RECOMMENDATIONS FOR CHANGES TO MINNESOTA'S NURSING HOME MORATORIUM LAW FROM THE GOVERNOR'S TASK FORCE ON LONG—TERM CARE HEALTH PLANNING

Minnesota State Planning Agency
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RECOMMENDATIONS FOR CHANGES TO MINNESOTA'S NURSING HOME MORATORIUM LAW FROM THE GOVERNOR'S TASK FORCE ON LONG-TERM CARE HEALTH PLANNING

Report to the Legislature

Minnesota State Planning Agency
Minnesota Department of Health

REPORT OF THE TASK FORCE ON LONG-TERM CARE HEALTH PLANNING

CONTENTS

EXECUTIVE SUMMARY

Nursing home payments constitute a major portion of Minnesota's medical assistance budget. In 1983, the Legislature limited nursing home reimbursements to control expenditures. Part of the plan to limit these reimbursements involved placing a moratorium on all nursing home beds eligible for payment under the Medical Assistance program. The moratorium also prohibited reclassification of beds to the higher paid "skilled care" level. In 1985, the moratorium was extended to include all nursing home beds, whether publicly financed or not.

Concern over the inability of nursing homes to remodel, renovate, or replace outdated physical plants led the Legislature to create a nine-member Task Force on Long-Term Care. The Task Force was mandated to examine the need to amend the moratorium law to allow replacement or reconfiguration of beds, upgrading of boarding care beds, and modernization or renovation of long-term care facilities. Meetings of the Task Force were held monthly between June, 1986 and January, 1987.

While the Task Force found no need for additional nursing home beds and urges that the moratorium be maintained, it does confirm the need to make exceptions in order to allow needed physical plant improvements. Some of these exceptions should be allowed without a lengthy review process: replacement of a facility in the event of a natural disaster; movement of licensed beds within a facility; and the recertification of facilities involuntarily decertified. For other exceptions to the moratorium, the Task Force recommends that a review process be established. Exceptions which should be subject to a review are: extensive renovation or replacement of outdated facilities; upgrading of certified boarding care beds; and conversion of nursing-home attached hospital space into nursing home space. The review process would provide a means of screening and prioritizing these types of requests for an exception to the moratorium.

The issue of multiple-bed rooms in nursing and boarding care homes was also addressed. The Task Force recommends that no more than four beds be allowed per resident room, with the goal, over time, of having no more than two residents per room.

The distribution of beds throughout the state is not addressed in the Task Force recommendations. Improved data collection and planning are needed and recommended in order to deal with state bed distribution and other future issues.

INTRODUCTION

The Task Force on Long-Term Care Health Planning was created during the 1986 Minnesota Legislative session. Its general purpose was to review the moratorium on nursing home beds and make recommendations for change.

A similar mandate exists in the law for the Minnesota Department of Health (MDH). The MDH is required to report annually on the impact of the nursing home bed moratorium. The Task Force on Long-Term Care Health Planning and MDH agreed to produce a combined report on the moratorium to satisfy the legislative requirements for each.

This report summarizes the work of the Task Force and the Health Department and outlines recommendations in Section V. (pp. 14-23) for modifying the moratorium law.

I. MANDATE AND TASK FORCE MEMBERS

The legislative mandate to the Task Force on Long-Term Care Health Planning is as follows:

"Subdivision 1. [CREATION.] There is created a task force on long-term care health planning. The nine-member task force appointed by the governor shall include: two members from the legislative commission on long-term care; two representatives from the Minnesota nursing home trade associations; two members from long-term care consumer groups, and one representative each of the commissioners of health and human services. The director of the state planning agency or a designee shall chair and convene the task force.

"Subd. 2. [DUTIES.] The task force on long-term care health planning shall conduct a study and report to the legislative commission on long-term care and to the legislature by January 15, 1987. In the study and report, the task force shall:

(1) propose a statewide plan for orderly and rational development of additional long-term care facilities;

(2) examine the need to amend the moratorium law to permit replacement or reconfiguration of beds provided no new beds are added to the system unless necessary;

(3) examine current classification of the intermediate care facilities class two (ICF II) as to the possibility of reclassification or upgrading; and

(4) address the need to modernize and renovate long-term care facilities built in 1950 to 1960 to improve energy efficiency and the quality of life in those older facilities.

"Subd. 3. [TASK FORCE EXPIRATION DATE.] The task force on long-term care health planning expires January 15, 1987."

Notice of the creation of the Task Force and a request for members was published in the State Register on April 28, 1986. Task Force members were appointed by the Governor in June from among those responding to the State Register notice. The Legislative Commission on Long Term Care appointed its own representatives. The members of the Task Force and the category of membership they represented are listed below.

TASK FORCE MEMBERS

Lani Kawamura, Chair
Director
State Planning Agency

Daniel J. McInerney
Assistant Commissioner
--representing--
Sister Mary Madonna Ashton
Commissioner
Minnesota Department of Health

Maria Gomez, Director
Long-Term Care Program
--representing--
Len Levine
Commissioner
Department of Human Services

Senator Linda Berglin
Legislative Commission on Long Term Care

Representative Tony Onnen
Legislative Commission on Long Term Care

Hazel A. Hanson
Consumer Representative

Joan Knowlton
Consumer Representative

Ted A. Schmidt
Minnesota Association of Homes for the Aging (MAHA)

Dale Thompson
Care Providers of Minnesota

II. MORATORIUM ON NURSING HOME BEDS -- HISTORY

A. REGULATORY HISTORY

1. Statute.

Between 1978 and 1983, the number of Medicaid certified beds in Minnesota increased from 43,927 to 46,207, an increase of 5.2%. This created financial concern because the cost of these additional beds amounted to over $34 million annually. In addition, during the same period, the proportion of skilled nursing facility (SNF) beds in Minnesota increased from 53.2% to 62.4%. The increasing proportion of SNF beds added further to the costs of the Medicaid program. The past Certificate-of-Need policies did not adequately control the growth in the number of nursing home beds, so the Legislature felt that a key step in controlling Medicaid nursing home costs was to place a moratorium on the certification (those eligible for payment under Medicaid) of nursing home beds.

The 1983 Minnesota Legislature enacted Minnesota Statutes, Section 144A.071 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. In 1984, the state adopted a case mix reimbursement system, in which payment is no longer tied to certification level, but is linked to the amount of care a resident requires. Thus there is no longer an issue related to upgrading of care levels within nursing homes.

The moratorium was extended in 1985 to include all nursing home beds, regardless of whether they are privately or publicly paid.

2. Rules.

During the 1983 Legislative session, the Minnesota Department of Health (MDH) was granted the authority under Chapter 199, section 16, to promulgate temporary and permanent rules necessary to implement the provisions of the moratorium.

On September 10, 1984, MDH published Minnesota Rules Parts 4655.0510 to 4655.0520 [TEMPORARY] in the State Register. These rules dealt only with the "replacement" of beds. "Replacement" of beds was defined as either a situation where: (A) beds were decertified as a result of remodeling or construction which necessitated beds being out of service, or (B) as a situation where a new wing or a new facility was built to replace another structure.

The term "replacement" of beds was the Health Department's description of the process whereby a facility would add a wing, and move an existing licensed, MA certified bed from the old room it occupied to a new room. Even if the remodeling or construction did not necessitate that the certified or licensed bed be "out of service" during the construction, MDH required that the MA bed be

decertified and delicensed, and after the move, be recertified and relicensed.

Under these temporary rules, MDH could approve a nursing home's request for "replacement" of existing beds if the following conditions were met:

1) The nursing home was requesting a change in certification status from the skilled nursing facility level to the intermediate care facility level.

2) The beds for which the change in certification status was requested were certified for participation in the Medical Assistance program.

3) The requested certification change would reduce the Medical Assistance reimbursement provided to the facility.

4) The nursing home was in compliance with the licensure and certification law applicable to the certification level requested.

On February 4, 1985, MDH published a withdrawal of these proposed temporary rules.

On February 18, 1985, MDH proposed new emergency rules that addressed only the implementation of the "exception to the moratorium law" contained in Minnesota Statutes Section 144A.071 subdivision 3, paragraph (a) that related to the replacement of beds and the addition of beds in response to an extreme hardship of situation. These new emergency rules did not address the "replacement" issue of Medical Assistance certified beds in nursing and boarding care homes.

The new emergency rule simply reiterated and clarified the exception language set forth in legislation and included a provision which stated that if there is imminent risk of harm to resident safety, health or well-being, the replacement of a certified bed may be granted at the discretion of the Commissioner of Health.

The February 18, 1985 emergency rule was not adopted. The authority to promulgate rules under the moratorium law expired in June, 1985.

3. Exceptions.

Several exceptions to the moratorium are allowed in accordance with 1984 statutes. Examples of exceptions include replacement of decertified beds in areas with an inadequate bed supply, certification of new beds in a nursing home that commenced construction before May, 1983, and certification of beds in a new nursing home needed to meet the special dietary needs of its residents. (The exact language describing exceptions is found in Section VI.)

B. EVALUATION OF THE MORATORIUM

The Minnesota Legislature directed the State Planning Agency to evaluate the moratorium on the supply of nursing home beds in the state. Minnesota's nursing home bed supply continued to increase following the moratorium on bed certification. The certified bed additions resulted from meeting either the commencement of construction or the replacement of beds exception. The average number of licensed beds increased from 87.4 per 1,000 population 65 and over in 1983 to 87.9 per 1,000 in 1985.

C. PREADMISSION SCREENING/ALTERNATIVE CARE GRANTS

The Legislature established the Preadmission Screening Program, and Alternative Care Grants to curtail the increase of institutional placement of the elderly by providing an option for those who could remain in their homes with some level of support services.

Preadmission Screening. The Preadmission Screening Program, implemented in 1982, screens potential nursing home residents and informs them of alternative choices. The potential resident has the ultimate choice, but usually the recommendation of the screening team is followed. It is thought that remaining in the community with alternative services is less costly than institutionalization.

Pre-Admission Screening was required in all counties in July 1983. By fiscal year 1985, 69% of those screened were recommended to remain in the community. The statewide average number of Alternative Care Grant recipients is 9.1 per 1,000 residents aged 65 and over. While these services are available in all counties, the rate of services provided varies widely.

Alternative Care Grant (ACG). The ACG program was developed specifically to provide funding for services provided as an alternative to nursing home placement for those individuals who could remain in the community with some level of support services. Presently 4,500 persons are receiving services with ACG funding. Some counties have run out of ACG money so the additional services cannot be offered.

III. TASK FORCE EFFORTS TO ADDRESS THE MANDATE -- BACKGROUND

A. CREATION OF TECHNICAL ADVISORY GROUP

The Task Force agreed that there was a need for a working group made up of members and others to do the research and writing. A Technical Advisory Group composed of representatives of the provider groups, consumer groups, and state agencies was created after the second Task Force meeting. The members of the Technical Advisory Group are listed below.

TECHNICAL ADVISORY GROUP

Linda Sutherland, Chair
Assistant Director
State Planning Agency

Anne Bruggemeyer
Department of Finance

John Dilley
State Planning Agency

Iris Freeman
Minnesota Alliance for
Health Care Consumers

Dave Giel
Senate Research

Meg McPherson
Care Providers of Minnesota

Dorothy Petsch
State Planning Agency

Pam Parker
Department of Human Services

Darrell Shreve
Minnesota Association of
Homes for the Aging (MAHA)

David Paul Slovut
State Planning Agency

Mike Tripple
Minnesota Department of Health

Jim Varpness
Minnesota Board on Aging

Kevin Walli
Minnesota Association of
Homes for the Aging (MAHA)

The Technical Advisory Group met at least twice a month, one week prior to and one week following the Task Force monthly meetings. Issues raised by the Task Force members were discussed and the relevant data collected and organized for review by the Task Force. The Technical Advisory Group was chaired by an Assistant Director of the State Planning Agency.

B. SURVEYS AND DATA

DHS surveyed nursing and boarding care homes regarding the number of licensed beds per room, occupancy, percent of licensed beds with restricted usage due to life safety code deficiencies, percent of licensed beds using multiple toilet facilities, and percent of licensed beds meeting minimum square footage requirements.

MDH collected data on nursing and boarding care homes with life safety code waivers. MDH and DHS data were combined and automated by the State Planning Agency.

C. SITE VISITS

Task Force members toured Ebenezer Luther/Field Hall and Cedar Pines Health Care Center to get a close look at nursing homes in need of renovation or replacement. Both facilities contain features unacceptable by current standards, such as rooms without commodes, small resident rooms, and poor ventilation.

D. PUBLIC FORUM

The Task Force held a public forum on October 30, 1986 to provide an opportunity for nursing home industry representatives and consumers to testify regarding the need to amend the nursing home moratorium law to permit replacement or reconfiguration of beds. Oral and written testimony were accepted.

IV. DISCUSSION OF ISSUES

The Task Force met on November 30, 1986 to discuss issues related to the moratorium. The major issues and background on these issues from the discussion are presented below.

A. RENOVATION/RECONFIGURATION

Three different types of renovation were discussed by the Task Force.

1. Should the moratorium be amended to allow renovation which requires the movement of beds within a facility?

Background:

Under the moratorium law facilities are allowed to renovate as long as beds are not moved. It is often not possible, however, to remodel without movement of beds.

2. Should the moratorium be amended to allow facilities to remodel by adding square footage and moving beds to accommodate ancillary services, post-acute care recovery, nursing efficiency, etc.?

Background:

Almost any remodeling which requires the addition of space will also require the movement of beds. Under current statute, only remodeling which does not require movement of beds is permitted.

3. Should the moratorium be amended to require or recommend reconfiguration of facilities having rooms with multiple beds?

Background:

Rooms with multiple beds reduce resident privacy and dehumanize residents. Reconfiguration of those rooms may require the movement of beds and thus is not allowed under the moratorium.

Some multiple bed wards may be acceptable, even desirable, to both residents and the facility, in terms of spaciousness and efficiency of nursing services rendered.

B. REPLACEMENT

Issue:

Should the moratorium be amended to allow the replacement of facilities? If so, what criteria should be used to determine which facilities could be replaced?

Background:

Currently, no nursing home is allowed to replace any existing bed. If all or part of a nursing home is destroyed by a natural disaster, replacement is not allowed. In some circumstances replacement is a less expensive option than remodeling. For some homes there is no feasible way to correct physical plant problems other than replacement.

1. Natural disaster:

There are no instances of natural disaster affecting a nursing home in recent memory - so the overall impact of allowing rebuilding in this circumstance should be minimal. Fiscal impact would be further minimized if nursing home owners were required to exhaust insurance dollars before Medical Assistance pays for costs of rebuilding.

2. Condition of the nursing home:

Several of the following criteria could be used singly or in combination to determine if a nursing home should be allowed to rebuild: age, ability to meet current minimum square footage standards for resident rooms and ancillary spaces, and waivers from licensing standards. Examples of waivers include small room size, narrow corridors, inadequate bath or toilet facilities, wood frame construction, inadequate storage, and inadequate electrical writing for resident room air conditioning.

3. Occupancy in the facility and in the service area:

Should the low occupancy of the home be a factor in determining whether a facility should be allowed to be replaced bed for bed?

Should the overall occupancy of the service area be a factor in determining the basis for replacement of a particular facility?

4. Other issues:

a. should the facility be required to build the replacement in the same geographic area? (Options range from replacement only on site to any where in the state.)

b. quality of care/quality of life: should the quality of care given to residents be a factor in determining which facilities can replace their structures?

c. current construction standards and costs may limit the possibility of replacement due to the current appraised value per bed limit in the property reimbursement formula.

C. UPGRADING OF BOARDING CARE BEDS

Issue:

Should the moratorium be amended to allow boarding care beds to be relicensed as nursing home beds?

Background:

The moratorium prohibits changes in certification of beds to a higher level of care to control nursing home expenditure growth.

Boarding care beds are viewed as an important part of the continuum of long-term care.

When a physician certifies that a boarding care resident needs a higher level of nursing care, the resident must be moved from the boarding care bed to a nursing home bed.

Recently, providers have experienced lower occupancy in boarding care beds than in nursing home beds.

1. Attached facilities

Should owners of boarding care beds which are attached to a nursing home be allowed to upgrade any of these beds?

2. Freestanding facilities

Should the law be amended to allow upgrading of a percentage of beds in certified, freestanding boarding care homes?

D. FACILITY CERTIFICATION AFTER INVOLUNTARY TERMINATION

Issue:

Should the moratorium law be amended to allow the certification of beds in a facility that was involuntarily terminated from the federal programs?

Background:

Under the provisions of the moratorium law, the Department of Health could not certify a facility which had been terminated from the MA program for noncompliance with federal regulations even after the necessary corrective actions had been completed. Recent federal initiatives stressing the termination process, e.g., "fast-track" terminations, and the fact that all MA certified SNF facilities are also Medicare certified increases the likelihood that MA terminations will

occur. (A Medicare termination would result in the loss of MA certification.) The loss of MA certification would result in the discontinuance of payments for the MA residents in the facility. In most instances, this would result in relocation of the MA residents from the facility.

Other issues for consideration:

Can other "qualitative" measures be developed which would relate to facility's capability to meet regulations? (The Medicare regulations establish a process for reapplication as an initial provider based upon evidence of compliance with the rules during a 60-day period subsequent to the reapplication.)

The ability to obtain certification should not apply to facilities that voluntarily terminated from the MA program. Any amendment addressing certification after an involuntary termination will also have to take into consideration the moratorium on licensure.

The result of the November 30 discussion is the set of recommendations for exceptions to the moratorium outlined in Section V., p. 14.

V. RECOMMENDATIONS

The Task Force recommends the following changes to the moratorium:

A. EXCEPTIONS TO MORATORIUM NOT SUBJECT TO REVIEW PROCESS

The 1983 Legislature found 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 the elderly by providing high quality services in the most appropriate manner along a continuum of care." (All beds in the state must be licensed in order to operate. Certification allows providers to be reimbursed under Medicare and Medicaid. Not all beds are certified.) In 1984, the state adopted a case mix reimbursement system. This made the moratorium on changes in certification to a higher level of care unnecessary. Under case mix, payment is no longer tied to certification level, but is linked to the amount of care a nursing home resident requires. The moratorium was extended to include licensure of nursing home beds in 1985. The revised law allowed certification changes from ICF I to SNF levels.

The Task Force strongly recommends that the moratorium be maintained. No increase in the total number of certified boarding care and licensed nursing home beds is currently needed. The intent of the proposed changes to the moratorium is to preserve the quality of existing nursing home capacity. The Task Force did not examine or recommend the alteration of the current distribution of beds statewide.

The following exceptions to the moratorium should be allowed. They should not be subject to the proposal and review process outlined in part D.

1. In the event of a natural disaster, a nursing home which is destroyed may be replaced. In order to be considered for replacement in the case of natural disaster, adequate insurance coverage for this type of event must have been maintained. Any insurance money the owners receive shall be used to fund construction of the new nursing home, after other legal obligations have been met.

2. Licensed beds may be moved within a facility. The cost of any remodeling required to move the beds shall not exceed the Permanent Rule 50 (PR50) trigger of 10 percent of the nursing home's appraised value or $200,000, whichever is less. (Remodeling which does not involve the movement of beds is currently allowed.) If the remodeling costs exceed the PR50 trigger, the project will be subject to the review process outlined below.

3. Nursing homes which have been decertified involuntarily may be permitted to come back into the system as soon as they are able to meet licensure and certification requirements. Application for recertification must be within 120 days of termination.

B. MULTIPLE-BED ROOMS

Rooms with more than two beds reduce resident privacy and dehumanize residents. The Task Force recommends the following two-part method for dealing with the issue of multiple-bed rooms:

1. No more than four beds should be allowed in any resident room. Additional beds (beyond four) must be delicensed within two years from the enactment of legislation covering this requirement. Facilities may, during this time period, apply to reconfigure, add square footage or undertake a similar project to eliminate multiple-bed rooms, according to the request for exception process outlined in Section D of these recommendations. Nineteen* (19) nursing home beds and seven (7) boarding care beds will be moved or eliminated under this proposal.

   Nursing homes or boarding care homes which have occupancies less than 96 percent and have residents in multiple-bed rooms should relocate these residents within the facility. As vacancies arise within full facilities, these should be filled first by intra-facility transfer. Transfers should be in accordance with the resident bill of rights. The Department of Human Services (DHS) has agreed to examine a possible reimbursement adjustment for facilities with 40 beds or less which must delicense beds in multiple-bed rooms.

2. All facilities are encouraged to delicense beds beyond two in multiple-bed rooms. In order to achieve the two person per room goal, 1,948* nursing home beds and 62 boarding care beds would be moved or eliminated.

*Figures may be slightly underestimated because several respondents to the DHS survey on multiple-bed rooms did not distinguish between nursing home and boarding care beds. These data were excluded in the analysis.

C. EXCEPTIONS TO MORATORIUM SUBJECT TO REVIEW PROCESS

The following types of exceptions to the moratorium may be requested, and will be subject to a proposal review:

1. Renovation and replacement (major projects, significant cost involved).

"Renovation": Extensive remodeling; facility remains on same site. Beds are taken out of service or are moved within the nursing home. This category includes "reconfiguration." The cost of this renovation would exceed the Permanent Rule 50 trigger of 10 percent of the facility's appraised value or $200,000.

"Replacement": A wing of the nursing home or the entire facility is torn down and built from the ground up. Nursing homes must rebuild on the same site or relocate on a different site selected according to criteria determined by the Task Force.

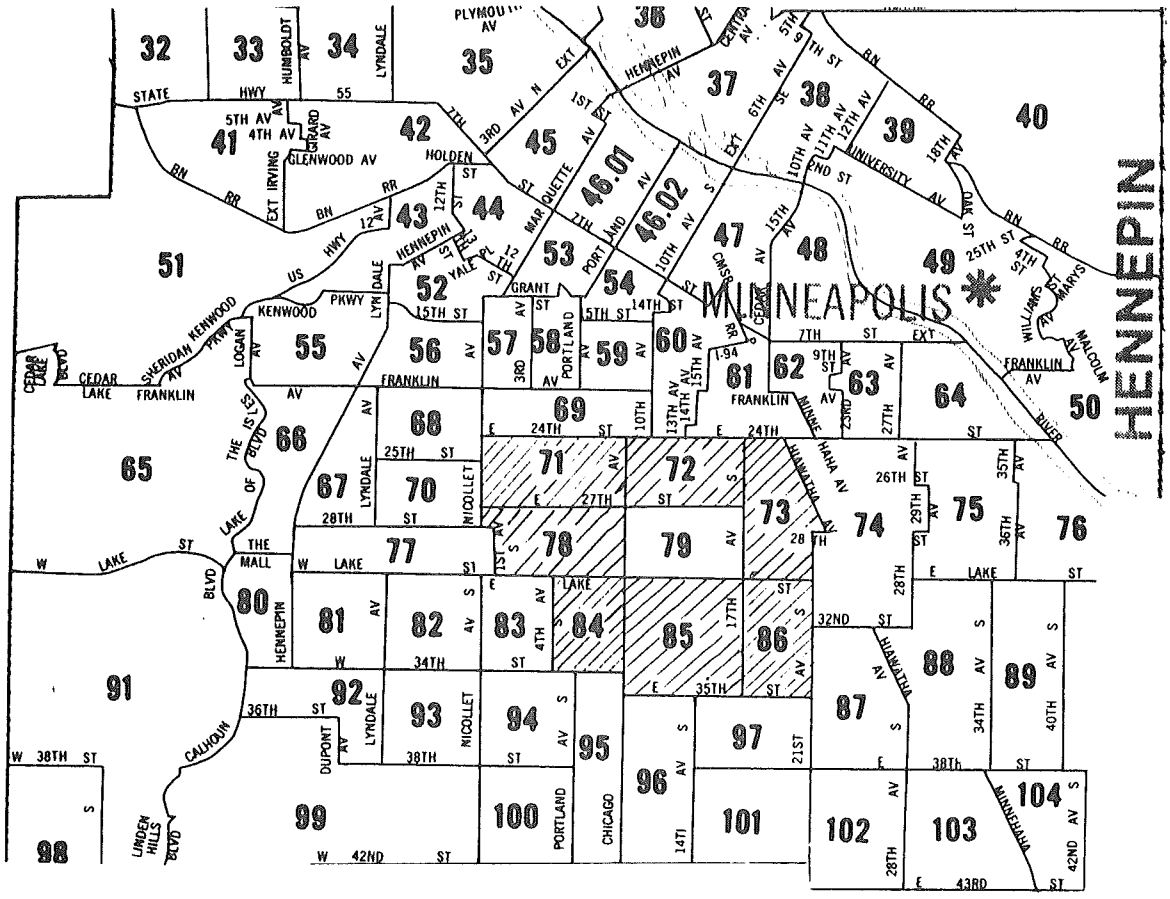
Relocation criteria:

Nursing homes will not be permitted to relocate except under the guidelines below. No nursing home may rebuild in a location more than six miles from its present site.

a. Metropolitan Statistical Areas. (Figure 1) Nursing homes located in MSAs must be replaced on the same site or on a different site within the same or adjoining census tracts. ("Adjoining" is defined as "touching at any point or along a line; contiguous.") For nursing homes located in a census tract which encompasses more than one township (Figure 2), the facility must be replaced within the same city, same township, or adjoining township.

MSAs in Minnesota are the Twin Cities (10 county area), Duluth (St. Louis), St. Cloud (Benton, Sherburne, Stearns), Rochester (Olmsted), and Moorhead (Clay).

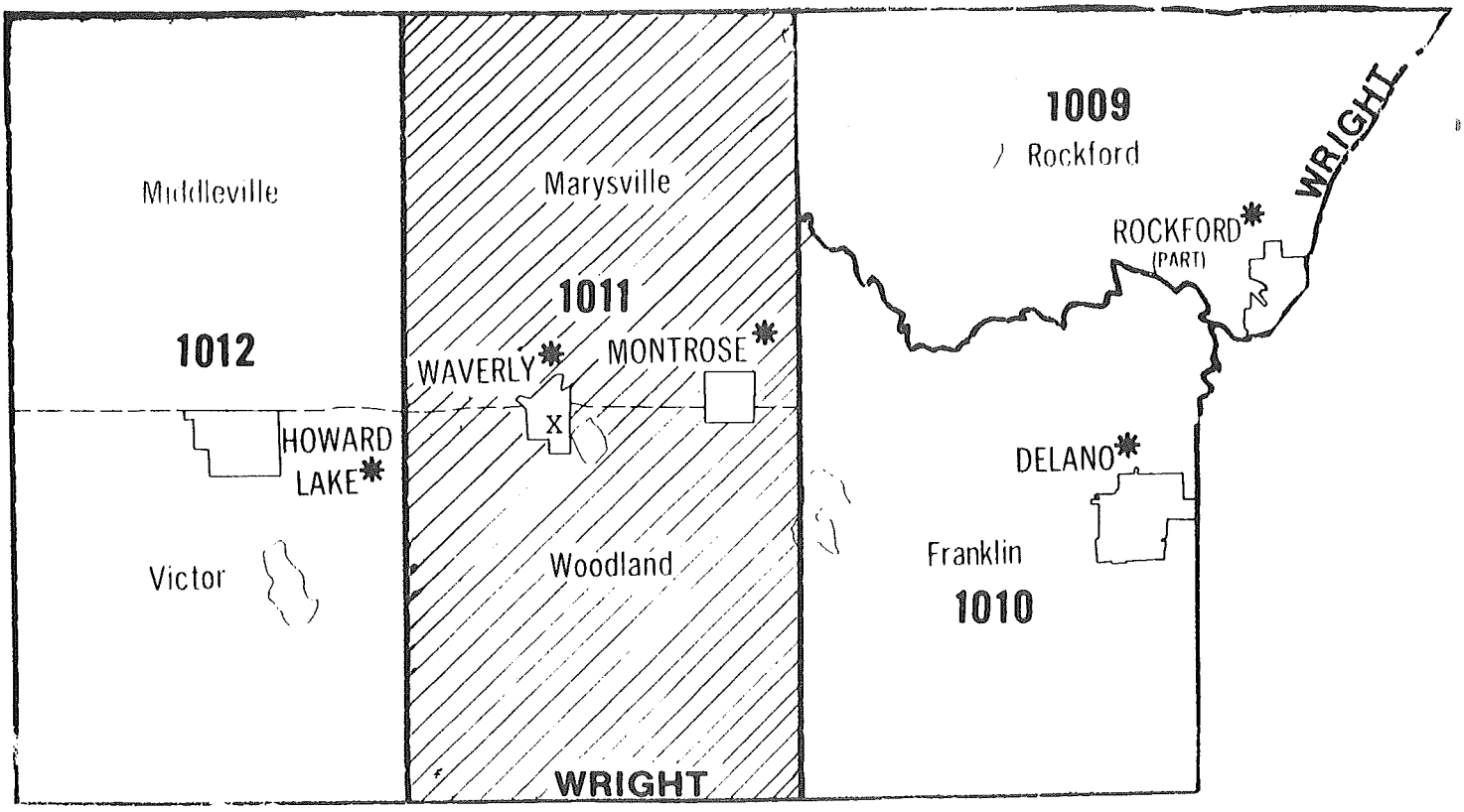
b. Non-Metropolitan Statistical Areas. (Figure 3) Nursing homes located outside of MSAs must be relocated within the same city, same township, or adjoining township.



METROPOLITAN STATISTICAL AREA (MSA)
CENSUS TRACT WHICH DOES NOT ENCOMPASS MORE THAN ONE TOWNSHIP

A nursing home located in census tract 79 may relocate within census tract 79, or the adjoining (touching) census tracts 71, 72, 73, 78, 84, 85, or 86. (Relocation must be within six miles of the present site.)

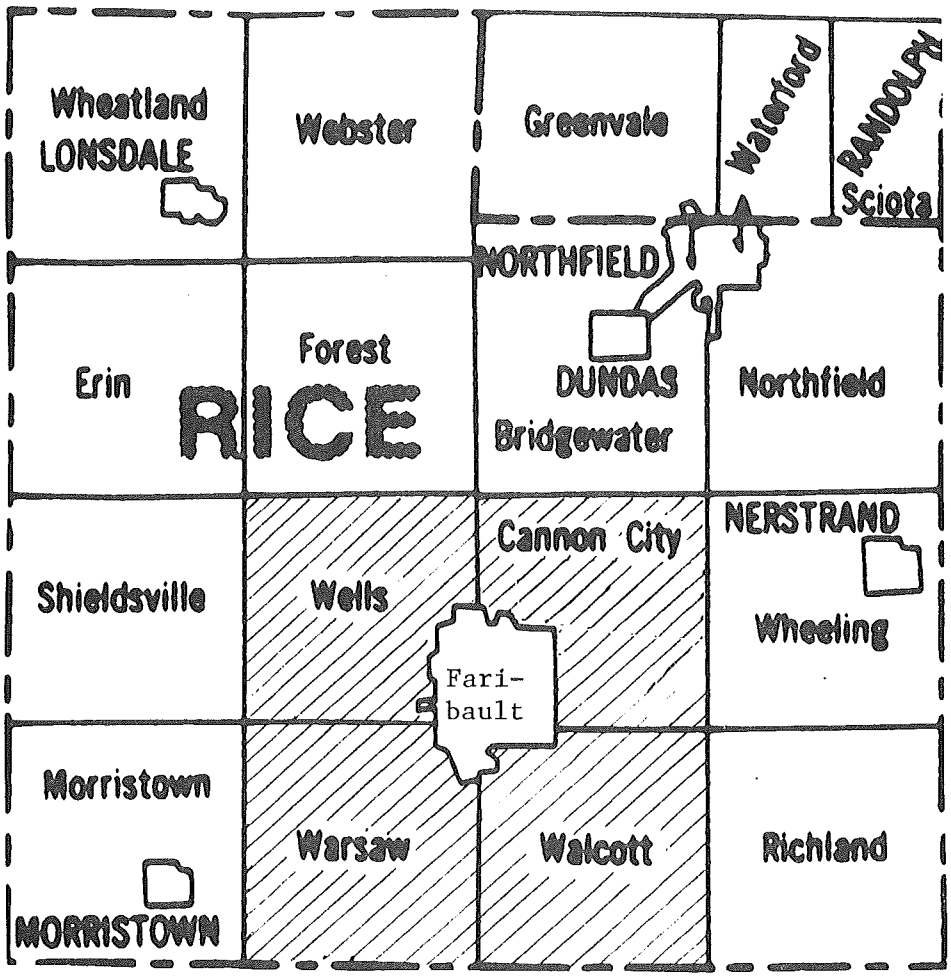
Figure 1



METROPOLITAN STATISTICAL AREA (MSA)
CENSUS TRACT WHICH ENCOMPASSES MORE THAN ONE TOWNSHIP

A nursing home located in the city of Waverly may relocate anywhere within the city of Waverly, the township of Woodland or the township of Marysville. The nursing home may not relocate within the city of Montrose, as Montrose does not adjoin (touch) the city of Waverly. (Relocation must be within six miles of the present site.)

Figure 2



NON-METROPOLITAN STATISTICAL AREA

A nursing home located in the city of Faribault may relocate anywhere within Faribault or the adjoining townships of Wells, Warsaw, Walcott, or Cannon City. (Relocation must be within six miles of the present site.)

Figure 3

2. Upgrading and conversion (little or no cost involved).

"Upgrading": Licensure change of certified beds from boarding care to nursing home level in boarding care facilities attached to nursing homes. Upgraded beds must meet new nursing home construction standards.

Upgrading criteria:

a. A certified boarding care home (BCH) attached to a nursing home may upgrade up to ten (10) certified beds during the next two years. Only facilities which already meet minimum nursing home standards for the additional beds under their present reimbursement rates are eligible to upgrade (i.e., no increase in operating costs would be allowed). Boarding care beds which are upgraded may not be replaced by new BCH beds. The number of BCH beds in a facility may not increase in the future if any beds are upgraded to nursing home level.

b. Only facilities where the average occupancy in existing nursing home beds is greater than 96%, based on the most recent Minnesota Department of Health (MDH) Annual Statistical Report, are eligible for certified boarding care bed upgrades.

c. Cost of upgrading the physical plant to new nursing home construction standards must be less than the PR50 trigger of 10 percent of the facility's appraised value or $200,000, whichever is less.

"Conversion": Hospital attached nursing homes may relocate up to five (5) nursing home beds in the hospital. This involves converting hospital space into nursing home space. No increase in present licensed nursing home capacity is allowed; beds are merely moved and no new beds are added.

Conversion criteria:

d. Conversion requires the delicensure of existing hospital beds and licensing that area as a nursing home, then moving existing licensed nursing home beds into that area. The relicensed areas must meet most recent nursing home construction standards before the beds may be relocated. No increase in operating costs would be allowed.

e. Only facilities where the average occupancy in existing nursing home beds is greater than 96%, based on the most recent MDH Annual Statistical Report, are eligible for conversion.

f. Cost of upgrading the physical plant to new nursing home construction standards must be less than the PR50 trigger of 10 percent of the facility's appraised value or $200,000, whichever is less.

D. REQUEST FOR EXCEPTION PROPOSALS (RFEP)

1. Appropriations

The Task Force recommends that the Legislature appropriate a specified amount to be added to the Medicaid budget which will cover increases to the budget caused by approved moratorium exceptions and the cost of administering the program. The intent of a specific appropriation is to control costs while allowing urgent physical plant changes to be made.

2. Publication

The State shall publish, in the State Register, a request to nursing home and boarding care providers to submit exception proposals by a specified date.

Proposals shall include the following:

a. Whether the request is for renovation, replacement, upgrading, or conversion.

b. A description of the project, including all costs and comparative estimates of renovation vs. replacement, where appropriate. ("Costs" refer both to the short-term, initial outlays for the project as well as long-term effects.)

c. Proposed location of the replacement, if applicable.

3. Review Panel

A panel should be established to review exception proposals. The panel should consist of representatives of the Department of Health, Department of Human Services, State Planning Agency, two consumer representatives and one representative from each of the two state nursing home trade associations. The panel would review proposals and submit its recommendations for priority treatment to the Departments of Health and Human Services.

4. Ranking Criteria

The following shall be considered for all facilities submitting exception proposals:

a. Occupancy of the facility and occupancy level of the area (definition of area is found in the current moratorium under "hardship situations").

b. Integration of the proposal with other state policies, such as the level of alternative care available in the area and the presence of multiple-bed rooms.

c. Feasibility and appropriateness of the proposal as determined by the Minnesota Department of Health (MDH).

d. Cost effectiveness of the proposal as determined by the Department of Human Services (DHS).

e. Long-term effect of the exception on the Medicaid budget as determined by DHS.

Upgrading and conversion exceptions to the moratorium shall be determined by the ability of the facility to meet the above criteria and the criteria outlined in section C., part 2.

Renovation and replacement exception proposals shall be ranked in order of greatest need according to the above criteria and the following additional criteria:

f. Presence of factors which threaten the health or safety of the residents. For example:

1) narrow corridors/door frames
2) non-enclosed fire exits
3) wood frame/ordinary construction

g. Presence of factors which seriously reduce resident quality of life. For example:

1) number of persons per room
2) lighting levels
3) ventilation requirements
4) location of toilet facilities
5) additional ancillary space, e.g. dining rooms, dayrooms, etc.
6) heating, cooling and other energy efficiency issues.

h. Presence of factors which limit the ability of the facility to provide efficient care. For example:

1) location of nursing stations
2) available dining room space
3) narrow corridors
4) availability of bathing areas, toilet training rooms, handicap accessible toilets.

Specific renovation and replacement exceptions to the moratorium shall be determined by MDH in consultation with DHS using a combination of the ranking procedure and the availability of funds for the projects.

E. OTHER ISSUES

1. Improving data

To assist Minnesota Department of Health (MDH) efforts to identify patterns of nursing home noncompliance with regulations and to help the state determine if a facility involuntarily decertified should be allowed to come back into the system, improved data collection and retrieval are needed. The Task Force recommends that MDH automate data from the annual nursing home statistical report and from the long-term care survey. This data should include information on the type and severity of violations.

2. Planning for future bed need

Data prepared by the State Planning Agency indicate that no additional beds will be needed in the system over the next two to three years. The state, however, needs to develop criteria for determining need for beds and dealing with future needs as they arise.

What constitutes over- or under-bedding for a region is currently not well defined. The traditional method for determining bed need uses the number of beds per 1000 elderly 65 years and older. The establishment of the preadmission screening/alternative care grant progams and the corresponding deferral of the use of nursing home services give reason to believe that a more appropriate age breakdown would be beds per 1000 elderly 75 years and older. The Task Force recommends that this concept be explored.

VI. EXCEPTIONS UNDER CURRENT LAW TO THE NURSING HOME MORATORIUM

"The commissioner of health, in coordination with the commissioner of human services, may approve the addition of a new certified bed or the addition of a new licensed nursing home 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 rquest 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, "commence 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;

"(d) to license a new nursing home bed in a facility that meets one of the exceptions contained in clauses (a) to (c);

"(e) to license nursing home beds in a facility that has submitted either a completed licensure application or a written request for licensure to the commissioner before March 1, 1985, and has either commenced any required construction as defined in clause (b) before May 1, 1985, or has, before May 1, 1985, received from the commissioner approval of plans for phased-in construction and written authorization to begin construction on a phased-in basis. For the purpose of this clause, "construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules; or

"(f) to certify or license new beds in a new facility that is to be operated by the commissioner of veterans' affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans' affairs or the United States Veterans Administration."