MN DEPARTMENT OF HUMAN SERVICES

Nursing Home Assisted Living Pilot Project

A Report to the Minnesota Legislature

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03/05/2012

I. Introduction

Laws of Minnesota, First Special Session, 2011, chapter 9, article 7, section 50, directs the Department of Human Services (DHS) to provide recommendations to the legislature on how to develop a pilot project demonstrating a new approach to nursing facility care. The intent was to determine how to test a model of care between nursing facility care and assisted living. This report was developed in consultation with the Minnesota Department of Health (MDH), stakeholders and other experts. The requirement states:

> *Sec. 50.* ***NURSING FACILITY PILOT PROJECT.***
> *Subdivision 1.* ***Report.*** *The commissioner of human services, in consultation with the commissioner of health, stakeholders, and experts, shall provide to the legislature recommendations by November 15, 2011, on how to develop a project to demonstrate a new approach to caring for certain individuals in nursing facilities.*
> *Subd. 2.* ***Contents of report.*** *The recommendations shall address the:*
> *(1) nature of the demonstration in terms of timing, size, qualifications to participate, participation selection criteria and post demonstration options for the demonstration and for participating facilities;*
> *(2) nature of needed new form of licensure;*
> *(3) characteristics of the individuals the new model is intended to serve and comparison of these characteristics with those individuals served by existing models of care;*
> *(4) quality standards for licensure addressing management, types and amounts of staffing, safety, infection control, care processes, quality improvement, and resident rights;*
> *(5) characteristics of inspection process;*
> *(6) funding for inspection process;*
> *(7) enforcement authorities;*
> *(8) role of Medicare;*
> *(9) participation in the elderly waiver program, including rate setting;*
> *(10) nature of any federal approval or waiver requirements and the method and timing of obtaining them;*
> *(11) consumer rights; and*
> *(12) methods and resources needed to evaluate the effectiveness of the model with regards to cost and quality.*

This report is submitted to the Legislature in response to these requirements.

II. Cost to Prepare this Report

Minnesota Statutes, chapter 3.197 requires disclosure of the cost to prepare this report. Approximately $11,500 of staff salaries, mileage and meeting expenses was spent to analyze the issues, conduct research and prepare this report.

III. Background

The legislative requirement directed the commissioner of human services, in consultation with the commissioner of health, stakeholders, and experts to develop a recommendation on how to develop a pilot project to demonstrate a new approach to caring for certain individuals in nursing facilities. Conducting a pilot would require some form of guidance as to how the project sites would be regulated and funded. This guidance could be provided either through legislation or through rule. See Appendix 1 for a description of the rulemaking process.

Integral to many of the discussions surrounding this report is the topic of assisted living, and specifically the rate setting methodology called the "Customized Living Tool." See Appendix 2 for background on this topic.

Another topic that was touched on in many of our conversations was regulation. See Appendix 3 for a description of regulation in nursing facilities.

Any change in payment methodology of Medicaid funds must be approved by the federal Centers for Medicare and Medicaid Services. See Appendix 4 for a description of this process.

IV. Methodology

Several steps were undertaken to prepare this report:

- A project leadership group, consisting of representatives from DHS and MDH was established.
- The project leadership group developed a work plan for the project.
- Representatives of the leadership group traveled to Waseca on October 21, 2011, to meet with the Senate author of the legislation, the Senate chair of the Health and Human Services Committee and several area providers, to discuss the project and review the work plan. The Leadership Group felt that it was critical to have input from this meeting before implementing the work plan, and, in fact, the meeting resulted in several refinements to the work plan.
- Key informant meetings were held in three locations, with a total of 80 stakeholders attending. Attendees represented nursing homes providers, assisted living providers, trade associations, the Ombudsman for Long-Term Care, county social services, county public health, health plans, the Alzheimer's Association, a law firm, an accounting firm, the Minnesota Senate, and the media. In addition, between four and six staff of DHS and MDH attended each meeting. Please see Appendix 5 for the invitation to the Key Informant meetings:
    - January 10, 2012 in Waseca - 20 attendees
    - January 12, 2012 in Alexandria - 42 attendees
    - January 18, 2012 in New Hope - 18 attendees

  The format of the three meetings was identical. The same handouts were provided (see Appendix 6 for the key informant meeting discussion guide and handout). All three meetings were facilitated by the same individual. The meetings began with an overview of the project and outlining ground rules intended to ensure that all attendees were

afforded an opportunity to speak. The facilitator asked stakeholders to clarify and elaborate as needed and invited attendees to also seek additional insight.

V. Key Informant Meeting Highlights

While the report to the legislature must address several issues related to conducting a pilot, the key informant meetings were focused on developing an understanding of the goals that the pilot project would address. The legislation speaks to "a new approach to caring for certain individuals in nursing facilities." Agency staff were particularly interested in developing a clear understanding of stakeholder perspectives on who the individuals are that would benefit from a new approach to care, what services they need and what that new approach to care should look like. We needed to understand why the current service models were less than satisfactory and what models might be more suitable.

In conducting the three key informant meetings and reviewing the input received, several general observations were noted:

- For many of the opinions that were voiced, other stakeholders held different and often conflicting opinions
- The issues, ideas and concerns that were emphasized differed substantially between the three locations.
- Two competing themes emerged:
    - That a new form of licensure is needed and that it needs to have higher rates than assisted living but not as high as nursing homes, and it needs to have the level of regulatory oversight of assisted living and not of nursing homes.
    - That a new form of licensure is not needed, but that there are people in need of long-term care (LTC) services whose needs are not being met and/or they are not in the most appropriate setting.

  While both themes had their adherents, the impression of agency staff was that the second theme was more widely held.
- The meetings were all introduced with comments placing the discussion in the context of "a new approach to caring for certain individuals in nursing facilities." And in each case, the meetings quickly gravitated toward a broader discussion of unmet needs of individuals needing some form of LTC.

Appendices 7, 8 and 9 contain articles published describing the key informant meetings.

Specific topics discussed at key informant meetings are displayed in the following table.

Concern/Issue	Waseca	Alex-andria	New Hope
Several comments were made having to do with the adequacy of Medicaid (MA) <u>funding</u>, both in nursing facilities and assisted living. • A commonly stated opinion was that MA rates for nursing facility care and for assisted living services are too low to cover costs. In the nursing facility, Medicare subsidizes MA. In assisted living, private pay subsidizes MA. • It is a problem that Elderly Waiver (EW) funding of assisted living does not include rental costs, room and board • The EW program should increase payment levels in assisted living so that they will be better able to admit individuals who currently are in nursing facilities but don't really need that level of care • The EW program should consider providing enhanced funding in assisted living for first thirty days of a stay when conditions require greater clinical oversight. • The EW program should consider providing the ability to add services at any time or flexibility in services and to drive care • With recent payment reductions in assisted living, some of these providers state that they are needing to limit the number of MA recipients they can serve	X	X	X
Gaps were seen regarding individuals with <u>mental health</u> diagnoses, chemical dependency, behavioral needs, and physical and developmental disabilities, especially those under age 65: • It can be difficult to integrate this population with traditional elderly nursing facility residents • Parts of the state lack access to psychiatric services • Perhaps separate settings should be provided for this population. • MA is not properly serving MI/behavior clients under 65 • Minnesota needs "step-down" care for individuals with behavior concerns • **Size and setting restrictions for waiver clients under age 65 prevent more than four unrelated people from living together.** These people often want their own apartment and choose not to live in adult foster care, and cannot be funded for care in assisted living under the disability waivers due to federal restrictions, because it is too institutional, so if an apartment is not feasible, they end up in a nursing facility.	X	X	X

Concern/Issue	Waseca	Alex-andria	New Hope
<u>Alzheimer's Disease</u> was raised as an issue at all three meetings: • A gap in many communities is for memory care for people with Alzheimer's Disease or other dementing illnesses in a setting other than the nursing home. Where the assisted living facility does not offer memory care, individuals who require continuous supervision or extensive care for activities of daily living may find that nursing home placement is their only alternative. • People with early stage Alzheimer's Disease may need 24 hour supervision but not necessarily the RN oversight or care for ADLs provided in a nursing facility. • People with Alzheimer's Disease don't do well in AL unless it specializes in memory care. • Caregiver issues: o New caregivers need education, social services and peer support o There are times where special, short-term support for caregivers may extend the ability of the caregiver to continue in their role. o Alzheimer's Disease caregivers need help to form a support team to sustain informal care longer.	X	X	X
Several issues were also raised related to <u>flexibility</u> in the use of available funds: • Providers need increased reimbursement flexibility or to be reimbursed for care actually given. • There is a need to match financial resources to consumer's needs. • Greater flexibility is needed in setting, regulation and MA payment. While there were no complaints about the level of regulation in assisted living, MA payment was considered too low. Restricting the number of people under age 65 in an assisted living setting was questioned. The greater regulation of nursing homes was noted along with the payment not meeting cost, and the use of the nursing home setting in cases where they could be in a less restrictive setting. •	X	X	X
<u>Technologies</u> may be helpful for meeting many needs currently addressed in nursing homes or in assisted living settings.	X	X	X
We need to take steps to preserve small, rural nursing facilities, particularly those with low Medicare utilization	X	X	

Concern/Issue	Waseca	Alex-andria	New Hope
Reduce regulatory burden in nursing facilities.	X		
Some nursing facility residents have high ADL needs but don't need skilled care.	X		
There is competition for clients between nursing facilities and assisted living providers.	X		
Doctors need to be educated as to the capabilities of assisted living providers.	X		
Need places for people with chronic illness to avoid acute care.	X		
General Consensus – There is no need for unique form of licensure, whatever we recommend should be built on top of the structure we already have.	X		
Many key informants expressed concerns about bariatric care, where costs associated with equipment, building adaptations and direct care staffing greatly exceed nursing facility RUG rates. While many providers are serving residents with this need, many more patients are refused admission to nursing facilities.		X	
Some said assisted living providers couldn't serve people who needed a nurse at various hours. Others said they could provide this service.		X	
Is there a way to implement flexibility in licensure so that beds/units can shift as needed between use as a nursing facility bed or as an assisted living unit?		X	
It can be a struggle to find the best ways to meet the needs of people from a variety of different cultures. This can entail challenges ranging from religious observance, language and food preferences to hair care.			X
Lack of transportation			X
The public needs to learn to accept risk			X
Gaps in home and community based services exist for impoverished, unbefriended elders, often leading to nursing home placement being the only viable option			X

VI. Strategies for the Legislature to Consider

The legislation requiring this report provides limited guidance as to the goal of the pilot project, stating: "recommendations … on how to develop a project to demonstrate a new approach to caring for certain individuals in nursing facilities." Development of recommendations requires that we first have a clear concept of the goal of the pilot, exactly what the characteristics are of the people in nursing homes who need a new approach, and what that approach should be. Based on several meetings, including the three key informant meetings described above, agency staff find themselves unable to detect a clear goal for a pilot or even a clear consensus that a pilot is desirable or necessary. Therefore, the recommendation from the Department of Human Services and the Minnesota Department of Health is that the state not conduct a pilot project of a new form of licensure. Our opinion, and we believe that of a great many of the key informants, is that there are areas of service gaps for specific populations, that there may be areas where MA funding is not sufficient to bring about optimal access to some services and that there may be some concerns about the costs of complying with some regulations. However, there is no consensus as to which specific regulations are of concern except that almost none appear to be state-only requirements. Rather than conducting a pilot, we are suggesting several strategies that the legislature may wish to consider. If there is interest in pursuing any of these strategies, the department will assist in determining fiscal implications.

1. Repeal the Minnesota law requiring mandatory Medicare certification – consideration has been given to providing greater flexibility for facilities to transition between Nursing Home/SNF-NF and BCH/NF licensure/certification. For the sake of clarification, we distinguish between state licensure requirements (Nursing Home and Boarding Care Home) and the federal certification requirements (Skilled Nursing Facilities and Nursing Facilities). Skilled Nursing Facilities (SNFs) are certified to participate in the Medicare program. Nursing Facilities (NFs) are certified to participate in the Medicaid program. Many facilities are dually certified as SNF/NF. For further definition of SNF and NF status, see Appendix 10.

   Nothing in current law prevents facility from converting from Nursing Home/SNF-NF to BCH/NF. A facility that does not want to participate in Medicare, may wish to consider making this change. However, they should take into consideration that conversion back from BCH/NF to NH/SNF-NF may be impeded due to loss of "existing construction" status. Before converting back, the facility would need to meet "new construction" standards for state rules.

   The goal of this flexibility can be achieved by amending Minnesota's Mandatory Medicare Certification Law at 256B.48, subdivision 6, removing the Minnesota requirement that state licensed Nursing Homes be dually certified as SNF/NFs. As illustrated in the table in Appendix 11, and the information in Appendices 10 and 12, dropping Medicare certification opens the possibility of different nursing staff waivers. **All other federal and state regulations would still apply.** State staff do not know how the Centers for Medicare and Medicaid Services (CMS) will interpret "existing healthcare occupancies" status versus "new healthcare occupancies" status for facilities that may want to reinstate their SNF certification at a later date. The difference in this

status is significant when the requirements of the federal Life Safety Code are taken into consideration.

Allowing decertification from Medicare will add costs to Medicaid if non-Medicare nursing facilities are allowed to admit individuals who would otherwise have a Medicare-qualifying stay, because Medicaid would have to pay the bill for those days of service. These costs may be eliminated by prohibiting nursing facilities that do not participate in Medicare from admitting individuals who would otherwise have a Medicare-qualifying stay and providing to DHS the resources and authority to detect when this occurs and to deny Medicaid payment.

Allowing decertification from Medicare could result in reduced access for some consumers in their local communities who may need to travel further to find a bed in a Medicare certified program. State staff do not know whether local health plans would modify their contracting arrangements with facilities who choose to decertify from the Medicare program.

2. Rural / Urban issues – in addition to the strategy discussed in item #1, above, the legislature may wish to consider establishing a Critical Access Nursing Home model. Under a model such as this, financial benefits, such as partial or full rebasing of operating payment rates, or other rate setting or payment changes could be provided to facilities that meet specified criteria, such as geographic isolation in an area with an elderly population that exceed a certain threshold. We do not believe that this mechanism could be used to provide any form of regulatory flexibility. Nursing homes would still need to follow all applicable state and federal regulations.

3. Provide additional funding for specialized services, such as specific services required by persons with very high acuity diagnoses or bariatric care in nursing facilities, to enable individuals to have greater access to this service and not have to remain in hospitals. There are several methods by which this may be accomplished. Services that may qualify for the additional funding would need to be clearly defined and should meet a set of criteria such as:
    a. The current case mix classification system does not adequately account for resources necessary to deal with the specialized conditions.
    b. Hospitals are not able to discharge patients with these conditions due to a lack of access to necessary services.

4. Assisted Living funding concerns – the impact of Elderly Waiver rate reductions and its Customized Living (Assisted Living) Rate Setting tool were frequently noted. Across the board rate increases were requested for Legislative consideration. Additional funding might also be targeted to serving people with complex needs, along with rate enhancements for specialized care. In prior paragraphs, some of the greater care needs are noted, like care for those with Alzheimer's Disease and mental health related needs. Other specialized areas cited included care of:
    a. People from different ethnic backgrounds that may require recruitment and retention of staff of a particular ethnicity or language skill, and

b. Un-befriended elders, who, lacking of family and other informal supports, may require additional staff time and care

The Elderly Waiver currently may pay a higher rate when a person is transitioning from a nursing home to home and community-based services, including assisted living. These "conversion rates" allow the higher nursing home payment amount to be used for up to a year, and may be renewed annually. The approval process for a "conversion rate" renewal includes a comparison with the rate set through the Customized Living Rate setting tool and if the "conversion rate" is not needed to cover the payment, then the lower rate of the tool is used.

Another necessary element in the rate setting process is the assessment of need, since service need and payment for those services are based on the assessed needs of individuals. Knowing when a change in condition, either a greater or lesser need, translates into a rate change is a training and experience issue which DHS has been available to provide. Since the calculated payments through the rate setting tool take into account minor fluctuations in need that happen during the course of care, DHS will continue to provide training and experience so provider and lead agencies can understand when a need change justifies a new assessment, or when the current rate has already accommodated the change.

5. The topic of care for people with Alzheimer's Disease or other dementias was raised at all three key informant meetings. A copy of the January 15, 2011, report to the legislature entitled "Preparing Minnesota for Alzheimer's: The Budgetary, Social and Personal Impacts," may be viewed at this link: http://archive.leg.state.mn.us/docs/2011/mandated/110079.pdf In follow-up to this report, a new process has been established called "Prepare Minnesota for Alzheimer's, 2020," (PMA 2020). Further information about PMA 2020 may be accessed at this link: http://collectiveactionlab.com/?q=pma2020 Given the extensive work already underway in regard to this topic, we do not feel that this report is a useful vehicle for further work in this area.

6. Mental health related concerns – substantial efforts are already underway in the Money Follows the Person program and in the Medicaid Reform Waiver request. Staff involved in this project will share concerns expressed at the key informant meeting with the staff working on those projects.

7. Flexibility in use of funds – because this is the issue being address in the Money Follows the Person Project, agency staff do not feel additional recommendations would be beneficial at this time.

Because our recommendation is to not conduct a pilot, we are not providing recommendations on pilot design, management of the pilot or evaluation of the pilot.

Appendices

1. Minnesota Rulemaking
2. Customized Living
3. Nursing Facility Regulatory Requirements
4. State Medicaid Plan Amendment Process
5. Invitation to Key Informant Meetings
6. Key Informant meetings discussion guide and handout
7. Aging Services of Minnesota Article
8. Care Providers of Minnesota Article
9. Article from the Waseca County Times
10. Definition of SNF and NF Status: Excerpts from Chapter 7 of the State Operations Manual – a federal document
11. Nursing Home/Boarding Care Home Nurse Staffing Requirements and Possible Waivers
12. Excerpts from Appendix PP of the State Operations Manual – a federal document

Appendix 1

A Synopsis of Minnesota Rulemaking

A statutory directive is required in order to adopt rules on a particular subject or there must be a general provision that rules are necessary in order to fill in details for administering a statute. "Required rules. Each agency shall adopt rules… setting forth the nature and requirements of all formal and informal procedures related to the administration of official agency duties to the extent that those procedures directly affect the rights of or procedure available to the public." MN Statutes, section 14.06, paragraph (a).

The process of rulemaking is governed by the MN Administrative Procedure Act (MN Statutes Chapter 14) https://www.revisor.mn.gov/statutes/?id=14 and MN Rules Chapter 1400 https://www.revisor.mn.gov/rules/?id=1400. There is a MN Rulemaking Manual: A Reference Book for the Practitioner, available to help a rule writer through the process. It is in excess of 300 pages in length. http://www.health.state.mn.us/rules/manual/manual2011.pdf

There are a number of legal requirements for adopting rules, including specific timelines and deadlines, specific notification requirements, review and comment by internal and external government agencies as well as stakeholders/affected parties. The development of a Statement of Need and Reasonableness (SONAR) that explains the need for each rule is required. A misstep in the process can be costly and can even mean a "redo". (See attached timeline of requirements from the Minnesota Rulemaking Manual)

It takes from 6 months to 2 years to develop rules.

Most state agencies have internal support capacity for rule writing staff, but some may have to hire staff specifically for the project. Agencies typically use program specialists as well as legal specialists during the rulemaking process.

The Office of Administrative Hearings (OAH), via an administrative law judge, must review any proposed rule before it is adopted. This can be accomplished with or without a public hearing. Usually there is a public hearing. The administrative law judge ensures that all persons involved in the rule hearing are treated fairly, that all requirements in the rulemaking process have been adhered to, that there are no defects in the proposed rule, and that the rule is "legal". The OAH can recommend approval of the proposed rule, however, the governor has the authority to veto rules and the rules will not be able to be promulgated if they are vetoed.

An official rulemaking record must be kept and the contents of this record are noted in the rule on rule writing. This record must be maintained indefinitely.

Costs of rule writing are borne by the agency initiating the rule and need to be budgeted for.

Appendix 2

Customized Living: Setting Payment Rates

The Elderly Waiver pays for Customized Living and 24-Hour Customized Living services using a monthly "bundled" payment calculated using the Customized Living tool, standardized component services, and component service rates established by the department and subject to legislatively mandated increases or decreases. Rather than require the billing and payment for each individual component service the provider bills a monthly rate adjusted for actual service days delivered during that month.

Customized Living and 24-Hour Customized Living are both home and community-based services paid through the Elderly Waiver. These services were previously known as Assisted Living and Assisted Living Plus. The department changed the service names in 2006 when Chapter 144G "Assisted Living Services" was enacted limiting the use of the term "assisted living" to services and settings that meet the criteria in that Chapter. The service package is tailored to meet each individual's documented needs and preferences. 24-Hour Customized Living is only available to individuals who require a 24 hour plan of care in accordance with criteria in statute. These waiver-eligible services are available to MA waiver participants who reside in registered housing with services establishments, registered through the Minnesota Department of Health. Under this arrangement, the building is registered and the services are provided by licensed home care providers. Elderly waiver services, generally, are alternative services participants can use when they are eligible but choose not to receive their services in a nursing home. No home and community-based service paid for by the waiver can be authorized in an institution, such as a nursing home, by federal definition.

Each person who receives home and community-based services must receive an assessment and have a community support plan developed by a lead agency in order to determine the payment. Lead agencies include counties, health plans, and tribes. The community support plan specifies the types and amount of services the person needs and is the basis for authorizing providers to deliver services. From the community support plan, the lead agency calculates the payment rate based on a standardized tool. There are a variety of component services that may be included in a customized living plan based on the qualifications of the home care provider, the needs of the person, and the other Elderly Waiver services chosen by the individual that fall outside of the responsibility of the customized services provided.

The law requires the component service rates to be no more than rates paid for "like" services delivered in someone's home Therefore, DHS bases the component rate limits in Customized Living and 24-Hour Customized Living on the rates paid for equivalent categories of home management, home care aide-like and home health aide-like services. The tasks assigned to these categories were based on Minnesota Department of Health state licensing standards for these services. Supportive services that require no state license were assigned the home management component rate for comparability.

Current component rates are the following:

- Home management and supportive services uses fee-for-service hourly home making rate
- Medication setups uses fee-for-service extended RN nursing rate.
- Home health-aide type tasks use 90% of the fee-for-service extended home health aide rate Ninety percent, instead of 100%, incorporates the statutory requirement that rates reflect "economies of scale."
- Home care aide tasks use the average between the home health aide and home management rates, as there was no established equivalent rate.
- Mileage uses the federal mileage rate.

Customized living services do not cover:

- Nursing services, with the exception of medication set ups
- Room and board
- Medical transportation

Customized living services, as a package of component services designed to meet the assessed needs of Elderly Waiver participants living in a qualified setting, covers these service components:

- Home management tasks
  - Snack and/or meal preparation
  - Personal laundry
  - Housekeeping/cleaning
  - Shopping
- Supportive services
  - Assisting consumers in setting up meetings and appointments
  - Assisting consumers with managing funds
  - Assisting consumers in setting up medical and social services
  - Arranging for or providing transportation
  - Socialization is an allowable component when:
    - individualized
    - not primarily diversional or recreational in nature
    - the service design supports the consumer in maintaining or developing relationships or supports the individual in socially valued roles of their choice, e.g. volunteering, being a grandmother, or serving on a committee
    - specifically included in customized living plan of care
    - establishes goals and outcomes for socialization
- Assistance with personal care
  - Dressing
  - Grooming
  - Bathing
  - Eating
  - Continence
  - Walking
  - Wheeling

- Transferring and/or positioning

• Assistance with medication
  - Medication reminders
  - Medication administration, including insulin injections
  - Medication set-ups, including insulin draws

• Delegated nursing tasks
  - Assisting with therapeutic or passive range of motion exercises
  - Performing other routine delegated medical or nursing or assigned therapy procedures, per Minnesota Rules, Chapter 4668.
  - Active behavior or cognitive support

Room and Board Costs, Waiver Obligations, and Spend Down

While the Elderly Waiver pays for Customized Living and 24-Hour Customized Living services, there are financial obligations for Elderly Waiver recipients. These areas include room and board costs, waiver obligations and spend down.

All Elderly Waiver recipients are responsible for paying the costs associated with room and board. In the context of home and community-based services, including Customized Living and 24-Hour Customized Living, the term "room" means rent or, if they don't pay rent, shelter type expenses, property related costs, maintenance and utilities. The term "board" means three meals a day or any other full nutritional regimen. Thus Elderly Waiver participants must pay their own rent and raw food costs.

Some recipients also must pay a waiver obligation, an obligated contribution toward the cost of long term care under rules governing the Special Income Standard. These are recipients who qualify for the Elderly Waiver under the Special Income Standard which is defined in federal regulations and equal to three times the Federal Benefit Rate for the Supplemental Security Income (SSI) Program. These recipients may keep a maintenance needs allowance, an amount of monthly income protected for people eligible under the Special Income Standard and equal to income up to $935 a month (in 2011) to pay for room, board (raw food) and other personal needs. Income over $935 is used to pay a waiver obligation.. The waiver obligation amount is dependent on the amount of income that they have. The recipient pays towards the waiver services that they use. They do not have to meet the entire waiver obligation each month to remain on the program. It should be noted that there are other deductions that can be budgeted and that there are spousal impoverishment protections as well. The recipient responsible for payment of a waiver obligation does not pay anything towards their non-waiver MA basic care costs.

Clients who have income that is above the Special Income Standard (300%SSI or $2022 in 2011) can be eligible for MA basic care with a spend down and thus also be eligible for Elderly Waiver. These clients need to spend down their monthly income to $681in 2011 (75% of the

federal poverty guideline). Spend down amounts are paid towards a person's medical and waiver services.

Appendix 3

Regulatory Requirements

Federal Requirements for Medicaid-Certified Long Term Care

The Social Security Act (the Act) mandates the establishment of minimum health and safety and CLIA standards that must be met by providers and suppliers participating in Medicaid and/or Medicare programs. These standards are found in the 42 Code of Federal Regulations http://www.access.gpo.gov/cgi-bin/cfrassemble.cgi?title=201042 . These federal regulations contain specific Conditions of Participation (CoPs) for entities who voluntarily choose to be part of the Medicare and/or Medicaid programs. Included in the requirements for nursing homes are regulations related to Resident Rights; Resident Behavior and Facility Practices which includes the rights to be free of physical and chemical restraints, and to be free from abuse; Quality of Life which includes being treated with dignity and respect, to participate in social and religious activities; Resident Assessment which includes that the residents will be comprehensively assessed and then care plans will be developed and implemented based on the comprehensive assessment; Quality of Care which includes providing care and services to reach the resident's highest practicable level of well-being, pressure ulcer prevention and treatment, care and treatment for nutrition and hydration, free of unnecessary drugs, and medication errors; Nursing Services; Dietary Services; Physician Services; Pharmacy Services; Infection Control; Physical Environment; and Administration which includes information about the training and competency of nursing assistants, the duties of the Medical Director, and laboratory services. There are similar CoPs for Medicare-certified home care providers. The Secretary of the Department of Health and Human Services (the Secretary) has designated CMS to administer the standards compliance aspects of these programs.

Medicaid is a State program that provides medical services to clients of the State public assistance program and, at the State's option, other needy individuals. When services are furnished through institutions that must be certified for Medicare, the institutional standards must be met for Medicaid as well.

In general, the only types of institutions participating solely in Medicaid are (unskilled) Nursing Facilities, Psychiatric Residential Treatment Facilities, and Intermediate Care Facilities for the Mentally Retarded. Medicaid requires Nursing Facilities to meet virtually the same requirements that Skilled Nursing Facilities participating in Medicare must meet. Intermediate Care Facilities for the Mentally Retarded must comply with special Medicaid standards.

Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratories testing to ensure the accuracy, reliability, and timeliness of patient test results, regardless of where the test was performed. The CLIA regulations are based on the complexity of the test method; thus, the more complicated the test, the more stringent the requirements. Facilities that conduct certain basic laboratory tests need CLIA waivers if they do not meet the standards for CLIA certification.

State Survey Agencies, under agreements between the State and the Secretary, carry out the Medicare certification process. The State Survey Agency is also authorized to set and enforce standards for CLIA and Medicaid. (The State Survey Agency may partially re-delegate the functions to local agencies.)

The Federal Certification Process

State Survey Agencies perform initial surveys (inspections) and periodic resurveys (including complaint surveys) of all providers who wish to be certified in the Medicare and/or Medicaid programs. These surveys are conducted to ascertain whether a provider meets applicable requirements for participation in the Medicare and/or Medicaid programs, and to evaluate performance and effectiveness in rendering a safe and acceptable quality of care. These requirements are found in the 42 Code of Federal Regulations. Part of a survey may concern a provider's efforts to prevent environmental hazards due to contagion, fire, contamination, or structural design and maintenance problems. It also ascertains that the responsible provider officials and key personnel are effectively doing all they must do to protect health and safety.

Certification occurs when the State Survey Agency officially recommends its findings regarding whether health care entities meet the Social Security Act's provider or supplier definitions, and whether the entities comply with standards required by Federal regulations. The functions that the State Survey Agencies perform are referred to collectively as the certification process. This includes, but is not limited to:
Conducting Investigations and Fact-Finding Surveys - Verifying how well the health care entities comply with the CoPs or requirements.
Certifying and Recertifying - Certifications are periodically sent to the appropriate Federal or State agencies regarding whether entities, including CLIA laboratories, are qualified to participate in the programs.
Explaining Requirements - Advising providers and potential providers in regard to applicable Federal regulations to enable them to qualify for participation in the programs and to maintain standards of health care consistent with the CoPs. Also, as mandated by the Social Security Act, States must conduct periodic educational programs for the staff and residents, and their representatives, of SNFs and NFs in order to present current regulations, procedures, and policies.
Nurse Aide Training - Specify and review Nurse Aide Training and Competency Evaluation Programs (NATCEPs) and/or Nurse Aide Competency Evaluation Programs (NACEPs).
Nurse Aide Registry (NAR) - Establish and maintain a registry for all individuals who have satisfactorily completed NATCEP or a NACEP.
Resident Assessment Instrument (RAI) - Specify a RAI for use in the LTC facilities participating in Medicare and/or Medicaid.
Records and Reports - Maintain pertinent survey, certification, statistical, or other records for a period of at least 4 years and make reports in the form and content as the Secretary may require.

State Survey Agencies do not have Medicare determination-making functions or

authorities; those authorities are delegated to CMS' Regional Offices. State Survey Agency certifications are the crucial evidence relied upon by the Regional Offices in approving health care entities to participate in Medicare and CLIA. Re-certifications are performed periodically by the State Survey Agencies.

After the State Survey Agency completes an inspection for the Medicare/Medicaid program, it submits evidence and a certification recommendation for a final CMS Regional Office determination.

When the State Survey Agency certifies just for Medicaid purposes, it is reporting its own adjudicative determination.

Appendix 4

State Medicaid Plan Amendment Process

The Medicaid program, governed in accordance with Title 19 of the Social Security Act, is a federal and state funded program to provide health care services to people who are indigent. Generally, the costs of the program are shared by the federal government (between 50-83%) and each state (between 17-50%). Minnesota's current Medicaid "match," called Federal Financial Participation (FFP) or Federal Medical Assistance Percentage (FMAP) is 50%, except that from July 1, 2009 through December 31, 2010, that rate was 61.59% due to the American Recovery and Reinvestment Act of 2009.

While the program is jointly financed, it is administered by the states. Each state's Medicaid Program looks different. Because the federal government has a financial stake in each state's Medicaid Program, each State must maintain a Medicaid State Plan. This plan documents each state's compliance with federal statutes, federal regulations, and state law and rules, describing specifics regarding recipient eligibility, services covered, reimbursement methodologies, payment levels for the services, and administrative and operating procedures

When a state wishes to change the Medicaid State Plan, for instance, in order to gain approval to implement a new state law, DHS submits a State Plan Amendment (SPA) to CMS. An SPA may be submitted any time during the calendar quarter during which it is to take effect. So, for example, if a change is to be effective on July 1, the SPA must be submitted to CMS by September 30. CMS then has 90 days to respond to an SPA, by either approving the proposed amendment, rejecting it, or formally submitting questions to the state about the SPA. If CMS submits questions, the state will then have 90 days to respond. CMS will then have another 90 days to either approve or reject the SPA or ask informal questions, which doesn't stop the clock. It is not uncommon for this process to take in excess of 200 days to gain approval of a requested change. Once a SPA is approved, the State may start to claim FFP for the new rate/service/policy. If a SPA is not approved by CMS, the state cannot claim or receive FFP but may request a reconsideration and a judicial decision.

Appendix 5

Invitation to Key Informant Meetings

The Minnesota Department of Human Services and the Minnesota Department of Health have been assigned by 2011 legislation to provide recommendations on how to develop a pilot project demonstrating a new approach to nursing facility care – how to test a model of care between nursing facility care and assisted living.

We would like to invite you to attend one of the meetings we are holding around the state to gather input from experts and affected individuals. These "Key Informant" discussions will be two hours long and will be held in three locations:

- **Waseca**

  January 10, 2012
  10 AM – Noon
  Latham Place and Lakeshore Inn
  108 NW 8th Street, Waseca
  Phone number is 507-835-2800
  Directions: Latham Place and Lake Shore Inn are on the north side of US 14, on the west side of Waseca. Turn north on 8th Street NW 3 blocks west of the Kwik Trip. The facility is on one corner where you turn; there's a white brick apartment building on the other corner (don't park in their lot!!) The meeting is at Latham Place; look to your left as you drive in and you'll see it.

- **Alexandria**

  January 12, 2012
  12:30 PM – 2:30 PM

  Grand Arbor in the Community Room
  4403 Pioneer Rd SE, Alexandria, MN 56308
  Phone number is 320 763 1600
  Directions: From I 94, exit 103, go north on MN 29 and take the first right onto 50th Av W/Co Rd 106. Go 1.5 mile and then turn left onto Pioneer Rd SE. Go 0.4 miles and Grand Arbor will be on the right.

- **New Hope**

  January 18, 2012
  9 AM – 11 AM
  In the Residence at St Therese Home in the party room
  8008 Bass Lake Road, New Hope , Mn 55428
  Phone number is 763-531-5000
  Directions: On the north side of Bass Lake Rd/Cty Rd 10, 0.1 miles west of Winnetka and 0.8 miles east of US 169.

  Please feel free to forward this invitation to others who may be interested and please RSVP your date and location of attendance to Robert.Held@state.mn.us

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NURSING HOME / ASSISTED LIVING PILOT PROJECT
January 12, 2011
Key Informant Discussion Guide

The Department of Human Services, with the Minnesota Department of Health is preparing a report to the legislature making recommendations on how to conduct a pilot project demonstrating a level of care that is a hybrid between nursing home and assisted living. We are interested in hearing a wide variety of perspectives on the various policy issues related to conducting this pilot. We thank you in advance for providing your input to this study.

1. This new level of care is for people needing a service between nursing home and assisted living. What do we know about this population? Help us understand the characteristics of a population for whom neither nursing home nor assisted living is suitable.
    a. *What are the characteristics that distinguish this population?*
    b. *Who is not being served?*
    c. *Who is being served, but in a setting that is more restrictive than necessary?*
    d. *Are there different types of need (different niches or sub-populations) that fit?*
    e. *If these individuals are in nursing homes now, are there services they are receiving that they do not need?*
    f. *Are there ways in which a nursing home may not meet their needs?*
    g. *Are there ways that assisted living, as currently structured, is not able to meet their needs?*

2. What are the characteristics you would want to see in a new type of service that would address the needs of the people described above?
    a. *What services, amenities, capabilities should it have that are lacking in assisted living?*
    b. *What capabilities should it have that are lacking in a nursing facility?*
    c. *Should it have a unique form of licensure or registration?*

d. *Should there be standards addressing areas such as:*
    i. *Staffing – type and amount*
    ii. *Environment – size and setting, other characteristics*
        1. *Integrate into NH, HWS, either, neither, other*
        2. *Should size be limited in any way*
        3. *What environmental characteristics would be necessary, desirable*
    iii. *Resident rights*
    iv. *Other consumer rights*
    v. *Management*
    vi. *Safety*
    vii. *Infection control*
    viii. *Assessment, care planning*
    ix. *Vulnerable adults/maltreatment*
    x. *Social activities*
    xi. *Social services*
e. *How should standards be enforced?*
    i. *Should enforcement be through an inspection process?*
    ii. *If yes, how should inspections be funded?*
    iii. *What authorities should the licensing agency have?*
f. *What strategies should be considered to provide Medicare services in this setting?*
g. *What strategies should be considered to provide Medicaid services including EW in this setting?*

3. Should provider reimbursement be through existing structures or is a new system needed?

4. [GOING AROUND THE ROOM AND GIVING EVERYONE A CHANCE TO RESPOND] What goal would you like the pilot to target, and do you think this is a valuable project to go forward?

Thank you for your input.

NURSING HOME / ASSISTED LIVING
PILOT PROJECT

January 12, 2011

Key Informant Discussion Guide

The Department of Human Services, with the Minnesota Department of Health is preparing a report to the legislature making recommendations on how to conduct a pilot project demonstrating a level of care that is a hybrid between nursing home and assisted living. We are interested in hearing a wide variety of perspectives on the various policy issues related to conducting this pilot. We thank you in advance for providing your input to this study.

1. This new level of care is for people needing a service between nursing home and assisted living. What do we know about this population? Help us understand the characteristics of a population for whom neither nursing home nor assisted living is suitable.

2. What are the characteristics you would want to see in a new type of service that would address the needs of the people described above?

3. Should provider reimbursement be through existing structures or is a new system needed?

4. What goal would you like the pilot to target, and do you think this is a valuable project to go forward?

Thank you for your input.

Appendix 7

Article in the Aging Services of Minnesota Monday Mailing of 1/23/12:

DHS Preparing Report on Pilot Project

2011 legislation requires DHS to provide recommendations on how to develop a pilot project demonstrating a new approach to caring for seniors -- a new level of care between nursing facility care and assisted living.

For our summary of the legislation, members can go to http://www.agingservicesmn.org/index/2011_Nursing_Facility.

To read the actual legislative language, go to http://www.agingservicesmn.org/inc/data/Legislative_Language_Nursing_Home_Pilot_Project.pdf.

In the last two weeks, DHS and MDH have hosted three listening sessions on the idea in Waseca, Alexandria and New Hope. Those sessions were well attended by providers and other stakeholders in the senior services system. The discussion varied considerably in each location, but there were some common themes. In all of the locations, the point was made that addressing the needs of the population that is between assisted living and nursing facility care could be accomplished with some regulatory flexibility and changes to the payment system, especially for elderly waiver customized living.

Now that the listening sessions are complete, DHS is working on a report to the Legislature with recommendations on how to initiate a pilot project on a new level of care. It will be up to the Legislature to decide whether to authorize a pilot project and to finalize its structure.

Many of the ideas raised in the listening sessions have a lot of merit, so Aging Services is hopeful that the Legislature will take action to create an opportunity for providers to try providing services to the identified population in a more effective and cost efficient manner.

Appendix 8

Article in the Care Providers of Minnesota Action Newsletter of 1/20/12:

DHS and MDH hold meetings on nursing home/assisted living pilot project
By Todd Bergstrom

Legislation that was passed in 2011 assigned the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) the task of providing recommendations on developing a pilot project demonstrating a new approach to nursing facility care — a model of care between nursing facility care and assisted living.

In order to gather input from experts and affected individuals, DHS and MDH held meetings in Waseca, Alexandria, and New Hope. The meetings were well attended by providers, advocates, county staff, elected officials, and other community members; and we appreciate the opportunity that the state agencies provided by seeking broader input on this pilot.

To better facilitate the discussion, the focus was directed to developing a pilot project for a level of care that is a hybrid between the nursing home and assisted living. Questions were then asked about the characteristics of this level of care population, the types of services needed, changes needed to provider reimbursement, and goals associated with the project.

Below is a summary of some of the feedback provided at the meetings. Note, the discussions varied greatly between the three locations, so it will be very interesting to see the report that is generated by the state agencies in response to the legislative language!

- The populations that may fit into the pilot include those residing in small rural communities where the traditional nursing facility model is struggling; the medically stable non-ambulatory population with moderate dementia and/or bariatric needs; clients whose needs have "outgrown" the payments allowed under the elderly waiver 24-hour customized living (EW-CL) model; post-acute consumers with significant behavioral issues who may need a behavioral stabilization period; post acute consumers who are under 65; consumers from different cultures who may have unique faith, language and treatment needs; consumers benefiting from palliative care.
- The services provided under the pilot could focus on access to services as well as creating more flexibility in terms of setting, licensure, payment and regulations. Additionally, new categories of services may need to be created for those who "fall between" EW-CL and nursing facility care.
- Whether the pilot would use existing or new reimbursement mechanisms to fund services inevitably circled back to whether current levels of funding or the current reimbursement/regulatory policies were causing the problems for the defined population. There was a great deal of feedback relating to the financial status of the population (Medicaid); and the "mis-match" between the services they need and the payments various providers receive for those services. Several suggestions were tied to reimbursement specifically, such as: altering the EW tool to raise the cap on 24 hour

customized living payments, or asking for a federal waiver for Medicaid to help pay for the housing costs under the waiver programs, instead of just the services.

- In general, while many reasons for creating the pilot were offered, most of the ideas at the meetings were generally concerned with creating access to long-term care services for consumers at the “right place” and the “right time.”

Please contact Todd Bergstrom at the Association office if you have any questions.

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Appendix 9

Waseca County News Article

Legislator, providers discuss nursing home bill

By *Zach Hacker*

Created *01/13/2012 - 17:46*

Submitted by Zach Hacker on Fri, 01/13/2012 - 17:46

By RUTH ANN HAGER, rhager@wasecacountynews.com [1]

1.18-Madel-bill.jpg [2]

County News/Ruth Ann Hager
Eric Worke, left, listens to Peter Madel, Jr. as Sen. Julie Rosen talks to Robert Held, Minnesota Department of Human Services, after a discussion Jan. 10 at Latham Place in Waseca.

County News/Ruth Ann Hager
Eric Worke, left, listens to Peter Madel, Jr. as Sen. Julie Rosen talks to Robert Held, Minnesota Department of Human Services, after a discussion Jan. 10 at Latham Place in Waseca.

WASECA — Twenty-five people met at Latham Place Jan. 10 to discuss a proposed hybrid level of care that falls between nursing homes and assisted living homes.

Robert Held, director of Nursing Facility Rates and Policy for the Minnesota Department of Human Services, held the meeting, the first of three in the state, to get stakeholder input on a pilot project demonstrating the new level of care. Held is preparing to report to the legislature on how to conduct the Nursing Facility Pilot Project, a law passed in 2011.

State Sen. Julie Rosen (R-Fairmont) authored the bill after working with Peter Madel, Jr., Peter Madel III and Mike Corchran, CEO, CFO and administrator of Latham Place and Lake Shore Nursing Home.

Also in attendance at the discussion were Department of Health and Department of Human Services officials, representatives of Waseca County Public Health, South Country Health Alliance, Caregivers of Minnesota and area nursing home and assisted living facilities, including Eric Worke of Colony Court.

“After three meetings, we want to get a real clear picture from the key informants of what this is for and what they get, what is the nature of service, how is it different and how funding would occur,” Held said. The law guiding the project is a concept for service that calls for higher staffing than assisted living but not as much as a care center.

Peter Madel, Jr. said the bill came out of the struggle of smaller nursing homes who don’t have enough Medicare patients to balance the cost of long term patients. The federal government decided standards are the same for long term and acute care, he said.

What is known about this population? Held asked.

Teresa Hildebrandt, owner of Good Samaritan Home in Waterville, said there are people who are falling through the cracks in the present system. She offered an example of a patient who had a stroke and a heart condition who doesn’t need nursing home care but for whom assisted living doesn’t work.

“A doctor would look at a patient with paralysis and say he was not appropriate for assisted living. It’s going to take education in the health care community,” she said.

“This is an opportunity I really hope you will take. Really take a look at Greater Minnesota. Every nursing home is a major employer. We can get this done. Let’s think about others in Greater Minnesota. There are a lot of facilities this could serve,” Rosen said.

Worke said it is more of a funding issue. Identify the population or find another funding mechanism, he said. “I would hate to see another level of regulation.”

He said the Elderly Waiver Program (which funds home and community-based services for people 65 and older who need nursing home care but choose to live in the community) was enacted by the state to prevent a premature level of entry into nursing homes but now the state is “chopping it” because it’s growing too fast.

Rosen told Worke the pilot project would determine what can be done on the state level, taking a fresh look at funding and what the needs are.

Waseca County Public Health director Cheri Lewer said with a growing population and finite resources, they should look at keeping seniors in their homes a bit longer.

“They can’t build enough facilities. Your doors are going to be overloaded,” she said to the nursing home providers. Lewer said they should look at ways to change the funding because it’s easier to meet the needs of people before they get to the facility doors.

After nearly 90 minutes of discussion, Rosen said she is not sure there is a buy-in to the new level of care.

“I’d love to see a pilot program work but it has to work,” she said.

Madel III said it is a model that leaves the federal government out of the equation and saves the state money at the same time. The general idea is that nursing homes are expensive because of the layers of regulations, he said.

If they can find a way to get the federal government out of nursing homes, they could develop a payment between [the cost of] nursing homes and assisted living that allows a little more money for nursing homes but lets the state regulate them and bring the costs down, Madel said.

“If there are 350 nursing homes [in Minnesota], maybe we only need 250,” he said.

If facilities can make a profit, they can improve their own facilities and compete with their neighbors for the residents to fill their homes, Corchran said.

“We’ve been asking for simplification for a long time and this is the first time someone has paid attention to us. Here is a chance; we have the ear of the legislature,” Deb Barnes, administrator of Parker Oaks Communities in Winnebago, said.

Ruth Ann Hager covers city and county government for the Waseca County News. Reach her at 837-5446.

Appendix 10

Definition of SNF and NF Status: Excerpts from Chapter 7 of the State Operations Manual (a federal document)

7004 - Skilled Nursing Facility - Citations and Description

(Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10)

7004.*1* - Citations

(Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10)

A skilled nursing facility is defined in §1819(a) of the Act and 42 CFR 488.301.

7004.*2* - Description of Skilled Nursing Facility

(Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10)

A skilled nursing facility is a facility which:

Is primarily engaged in providing to residents skilled nursing care and related services for residents who require medical or nursing care; or

Is primarily engaged in providing to residents skilled rehabilitation services for the rehabilitation of injured, disabled, or sick persons **and is not primarily for the care and treatment of mental diseases**;

Has in effect a transfer agreement (meeting the requirements of §1861(1) of the Act with one or more hospitals having agreements in effect under §1866 of the Act); and

Meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of §1819 of the Act.

A skilled nursing facility provides a level of care distinguishable both from the level of intensive care furnished by a general hospital and from the level of custodial or supportive care furnished by nursing homes primarily designed to provide daily services above room and board. This level of care is reflected in the participation requirements for skilled nursing facilities. While the requirements call for a wide range of specialized medical services and the employment by the facility of a variety of paramedical and skilled nursing personnel, the emphasis on restorative services is oriented toward providing services for residents who require and can benefit from skilled nursing and one or more types of skilled restorative services, e.g., physical or speech therapy.

7006 - Nursing Facility - Citations and Description

(Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10)

7006.*1* - Citations

(Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10)

A nursing facility is defined in §1919(a) of the Act and 42 CFR 488.301.

7006.*2* - Description of Nursing Facility

(Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10)

A nursing facility is a facility that:

Is primarily engaged in providing residents with skilled nursing care and related services for residents who require medical or nursing care; rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which is available to them only through these facilities, **and is not primarily for the care and treatment of mental diseases;**

Has in effect a transfer agreement (meeting the requirements of §1861(l) of the Act) with one or more hospitals having agreements in effect under §1866 of the Act; and

Meets the above requirements and subsections (b), (c), and (d) of §1919 of the Act.

7008 - Types of Facilities That May Qualify as Skilled Nursing Facilities and Nursing Facilities

(Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10)

A Skilled Nursing Facility or Nursing Facility may be:

An entire facility for skilled nursing facility or nursing facility care;

A distinct part of a rehabilitation center;

A distinct part of a hospital, such as a wing or a section;

A distinct part of a skilled nursing facility or nursing facility (see §2762.B *of this manual*); or

A religious nonmedical health care institution operated or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts.

An institution that is primarily for the care and treatment of mental diseases cannot be a skilled nursing facility or nursing facility.

Appendix 11

Nursing Home/Boarding Care Home Nurse Staffing Requirements and Possible Waivers

Facility Type	*RN*	*RN or LPN*	*General Nursing Services Staffing*
Medicare Certified Skilled Nsg Facility (SNF) CFR 483.30 CFR 483.30(a) CFR 483.30(b)	Except when waived…must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived…must designate a registered nurse to service as director of nursing on a full time basis. The DON may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans…. Except when waived, licensed nurses; … Except when waived…the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans…. Except when waived, licensed nurses; and other nursing personnel.
SNF Possible Waivers	**CMS may waive (States cannot approve these waivers).** CMS may waive the requirement of an RN for more than 40 hours/week, including a DON, if— The facility is located in a rural area and the SNF services in the area is not sufficient to meet the needs of individuals residing in the area; The facility has one full-time RN who is regularly on duty at the facility 40 hours/week;	Cannot be waived	Cannot be waived

Facility Type	*RN*	*RN or LPN*	*General Nursing Services Staffing*
SNF Possible Waivers (continued)	The facility has only patients whose physicians have indicated they do not require the services of an RN or a physician for a 48 hour period or; has made arrangements for an RN or a physician to spend time at the facility prn…when the regular full-time RN is not on duty; CMS provides notice of the waiver to the Ombudsman The facility informs residents and representatives of the waiver. The waiver is subject to annual renewal by CMS.		
Medicaid Certified Nursing Facility (NF)	Except when waived…must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived…must designate a registered nurse to service as director of nursing on a full time basis. The DON may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans…. Except when waived, licensed nurses; … Except when waived…the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans…. Except when waived, licensed nurses; and other *nursing personnel.*

Facility Type	*RN*	*RN or LPN*	*General Nursing Services Staffing*
NF Possible Waivers **CFR 483.30** **CFR 483.30(a)** **CFR 483.30(b)** **483.30(c)**	**The State may waive this requirement** of the RN for 8 consecutive hours a day, 7 days a week, and that there be an RN designated as DoN on a full time basis. Must meet the requirements as outlined in the column under 24 hour licensed nurse. →	***A* State may waive such requirements** if— The facility has been unable to recruit appropriate personnel; The waiver will not endanger the health or safety of residents; For any periods in which licensed nursing services are not available, an RN or a physician is obligated to respond immediately to phone calls from the facility. Waiver subject to annual State Review. May be required to use other qualified personnel. The state agency informs the Ombudsman.. The facility notifies residents or representatives of the waiver.	Cannot be waived.

Facility Type	*RN*	*RN or LPN*	*General Nursing Services Staffing*
State Licensure Rules Nursing Home **4658.0500** **4658.0505** **4658.0510**	Must have a full-time (at least 35 hours/week) DON who is an RN	Must have a nurse designated to be responsible for DON duties when DON not available. A nurse must be employed so that on-site nursing coverage is provided 8 hours per day, seven days per week. A registered nurse must be on call during all hours when a registered nurse is not on duty.	Must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.
State Licensure Rules **Boarding Care Home** **4655.5100**			Adequate staff shall be provided to meet the nursing and personal care needs and the maintenance necessary for the well-being of the patients and residents at all times. There shall be at least one responsible person awake, dressed, and on duty at all times. These persons shall be at least 21 years of age and capable of performing the required duties of evacuating the patients and residents

* References: Chapter 7 and Appendix PP of the State Operations Manual, MN Rules 4658 and 4655

Appendix 12

Excerpts from Appendix PP of the State Operations Manual (a federal document)

F353

§483.30 Nursing Services

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

Intent §483.30

To assure that sufficient qualified nursing staff are available on a daily basis to meet residents' needs for nursing care in a manner and in an environment which promotes each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life.

Procedures §483.30

§483.30(a) and (b) are to be reviewed during the standard survey whenever quality of care problems have been discovered (see Appendix P, Survey Protocol, Task 4, for further information and Task 5C for the investigative protocol to complete this review). In addition, fully review requirements of nursing services during an extended survey or when a waiver of RN and/or licensed nurse (RN/LPN) staffing has been requested or granted. Except as licensed nursing personnel are specifically required by the regulation (e.g., an RN for 8 consecutive hours a day, 7 days a week), the determination of sufficient staff will be made based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being. The ability to meet the requirements of §§483.13, 483.15(a), 483.20, 483.25 and 483.65 determines sufficiency of nurse staffing.

§483.30(a) Sufficient Staff

§483.30(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (c) of this section, licensed nurses; and

(ii) other nursing personnel.

§483.30(a)(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

For Interpretive Guidelines and Probes on §483.30(a) see Tag F354

F354

§483.30(b) Registered Nurse

§483.30(b)(1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

§483.30(b)(2) Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

§483.30(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

Interpretive Guidelines §483.30(a) and (b)

At a minimum, "**staff**" is defined as licensed nurses (RNs and/or LPNs/LVNs), and nurse aides. Nurse aides must meet the training and competency requirements described in §483.75(e).

"**Full-time**" is defined as working 35 or more hours a week.

Except for licensed staff noted above, the determining factor in sufficiency of staff (including both numbers of staff and their qualifications) will be the ability of the facility to provide needed care for residents. A deficiency concerning staffing should ordinarily provide examples of care deficits caused by insufficient quantity and quality of staff. If, however, inadequate staff (either the number or category) presents a clear threat to residents reaching their highest practicable level of well-being, cite this as a deficiency. Provide specific documentation of the threat.

The facility is required to designate an RN to serve as DON on a full time basis. This requirement can be met when RNs share the position. If RNs share the DON position, the total hours per week must equal 40. Facility staff must understand the shared responsibilities. The facility can only be waived from this requirement if it has a waiver under subsection (c) or (d).

Probes: §483.30(a) and (b)

Determine nurse staffing sufficiency for each unit:

• Is there adequate staff to meet direct care needs, assessments, planning, evaluation, supervision?

• Do work loads for direct care staff appear reasonable?

• Do residents, family, and ombudsmen report insufficient staff to meet resident needs?

• Are staff responsive to residents' needs for assistance, and call bells answered promptly?

• Do residents call out repeatedly for assistance?

• Are residents, who are unable to call for help, checked frequently (e.g., each half hour) for safety, comfort, positioning, and to offer fluids and provision of care?

• Are identified care problems associated with a specific unit or tour of duty?

• Is there a licensed nurse that serves as a charge nurse (e.g., supervises the provision of resident care) on each tour of duty (if facility does not have a waiver of this requirement)?

• What does the charge nurse do to correct problems in nurse staff performance?

• Does the facility have the services of an RN available 8 consecutive hours a day, 7 days a week (if this requirement has not been waived)?

• How does the facility assure that each resident receives nursing care in accordance with his/her plan of care on weekends, nights, and holidays?

• How does the sufficiency (numbers and categories) of nursing staff contribute to identified quality of care, resident rights, quality of life, or facility practices problems?

F355 – Nursing Waivers

§483.30(c) Nursing facilities

Waiver of requirement to provide licensed nurses on a 24-hour basis.

To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if--

(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;

(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;

(4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review;

(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;

(6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) andmembers of their immediate families of the waiver.

Intent §483.30(c)

To give the facility flexibility, in limited circumstances, when the facility cannot meet nurse staffing requirements.

Interpretive Guidelines §483.30(c)

The facility may request a waiver of the RN requirement, and/or the 24-hour licensed nurse requirement. If the facility is Medicaid-certified only, the State has the authority to grant the waiver. If the facility is dually-participating, CMS has the delegated authority to grant the waiver. (See guidelines for §483.30(d).)

A survey of Nursing Services must be conducted if a waiver has been granted or requested.

Probes: §483.30(c)

Before granting a continuation of this waiver, or during the annual review, at a minimum, determine:

• Is a continuing effort being made to obtain licensed nurses?

• How does the facility ensure that residents' needs are being met?

• Are all nursing policies and procedures followed on each shift during times when licensed services are waived?

• Is there a qualified person to assess, evaluate, plan and implement resident care?

• Is care being carried out according to professional practice standards on each shift?

• Can the survey team ensure the State that the absence of licensed nurses will NOT endanger the health or safety of residents?

• Are there trends in the facility, which might be indicators of decreased quality of care as a result of insufficient staffing to meet resident needs (e.g., increases in incident reports, the infection rate, hospitalizations)?

• Are there increases in loss of function, pressure sores, tube feedings, catheters, weight loss, mental status?

• Is there evidence that preventive measures (e.g., turning, ambulating are taken to avoid poor quality of care outcomes and avoidable sudden changes in health status?

• Is there evidence that sudden changes in resident health status and emergency needs are being properly identified and managed by appropriate facility staff and in a timely manner?

• If the facility has a waiver of the requirement to provide licensed nurses on a 24-hour basis, have they notified the ombudsman, residents, surrogates or legal representatives, and members of their immediate families of the waiver, and are there services residents need that are not provided because licensed nurses are not available?

• Is there an increase in hospitalizations because licensed personnel are not available to provide appropriate services?

• Does the facility meet all applicable requirements to continue to receive a waiver?

• Does the staff indicate that an RN or physician is available to respond immediately to telephone calls when licensed nurses are not available?

§483.30(d) SNFs

Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.

§483.30(d)(1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that --

(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;

(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and

(iii) The facility either--

(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period or;

(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;

(iv) The Secretary provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

(2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.

Interpretive Guidelines §483.30(d)

CMS is delegated the waiver authority for SNFs, including dually-participating facilities (SNF/NFs). The Medicare waiver authority is far more limited than is the States' authority under Medicaid since a State may waive any element of the nurse staffing requirement, whereas the Secretary may waive only the RN requirement. The requirements that a registered nurse provide services for 8 hours a day, 7 days a week (more than 40 hours a week), and that there be an RN designated as director of nursing on a full-time basis, may be waived by the Secretary in the following circumstances:

• The facility is located in a rural area with an inadequate supply of SNF services to meet area needs. Rural is defined as "all areas not delineated as `urban` by the Bureau of Census, based on the most recent census;

• The facility has one full-time registered nurse regularly working 40 hours a week. This may be the same individual, or part-time individuals. This nurse may or may not be the DON, and may perform some DON and some clinical duties if the facility so desires; **and either**;

• The facility has only residents whose physicians have noted, in writing, do not need RN or physician care for a 48 hour period. This does not relieve the facility from responsibility for providing for emergency availability of a physician, when necessary, nor does it relieve the facility from being responsible for meeting all needs of the residents during those 48 hours;

OR

• A physician or RN will spend the necessary time at the facility to provide care residents need during the days that an RN is not on duty. This requirement refers to clinical care of the residents that need skilled nursing services.

• If a waiver of this requirement has been granted, conduct a survey of nursing services during each certification survey. Dually-participating facilities must meet the waiver provisions of the SNF.

Probes: §483.30(d)

If the SNF has a waiver of the more than 40 hours a week RN requirement:

• Is there an RN on duty 40 hours a week?

• If more than one RN provides the 40 hour per week coverage, how is information exchanged that maintains continuity of resident care?

• Does each clinical record have documentation by the physician that the resident does not need services of a physician or an RN for a 48 hour period each week.

• Are there any emergency or routine services that should be, but are not, provided to residents during the days that a registered nurse is not on duty?

• If specific skilled care is necessary for a resident during the time that an RN is not on duty, does an RN or physician provide that service on an “as needed” basis?

• Did the facility notify residents (or their legal guardians) and their immediate families about the waiver and the ombudsman?

See also probes at §483.30(c).

If the SNF requests continuation of the waiver to provide the services of a registered nurse for more than 40 hours a week, the survey team is to provide the Secretary with information needed to grant this continuation.

• Does the SNF meet all requirements necessary for continuation of the waiver?

Procedures §483.30(a)-(d)

If the facility has an approved nurse staffing waiver, it is **not** considered a deficiency. The facility does not need to submit a POC.

The following procedure should be used to document that a facility has a waiver of nurse staffing requirements.

When a facility does not meet the nurse staffing requirements, cite the appropriate tag. If the facility does have a waiver, reference the tag number based on the type of facility. The type of facility (SNF, NF, or SNF/NF) determines what type of waiver is granted:

• For SNFs and SNF/NFs which may be waived from the requirement to provide more than 40 hours of registered nurse services a week, and for NFs which have been granted a waiver from the 56 hour registered nurse requirement, cite F354;

o For NFs that have a waiver of the 24-hour licensed nursing requirement, cite F353, or

o Both facility types could be waived for the requirement to designate a registered nurse as the director of nursing on a full-time basis. Cite F355.

When the Form CMS-2567 is entered into OSCAR, code the waived tag as a “W.” Enter the tag number, leave the correction date blank, and enter a “W” in the CP field. This will indicate that this is not a deficiency--that the requirement has been waived.
