3	SNF TO PSYCH	3	0	0
		1	SNF TO ACUTE	1	0	0
		2	SNF TO INDEPEND LIVING	2	1	50
		156	ICFI TO SNF	474	248	52
		6	ICFII TO SNF	7	4	57
		101	ICFI TO ICFII	237	27	11
		8	ICFII TO ICFI	31	4	13
		21	ICFI TO ICF-MR(C)	26	5	19
		1	ICFII TO ICF-MR(C)	2	0	0
		1	ICFI TO PSYCH	1	0	0
		4	ICFI TO INDEPEND LIVING	4	1	25
		1	ICFII TO INDEPEND LIVING	1	0	0
		1	ICFI TO ACUTE	1	0	0
		2	ICFI TO SILS	2	2	100
ICF	115	83	ICFI TO SNF	1149	72	6
		40	ICFI TO ICFII	95	5	5
		9	ICFI TO ICF-MR(C)	11	1	9
		1	ICFI TO ACUTE	1	0	0
		3	ICFI TO INDEPEND LIVING	3	1	33
		1	ICFI TO SILS	1	0	0
		11	ICFII TO SNF	32	9	28
		13	ICFII TO ICFI	37	10	27
		3	ICFII TO ICF-MR(C)	4	1	25
		1	ICFII TO INDEPEND LIVING	1	1	100
ICF-MR(C)	310	2	ICF-MR TO SNF	3	0	0
		2	ICF-MR TO ICFI	2	0	0
		5	ICF-MR TO ICFII	11	6	54
		1	ICF-MR TO ICF-MR(H)	1	1	100
		1	ICF-MR TO PSYCH	1	1	100
		1	ICF-MR TO INDEPEND LIVING	1	1	100
		47	ICF-MR TO SILS	81	41	51
ICF-MR(H)	8	2	ICF-MR TO SNF	26	26	100
		7	ICF-MR TO ICF-MR(C)	132	62	47
		2	ICF-MR TO PSYCH	3	0	0
		2	ICF-MR TO SILS	2	1	50
		3	PSYCH TO SNF	3	1	33
		2	PSYCH TO ICFI	7	2	29
		1	PSYCH TO ICFII	1	0	0

Quality Assurance and Review Program, Minnesota Department of Health, 1983.

APPENDIX G

CERTIFICATION DENIALS

MINNESOTA DEPARTMENT OF HEALTH
HEALTH RESOURCES DIVISION
NOVEMBER 1, 1984

CERTIFICATION DENIALS

Facility	Date Received	Request
Glencoe Health Care Center Glencoe	June 1983	5 SNF
Bethany Covenant Minneapolis	June 1983	1 SNF, 22 ICF
Fosston C & NC Fosston	June 1983	20 ICF to SNF
Teachers Home Minneapolis	June 1983	12 SNF
Midway Manor St. Paul	June 1983	9 ICF to SNF
Richview Richfield	June 1983	9 ICF to SNF
Good Samaritan Center Clearbrook	June 1983	43 ICF to SN
Good Samaritan Center Blackduck	June 1983	34 ICF to SNF
Highland Manor New Ulm	June 1983	29 ICF
Grandview Christian Home Cambridge	July 1983	25 ICF
Willows Central Nursing Home Minneapolis	July 1983	30 ICF to SN
Monticello-Big Lake Nrsg. Home Monticello	September 1983	16 SNF
Howard Lake Care Center Howard Lake	December 16, 1983	7 ICF to SNF
Ambassador Health Care Center New Hope	December 16, 1983	9 ICF to SNF
Sunwood Care Center Redwood Falls	December 16, 1983	9 ICF to SNF
Weldwood Health Care Center Golden Valley	December 16, 1983	8 ICF to SNF
Crystal Lake Health Care Center Robbinsdale	December 16, 1983	9 ICF to SNF

Facility	Date Received	Request
Waconia Health Care Center Waconia	December 16, 1983	10 ICF to SNF
Nicollet Health Care Center Minneapolis	December 16, 1983	10 ICF to SNF
Anoka Maple Manor Anoka	December 16, 1983	10 ICF to SNF
Stillwater Maple Manor Stillwater	December 16, 1983	9 ICF to SNF
Grandview Care Center St. Peter	December 19, 1983	4 ICF to SNF
Lakeview Care Center Glenwood	December 19, 1983	6 ICF to SNF
David Herman Care Center Minneapolis	December 27, 1983	10 ICF to SNF
Koronis Manor Paynesville	March 1, 1984	7 SNF
Luther Memorial Home Madelia	March 15, 1984	17 ICF to SNF
Pipestone Co. Hosp. and C &NC Pipestone	March 28, 1984	3 SNF

APPENDIX H

CERTIFICATION APPROVALS AND RECLASSIFICATIONS

Minnesota Department of Health
Health Resouces Division

November 1, 1984

Certification Approvals and Reclassifications
Subsequent to May 23, 1983

New Beds

Facility/Location	Number and Type of Beds	Date Approved
Carlton Nursing Home Carlton	1 SNF	6/1/83
University Health Care Center Minneapolis	13 SNF	6/1/83
Castle Ridge Eden Prairie	29 SNF	6/21/83
Apple Valley Health Care Center Apple Valley	67 SNF	7/1/83
Aicota Nursing Home Aitkin	16 ICF I	9/30/83
Howard Lake Care center Howard Lake	3 SNF	11/15/83
Assumption Home Cold Spring	3 SNF	10/14/83
Assumption Home Cold Spring	24 ICF I	10/31/83
St. Anthony Eldercenter on Main Minneapolis	48 ICF I	9/1/83
St. Anthony Eldercenter on Main Minneapolis	50 SNF	9/8/83
St. Anthony Eldercenter on Main Minneapolis	50 SNF	10/28/83
Good Shepherd Home Rushford	6 SNF 4 ICF I	11/7/83
Good Shepherd Home Rushford	3 SNF 7 ICF I	12/1/83
Good Shepherd Home Rushford	12 SNF	1/1/84

New Beds-continued

Facility/Location	Number and Type of Beds	Date Approved
North Ridge Care Center New Hope	42 SNF	2/1/84
St. Anne's Hospice Winona	13 SNF	1/20/84
Park River Estates Coon Rapids	35 SNF	2/21/84
Lake Ridge Health Care Center Roseville	10 SNF	12/20/83
Lewiston Villa Lewiston	31 SNF 19 13 ICF I (-22 ICF II)	3/29/84
Nile Health Care Center Minneapolis	50 SNF	5/8/84
Nile Health Care Center Minneapolis	25 SNF	5/29/84
Sandstone Area Nursing Home Sandstone	40 SNF	2/10/84
Nile Health Care Center Minneapolis	50 SNF	6/24/84
Ebenezer Caroline Center Minneapolis	57 SNF	2/24/84
Ebenezer Caroline Center Minneapolis	37 SNF	4/11/84
Ebenezer Caroline Center Minneapolis	91 SNF	5/16/84
North Ridge Care Center New Hope	122 ICF I	3/30/84
Martin Luther Manor Bloomington	20 SNF 38 ICF I (-20 ICF II)	7/9/84
Martin Luther Manor Bloomington	60 SNF	7/13/84
Martin Luther Manor Bloomington	60 SNF	8/13/84
Cambridge Nursing Care Center Cambridge	13 SNF 40 ICF I	5/14/84

New Beds-continued

Facility/Location	Number and Type of Beds	Date Approved
White Bear Lake Care Center White Bear Lake	50 SNF	2/13/84
Glencoe Area Health Care Center Glencoe	33 SNF	5/1/84

Reclassifications

Facility/Location	Number and Type of Beds	Date Approved
Midway Boarding Care Home Fosston	13 ICF II to 15 ICF I	6/1/83
Woodbury Health Care Center Woodbury	10 ICF I to SNF	6/1/83
Alcota Nursing Home Aitkin	20 ICF I to SNF	6/14/83
Jones-Harrison Home Minneapolis	26 ICF II to ICF I	10/24/83
Howard Lake Care Center Howard Lake	6 ICF II to SNF	11/1/83

APPENDIX I

MINNESOTA STATUTE 144A

CHAPTER 144A

NURSING HOMES

144A.01 DEFINITIONS.

Subdivision 1. For the purposes of sections 144A.01 to 144A.27, the terms defined in this section have the meanings given them.

Subd. 2. "Commissioner of health" means the state commissioner of health established by section 144.011.

Subd. 3. "Board of examiners" means the board of examiners for nursing home administrators established by section 144A.19.

Subd. 4. "Controlling person" means any public body, governmental agency, business entity, officer, nursing home administrator, or director whose responsibilities include the direction of the management or policies of a nursing home. "Controlling person" also means any person who, directly or indirectly, beneficially owns any interest in:

(a) Any corporation, partnership or other business association which is a controlling person;

(b) The land on which a nursing home is located;

(c) The structure in which a nursing home is located;

(d) Any mortgage, contract for deed, or other obligation secured in whole or part by the land or structure comprising a nursing home; or

(e) Any lease or sub-lease of the land, structure, or facilities comprising a nursing home.

"Controlling person" does not include:

(a) A bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity directly or through a subsidiary operates a nursing home;

(b) An individual state official or state employee, or a member or employee of the governing body of a political subdivision of the state which operates one or more nursing homes, unless the individual is also an officer or director of a nursing home,

receives any remuneration from a nursing home, or owns any of the beneficial interests not excluded in this subdivision;

(c) A natural person who is a member of a tax-exempt organization under section 290.05, subdivision 1, clause (i), unless the individual is also an officer or director of a nursing home, or owns any of the beneficial interests not excluded in this subdivision; and

(d) A natural person who owns less than five percent of the outstanding common shares of a corporation:

(1) whose securities are exempt by virtue of section 80A.15, subdivision 1, clause (f); or

(2) whose transactions are exempt by virtue of section 80A.15, subdivision 2, clause (b).

Subd. 5. "Nursing home" means a facility or that part of a facility which provides nursing care to five or more persons. "Nursing home" does not include a facility or that part of a facility which is a hospital, clinic, doctor's office, diagnostic or treatment center, or a residential facility licensed pursuant to sections 245.781 to 245.821 or 252.28.

Subd. 6. "Nursing care" means health evaluation and treatment of patients and residents who are not in need of an acute care facility but who require nursing supervision on an inpatient basis. The commissioner of health may by rule establish levels of nursing care.

Subd. 7. "Uncorrected violation" means (a) a violation of a statute or rule or any other deficiency for which a notice of noncompliance has been issued and fine assessed and allowed to be recovered pursuant to section 144A.10, subdivision 6, or (b) the issuance of two or more correction orders, within a 12-month period, for a violation of the same provision of a statute or rule.

Subd. 8. "Managerial employee" means an employee of a nursing home whose duties include the direction of some or all of the management or policies of the nursing home.

Subd. 9. "Nursing home administrator" means a person who administers, manages, supervises, or is in general administrative charge of a nursing home, whether or not the individual has an ownership interest in the home, and whether or not his functions and duties are shared with one or more individuals, and who is licensed pursuant to section 144A.21.

History: *1976 c 173 s 1; 1977 c 305 s 45; 1980 c 509 s 43; 1Sp1981 c 4 art 1 s 79; 1982 c 633 s 1*

144A.02 LICENSURE; PENALTY.

Subdivision 1. No facility shall be used as a nursing home to provide nursing care unless the facility has been licensed as a nursing home. The commissioner of health may license a facility as a nursing home if the facility meets the criteria established by sections 144A.02 to 144A.10, and the rules promulgated thereunder. A license shall describe the facility to be licensed by address and by legal property description. The license shall specify the location and square footage of the floor space constituting the facility and shall incorporate by reference the plans and specifications of the facility, which plans and specifications shall be kept on file with the commissioner of health. The license may also specify the level or levels of nursing care which the facility is licensed to provide and shall state any conditions or limitations imposed on the facility in accordance with the rules of the commissioner of health.

Subd. 2. A controlling person of a nursing home in violation of this section is guilty of a misdemeanor. The provisions of this subdivision shall not apply to any controlling person who had no legal authority to affect or change decisions related to the operation of the nursing home.

History: *1976 c 173 s 2; 1977 c 305 s 45*

144A.03 LICENSE APPLICATION.

Subdivision 1. The commissioner of health by rule shall establish forms and procedures for the processing of nursing home license applications. An application for a nursing home license shall include the following information:

(a) The names and addresses of all controlling persons and managerial employees of the facility to be licensed;

(b) The address and legal property description of the facility;

(c) A copy of the architectural and engineering plans and specifications of the facility as prepared and certified by an architect or engineer registered to practice in this state; and

(d) Any other relevant information which the commissioner of health by rule or otherwise may determine is necessary to properly evaluate an application for license.

A controlling person which is a corporation shall submit copies of its articles of incorporation and bylaws and any amendments thereto as they occur, together with the names and addresses of its officers and directors. A controlling person which is a foreign corporation shall furnish the commissioner of health with a copy of its certificate of authority to do business in this state. An application on behalf of a controlling person which is a corporation, association or a governmental unit or instrumentality shall be signed by at least two officers or managing agents of that entity.

Subd. 2. Each application for a nursing home license or for renewal of a nursing home license shall specify one or more controlling persons or managerial employees as agents:

(a) Who shall be responsible for dealing with the commissioner of health on all matters provided for in sections 144A.01 to 144A.17; and

(b) On whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of all of the controlling persons of the facility, in proceedings under sections 144A.06; 144A.10, subdivisions 4, 5, and 7; 144A.11, subdivision 3; and 144A.15. Notwithstanding any law to the contrary, personal service on the designated person or persons named in an application shall be deemed to be service on all of the controlling persons or managerial employee of the facility, and it shall not be a defense to any action arising under sections 144A.06; 144A.10, subdivisions 4, 5 and 7; 144A.11, subdivision 3; and 144A.15, that personal service was not made on each controlling person or managerial employee of the facility. The designation of one or more controlling persons or managerial employees pursuant to this subdivision shall not affect the legal responsibility of any other controlling person or managerial employee under sections 144A.01 to 144A.17.

History: *1976 c 173 s 3; 1977 c 305 s 45*

144A.04 QUALIFICATIONS FOR LICENSE.

Subdivision 1. No nursing home license shall be issued to a facility unless the commissioner of health determines that the facility complies with the requirements of this section.

Subd. 2. The controlling persons of the facility must comply with the application requirements specified by section 144A.03 and the rules of the commissioner of health.

Subd. 2a. The commissioner shall not adopt any rule unconditionally prohibiting locks on patient room doors in nursing homes. The commissioner may adopt a rule requiring locks to be consistent with the applicable rules enforced by the state fire marshal.

Subd. 3. The facility must meet the minimum health, sanitation, safety and comfort standards prescribed by the rules of the commissioner of health with respect to the construction, equipment, maintenance and operation of a nursing home. The commissioner of health may temporarily waive compliance with one or more of the standards if he determines that:

(a) Temporary noncompliance with the standard will not create an imminent risk of harm to a nursing home resident; and

(b) A controlling person on behalf of all other controlling persons:

(1) Has entered into a contract to obtain the materials or labor necessary to meet the standard set by the commissioner of health, but the supplier or other contractor has failed to perform the terms of the contract and the inability of the nursing home to meet the standard is due solely to that failure; or

(2) Is otherwise making a diligent good faith effort to meet the standard.

The commissioner of health shall allow, by rule, a nursing home to provide fewer hours of nursing care to intermediate care residents of a nursing home than required by the present rules of the commissioner if the commissioner determines that the needs of the residents of the home will be adequately met by a lesser amount of nursing care.

Subd. 3a. The commissioner shall not adopt any rule which unconditionally prohibits double beds in a nursing home. The commissioner may adopt rules setting criteria for when double beds will be allowed.

Subd. 4. The controlling persons of a nursing home may not include any person who was a controlling person of another nursing home during any period of time in the previous two year period:

(a) during which time of control that other nursing home incurred the following number of uncorrected violations:

(1) two or more uncorrected violations which created an imminent risk to direct resident care or safety; or

(2) five or more uncorrected violations of any nature for which the fines are in the two highest daily fine categories prescribed in rule; or

(b) who was convicted of a felony that relates to operation of the nursing home or directly affects resident safety or care, during that period.

The provisions of this subdivision shall not apply to any controlling person who had no legal authority to affect or change decisions related to the operation of the nursing home which incurred the uncorrected violations.

Subd. 5. **Administrators.** Except as otherwise provided by this subdivision, a nursing home must have a full time licensed nursing home administrator serving the facility. In any nursing home of less than 25 beds, the director of nursing services may also serve as the licensed nursing home administrator. Two nursing homes having a total of 100 beds or less and located within 50 miles of each other may share the services of a licensed administrator if the administrator divides his full time work week between the two facilities in proportion to the number of beds in each facility. Every nursing home shall have a person-in-charge on the premises at all times in the absence of the licensed administrator. The name of the person in

charge must be posted in a conspicuous place in the facility. The commissioner of health shall by rule promulgate minimum education and experience requirements for persons-in-charge, and may promulgate rules specifying the times of day during which a licensed administrator must be on the nursing home's premises. A nursing home may employ as its administrator the administrator of a hospital licensed pursuant to sections 144.50 to 144.56 if the individual is licensed as a nursing home administrator pursuant to section 144A.20 and the nursing home and hospital have a combined total of 150 beds or less and are located within one mile of each other. A nonproprietary retirement home having fewer than 15 licensed nursing home beds may share the services of a licensed administrator with a nonproprietary nursing home, having fewer than 150 licensed nursing home beds, that is located within 25 miles of the retirement home. A nursing home which is located in a facility licensed as a hospital pursuant to sections 144.50 to 144.56, may employ as its administrator the administrator of the hospital if the individual meets minimum education and long term care experience criteria set by rule of the commissioner of health.

Subd. 6. A nursing home may not employ as a managerial employee or as its licensed administrator any person who was a managerial employee or the licensed administrator of another facility during any period of time in the previous two year period:

(a) During which time of employment that other nursing home incurred the following number of uncorrected violations which were in the jurisdiction and control of the managerial employee or the administrator:

(1) two or more uncorrected violations which created an imminent risk to direct resident care or safety; or

(2) five or more uncorrected violations of any nature for which the fines are in the two highest daily fine categories prescribed in rule; or

(b) who was convicted of a felony that relates to operation of the nursing home or directly affects resident safety or care, during that period.

History: *1976 c 173 s 4; 1977 c 305 s 45; 1977 c 326 s 2; 1977 c 305 s 45; 1978 c 536 s 1; 1981 c 23 s 3; 1981 c 24 s 2; 1982 c 614 s 3; 1982 c 633 s 2,3; 1983 c 312 art 1 s 17*

144A.05 LICENSE RENEWAL.

Unless the license expires in accordance with section 144A.06 or is suspended or revoked in accordance with section 144A.11, a nursing home license shall remain effective for a period of one year from the date of its issuance. The commissioner of health by rule shall establish forms and procedures for the processing of license renewals. The commissioner of health shall approve a license renewal application if the facility continues to satisfy the requirements, standards and conditions prescribed by sections 144A.01 to 144A.17 and the rules promulgated thereunder. Except as provided in section 144A.08, a facility shall not be required to submit with each application for a license renewal additional copies of the architectural and engineering plans and specifications of the facility. Before approving a license renewal, the commissioner of health shall determine that the facility's most recent balance sheet and its most recent statement of revenues and expenses, as audited by the state auditor, by a certified public accountant licensed by this state or by a public accountant as defined in section 412.222, have been received by the department of human services.

History: *1976 c 173 s 5; 1977 c 305 s 45; 1977 c 326 s 3; 1984 c 654 art 5 s 58*

144A.06 TRANSFER OF INTERESTS.

Subdivision 1. **Notice; expiration of license.** Any controlling person who makes any transfer of a beneficial interest in a nursing home shall notify the commissioner of health of the transfer within 14 days of its occurrence. The notification shall identify by name and address the transferor and transferee and shall specify the nature and amount of the transferred interest. If the commissioner of health determines that the transferred beneficial interest exceeds ten percent of the total beneficial interest in the nursing home facility, the structure in which the facility is located, or the land upon which the structure is located, he may, and if he determines that the transferred beneficial interest exceeds 50 percent of the total beneficial interest in the facility, the structure in which the facility is located, or the land upon which the structure is located, he shall, require that the license of the nursing home expire 90 days after the date of transfer. The commissioner of health shall notify the nursing home by certified mail of the expiration of the license at least 60 days prior to the date of expiration.

Subd. 2. **Relicensure.** The commissioner of health by rule shall prescribe procedures for relicensure under this section. The commissioner of health shall relicense a nursing home if the facility satisfies the requirements for license renewal established by section 144A.05. A facility shall not be relicensed by the commissioner if at the time of transfer there are any uncorrected violations. The commissioner of health may temporarily waive correction of one or more violations if he determines that:

(a) Temporary noncorrection of the violation will not create an imminent risk of harm to a nursing home resident; and

(b) A controlling person on behalf of all other controlling persons:

(1) Has entered into a contract to obtain the materials or labor necessary to correct the violation, but the supplier or other contractor has failed to perform the terms of the contract and the inability of the nursing home to correct the violation is due solely to that failure; or

(2) Is otherwise making a diligent good faith effort to correct the violation.

History: *1976 c 173 s 6; 1977 c 305 s 45*

144A.07 FEES.

Each application for a license to operate a nursing home, or for a renewal of license, except an application by the Minnesota veterans home or the commissioner of human services for the licensing of state institutions, shall be accompanied by a fee to be prescribed by the commissioner of health pursuant to section 144.122. No fee shall be refunded.

History: *1976 c 173 s 7; 1977 c 305 s 45; 1984 c 654 art 5 s 58*

144A.071 MORATORIUM ON CERTIFICATION OF NURSING HOME BEDS.

Subdivision 1. **Findings.** The legislature finds that medical assistance expenditures are increasing at a much faster rate than the state's ability to pay them; that reimbursement for nursing home care and ancillary services comprises over half of medical assistance costs, and, therefore, controlling expenditures for nursing home care is essential to prudent management of the state's budget; that construction of new nursing homes, the addition of more nursing home beds to the state's long-term care resources, and increased conversion of beds to skilled nursing facility bed status inhibits the ability to control expenditures; that Minnesota already leads the nation in nursing home expenditures per capita, has the fifth highest number of beds per

capita elderly, and that private paying individuals and medical assistance recipients have equivalent access to nursing home care; and that in the absence of a moratorium the increased numbers of nursing homes and nursing home beds will consume resources that would otherwise be available to develop a comprehensive long-term care system that includes a continuum of care. Unless action is taken, this expansion of bed capacity and changes of beds to a higher classification of care are likely to accelerate with the repeal of the certificate of need program effective March 15, 1984. The legislature also finds that Minnesota's dependence on institutional care for elderly persons is due in part to the dearth of alternative services in the home and community.

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

Subd. 2. **Moratorium.** Notwithstanding the provisions of the Certificate of Need Act, sections 145.832 to 145.845, or any other law to the contrary, the commissioner of health, in coordination with the commissioner of human services, shall deny each request by a nursing home or boarding care home, except an intermediate care facility for the mentally retarded, for addition of new certified beds or for a change or changes in the certification status of existing beds except as provided in subdivision 3. The total number of certified beds in the state in the skilled level and in the intermediate levels of care shall remain at or decrease from the number of beds certified at each level of care on May 23, 1983, except as allowed under subdivision 3. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq.

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

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

(a) To replace a bed decertified after May 23, 1983 or to address an extreme hardship situation, in a particular county that, together with all contiguous Minnesota counties, has fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than the national average of nursing home beds per 1,000 elderly individuals. For the purposes of this section, the national average of nursing home beds shall be the most recent figure that can be supplied by the federal health care financing administration and the number of elderly in the county or the nation shall be determined by the most recent federal census or the most recent estimate of the state demographer as of July 1, of each year of persons age 65 and older, whichever is the most recent at the time of the request for replacement. In allowing replacement of a decertified bed, the commissioners shall ensure that the number of added or recertified beds does not exceed the total number of decertified beds in the state in that level of care. An extreme hardship situation can only be found after the county documents the existence of unmet medical needs that cannot be addressed by any other alternatives;

(b) To certify a new bed in a facility that commenced construction before May 23, 1983. For the purposes of this section, "commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were

let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were secured;

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

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

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

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

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

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

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

(4) availability of and access to alternative services by geographic region; and

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

History: *1983 c 199 s 1; 1983 c 289 s 115 subd 1; 1984 c 654 art 5 s 58; 1984 c 655 art 1 s 28*

144A.08 PHYSICAL STANDARDS; PENALTY.

Subdivision 1. **Establishment.** The commissioner of health by rule shall establish minimum standards for the construction, maintenance, equipping and operation of nursing homes. The rules shall to the extent possible assure the health, treatment, comfort, safety and well being of nursing home residents.

Subd. 1a. **Corridor doors.** Nothing in the rules of the commissioner of health shall require that each door entering a sleeping room from a corridor in a nursing home with an approved complete standard automatic fire extinguishing system be constructed or maintained as self-closing or automatically closing.

Subd. 2. **Report.** The controlling persons of a nursing home shall, in accordance with rules established by the commissioner of health, within 14 days of the occurrence, notify the commissioner of health of any change in the physical structure of a nursing home, which change would affect compliance with the rules of the commissioner of health or with sections 144A.01 to 144A.17.

Subd. 3. **Penalty.** Any controlling person who establishes, conducts, manages or operates a nursing home which incurs the following number of uncorrected violations, in any two year period:

(a) Two or more uncorrected violations which created an imminent risk of harm to a nursing home resident; or

(b) Five or more uncorrected violations of any nature, is guilty of a misdemeanor.

The provisions of this subdivision shall not apply to any controlling person who had no legal authority to affect or change decisions as to the operation of the nursing home which incurred the uncorrected violations.

History: *1976 c 173 s 8; 1977 c 305 s 45; 1981 c 360 art 2 s 5; 1982 c 633 s 4*

144A.09 FACILITIES EXCLUDED.

Subdivision 1. No rule established under sections 144A.01 to 144A.17 other than a rule relating to sanitation and safety of premises, to cleanliness of operation or to physical equipment, shall apply to a nursing home conducted in accordance with the teachings of the body known as the Church of Christ, Scientist.

Subd. 2. The provisions of sections 144A.01 to 144A.27 shall not apply to a facility operated by a religious society or order to provide nursing care to 20 or fewer non-lay members of the order or society.

History: *1976 c 173 s 9*

144A.10 INSPECTION; COMMISSIONER OF HEALTH; FINES.

Subdivision 1. **Enforcement authority.** The commissioner of health is the exclusive state agency charged with the responsibility and duty of inspecting all facilities required to be licensed under section 144A.02. The commissioner of health shall enforce the rules established pursuant to sections 144A.01 to 144A.17, subject only to the authority of the department of public safety respecting the enforcement of fire and safety standards in nursing homes and the responsibility of the commissioner of human services under sections 245.781 to 245.821 or 252.28.

Subd. 2. **Inspections.** The commissioner of health shall inspect each nursing home to ensure compliance with sections 144A.01 to 144A.17 and the rules promulgated to implement them. The inspection shall be a full inspection of the nursing home. If upon a reinspection provided for in subdivision 5 the representative of the commissioner of health finds one or more uncorrected violations, a second inspection of the facility shall be conducted. The second inspection need not be a full inspection. No prior notice shall be given of an inspection conducted pursuant to this subdivision. Any employee of the commissioner of health who willfully gives or causes to be given any advance notice of an inspection required or authorized by this subdivision shall be subject to suspension or dismissal in accordance with chapter 43A. An inspection required by a federal rule or statute may be conducted in conjunction with or subsequent to any other inspection. Any inspection required by this subdivision may be in addition to or in conjunction with the reinspections required by subdivision 5. Nothing in this subdivision shall be construed to prohibit the commissioner of health from making more than one unannounced inspection of any nursing home during its license year. The commissioner of health shall coordinate his inspections of nursing homes with inspections by other state and local agencies.

The commissioner shall conduct inspections and reinspections of health facilities with a frequency and in a manner calculated to produce the greatest benefit to residents within the limits of the resources available to the commissioner. In

performing this function, the commissioner may devote proportionately more resources to the inspection of those facilities in which conditions present the most serious concerns with respect to resident health, treatment, comfort, safety, and well-being.

These conditions include but are not limited to: change in ownership; frequent change in administration in excess of normal turnover rates; complaints about care, safety, or rights; where previous inspections or reinspections have resulted in correction orders related to care, safety, or rights; and, where persons involved in ownership or administration of the facility have been indicted for alleged criminal activity. Any facility that has none of the above conditions or any other condition established by the commissioner that poses a risk to resident care, safety, or rights shall be inspected once every two years.

Subd. 3. **Reports; posting.** After each inspection or reinspection required or authorized by this section, the commissioner of health shall, by certified mail, send copies of any correction order or notice of noncompliance to the nursing home. A copy of each correction order and notice of noncompliance, and copies of any documentation supplied to the commissioner of health or the commissioner of human services under sections 144A.03 or 144A.05 shall be kept on file at the nursing home and shall be made available for viewing by any person upon request. Except as otherwise provided by this subdivision, a copy of each correction order and notice of noncompliance received by the nursing home after its most recent inspection or reinspection shall be posted in a conspicuous and readily accessible place in the nursing home. No correction order or notice of noncompliance need be posted until any appeal, if one is requested by the facility, pursuant to subdivision 8, has been completed. All correction orders and notices of noncompliance issued to a nursing home owned and operated by the state or political subdivision of the state shall be circulated and posted at the first public meeting of the governing body after the order or notice is issued. Confidential information protected by section 13.05 or section 13.46, shall not be made available or posted as provided in this subdivision unless it may be made available or posted in a manner authorized by chapter 13.

Subd. 4. **Correction orders.** Whenever a duly authorized representative of the commissioner of health finds upon inspection of a nursing home, that the facility or a controlling person or an employee of the facility is not in compliance with sections 144.651, 144A.01 to 144A.17, or 626.557 or the rules promulgated thereunder, a correction order shall be issued to the facility. The correction order shall state the deficiency, cite the specific rule or statute violated, state the suggested method of correction, and specify the time allowed for correction. If the commissioner finds that the nursing home had uncorrected violations and that two or more of the uncorrected violations create a risk to resident care, safety, or rights, the commissioner shall notify the commissioner of human services who shall review reimbursement to the nursing home to determine the extent to which the state has paid for substandard care.

Subd. 5. **Reinspections.** A nursing home issued a correction order under this section shall be reinspected at the end of the period allowed for correction. The reinspection may be made in conjunction with the next annual inspection or any other scheduled inspection. If upon reinspection the representative of the commissioner of health determines that the facility has not corrected a violation identified in the correction order, a notice of noncompliance with the correction order shall be mailed by certified mail to the nursing home. The notice shall specify the violations not corrected and the fines assessed in accordance with subdivision 6.

Subd. 6. **Fines.** A nursing home which is issued a notice of noncompliance with a correction order shall be assessed a civil fine in accordance with a schedule of fines established by the commissioner of health before December 1, 1983. In

establishing the schedule of fines, the commissioner shall consider the potential for harm presented to any resident as a result of noncompliance with each statute or rule. The fine shall be assessed for each day the facility remains in noncompliance and until a notice of correction is received by the commissioner of health in accordance with subdivision 7. No fine for a specific violation may exceed $500 per day of noncompliance.

Subd. 6a. **Schedule of fines.** The commissioner of health shall propose for adoption the schedule of fines by publishing it in the State Register and allowing a period of 60 days from the publication date for interested persons to submit written comments on the schedule. Within 60 days after the close of the comment period, and after considering any comments received, the commissioner shall adopt the schedule in final form.

The schedule of fines is exempt from the definition of "rule" in section 14.02, subdivision 4, and has the force and effect of law upon compliance with section 14.38, subdivision 7. The effective date of the schedule of fines is five days after publication, as provided in section 14.38, subdivision 8. The provisions of any rule establishing a schedule of fines for noncompliance with correction orders issued to nursing homes remain effective with respect to nursing homes until repealed, modified, or superseded by the schedule established in accordance with this subdivision.

Subd. 7. **Accumulation of fines.** A nursing home shall promptly notify the commissioner of health in writing when a violation noted in a notice of noncompliance is corrected. Upon receipt of written notification by the commissioner of health, the daily fine assessed for the deficiency shall stop accruing. The facility shall be reinspected within three working days after receipt of the notification. If upon reinspection the representative of the commissioner of health determines that a deficiency has not been corrected as indicated by the notification of compliance the daily fine assessment shall resume and the amount of fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment due from the nursing home. The commissioner of health shall notify the nursing home of the resumption by certified mail. The nursing home may challenge the resumption as a contested case in accordance with the provisions of chapter 14. Recovery of the resumed fine shall be stayed if a controlling person or his legal representative on behalf of the nursing home makes a written request for a hearing on the resumption within 15 days of receipt of the notice of resumption. The cost of a reinspection conducted pursuant to this subdivision shall be added to the total assessment due from the nursing home.

Subd. 8. **Recovery of fines; hearing.** Fines assessed under this section shall be payable 15 days after receipt of the notice of noncompliance and at 15 day intervals thereafter, as the fines accrue. Recovery of an assessed fine shall be stayed if a controlling person or his legal representative on behalf of the nursing home makes a written request for a hearing on the notice of noncompliance within 15 days after the home's receipt of the notice. A hearing under this subdivision shall be conducted as a contested case in accordance with chapter 14. If a nursing home, after notice and opportunity for hearing on the notice of noncompliance, or on the resumption of the fine, does not pay a properly assessed fine in accordance with this subdivision, the commissioner of health shall notify the commissioner of human services who shall deduct the amount from reimbursement moneys due or to be due the facility under chapter 256B. The commissioner of health may consolidate the hearings provided for in subdivisions 7 and 8 in cases in which a facility has requested hearings under both provisions. The hearings provided for in subdivisions 7 and 8 shall be held within 30 days after the request for the hearing. If a

consolidated hearing is held, it shall be held within 30 days of the request which occurred last.

Subd. 9. **Nonlimiting.** Nothing in this section shall be construed to limit the powers granted to the commissioner of health by section 144A.11.

History: *1976 c 173 s 10; 1977 c 305 s 45; 1977 c 326 s 4,5; 1980 c 509 s 44; 1981 c 210 s 54; 1981 c 311 s 39; 1Sp1981 c 4 art 1 s 12; 1982 c 424 s 130; 1982 c 545 s 24; 1982 c 633 s 5; 1983 c 199 s 2-4; 1983 c 312 art 1 s 18; 1984 c 654 art 5 s 58*

144A.11 LICENSE SUSPENSION OR REVOCATION; HEARING; RELICENSING.

Subdivision 1. **Optional proceedings.** The commissioner of health may institute proceedings to suspend or revoke a nursing home license, or he may refuse to grant or renew the license of a nursing home if any action by a controlling person or employee of the nursing home:

(a) Violates any of the provisions of sections 144A.01 to 144A.08, 144A.13 or 144A.16, or the rules promulgated thereunder;

(b) Permits, aids, or abets the commission of any illegal act in the nursing home;

(c) Performs any act contrary to the welfare of a patient or resident of the nursing home; or

(d) Obtains, or attempts to obtain, a license by fraudulent means or misrepresentation.

Subd. 2. **Mandatory proceedings.** The commissioner of health shall initiate proceedings to suspend or revoke a nursing home license or shall refuse to renew a license if within the preceding two years the nursing home has incurred the following number of uncorrected violations:

(1) two or more uncorrected violations which created an imminent risk to direct resident care or safety, violated the patients' bill of rights section 144.651, or violated the vulnerable adults reporting act, section 626.557; or

(2) five or more uncorrected violations of any nature for which the fines are in the two highest daily fine categories prescribed in rule.

Subd. 3. **Hearing.** No nursing home license may be suspended or revoked without a hearing held as a contested case in accordance with chapter 14. If the controlling person designated under section 144A.03, subdivision 2, as an agent to accept service on behalf of all of the controlling persons of the nursing home has been notified by the commissioner of health that the facility will not receive an initial license or that a license renewal has been denied, the controlling person or his legal representative on behalf of the nursing home may request and receive a hearing on the denial. This hearing shall be held as a contested case in accordance with chapter 14.

Subd. 3a. **Mandatory revocation.** Notwithstanding the provisions of subdivision 3, the commissioner shall revoke a nursing home license if a controlling person is convicted of a felony that relates to operation of the nursing home or directly affects resident safety or care. The commissioner shall notify the nursing home 30 days in advance of the date of revocation.

Subd. 4. **Relicensing.** If a nursing home license is revoked a new application for license may be considered by the commissioner of health when the conditions upon which revocation was based have been corrected and satisfactory evidence of this fact has been furnished to the commissioner of health. A new license may be granted after an inspection has been made and the facility has been found to comply

with all provisions of sections 144A.01 to 144A.17 and the rules promulgated thereunder.

History: *1976 c 173 s 11; 1977 c 305 s 45; 1982 c 424 s 130; 1982 c 633 s 6,7*

144A.12 INJUNCTIVE RELIEF; SUBPOENAS.

Subdivision 1. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner of health may in his own name bring an action in the district court in Ramsey county or in the district in which a nursing home is located to enjoin a controlling person or an employee of the nursing home from illegally engaging in activities regulated by sections 144A.01 to 144A.17. A temporary restraining order may be granted by the court in the proceeding if continued activity by the controlling person or employee would create an imminent risk of harm to a resident of the facility.

Subd. 2. **Subpoenas.** In all matters pending before him under sections 144A.01 to 144A.17, the commissioner of health shall have the power to issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents and other evidentiary material. Any person failing or refusing to appear or testify regarding any matter about which he may be lawfully questioned or to produce any papers, books, records, documents or evidentiary materials in the matter to be heard, after having been required by order of the commissioner of health or by a subpoena of the commissioner of health to do so may, upon application by the commissioner of health to the district court in any district, be ordered by the court to comply therewith. The commissioner of health may issue subpoenas and may administer oaths to witnesses, or take their affirmation. Depositions may be taken within or without the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served upon any named person anywhere within the state by any officer authorized to serve subpoenas in civil actions, with the same fees and mileage and in the same manner as prescribed by law for process issued out of the district court of this state. Fees and mileage and other costs of persons subpoenaed by the commissioner of health shall be paid in the same manner as for proceedings in district court.

History: *1976 c 173 s 12; 1977 c 305 s 45*

144A.13 COMPLAINTS; RESIDENT'S RIGHTS.

Subdivision 1. **Processing.** All matters relating to the operation of a nursing home which are the subject of a written complaint from a resident and which are received by a controlling person or employee of the nursing home shall be delivered to the facility's administrator for evaluation and action. Failure of the administrator within seven days of its receipt to resolve the complaint, or alternatively, the failure of the administrator to make a reply within seven days after he receives it to the complaining resident stating that the complaint did not constitute a valid objection to the nursing home's operations, shall be a violation of section 144A.10. If a complaint directly involves the activities of a nursing home administrator, the complaint shall be resolved in accordance with this section by a person, other than the administrator, duly authorized by the nursing home to investigate the complaint and implement any necessary corrective measures.

Subd. 2. **Resident's rights.** The administrator of a nursing home shall inform each resident in writing at the time of admission of his right to complain to the administrator about facility accommodations and services. A notice of the right to complain shall be posted in the nursing home. The administrator shall also inform each resident of his right to complain to the commissioner of health. No controlling

person or employee of a nursing home shall retaliate in any way against a complaining nursing home resident and no nursing home resident may be denied any right available to him under chapter 566.

History: *1976 c 173 s 13; 1977 c 305 s 45*

144A.14 VOLUNTARY RECEIVERSHIP.

A majority in interest of the controlling persons of a nursing home may at any time request the commissioner of health to assume the operation of the nursing home through appointment of a receiver. Upon receiving a request for a receiver, the commissioner of health may, if he deems receivership desirable, enter into an agreement with a majority in interest of the controlling persons, providing for the appointment of a receiver to take charge of the facility under conditions deemed appropriate by both parties. The agreement shall specify all terms and conditions of the receivership and shall preserve all rights of the facility residents as granted by law. A receivership initiated in accordance with this section shall terminate at the time specified by the parties or at the time when either party notifies the other in writing that he wishes to terminate the receivership agreement.

History: *1976 c 173 s 14; 1977 c 305 s 45*

144A.15 INVOLUNTARY RECEIVERSHIP.

Subdivision 1. **Petition, notice.** In addition to any other remedy provided by law, the commissioner of health may petition the district court in Ramsey county or in the district in which a nursing home is located for an order directing the controlling persons of the nursing home to show cause why the commissioner of health or his designee should not be appointed receiver to operate the facility. The petition to the district court shall contain proof by affidavit that the commissioner of health has either commenced license suspension or revocation proceedings, suspended or revoked a license, or decided not to renew the nursing home license. The order to show cause shall be returnable not less than five days after service is completed and shall provide for personal service of a copy to the nursing home administrator and to the persons designated as agents by the controlling persons to accept service on their behalf pursuant to section 144A.03, subdivision 2.

Subd. 2. **Appointment of receiver, rental.** If, after hearing, the court finds that involuntary receivership is necessary as a means of protecting the health, safety or welfare of a resident of a nursing home, the court shall appoint the commissioner of health, or any other person designated by the commissioner of health, as a receiver to take charge of the facility. The court shall determine a fair monthly rental for the facility, taking into account all relevant factors including the condition of the facility. This rental fee shall be paid by the receiver to the appropriate controlling persons for each month that the receivership remains in effect. Notwithstanding any other law to the contrary, no payment made to a controlling person by any state agency during a period of involuntary receivership shall include any allowance for profit or be based on any formula which includes an allowance for profit.

Subd. 3. **Powers and duties of receiver.** A nursing home receiver appointed pursuant to this section shall with all reasonable speed, but in any case, within 18 months after the receivership order, provide for the orderly transfer of all the nursing home's residents to other facilities or make other provisions for their continued safety and health care. The receiver may correct or eliminate those deficiencies in the facility which seriously endanger the life, health or safety of the residents unless the correction or elimination of deficiencies involves major alterations in the physical structure of the nursing home. He shall, during this period,

operate the nursing home in a manner designed to guarantee the safety and adequate health care of the residents. The receiver shall take no action which impairs the legal rights of a resident of the nursing home. He shall have power to make contracts and incur lawful expenses. He shall collect incoming payments from all sources and apply them to the cost incurred in the performance of his functions as receiver. No security interest in any real or personal property comprising the nursing home or contained within it, or in any fixture of the facility, shall be impaired or diminished in priority by the receiver. The receiver shall pay all valid obligations of the nursing home and shall deduct these expenses, if appropriate, from rental payments owed to any controlling person by virtue of the receivership.

Subd. 4. **Receiver's fee; liability; commissioner assistance.** A nursing home receiver appointed pursuant to this section shall be entitled to a reasonable receiver's fee as determined by the court. The receiver shall be liable only in his official capacity for injury to person and property by reason of the conditions of the nursing home. He shall not be personally liable, except for his gross negligence and intentional acts. The commissioner of health shall assist the receiver in carrying out his duties.

Subd. 5. **Termination.** An involuntary receivership imposed pursuant to this section shall terminate 18 months after the date on which it was ordered or at any other time designated by the court or upon the occurrence of any of the following events:

(a) A determination by the commissioner of health that the nursing home's license should be renewed or should not be suspended or revoked;

(b) The granting of a new license to the nursing home; or

(c) A determination by the commissioner of health that all of the residents of the nursing home have been provided alternative health care, either in another facility or otherwise.

History: *1976 c 173 s 15; 1977 c 305 s 45*

144A.16 CESSATION OF OPERATIONS.

If a nursing home plans to cease operations or to curtail operations to the extent that relocation of residents is necessary, the controlling persons of the facility shall notify the commissioner of health at least 90 days prior to the scheduled cessation or curtailment. The commissioner of health shall cooperate with and advise the controlling persons of the nursing home in the resettlement of residents. Failure to comply with this section shall be a violation of section 144A.10.

History: *1976 c 173 s 16; 1977 c 305 s 45*

144A.17 [Repealed, 1983 c 260 s 68]

144A.18 ADMINISTRATOR'S LICENSES; PENALTY.

No person shall act as a nursing home administrator or purport to be a nursing home administrator unless he is licensed by the board of examiners for nursing home administrators. A violation of this section is a misdemeanor.

History: *1976 c 173 s 18*

144A.19 BOARD OF EXAMINERS FOR ADMINISTRATORS; CREATION, MEMBERSHIP.

Subdivision 1. There is hereby created the board of examiners for nursing home administrators which shall consist of the following members:

(a) A designee of the commissioner of health who shall be a nonvoting member;

(b) The commissioner of human services, or his designee who shall be a nonvoting member; and

(c) The following members appointed by the governor:

(1) Two members actively engaged in the management, operation, or ownership of proprietary nursing homes;

(2) Two members actively engaged in the management or operation of nonprofit nursing homes;

(3) One member actively engaged in the practice of medicine;

(4) One member actively engaged in the practice of professional nursing; and

(5) Three public members as defined in section 214.02.

Subd. 2. Membership terms, compensation of members, removal of members, the filling of membership vacancies, fiscal year and reporting requirements, the provision of staff, administrative services and office space, the review and processing of complaints, the setting of board fees and other provisions relating to board operations for the board of examiners shall be as provided in chapter 214.

Subd. 3. The provision of staff, administrative services and office space, the review and processing of complaints; the setting of board fees; and other provisions relating to board operations shall be as provided in chapter 214.

History: *1976 c 173 s 19; 1977 c 305 s 45; 1977 c 347 s 24; 1977 c 444 s 10; 1984 c 654 art 5 s 58*

144A.20 ADMINISTRATOR QUALIFICATIONS.

Subdivision 1. The board of examiners may issue licenses to qualified persons as nursing home administrators, and shall establish qualification criteria for nursing home administrators. No license shall be issued to a person as a nursing home administrator unless he:

(a) Is at least 18 years of age and otherwise suitably qualified;

(b) Has satisfactorily met standards set by the board of examiners, which standards shall be designed to assure that nursing home administrators will be individuals who, by training or experience are qualified to serve as nursing home administrators; and

(c) Has passed an examination approved by the board and designed to test for competence in the subject matters referred to in clause (b), or has been approved by the board of examiners through the development and application of other appropriate techniques.

Subd. 2. Notwithstanding any law to the contrary, no person desiring to be licensed to administer a nursing home operated exclusively in accordance with the teachings of the body known as the Church of Christ, Scientist, shall be required to demonstrate proficiency in any medical technique or meet any medical educational qualification or medical standard which is not in accord with the type of remedial care and treatment provided in a nursing home operated exclusively in accordance with the teachings of that body.

History: *1976 c 173 s 20*

144A.21 ADMINISTRATOR LICENSES.

Subdivision 1. A nursing home administrator's license shall not be transferable.

Subd. 2. The board of examiners by rule shall establish forms and procedures for the processing of license renewals. A nursing home administrator's license may

be renewed only in accordance with the standards adopted by the board of examiners pursuant to section 144A.24.

Subd. 3. [Repealed, 1977 c 444 s 21]

Subd. 4. [Repealed, 1977 c 444 s 21]

History: *1976 c 173 s 21; 1977 c 444 s 11*

144A.22 ORGANIZATION OF BOARD.

The board of examiners shall elect from its membership a chairman, vice-chairman and secretary-treasurer, and shall adopt rules to govern its proceedings. Except as otherwise provided by law the board of examiners shall employ and fix the compensation and duties of an executive secretary and other necessary personnel to assist it in the performance of its duties. The executive secretary shall not be a member of the board of examiners.

History: *1976 c 173 s 22*

144A.23 JURISDICTION OF BOARD.

Except as provided in section 144A.04, subdivision 5, the board of examiners shall have exclusive authority to determine the qualifications, skill and fitness required of any person to serve as an administrator of a nursing home. The holder of a license shall be deemed fully qualified to serve as the administrator of a nursing home.

History: *1976 c 173 s 23*

144A.24 DUTIES OF THE BOARD.

The board of examiners shall:

(a) Develop and enforce standards for nursing home administrator licensing, which standards shall be designed to assure that nursing home administrators will be individuals of good character who, by training or experience, are suitably qualified to serve as nursing home administrators;

(b) Develop appropriate techniques, including examinations and investigations, for determining whether applicants and licensees meet the board's standards;

(c) Issue licenses to those individuals who are found to meet the board's standards;

(d) Establish and implement procedures designed to assure that individuals licensed as nursing home administrators will comply with the board's standards;

(e) Receive, investigate, and take appropriate action consistent with chapter 214, to revoke or suspend the license of a nursing home administrator who fails to comply with sections 144A.18 to 144A.27 or the board's standards;

(f) Conduct a continuing study and investigation of nursing homes, and the administrators of nursing homes within the state, with a view to the improvement of the standards imposed for the licensing of administrators and improvement of the procedures and methods used for enforcement of the board's standards; and

(g) Approve or conduct courses of instruction or training designed to prepare individuals for licensing in accordance with the board's standards. Courses designed to meet license renewal requirements shall be designed solely to improve professional skills and shall not include classroom attendance requirements exceeding 50 hours per year. The board may approve courses conducted within or without this state.

History: *1976 c 173 s 24; 1980 c 509 s 45*

144A.25 [Repealed, 1977 c 444 s 21]

144A.251 MANDATORY PROCEEDINGS.

In addition to its discretionary authority to initiate proceedings under section 144A.24 and chapter 214, the board of examiners shall initiate proceedings to suspend or revoke a nursing home administrator license or shall refuse to renew a license if within the preceding two year period the administrator was employed at a nursing home which during the period of his employment incurred the following number of uncorrected violations, which violations were in the jurisdiction and control of the administrator and for which a fine was assessed and allowed to be recovered:

(a) Two or more uncorrected violations which created an imminent risk of harm to a nursing home resident; or

(b) Ten or more uncorrected violations of any nature.

History: *1976 c 173 s 26; 1977 c 444 s 12*

144A.26 RECIPROCITY WITH OTHER STATES.

The board of examiners may issue a nursing home administrator's license, without examination, to any person who holds a current license as a nursing home administrator from another jurisdiction if the board finds that the standards for licensure in the other jurisdiction are at least the substantial equivalent of those prevailing in this state and that the applicant is otherwise qualified.

History: *1976 c 173 s 27*

144A.27 ACTING ADMINISTRATORS.

If a licensed nursing home administrator is removed from his position by death or other unexpected cause, the controlling persons of the nursing home suffering the removal may designate an acting nursing home administrator who may serve without a license for no more than 90 days, unless an extension is granted by the board of examiners.

History: *1976 c 173 s 28*

144A.28 SEVERABILITY.

Any part of sections 144A.18 to 144A.27 which is in conflict with any act of congress of the United States or any rule of a federal agency, so as to deprive nursing homes of this state of federal funds, shall be deemed void without affecting the remaining provisions of sections 144A.18 to 144A.27.

History: *1976 c 173 s 29*

144A.29 CONTINUITY OF RULES; AUTHORITY.

Subdivision 1. The provisions of any rule affecting nursing homes or nursing home administrators heretofore promulgated in accordance with chapter 144, or hereafter promulgated in accordance with subdivision 2, shall remain effective with respect to nursing homes and nursing home administrators until repealed, modified or superseded by a rule promulgated in accordance with Laws 1976, Chapter 173.

Subd. 2. Any investigation, disciplinary hearing, court action or other proceeding affecting a nursing home or nursing home administrator heretofore initiated by the commissioner of health or board of examiners in accordance with chapter 144, shall be conducted and completed in accordance with that chapter as it existed prior to the effective date of this section. Proceedings heretofore initiated by the commissioner of health or board of examiners leading to the establishment of a rule affecting nursing homes or nursing home administrators may be continued and the

rule may be promulgated in accordance with heretofore existing law, notwithstanding any other provision of Laws 1976, Chapter 173.

Subd. 3. As soon as possible after the effective date of this section, the commissioner of health shall by rule establish a schedule of fines in accordance with section 144A.10, subdivision 6.

Subd. 4. Each rule promulgated by the commissioner of health pursuant to sections 144A.01 to 144A.17 shall contain a short statement of the anticipated costs and benefits to be derived from the provisions of the rule.

History: *1976 c 173 s 30; 1977 c 305 s 45*

144A.30 PETS IN NURSING HOMES.

Nursing homes may keep pet animals on the premises subject to reasonable rules as to the care, type and maintenance of the pet.

History: *1979 c 38 s 1*

144A.31 INTERAGENCY BOARD FOR QUALITY ASSURANCE.

Subdivision 1. **Interagency board.** The commissioners of health and human services shall establish, by July 1, 1983, an interagency board of employees of their respective departments who are knowledgeable and employed in the areas of long-term care, geriatric care, long-term care facility inspection, or quality of care assurance. The number of interagency board members shall not exceed seven; three members each to represent the commissioners of health and human services and one member to represent the commissioner of public safety in the enforcement of fire and safety standards in nursing homes. The commissioner of human services or a designee shall chair and convene the board. The board may utilize the expertise and time of other individuals employed by either department as needed. The board may recommend that the commissioners contract for services as needed. The board shall meet as often as necessary to accomplish its duties, but at least monthly. The board shall establish procedures, including public hearings, for allowing regular opportunities for input from residents, nursing homes, and other interested persons.

Subd. 2. **Inspections.** No later than January 1, 1984, the board shall develop and recommend implementation and enforcement of an effective system to ensure quality of care in each nursing home in the state. Quality of care includes evaluating, using the resident's care plan, whether the resident's ability to function is optimized and should not be measured solely by the number or amount of services provided.

The board shall assist the commissioner of health in ensuring that inspections and reinspections of nursing homes are conducted with a frequency and in a manner calculated to most effectively and appropriately fulfill its quality assurance responsibilities and achieve the greatest benefit to nursing home residents. The commissioner of health shall require a higher frequency and extent of inspections with respect to those nursing homes that present the most serious concerns with respect to resident health, treatment, comfort, safety, and well-being. These concerns include but are not limited to: complaints about care, safety, or rights; situations where previous inspections or reinspections have resulted in correction orders related to care, safety, or rights; instances of frequent change in administration in excess of normal turnover rates; and situations where persons involved in ownership or administration of the nursing home have been convicted of engaging in criminal activity. A nursing home that presents none of these concerns or any other concern or condition established by the board that poses a risk to resident care, safety, or rights shall be inspected once every two years for compliance with key requirements as determined by the board.

The board shall develop and recommend to the commissioners mechanisms beyond the inspection process to protect resident care, safety, and rights, including but not limited to coordination with the office of health facility complaints and the nursing home ombudsman program.

Subd. 3. **Methods for determining resident care needs.** The board shall develop and recommend to the commissioners definitions for levels of care and methods for determining resident care needs for implementation on July 1, 1985 in order to adjust payments for resident care based on the mix of resident needs in a nursing home. The methods for determining resident care needs shall include assessments of ability to perform activities of daily living and assessments of medical and therapeutic needs.

Subd. 4. **Enforcement.** The board shall develop and recommend for implementation effective methods of enforcing quality of care standards. When it deems necessary, and when all other methods of enforcement are not appropriate, the board shall recommend to the commissioner of health closure of all or part of a nursing home or certified boarding care home and revocation of the license. The board shall develop, and the commissioner of human services shall implement, a resident relocation plan that instructs the county in which the nursing home or certified boarding care home is located of procedures to ensure that the needs of residents in nursing homes or certified boarding care homes about to be closed are met. The duties of a county under the relocation plan also apply when residents are to be discharged from a nursing home or certified boarding care home as a result of a change in certification, closure, or loss or termination of the facility's medical assistance provider agreement. The county shall ensure placement in swing beds in hospitals, placement in unoccupied beds in other nursing homes, utilization of home health care on a temporary basis, foster care placement, or other appropriate alternative care. In preparing for relocation, the board shall ensure that residents and their families or guardians are involved in planning the relocation.

Subd. 5. **Reports.** The board shall prepare a report and the commissioners of health and human services shall deliver this report to the legislature no later than January 15, 1984, on the board's proposals and progress on implementation of the methods required under subdivisions 2, 3, and 4. The commissioners shall recommend changes in or additions to legislation necessary or desirable to fulfill their responsibilities. The board shall prepare an annual report and the commissioners shall deliver this report annually to the legislature, beginning in January, 1985, on the implementation and enforcement of the provisions of this section.

Subd. 6. **Data.** The interagency board may have access to data from the commissioners of health, human services, and public safety for carrying out its duties under this section. The commissioner of health and the commissioner of human services may each have access to data on persons, including data on vendors of services, from the other to carry out the purposes of this section. If the interagency board, the commissioner of health, or the commissioner of human services receives data on persons, including data on vendors of services, that is collected, maintained, used or disseminated in an investigation, authorized by statute and relating to enforcement of rules or law, the board or the commissioner shall not disclose that information except:

(a) pursuant to section 13.05;

(b) pursuant to statute or valid court order; or

(c) to a party named in a civil or criminal proceeding, administrative or judicial, for preparation of defense.

Data described in this subdivision is classified as public data upon its submission to an administrative law judge or court in an administrative or judicial proceeding.

History: *1983 c 199 s 5; 1984 c 640 s 32; 1984 c 641 s 12; 1984 c 654 art 5 s 58*

HEALTH CARE FACILITY GRIEVANCES

144A.51 DEFINITIONS.

Subdivision 1. For the purposes of sections 144A.51 to 144A.55, the terms defined in this section have the meanings given them.

Subd. 2. "Administrative agency" or "agency" means any division, official, or employee of a state or local governmental agency, but does not include:

(a) Any member of the senate or house of representatives;

(b) The governor or his personal staff;

(c) Any instrumentality of the federal government of the United States; or

(d) Any court or judge.

Subd. 3. "Director" means the director of the office of health facility complaints.

Subd. 4. "Health care provider" means any professional licensed by the state to provide medical or health care services who does provide the services to a resident of a health facility.

Subd. 5. "Health facility" means a facility or that part of a facility which is required to be licensed pursuant to sections 144.50 to 144.58, and a facility or that part of a facility which is required to be licensed under any law of this state which provides for the licensure of nursing homes.

Subd. 6. "Resident" means any resident or patient of a health facility, or the guardian or conservator of a resident or patient of a health facility, if one has been appointed.

History: *1976 c 325 s 1*

144A.52 OFFICE OF HEALTH FACILITY COMPLAINTS; CREATION.

Subdivision 1. The office of health facility complaints is hereby created in the department of health. The office shall be headed by a director appointed by the state commissioner of health. The director shall report to and serve at the pleasure of the state commissioner of health.

The commissioner of health shall provide the office of health facility complaints with office space, administrative services and secretarial and clerical assistance.

Subd. 2. The director may appoint a deputy director and one personal secretary to discharge the responsibilities of his office. Any deputy director or personal secretary and all other employees of the office shall be classified employees of the state commissioner of health.

Subd. 3. The director may delegate to members of his staff any of his authority or duties except the duty of formally making recommendations to the legislature, administrative agencies, health facilities, health care providers, and the state commissioner of health.

Subd. 4. The director shall attempt to include on his staff persons with expertise in areas such as law, health care, social work, dietary needs, sanitation, financial audits, health-safety requirements as they apply to health facilities, and any

other relevant fields. To the extent possible, employees of the office shall meet federal training requirements for health facility surveyors.

History: *1976 c 325 s 2; 1977 c 305 s 45; 1982 c 560 s 48*

144A.53 DIRECTOR; POWERS AND DUTIES.

Subdivision 1. **Powers.** The director may:

(a) Promulgate by rule, pursuant to chapter 14, and within the limits set forth in subdivision 2, the methods by which complaints against health facilities, health care providers or administrative agencies are to be made, reviewed, investigated, and acted upon; provided, however, that he may not charge a fee for filing a complaint;

(b) Recommend legislation and changes in rules to the state commissioner of health, legislature, governor, administrative agencies or the federal government;

(c) Investigate, upon a complaint or upon his own initiative, any action or failure to act by a health care provider or a health facility;

(d) Request and receive access to relevant information, records, or documents in the possession of an administrative agency, a health care provider, or a health facility which he deems necessary for the discharge of his responsibilities;

(e) Enter and inspect, at any time, a health facility; provided that the director shall not unduly interfere with or disturb the activities of a resident unless the resident consents;

(f) Issue a correction order pursuant to section 144.653 or any other law which provides for the issuance of correction orders to health care facilities;

(g) Recommend the certification or decertification of health facilities pursuant to Title XVIII or Title XIX of the United States Social Security Act;

(h) Assist residents of health facilities in the enforcement of their rights under Minnesota law; and

(i) Work with administrative agencies, health facilities, health care providers and organizations representing consumers on programs designed to provide information about health facilities to the public and to health facility residents.

Subd. 2. **Complaints.** The director may receive a complaint from any source concerning an action of an administrative agency, a health care provider, or a health facility. He may require a complainant to pursue other remedies or channels of complaint open to the complainant before accepting or investigating the complaint.

The director shall keep written records of all complaints and his action upon them. After completing his investigation of a complaint, he shall inform the complainant, the administrative agency having jurisdiction over the subject matter, the health care provider and the health facility of the action taken.

Subd. 3. **Recommendations.** If, after duly considering a complaint and whatever material he deems pertinent, the director determines that the complaint is valid, he may recommend that an administrative agency, a health care provider or a health facility should:

(a) Modify or cancel the actions which gave rise to the complaint;

(b) Alter the practice, rule or decision which gave rise to the complaint;

(c) Provide more information about the action under investigation; or

(d) Take any other step which the director considers appropriate.

If the director requests, the administrative agency, a health care provider or health facility shall, within the time specified, inform the director about the action taken on his recommendation.

Subd. 4. **Referral of complaints.** If a complaint received by the director relates to a matter more properly within the jurisdiction of an occupational licensing

board or other governmental agency, the director shall forward the complaint to that agency and shall inform the complaining party of the forwarding. The agency shall promptly act in respect to the complaint, and shall inform the complaining party and the director of its disposition. If a governmental agency receives a complaint which is more properly within the jurisdiction of the director, it shall promptly forward the complaint to the director, and shall inform the complaining party of the forwarding. If the director has reason to believe that an official or employee of an administrative agency or health facility has acted in a manner warranting criminal or disciplinary proceedings, he shall refer the matter to the state commissioner of health, the commissioner of human services, an appropriate prosecuting authority, or other appropriate agency.

History: *1976 c 325 s 3; 1977 c 305 s 45; 1982 c 424 s 130; 1983 c 289 s 98; 1984 c 654 art 5 s 58*

144A.54 PUBLICATION OF RECOMMENDATIONS; REPORTS.

Subdivision 1. Except as otherwise provided by this section, the director may determine the form, frequency, and distribution of his conclusions and recommendations. The director shall transmit his conclusions and recommendations to the state commissioner of health and the legislature. Before announcing a conclusion or recommendation that expressly or by implication criticizes an administrative agency, a health care provider or a health facility, the director shall consult with that agency, health care provider or facility. When publishing an opinion adverse to an administrative agency, a health care provider or a health facility, he shall include in the publication any statement of reasonable length made to him by that agency, health care provider or health facility in defense or explanation of the action.

Subd. 2. In addition to whatever other reports the director may make, he shall, at the end of each year, report to the state commissioner of health and the legislature concerning the exercise of his functions during the preceding year. The state commissioner of health may, at any time, request and receive information, other than resident records, from the director.

Subd. 3. In performing his duties under Laws 1976, Chapter 325, the director shall preserve the confidentiality of resident records. He may release a resident's records with the written approval of the resident who is the subject of the records.

History: *1976 c 325 s 4; 1977 c 305 s 45*

144A.55 [Repealed, 1983 c 260 s 68]

144A.61 NURSING ASSISTANT TRAINING.

Subdivision 1. **Purpose.** The purpose of sections 144A.61 and 144A.611 is to improve the quality of care provided to patients of nursing homes by assuring that approved programs for the training of nursing assistants are established as necessary throughout the state.

Subd. 2. **Nursing assistants.** For the purposes of sections 144A.61 and 144A.611 "nursing assistant" means a nursing home employee, including a nurse's aide or an orderly, who is assigned by the director of nursing to provide or assist in the provision of direct patient care services under the supervision of a registered nurse. The commissioner of education may, by rule, establish categories of nursing assistants who are not required to comply with the educational requirements of sections 144A.61 and 144A.611.

Subd. 3. **Curricula; test.** The commissioner of education shall develop curricula and a test to be used for nursing assistant training programs for employees of nursing homes. The curricula, as reviewed and evaluated by the board of nursing,

shall be utilized by all facilities, institutions, or programs offering nursing assistant training programs. The test may be given by any area vocational-technical institute or community college in accordance with instructions from the commissioner of education. The commissioner of education may prescribe a fee for the administration of the test not to exceed $30.

Subd. 4. **Technical assistance.** The commissioner of education shall, upon request, provide necessary and appropriate technical assistance in the development of nursing assistant training programs.

Subd. 5. [Repealed, 1977 c 326 s 18]

Subd. 6. **Training program.** Each nursing assistant hired to work in a nursing home on or after January 1, 1979, shall have successfully completed an approved nursing assistant training program or shall be enrolled in the first available approved training program which is scheduled to commence within 60 days of the date of the assistant's employment. Approved training programs shall be offered at the location most reasonably accessible to the enrollees in each class.

Subd. 7. **Violation, penalty.** Violation of sections 144A.61 and 144A.611 by a nursing home shall be grounds for the issuance of a correction order to the nursing home by the state commissioner of health. The failure of the nursing home to correct the deficiency or deficiencies specified in the correction order shall result in the assessment of a fine in accordance with the schedule of fines promulgated by rule of the state commissioner of health.

Subd. 8. **Exceptions.** Employees of nursing homes conducted in accordance with the teachings of the body known as the Church of Christ, Scientist, shall be exempt from the requirements of sections 144A.61 and 144A.611.

History: *1976 c 310 s 1; 1977 c 305 s 45; 1977 c 326 s 6,7; 1977 c 453 s 26; 1981 c 359 s 17*

144A.611 REIMBURSABLE EXPENSES PAYABLE TO NURSING ASSISTANTS.

Subdivision 1. **Nursing homes.** The actual costs of tuition and reasonable expenses for that approved program deemed by the commissioner of education to be minimally necessary to protect the health and welfare of nursing home residents, which are paid to nursing home assistants pursuant to subdivision 2, shall be a reimbursable expense for nursing homes under the provisions of chapter 256B and the rules promulgated thereunder.

Subd. 2. **Nursing assistants.** A nursing assistant who has completed an approved training program shall be reimbursed by the nursing home for his actual costs of tuition and reasonable expenses for the training program 90 days after the date of his employment, or upon completion of the approved training program, whichever is later.

Subd. 3. **Rules.** The commissioner of human services shall promulgate any rules necessary to implement the provisions of this section. The rules shall include, but not be limited to:

(a) Provisions designed to prevent reimbursement by the commissioner under sections 144A.61 and 144A.611 to a nursing home or a nursing assistant for the assistant's training in more than one approved program;

(b) Provisions designed to prevent reimbursement by the commissioner under sections 144A.61 and 144A.611 to more than one nursing home for the training of any individual nursing assistant; and

(c) Provisions permitting the reimbursement by the commissioner to nursing homes and nursing assistants for the retraining of a nursing assistant after an absence from the labor market of not less than five years.

History: *1976 c 310 s 2; 1977 c 326 s 9; 1984 c 654 art 5 s 58*

144A.65 MS1980 [Expired]
144A.66 MS1980 [Expired]
144A.67 MS1980 [Expired]

APPENDIX J

PROPOSED TEMPORARY MORATORIUM RULE

Emergency Rules as Proposed (all new material)

4655.0510 [Emergency] PURPOSE.

Parts 4655.0510 to 4655.0520 [Emergency] govern procedures for the replacement or addition of medical assistance certified beds in nursing homes and boarding care homes under Minnesota Statutes, section 144A.071, subdivision 3, paragraph (a).

4655.0520 [Emergency] CONDITIONS FOR MEDICAL ASSISTANCE.

Subpart 1. Conditions for replacement or hardship. The commissioner of health may approve a nursing home's or a boarding care home's request for the medical assistance certification of beds based upon the following conditions:

A. The county in which the facility is located, together with all contiguous Minnesota counties, has fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than the national average of nursing home beds per 1,000 elderly individuals. For the purposes of parts 4655.0510 to 4655.0520, the national average of nursing home beds shall be the most recent figure that can be supplied by the federal health care financing administration and the number of elderly in the county or the nation shall be determined by the most recent federal census or the most recent estimate of the state demographer as of July 1, of each year of persons age 65 and older, whichever is the most recent at the time of the request for replacement or addition of beds.

B. The number and certification level of the requested beds shall not exceed the lesser of:

(1) the number and certification level of beds decertified in the county in which the facility is located and in the contiguous Minnesota counties; or

(2) the number and certification levels of beds necessary to meet the standards contained in item A.

C. If the request is for the addition of beds under the extreme hardship exception of Minnesota Statutes, section 144A.071, subdivision 3, paragraph (a), the county in which the beds are to be located must document the existence of unmet

medical needs that cannot be addressed by any other alternatives.

Subp. 2. **Replacement of beds pursuant to commissioner of health order.** The provisions of subpart 1 do not apply if the commissioner of health issues an order as the result of noncompliance with a law or rule which presents an imminent risk of harm to residents' safety, health, or well being and when in the commissioner's judgment compliance with the order can only be attained by the replacement of a certified bed.

Subp. 3. **Receipt of multiple requests.** If within 30 days of the receipt of a request for the certification of beds, other requests are received for the certification of beds in the same county or in a contiguous Minnesota county, the department shall notify the applicants and request information required by subpart 4. The applicants shall submit the information to the department within 45 days of the request.

Subp. 4. **Multiple requests; review criteria.** In reviewing the requests, the commissioner of health shall evaluate the following criteria:

A. the need for beds based upon the population requirements of the county in which the replacement or additional beds will be located;

B. the need for the beds as determined by past, present, and future utilization data with specific attention given to the following:

(1) utilization rates of similar facilities within the county and the contiguous Minnesota counties for the most recent five years;

(2) utilization rates of the existing facility for the most recent five years; and

(3) five years projected utilization rates for the proposed project;

C. the availability and adequacy of other less costly or more effective health care facilities and services which may serve as alternatives or substitutes for the whole or any part of the project; and

D. the immediate and long-term financial feasibility

APPROVED BY THE REVISOR OF STATUTES OFFICE BY:

of the project, its probable impact on the operational costs and charges of the facility, and the impact of the project on the medical assistance program.

Subp. 5. **Multiple requests; determination.** Within 30 days of the receipt of the information required by subpart 3, the commissioner shall inform the applicants of the decision to approve or deny the requests.

Subp. 6. **Appeal procedure.** An applicant may contest the denial of the request for the certification of beds by requesting a contested case proceeding under Minnesota Statutes, sections 14.57 to 14.69.

APPENDIX K

LIST OF NURSING HOMES AND HOSPITALS SURVEYED
POLICH AND ASSOCIATES
1985

LIST OF NURSING HOMES AND HOSPITALS SURVEYED

Three small surveys were conducted for this report to determine the impact of the moratorium on the placement of elderly clients in nursing homes. The surveys were conducted with a random sample of 25 nursing homes across the State, discharge planners from 18 Minnesota hospitals, and seven county pre-admission screening programs.

While these survey samples were not large enough to be representative of all nursing homes, hospitals, and pre-admission screening programs in Minnesota, the surveys did provide information on the impact of the moratorium on these facilities. The following is a list of the facilities and counties that were contacted.

Nursing Homes

Aicota Nursing Home, Aitkin
Presbyterian Home, St. Paul
Buffalo Lake Home, Buffalo
Cannon Falls Manor, Cannon Falls
Emmanuel Nursing Home, Detroit Lakes
Edina Care Center, Edina
Itasca Nursing Home, Grand Rapids
Excelsior Nursing Home, Excelsior
Chapel View Nursing Home, Hopkins
Birchwood Health Care Center, Forest Lake
Emmanuel Home, Litchfield
Eventide Lutheran Home, Moorhead
Elim Home, Milaca
Mala Strana Nursing Home, New Prague
Careview Home, Minneapolis
Stevens Square, Minneapolis
Cedarview Nursing Home, Owatonna
Sholom Home, St. Paul
Samaritan Bethany Home, Rochester
Slayton Manor, Slayton
Pleasant Manor, Faribault
Sunwood Care Center, Redwood Falls
St. Cloud Manor, St. Cloud
White Bear Lake Care Center, White Bear Lake
Woodbury Health Care Center, Woodbury

Hospitals

Fairview-Southdale, Edina
St. Paul Ramsey Medical Center, St. Paul
Hennepin County Medical Center, Minneapolis
Abbott-Northwestern Hospital, Minneapolis
Mount Sinai Hospital, Minneapolis
Mercy Medical Center, Coon Rapids
Metropolitan Medical Center, Minneapolis
Methodist Hospital, St. Louis Park
Unity Medical Center, Fridley
Cuyuna Range District Hospital, Crosby
Immanuel - St. Joseph's Hospital, Mankato

Lake Region Hospital, Fergus Falls
Aitkin Community Hospital, Aitkin
St. Olaf Hospital, Austin
Bemidji Community Hospital, Bemidji
St. Luke's Hospital, Duluth
St. Ansgar Hospital, Moorhead
Murray County Memorial Hospital, Slayton

County Pre-Admission Screening Programs

Hennepin County
Ramsey County
St. Louis County
Olmsted County
Otter Tail County
Blue Earth County
Crow Wing County

APPENDIX L

REFERENCES

REFERENCES

Minnesota Department of Health. Impact of the Moratorium on the Medical Assistance Certification of Nursing Home and Boarding Care Home Beds, Minneapolis, 1984.

Minnesota Department of Health. Directory of Licensed and Certified Health Care Facilities, Minneapolis, 1982.

Minnesota Department of Health. Minnesota Long-Term Care Plan, Minneapolis, 1981.

Minnesota Department of Health. Healthy People - the Minnesota Experience, 1982.

Minnesota Department of Health. MCHS Report, Spring 1983.

Minnesota Department of Veteran Affairs, Final Report: Interagency Task Force on Long-Term Care Services for Veterans, 1984.

Minnesota Gerontological Society. Care of Older People: Family Roles and Responsibilities, St.Paul, 1984.

Office of the State Demographer. Population Notes, December, 1982.

Office of the State Demographer. Population Notes, December, 1983.

Office of the State Demographer. Population Notes, November, 1984.

Polich, Cynthia. Eldertrends: A Profile of Minnesota's Elderly, Health Futures Institute, Minneapolis, 1984.

Polich, Cynthia. The Pre-Admission Screening and Alternative Care Grants Programs: A Description and Analysis of Minnesota's Experience, Health Futures Institute, Minneapolis, 1984.

Polich, Cynthia. Home Care in Minnesota: Issues and Future Directions, Center for Health Services Research, University of Minnesota, Minneapolis, 1985.

Stryker-Gordon, Ruth. A Study of Public Policy and Availability of Nursing Home Beds in Minnesota, University of Minnesota, Minneapolis, 1984.

U.S. Senate Special Committee on Aging and the American Association of Retired Persons. Aging America: Trends and Projections, Washington, D.C., 1983.