

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File No. 1157

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 5-10-85
DATE FOR REVIEW
DATE DUE 5-17-85

Adopted w/a hearing
Adopted w/o hearing
Temporary rule ✓

Approved 5-14-85 (CDS) Disapproved Returned to Agency

Resubmitted Due
Approved Disapproved Returned to Agency

Date filed w/Secretary of State 5-15-85 Revisor approved 5/13/85
disapproved

✓ Rule as Adopted

Rule as Proposed

✓ Order Adopting 5.10.85, Date

Notice of Intent to Solicit Outside Opinion

✓ Order for rulemaking
N/A date of Hearing

N/A Certificate of Board's Authorizing Resolution

✓ Notice of rulemaking
✓ Sufficiency

✓ Affidavit of Mailing Notice or rulemaking
4.3.85 At least ~~30~~ 20 days prior to ~~hearing~~/adoption

✓ Affidavit of Add. Mailing
✓ Mailing list Certificate

✓ Publication in State Register
4.8.85 At least ~~30~~/20 days prior to ~~hearing~~/adoption

N/A Hearing Examiner's Report

Chief Hearing Examiner's Report(s)
Approving H.E.'s Report
Approving agency action

✓ Agency's Findings of Fact

N/A LCRAR Report or agency Affidavit

Certificate of Board's Resolution Adopting Rules

✓ Order Approving Incorporation by Reference

Statement of Need and Reasonableness

✓ Petition for Adoption of a Rule

✓ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

✓ Certificate of Compliance w/Rulemaking Procedures

N/A Affidavit of Mailing Notice of Submission to Attorney General

✓ Notice of Submission to the Attorney General

SF-00006-03

STATE OF MINNESOTA

DEPARTMENT Human Services

Office Memorandum

TO: Judith Wehrwein

DATE: 5-9-85

FROM: Rosemary Chapin RC
DHS - Rulemaking

PHONE: 7-1488

SUBJECT: Rule Parts 9549.0050 - 9549.0059

These rule parts are submitted for your review in accordance with Minnesota Statutes 256B.431, Subdivision 6, which states "any emergency rules adopted by the Commissioner of Health or the Commissioner of Human Services under this section shall be adopted in accordance with the provisions contained in sections 14.29 to 14.36 in effect on March 1, 1984. . . .The procedures for the adoption of the emergency rules authorized by this subdivision shall prevail over any other act that amends Chapter 14 regardless of the date of final enactment of those amendments. . . .The rules are effective five days after publication in the State Register". Under these provisions it is my understanding that the Attorney General Administration has five working days to review the rule.

The Department of Human Services received no requests for notification to be sent when the rule was submitted to you. Therefore, no notice of submission or affidavit of mailing has been included.

Please contact me at 297-1488 if you have any further questions.

RC/acb

RECEIVED
MAY 10 1985
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

SF-00006-03

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO: LEONARD W. LEVINE, Commissioner
Department of Human Services

DATE: 5-15-85

ATTN: GAIL M. OLSON
Special Assistant Attorney General

FROM: LARRY D. STARNS LDS
Special Assistant Attorney General

PHONE: 297-3493

SUBJECT: In the Matter of the Proposed Temporary Rules Governing Nursing Home Payment Rate, Minnesota Rules, Part 9549.0050 to 9549.0059 (Temporary)

The above-referenced rule has been approved as to its legality by the Attorney General on May 14, 1985.

Enclosed is the agency's copy of the approved rule. This office has already filed two copies of the approved rule with the Secretary of State, who will forward one copy to the Revisor of Statutes. The fourth copy is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submission or comments received by the agency and any extra copies of documents which the agency submitted to the Attorney General.

In order for a permanent rule without a hearing to become effective, your agency must publish a notice of adoption in the State Register in accordance with Minn. Stat. § 14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. § 14.34.

If you have any questions in this regard, please contact me.

LDS:sz

Enclosures

cc: Executive Director
Legislative Commission to Review
Administrative Rules

Chief Administrative Law Judge
Office of Administrative Hearings

AG copy.

Department of Human Services

Adopted Temporary Rules Relating to Nursing Home Payment Rate Determination

Temporary Rules as Adopted

DEPARTMENT OF HUMAN SERVICES

NURSING HOME PAYMENT RATE DETERMINATION [Temporary]

9549.0050 [Temporary] SCOPE.

Parts 9549.0050 to 9549.0059 [Temporary] establish procedures for determining the operating cost payment rates for all nursing homes participating in the medical assistance program. Parts 9549.0050 to 9549.0059 [Temporary] are effective for rate years beginning on or after July 1, 1985. Procedures for assessment and classification of residents by the Department of Health in accordance with parts 9549.0050 to 9549.0059 [Temporary] are found in parts 4656.0010 to 4656.0070.

9549.0051 [Temporary] DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 9549.0050 to 9549.0059 [Temporary], the following terms have the meanings given them.

Subp. 2. **Assessment form.** "Assessment form" means the form developed by the Department of Health Quality Assurance and Review Program which was in effect on March 1, 1984, and used for performing resident assessments. The assessment form is incorporated by reference. It is available at Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155. It is available through Minitex interlibrary loan system. This form is not subject to frequent change.

Subp. 3. **Base year.** "Base year" means the reporting year ending September 30, 1984.

Subp. 4. **Case mix index.** "Case mix index" means the sum of the results obtained by multiplying the number of residents in each resident class in each home by the weights listed in part 9549.0058 [Temporary].

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Subp. 5. **Case mix operating costs.** "Case mix operating costs" means the operating costs listed in part 9549.0040, subpart 5, as proposed in State Register, volume 9, page 1716, February 4, 1985, and the portion of fringe benefits and payroll taxes allocated to the nursing services cost category in accordance with part 9549.0053.

Subp. 6. **Case mix score.** "Case mix score" means the case mix index divided by the total number of residents in each home.

Subp. 7. **Medical plan of care.** "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatment and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures, and discharge potential.

Subp. 8. **Other care related operating costs.** "Other care related operating costs" means the operating costs listed in part 9549.0040, subpart 6, as proposed in State Register, volume 9, page 1716, February 4, 1985, and the portion of fringe benefits and payroll taxes allocated to the other care related cost category ~~in accordance with part 9549.0053 and~~, the cost of food, and the required dietician consulting fees charged by a nonrelated organization in accordance with part 9549.0053. FF 1

Subp. 9. **Other operating costs.** "Other operating costs" means the operating costs listed in part 9549.0040, subparts 1, 2, 3, 4, and 7, as proposed in State Register, volume 9, page 1716, February 4, 1985, and the portion of fringe benefits and payroll taxes allocated to each of these operating costs categories in accordance with part 9549.0053, excluding the cost of food.

Subp. 10. **Quality assurance and review or QAR.** "Quality assurance and review" or "QAR" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. 11. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058 [Temporary].

Subp. 12. **Resident plan of care.** "Resident plan of care" for residents of nursing homes not licensed as boarding care

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homes means the patient care plan specified in part 4655.6000. "Resident plan of care" for residents of nursing homes licensed as boarding care homes means the overall plan of care as defined in Code of Federal Regulations, title 42, section 442.319, as amended through December 31, 1984.

Subp. 13. **Standardized resident days.** "Standardized resident days" means the sum of the number of resident days in the nursing home in each resident class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary]. For the rate years beginning on July 1, 1985, and July 1, 1986, standardized resident days must be determined in accordance with part 9549.0054 [Temporary], subparts 1 and 2.

9549.0052 [Temporary] ESTABLISHMENT OF GEOGRAPHIC GROUPS.

The commissioner shall classify Minnesota nursing homes according to their geographic location as indicated in subparts 1 to 3.

Subpart 1. **Group 1.** All nursing homes in Beltrami, Big Stone, Cass, Chippewa, Clearwater, Cottonwood, Crow Wing, Hubbard, Jackson, Kandiyohi, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, McLeod, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Yellow Medicine, and Wadena counties must be placed in geographic group 1.

Subp. 2. **Group 2.** All nursing homes in counties other than the counties listed under subparts 1 and 3 must be placed in geographic group 2.

Subp. 3. **Group 3.** All nursing homes in Aitkin, Anoka, Carlton, Carver, Cook, Dakota, Hennepin, Itasca, Koochiching, Lake, Ramsey, St. Louis, Scott, and Washington counties must be placed in geographic group 3.

9549.0053 DETERMINATION AND ALLOCATION OF FRINGE BENEFITS AND PAYROLL TAXES, ~~AND~~ FOOD COSTS, AND REQUIRED DIETICIAN CONSULTING FEES. FF1

Subpart 1. **Fringe benefits and payroll taxes.** Fringe benefits and payroll taxes must be allocated to case mix, other

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care-related costs, and other operating costs according to items A to D.

A. Fringe benefits and payroll taxes must be allocated to case mix operating costs in the same proportion to salaries reported under part 9549.0040, subpart 5, as proposed in State Register, volume 9, page 1716, February 4, 1985.

B. Fringe benefits and payroll taxes must be allocated to other care-related costs in the same proportion to salaries reported under part 9549.0040, subpart 6, as proposed in State Register, volume 9, page 1716, February 4, 1985.

C. Fringe benefits and payroll taxes must be allocated to other operating costs in the same proportion to salaries reported under part 9549.0040, subparts 1, 2, 3, 4, and 7, as proposed in State Register, volume 9, page 1716, February 4, 1985.

D. For any nursing home which has not separately reported each salary component of an operating cost category, the commissioner shall determine the fringe benefits and payroll taxes to be allocated under this subpart according to subitems (1) and (2).

(1) The commissioner shall determine the ratio of allowable salaries in each cost category to total allowable salaries in all cost categories for all nursing homes separately reporting allowable salaries in each cost category.

(2) The nursing home's total allowable fringe benefits and payroll taxes must be multiplied by each ratio determined in subitem (1) to determine the amount of payroll taxes and fringe benefits allocated to each cost category for each nursing home under item D.

Subp. 2. **Determination of food costs.** For any nursing home which has not separately reported the cost of food under part 9549.0040, subpart 1, as proposed in State Register, volume 9, page 1716 (February 4, 1985), the commissioner shall determine the food costs according to items A and B.

A. The commissioner shall determine the average ratio of food costs to total dietary costs for all nursing homes that

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separately reported food costs.

B. The nursing home's total allowable dietary costs must be multiplied by the ratio determined in item A to determine the food costs for that nursing home.

Subp. 3. **Determination of required dietician consulting fees.** For any nursing home that has not separately reported required dietician consulting fees charged by a nonrelated organization, the commissioner shall determine the required dietician consulting fees according to items A to C.

A. The commissioner shall determine the average cost per licensed bed of dietician consulting fees charged by a nonrelated organization for all nursing homes that separately reported dietician consulting fees.

B. The nursing home's total number of licensed beds must be multiplied by the amount determined in item A to determine the required dietician consulting fees for that nursing home.

C. The amount determined in item B must be subtracted from the total dietary salary cost.

FF 1

9549.0054 [Temporary] DETERMINATION OF THE ALLOWABLE HISTORICAL OPERATING COSTS PER DIEMS.

The commissioner shall annually review and adjust the operating costs incurred by the nursing home during the reporting year preceding the rate year to determine the nursing home's actual allowable historical operating costs. The review and adjustment must comply with the provisions of parts 9549.0010 to 9549.0080, as proposed in State Register, volume 9, page 1716 (February 4, 1985).

Subpart 1. **Standardized resident days for rate year beginning July 1, 1985.** For the rate year beginning on July 1, 1985, each nursing home's standardized resident days must be determined according to items A to H.

A. The commissioner shall select the two most recent QAR assessments completed prior to April 1, 1985. If only one QAR assessment is available, the commissioner shall compute the standardized resident days in accordance with item I.

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B. For each of the two QAR assessments selected in item A, the medical assistance case mix index must be the sum of the number of medical assistance residents in each resident class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

C. The medical assistance case mix index for each QAR assessment determined in item B must be divided by the total number of medical assistance residents in order to compute the medical assistance case mix score. If the total number of medical assistance residents is equal to zero in the most recent QAR assessment, the medical assistance case mix score must be the private pay case mix score determined in item F, subitem (1). FF2

D. The average monthly change in the medical assistance case mix score must be computed by subtracting the ~~most-recent~~ previous medical assistance case mix score from the ~~previous~~ most recent medical assistance case mix score and dividing the result by the number of months between the two QAR ~~assessments~~ assessment dates. For any partial calendar month, the commissioner shall count as a full month any period of more than 14 days and shall disregard periods of 14 days or less. FF3.

E. The average medical assistance case mix score must be determined by subtracting from the most recent medical assistance case mix score, the product of the average monthly change in the medical assistance case mix score times the number of months from April 1, 1984, to the date of the most recent QAR assessment. For a partial calendar month, the commissioner shall count as a full month the period of more than 14 days, and shall disregard periods of 14 days or less.

F. The commissioner shall compute the private pay adjustment ratio in accordance with subitems (1) to (3).

(1) Using the method described in item C, compute the private pay case mix score for ~~private-paying~~ nonmedical assistance residents for each nursing home whose most recent QAR assessment included assessments of ~~private-paying~~ nonmedical assistance residents. FF4

(2) Compute a ratio by dividing the private pay

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case mix score in subitem (1) by the medical assistance case mix score in item C for that QAR assessment.

(3) Compute the private pay adjustment ratio by determining the average of all ratios determined in subitem (2).

G. The commissioner shall determine the average private pay ~~average~~ case mix score for each nursing home in item F, subitem (1), by multiplying the private pay adjustment ratio determined in item F, subitem (3) times the average medical assistance case mix score determined in item E.

H. The commissioner shall compute the standardized resident days in accordance with subitems (1) to (3).

(1) For each nursing home whose most recent QAR assessment included assessments of nonmedical assistance residents, multiply the ~~private-pay~~ nonmedical assistance resident days during the reporting year by the ~~average~~ nursing home's private pay case mix score as determined in item F, subitem (1). If the nursing home's QAR assessment does not include assessments of nonmedical assistance residents, multiply the nonmedical assistance resident days during the reporting year by the average private pay case mix score determined in item G.

FF 5

(2) Multiply the medical assistance resident days during the reporting year by the average medical assistance case mix score as determined in item E.

(3) The standardized resident days must be the sum of subitems (1) and (2).

I. If only one QAR assessment is available, the commissioner shall compute the standardized resident days in accordance with subitems (1) to (3).

(1) The case mix index must be the sum of the number of residents in each class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

(2) The case mix score must be computed by dividing the case mix index in subitem (1) by the total number of residents.

(3) The case mix score must be multiplied by the

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total number of resident days during the reporting year to determine the standardized resident days.

Subp. 2. **Standardized resident days for rate year beginning July 1, 1986.** For the rate year beginning on July 1, 1986, each nursing home's standardized resident days must be determined in accordance with items A to C.

A. The resident days in each resident class for the months of July, August, and September 1985, must be multiplied by 3.9674 to determine the annualized resident days.

B. For each resident class, the annualized resident days determined in item A, must be multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

C. The amounts determined in item B must be summed to determine the nursing home's standardized resident days for the reporting year.

Subp. 3. **Allowable historical case mix operating cost standardized per diem.** The allowable historical case mix operating cost standardized per diem must be computed by dividing the allowable historical case mix operating cost by the standardized resident days determined in subpart 1 or 2.

Subp. 4. **Allowable historical other care related operating cost per diem.** The allowable historical other care related operating cost per diem must be computed by dividing the allowable historical other care related operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period, except that a nursing home that is certified to provide a skilled level of care and that has an average length of stay of 180 days or less in their skilled level of care must divide the allowable historical other care related operating costs by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

Subp. 5. **Allowable historical other operating cost per diem.** The allowable historical other operating cost per diem must be computed by dividing the allowable historical other operating costs by the greater of resident days or 90 percent of

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the number of licensed beds multiplied by the number of days in the reporting period, except that a nursing home that is certified to provide a skilled level of care and that has an average length of stay of 180 days or less in their skilled level of care must divide the allowable historical other operating costs by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

9549.0055 [Temporary] DETERMINATION OF THE OPERATING COST ADJUSTMENT FACTORS AND LIMITS.

Subpart 1. **Annual adjustment factors.** The annual adjustment factors must be determined according to items A and B.

A. The annual adjustment factor for the case mix and other care-related operating costs must be established according to subitems (1) to (4).

(1) The components and indices for the case mix and other care related operating costs adjustment factor must be as specified in the following table.

CASE MIX AND CARE RELATED COMPONENTS AND INDICES

Component	Weight	Index
Salaries	.7347	Average hourly earnings of employees in nursing and personal care facilities (SIC 805). <u>SIC 805 is incorporated by reference.</u>
Benefits	.1107	Difference between movements in compensation and wages and salary index components of the Employment Cost Index for Service Workers. <u>This index is incorporated by reference.</u>
Supplies and Drugs	.0363	Consumer Price Index for nonprescription medical equipment and supplies. <u>This index is</u>

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		incorporated by reference.
Food	.1183	Producer Price Index for consumer foods. This index is incorporated by reference.
TOTAL	1.0000	

(2) The average price index for the reporting year must be computed by multiplying the weight for each component contained in subitem (1) by the average index for that component for the reporting year and adding the products.

(3) The average forecasted price index for the rate year immediately following the reporting year must be computed by multiplying the weight for each component contained in subitem (1) by the average forecasted index for that component for the rate year and adding the products.

(4) The adjustment factor for the case mix and other care related operating costs must be computed by dividing the amount computed in subitem (3) by the amount computed in subitem (2).

B. The annual adjustment factor for the other operating costs must be established according to subitems (1) to (4).

(1) The components and indices for the other operating cost adjustment factor must be as specified in the following table.

OTHER OPERATING COSTS COMPONENTS AND INDICES

Component	Weight	Index
Utilities	.1099	Producer Price Index for natural gas (80 percent); and Producer Price Index for commercial power in west north central state (20 percent). This index is incorporated by reference.
Salaries	.5864	Average hourly earnings of employees

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		in nursing and personal care facilities (SIC 805). This index is incorporated by reference.
Benefits	.0799	Difference between movements in compensation and wages and salaries index components of the Employment Cost Index for Service Workers. This index is incorporated by reference.
Additional Professional Services	.1107	Employment Cost Index for wages and salaries of professional and technical workers. This index is incorporated by reference.
Additional Miscellaneous Service Purchases	.0322	Consumer Price Index for maintenance and repair services. This index is incorporated by reference.
Miscellaneous Purchases (Commodities)	.0809	Consumer Price Index for maintenance and repair commodities. This index is incorporated by reference.
TOTAL	1.0000	

(2) The average price index for the reporting year must be computed by multiplying the weight for each component contained in subitem (1) by the average index value for that component for the reporting year and adding the products.

(3) The average forecasted price index for the rate year immediately following the reporting year must be computed by multiplying the weight for each component contained in subitem (1) by the forecasted average index values for that component for the same rate year and adding the products.

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(4) The adjustment factor for the other operating costs must be computed by dividing the amount computed in subitem (3) by the amount computed in subitem (2).

Subp. 2. **Limits.** For each geographic group established in part 9549.0052 [Temporary] the operating costs limits must be determined according to items A to F. No redetermination of the operating costs limits shall be made due to audit adjustments or appeal settlement.

A. The commissioner shall compute 115 percent of the median of the array of the allowable historical case mix related operating cost per diems for the base year.

B. The commissioner shall compute 115 percent of the median of the array of the allowable historical other care related operating cost per diems for the base year.

C. The total care related operating cost limit for each resident class must be determined by multiplying the amount determined in item A by the weight for each resident class and adding the amount determined in item B. For the rate year beginning July 1, 1985, the total care-related operating cost limit for nursing homes with an average length of stay of 180 days or less in their skilled nursing level of care must be 125 percent of the total care-related operating cost limit. For the rate year beginning July 1, 1985, a nursing home licensed on May 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600 must be exempt from the total care-related operating cost limit.

D. The commissioner shall disallow any portion of the general and administrative cost category, exclusive of fringe benefits and payroll taxes that exceeds 15 percent of the allowable expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administrative.

E. The other operating costs limits must be determined in accordance with subitems (1) to ~~(3)~~ (5).

(1) For each geographic group in part 9549.0052 [Temporary], the commissioner shall group all hospital attached nursing homes, all nursing homes with an average length of stay

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of 180 days or less in their skilled nursing level of care, and nursing homes licensed on May 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600.

(2) The other operating cost limit for hospital attached nursing homes in each geographic group in part 9549.0052 [Temporary] must be 105 percent of the median of the array of the allowable historical other operating cost per diem for each nursing home in the group established under subitem (1) in the base year.

(3) The other operating cost limit for all nursing homes with an average length of stay of 180 days or less in their skilled nursing level of care, and nursing homes licensed on May 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600 in each geographic group in part 9549.0052 [Temporary] must be 105 percent of the limit established in subitem (2).

(4) For each geographic group in part 9549.0052 [Temporary], the commissioner shall group all nursing homes not included in subitem (1).

~~(3)~~ (5) The other operating cost limit for each group established in ~~subitems (1) and (2)~~ subitem (4) must be 105 percent of the median of the array of the allowable historical other operating cost per diems for each nursing home in the group for the base year.

F. The commissioner may establish a different base year once within a five-year period.

Subp. 3. **Incorporations by reference.** The references for the indices specified in this part are listed in items A to D, and are available through the Minitex interlibrary loan system. The references in items A to D are subject to frequent change.

A. The index for average hourly earnings of employees in nursing and personal care facilities is published monthly in "Employment and Earnings," Bureau of Labor Statistics, United States Department of Labor. (SIC 805) Standard Industrial Code

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805 is the code used for employees in nursing and personal care facilities in this publication.

B. The Employment Cost Index for Service Workers and the Employment Cost Index for wages and salaries of professional and technical workers are published monthly in "Current Wage Developments," Bureau of Labor Statistics, United States Department of Labor.

C. The Consumer Price Index for nonprescription medical equipment and supplies and the Consumer Price Index for maintenance and repair commodities are published in the "Monthly Labor Review," Bureau of Labor Statistics, United States Department of Labor.

D. The Producer Price Index for consumer foods, the Producer Price Index for natural gas, and the Producer Price Index for commercial power in west north central states are published monthly in "Producer Prices and Price Indices," Bureau of Labor Statistics, United States Department of Labor.

9549.0056 [Temporary] DETERMINATION OF THE OPERATING COST PAYMENT RATE.

Subpart 1. **Nonadjusted case mix and other care related payment rate.** For each nursing home, the nonadjusted case mix and other care related payment rate for each resident class must be determined according to items A to D.

A. The nursing home's allowable historical case mix operating cost standardized per diem established in part 9549.0054 [Temporary], subpart 3, must be multiplied by the weight for each resident class listed in part 9549.0058 [Temporary].

B. The allowable historical other care related operating cost per diem established in part 9549.0054 [Temporary], subpart 4, must be added to each weighted per diem established in item A.

C. If the amount determined in item B for each resident class is below the limit for that resident class and group established in part 9549.0055 [Temporary], subpart 2, item C, the nursing home's nonadjusted case mix and other care

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related payment rate must be the amount determined in item B for each resident class.

D. If the amount determined in item B for each resident class is at or above the limit for that resident class and group established in part 9549.0055 [Temporary], subpart 2, item C, the nursing home's nonadjusted case mix and other care related payment rate must be set at the limit.

Subp. 2. **Adjusted prospective case mix and other care related payment rate.** For each nursing home, the adjusted prospective case mix and other care related payment rate for each resident class must be the nonadjusted case mix and other care related payment rate multiplied by the case mix and other care related adjustment factor determined in part 9549.0055 [Temporary], subpart 1, item A.

Subp. 3. **Nonadjusted other operating cost payment rate.** The nonadjusted other operating cost payment rate must be determined according to items A and B.

A. If the allowable historical other operating cost per diem determined in part 9549.0054 [Temporary], subpart 5, is below the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, ~~subitem (3),~~ the nursing home's nonadjusted other operating cost payment rate must be the allowable historical other operating cost per diem.

B. If the allowable historical other operating cost per diem determined in part 9549.0054 [Temporary], subpart 5, is at or above the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, ~~subitem (3),~~ the nursing home's nonadjusted other operating cost payment rate must be set at that limit.

Subp. 4. **Adjusted prospective other operating cost payment rate.** The adjusted prospective other operating cost payment rate must be determined according to items A ~~and~~ or B.

A. Except as provided in item B, if the nursing home's nonadjusted other operating cost payment rate is below the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, ~~subitem (3),~~ the nursing home's

FF6

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adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item H A, multiplied by the other operating cost adjustment factor determined in part 9549.0055 [Temporary], subpart 1, item B, plus an efficiency incentive equal to the difference between the limit in part 9549.0055 [Temporary], subpart 2, item E, ~~subitem (3),~~ and the nonadjusted other operating cost payment rate in subpart 3 up to maximum of two dollars.

B. For any nursing home with an average length of stay of 180 days or less in its skilled nursing level of care and any nursing home licensed on May 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600 which is under the limits established in part 9549.0055 [Temporary], subpart 2, item E, subitem (3), the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item A, multiplied by the other operating cost adjustment factor determined in part 9549.0055 [Temporary], subpart 1, item B, plus an efficiency incentive equal to the difference between the limit in part 9549.0055 [Temporary], subpart 2, item E, subitem (2) and the nonadjusted other operating cost payment rate in subpart 3, up to a maximum of two dollars.

FF6.

C. If the nursing home's nonadjusted other operating cost payment rate is at or above the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, ~~subitem (3),~~ the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item B, multiplied by the other operating cost adjustment factor determined in part 9549.0055 [Temporary], subpart 1, item B.

D. The nursing home's efficiency incentives in items A or B must not be changed as a result of field audit adjustment.

FF7

Subp. 5. **Total operating cost payment rate.** The nursing home's total operating cost payment rate must be the sum of the

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adjusted prospective case mix and other care related payment rate determined in subpart 2 and the adjusted other operating cost payment rate determined in subpart 4.

9549.0057 [Temporary] DETERMINATION OF THE INTERIM AND SETTLE-UP OPERATING COST PAYMENT RATES.

To receive an interim payment rate, a nursing home must comply with the requirements and is subject to the conditions of part 9549.0060, subpart 14, items A to C. The commissioner shall determine interim and settle-up operating cost payment rates for a newly constructed nursing home, or one with a capacity increase of 50 percent or more according to subparts 1 and 2.

Subpart 1. **Interim operating cost payment rate.** For the rate year or portion of an interim period beginning on or after July 1, 1985, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 [Temporary], except that:

A. Each nursing home must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in part 9549.0058 [Temporary] to determine the anticipated standardized resident days for the reporting period.

B. The commissioner shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The commissioner shall use the anticipated resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem. Ninety percent of licensed beds multiplied by the number of days in the reporting period must not be used in determining these per diems.

D. The annual adjustment factors determined in part 9549.0055 [Temporary], subpart 1, must not be applied to the nursing home's allowable historical per diems as provided in part 9549.0056 [Temporary], subparts 2 and 4.

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E. The limits established in part 9549.0055 [Temporary], subpart 2, items C and E, must be increased by ten percent.

F. The efficiency incentive in part 9549.0056 [Temporary], subpart 4, item A, must not apply.

Subp. 2. **Settle-up operating cost payment rate.** The settle-up total operating cost payment rate must be determined according to items A to C.

A. The settle-up operating cost payment rate for a nursing home which commenced construction before July 1, 1985, is determined under 12 MCAR S 2.05014 [Temporary] for the interim period before July 1, 1985.

B. The settle-up operating cost payment rate for a nursing home which commenced construction after June 30, 1985, or whose interim reporting period included a period of time after that date must be determined for the portion of that interim period occurring after June 30, 1985, as in parts 9549.0050 to 9549.0059 [Temporary].

(1) The standardized resident days occurring after July 1, 1985, must be annualized for the interim reporting period.

(2) The commissioner shall use the annualized standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

(3) The commissioner shall use the actual resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem. Ninety percent of licensed beds multiplied by the number of days in the reporting period must not be used in determining these per diems.

(4) The annual adjustment factors determined in part 9549.0055 [Temporary], subpart 1, must not be applied to the nursing home's allowable historical per diems as provided in part 9549.0056 [Temporary], subparts 2 and 4.

(5) The limits established in subpart 1, item E, must be the limits for the settle-up reporting period occurring

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after July 1, 1985.

(6) The efficiency incentive in part 9549.0056 [Temporary], subpart 4, item A or B, must not apply.

C. For the nine-month period following the settle-up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive in part 9549.0056 [Temporary], subpart 4, item A or B, shall apply.

9549.0058 [Temporary] RESIDENT CLASSES AND CLASS WEIGHTS.

Subpart 1. **Resident classes.** Each resident must be classified according to items A to E based on the assessments performed under part 9549.0059 [Temporary] on the assessment form.

A. Each nursing home resident or applicant must be assessed as dependent in an activity of daily living or ADL according to the following table:

ADL	Dependent if Score At or Above
Dressing	2
Grooming	2
Bathing	4
Eating	2
Bed mobility	2
Transferring	2
Walking	2
Toileting	1

B. Each nursing home resident assessed as dependent in fewer than four of the ADL's in item A must be defined as Low ADL. Each resident assessed as dependent in four through six of the ADL's in item A must be defined as Medium ADL. Each resident assessed as dependent in seven or eight of the ADL's in item A must be defined as High ADL.

C. Each resident must be defined as special nursing according to subitems (1) and (2).

(1) the resident is assessed to require tube

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feeding; or

(2) the resident is assessed to require clinical monitoring including evening and night shifts plus one or more of the following special treatments on the assessment form:

(a) oxygen and respiratory therapy;

(b) ostomy care;

(c) care of dressings;

(d) skin care;

(e) IV therapy;

(f) drainage tubes;

(g) blood transfusions; or

(h) hyperalimentation.

D. Each resident must be defined as having a neuromuscular condition if the resident is assessed to have one or more of the diagnoses coded to the following categories according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), as published by the Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Michigan (1978). This publication is incorporated by reference. This is available through the Minitex interlibrary loan system. This is not subject to frequent change.

(1) diseases of nervous system excluding sense organs (320-359);

(2) cerebrovascular disease (430-438);

(3) fracture of skull (800-804), excluding cases without intracranial injury;

(4) intercranial injury, excluding those with skull fracture (850-854);

(5) fracture of vertebral column with spinal cord injury (806);

(6) spinal cord injury without evidence of spinal bone injury (952); or

(7) injury to nerve roots and spinal plexus (953).

E. Each resident must be defined as having a behavioral condition if the resident's assessment score is three

OFFICE BY:

FF8

two or more for behavior on the assessment form.

F. The commissioner shall establish resident classes based on the definitions in items A to E and according to subitems (1) to (11).

(1) Class A. Low ADL, and not defined behavioral condition, and not defined special nursing.

(2) Class B. Low ADL, and defined behavioral condition, and not defined special nursing.

(3) Class C. Low ADL, and defined special nursing.

(4) Class D. Medium ADL, and not defined behavioral condition, and not defined special nursing.

(5) Class E. Medium ADL, and defined behavioral condition, and not defined special nursing.

(6) Class F. Medium ADL, and defined special nursing.

(7) Class G. High ADL, and scoring less than three on the eating ADL in item A, and not defined special nursing, and not defined behavioral condition on assessment form.

(8) Class H. High ADL, and scoring less than three on eating ADL in item A, and defined behavioral condition, and not defined special nursing.

(9) Class I. High ADL, and scoring three or four on eating ADL in item A, and not defined special nursing, and not defined neuromuscular condition.

(10) Class J. High ADL, and defined neuromuscular condition, and scoring three or four on the eating ADL in item A, and not defined special nursing.

(11) Class K. High ADL, and defined special nursing.

Subp. 2. **Class weights.** The commissioner shall assign weights to each resident class established in subpart 1, item F, according to items A to K.

A. Class A, 1.00;

B. Class B, 1.30;

C. Class C, 1.64;

D. Class D, 1.95;

E. Class E, 2.27;

F. Class F, 2.29;

G. Class G, 2.56;

H. Class H, 3.07;

I. Class I, 3.25;

J. Class J, 3.53;

K. Class K, 4.12.

9549.0059 [Temporary] RESIDENT ASSESSMENT.

Subpart 1. **Assessment of nursing home applicants and newly admitted residents.** Each nursing home applicant or newly admitted resident shall be assessed for the purpose of determining the applicant's or newly admitted resident's class according to items A to I.

A. Each county preadmission screening team or hospital screening team under contract with the county must assess all nursing home applicants for whom preadmission screening is required by Minnesota Statutes, section 256B.091, and any applicant for whom a preadmission screening is not required but who voluntarily requests such a screening in accordance with Minnesota Statutes, section 256B.091, except as provided in subitems (1) and (2).

(1) The public health nurse of the county preadmission screening team or the RN case manager shall assess a nursing home applicant, if the applicant was previously screened by the county preadmission screening team and the applicant is receiving services under the Alternative Care Grants program defined in part 9505.2340 or under the medical assistance program.

(2) A nursing home applicant whose admission to the nursing home is for the purpose of receiving respite care services under the Alternative Care Grants program or under the medical assistance program need not be reassessed more than once every six months for the purpose of computing resident days under part 9549.0054 [Temporary], subpart 2, if the applicant has been classified by the Department of Health within the prior

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six-month period. In this case, the resident class established by the Department of Health within the prior six-month period may be the resident class of the applicant.

B. Each nursing home must assess each applicant or newly admitted resident for whom a preadmission screening is not required by Minnesota Statutes, section 256B.091, or is not requested voluntarily in accordance with Minnesota Statutes, section 256B.091. For purposes of this item, a newly admitted resident includes a resident who moves to a section of the nursing home which is licensed differently than the section from which the resident came or a resident who has been transferred from another nursing home. Each assessment must be performed by the registered nurse who signs the assessment form.

C. The assessment required by this subpart must be performed within ten working days before or ten working days after the date the applicant is admitted to the nursing home.

D. The nursing home must perform the assessment for any resident who is required to be assessed by the preadmission screening team under item A ~~and~~ or who has received a prior preadmission screening, and for whom the assessment required under this subpart has not been performed by the preadmission screening team within ten working days before or ten working days after the date the applicant is admitted to the nursing home. The nursing home must perform the assessment and submit the forms to the Department of Health within 15 working days after admission.

FF 9

E. A registered nurse performing the assessment must sign the assessment form.

F. The assessment of each applicant or newly admitted resident must be based on the QAR procedures of the Department of Health, and must be recorded on the assessment form defined in part 9549.0051 [Temporary], subpart 2.

G. The preadmission screening team or hospital screening team under contract with the county must provide the completed assessment form to the ~~nursing home~~ Department of Health, and provide a copy to the ~~Department of Health~~ nursing

FF 10

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home, within five working days following the assessment.

H. Each assessment completed in accordance with items A to G and a completed medical plan of care must be submitted to the Department of Health by the nursing home as a request for classification within ten working days after admission or after the assessment, whichever is later.

I. The resident class for nursing home applicants or newly admitted residents must be effective on the date of admission to the nursing home.

Subp. 2. **Assessment of residents for July 1, 1985, rate year.** For the July 1, 1985, rate year only, each nursing home must assess each resident whose name does not appear on the Department of Health's May 15, 1985, classification list under the procedures prescribed by subpart 3, item B. The nursing home must submit a request for classification for each resident assessed by the nursing home to the Department of Health by June 1, 1985. The request for classification must include the completed assessment form and the resident's plan of care. For any resident admitted after June 1, 1985, the procedure outlined in subpart 1 must be followed. For any nursing home whose annual QAR assessment occurred between May 1, 1985, and June 30, 1985, the classification established under part 4656.0030, subpart 3, shall apply. FF II

Subp. 3. **Semiannual assessment by nursing homes.** Semiannual assessments of residents by the nursing home must be completed in accordance with items A to E.

A. A nursing home must assess each of its residents no earlier than 170 days and no later than 190 days after the date of the most recent QAR assessment.

B. A registered nurse shall perform the assessment on each resident according to QAR procedures established by the Department of Health including physical observation of the resident, review of the medical plan of care, and review of the resident's care plan, and shall record the assessment on the assessment form defined in part 9549.0051 [Temporary], subpart 2. The registered nurse performing the assessment shall sign

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the assessment form.

C. Within five working days of the completion of the nursing home's semiannual resident assessments, the nursing home must forward to the Department of Health requests for classification for all residents assessed for the semiannual assessment. These requests must include the assessment forms, the resident plans of care, and the nursing home's daily census for the date on which the assessments were completed including an explanation of any discrepancy between the daily census and the number of assessments submitted. The nursing home must provide further information to the Department of Health if the Department of Health requests it in order to determine a resident's classification.

D. Any change in resident class due to a semi-annual assessment must be effective as of the first day of the month following the date of the ~~Department of Health's classification~~ completion of the semiannual assessment. FF12

E. For the rate year beginning July 1, 1985, only, a nursing home must assess residents according to subitems (1) to (4).

(1) In July 1985, the nursing home must assess all residents whose most recent QAR assessments were performed in October or November 1984.

(2) In August 1985, the nursing home must assess all residents whose most recent QAR assessments were performed in December 1984, or January 1985.

(3) In September 1985, the nursing home must assess all residents whose most recent QAR assessments were performed in February or March 1985.

(4) For residents assessed according to subitems (1) to (3), the nursing home must submit a request for classification for each resident assessed including the assessment form and a copy of the resident's plan of care to the Department of Health no later than the end of the calendar month when the assessments are required. The nursing home must provide further information to the Department of Health if

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requested by the Department of Health in order to determine a resident's classification. For each assessment performed in subitems (1) to (3), the resident classification determined by the Department of Health shall remain in effect until an assessment is performed under subpart 4 or 5.

Subp. 4. **Change in classification due to annual assessment by Department of Health.** Any change in resident class due to an annual assessment by the Department of Health's QAR team will be effective as of the first day of the month following the date of the Department of Health's assessment.

Subp. 5. **Assessment upon return to the nursing home from a hospital.** Residents returning to a nursing home after hospitalization must be assessed according to items A to C.

A. A nursing home must assess any resident who has returned to the same nursing home after a hospital admission. The assessment shall occur no more than five working days after the resident returns to the same nursing home.

B. A registered nurse shall perform the assessment on each resident according to QAR procedures established by the Department of Health, including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form defined in part 9549.0051 [Temporary], subpart 2. The registered nurse who performs the assessment shall sign the assessment form. Within five working days of the completion of the assesssment, the nursing home must forward to the Department of Health a request for a classification for any resident assessed upon return to a nursing home after a hospital admission. This request must include the assessment form~~,-the hospital-discharge-summary,~~ and the resident's medical plan of care. Upon request, the nursing home must furnish the Department of Health with further information when required in order to determine a resident's classification. FF 13

C. Any change in resident class due to an assessment provided under this subpart must be effective as of the date the resident returns to the nursing home from the hospital.

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Subp. 6. **Change in resident class due to audits of assessments of nursing home residents.** Any change in resident class due to a reclassification required by part ~~4656.0060~~ 4656.0050 must be effective as of the first day of the month following the date of the Department of Health's classification. FF14

Subp. 7. **Change in resident class due to request for reconsideration of resident classification.** Any change in a resident class due to a request for reconsideration of the classification must be made in accordance with items A and B.

A. The resident classification established by the Department of Health must be the classification that applies to the resident while any request for reconsideration under part 4546.0060 is pending.

B. Any change in a resident class due to a reclassification under part 4546.0060 must be effective as of the date of the assessment for which a reconsideration was requested.

Subp. 8. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made pursuant to the procedures set forth in part 4546.0060.

Subp. 9. **Resident access to assessments and documentation.** The nursing home must provide each nursing home resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the Department of Health in support of the assessment within one working day of receipt of a written or verbal request from the resident or the resident's authorized representative. FF15

APPROVED IN THE REVISOR OF STATUTES OFFICE BY:

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
MAY 15 1985
Joan Anderson Growe
Secretary of State

10:15 AM

APPROVED AS TO LEGALITY

May 14, 1985

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY _____
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Temporary Rules Governing Nursing Home Payment Rate, Minnesota Rules, Part 9549.0050 to 9549.0059 [Temporary]

ORDER ADOPTING TEMPORARY RULES

The above-entitled matter was published in the State Register on April 9, 1985 as a proposed temporary rule pursuant to Minnesota Statutes, 1983, sections 14.29-14.36 and Laws of Minnesota, 1984, chapter 641.

After affording interested and affected persons an opportunity to submit written data an views within 20 days of the publication date, reviewing and considering the data and views, and determining that the above-captioned rules are needed and reasonable,

NOW, THEREFORE, IT IS ORDERED that these rules identified as temporary rules governing Nursing Home Payment Rate Determination, Minnesota Rules, parts 9549.0050 to 9549.0059 [Temporary] are adopted this 10th day of May, 1985, pursuant to authority vested in me by Laws of Minnesota 1984, chapter 641 and Minnesota Statutes, section 256B.41, 256B.21, 256B.431, subdivisions 1, 2(c) and 6.

STATE OF MINNESOTA



LEONARD W. LEVINE, Commissioner
Department of Human Services

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF TEMPORARY RULES OF THE STATE DEPARTMENT OF HUMAN SERVICES GOVERNING NURSING HOME PAYMENT RATES, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

ORDER FOR PUBLICATION OF TEMPORARY RULES

IT IS ORDERED THIS 21st day of March, 1985, that the proposed temporary rules in the above-entitled matter be published in the State Register.

STATE OF MINNESOTA



LEONARD W. LEVINE, Commissioner
Department of Human Services

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED TEMPORARY RULES GOVERNING NURSING HOME PAYMENT RATES, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

AFFIDAVIT OF MAILING

Ann M. Berg, being first duly sworn, deposes and says:

That on the 3rd day of April, 1985, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Intent to Adopt Temporary Rules by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who have requested that their names be placed on file with the Department of Human Services for the purpose of receiving notice of the proposed adoption of rules by this Department.

Ann M. Berg

Subscribed and sworn to before me

this 4 day of April, 1985.

Margaret Holt

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
MY COMMISSION EXPIRES SEPTEMBER 26, 1990

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED TEMPORARY RULES GOVERNING NURSING HOME PAYMENT RATE, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

NOTICE OF INTENT TO ADOPT TEMPORARY RULES

The State Department of Human Services proposes to adopt the above-entitled temporary rules to implement Laws of Minnestoa 1984, chapter 641, section 22, subdivision 6 and Minnesota Statutes, section 256B.431, subdivision 6.

Persons interested in these rules have until 4:30 p.m. on April 29, 1985, to submit written comments. The proposed temporary rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language. Written comments should be sent to:

Rosemary Chapin
Department of Human Services
Sixth Floor, Space Center
444 Lafayette Road
St. Paul, Minnesota 55101

After consideration of all comments received, the Department of Human Services shall submit the temporary rules as published, with any modifications, this notice, and all written comments received to the Attorney General.

The Attorney General shall review the proposed temporary rule, with any modifications, as to its legality, review its form to the extent the form relates to legality and shall approve or disapprove the rule and any modifications within five working days.

The approved rule shall also be certified by the Revisor of Statutes.

The Department of Human Services shall not implement the temporary rules until a report on the proposed rules has been presented to the Senate Health and Human Services Committee and the House of Representatives Health and Welfare Committee. The rules are effective five days after publication in the State Register.

The temporary rules adopted under the provision of Laws of Minnesota, chapter 641, section 22, subdivision 6, and Minnesota Statutes, section 256B.431, subdivision 6, shall have the force and effect of law and remain in effect until June 30, 1986, unless otherwise superseded by rule.

The Department of Human Services' authority for adoption of these rules is found in Laws of Minnesota 1984, chapter 641 and Minnesota Statutes, section 256B.41, 256B.21, 256B.431, subdivisions 1, 2 c, and 6.

The purpose of the proposed rules is to implement a case mix reimbursement system which bases nursing home operating costs payments on the condition and needs of residents in each home. This system entails ongoing assessment of resident needs to determine to which of eleven payment classifications each resident belongs. For purposes of establishing these prospective payment rates, operating costs are divided into two parts; "care related" and "other operating" costs. Separate limitations and incentives are established for each of these two parts.

This rule will impact the operating costs payment rate for nursing homes licensed under Minnesota Statutes, chapter 144A or boarding care facilities licensed under Minnesota Statutes, section 144.50 to 144.58 participating in the Medical Assistance Program.

The rule contains parts including:

-scope;
-definitions;
-establishment of geographic groups;
-allocation of fringe benefits and payroll taxes, and raw food costs;
-determination of the allowable historical operating costs per diems;
-determination of the operating cost adjustment factors and limits;
-determination of the operating cost payment rate;
-determination of the interim and settle-up operating costs payment rates;
-resident classes and class weight; and
-resident assessment.

Procedures for assessment and classification of residents by the Minnesota Department of Health in accordance with parts 9549.0050 to 9549.0059 [Temporary] are found in proposed Minnesota Rules, parts 4656.0001 to 4656.0006 [Temporary].

The fiscal impact of this rule is approximately budget neutral. The rule will not result in additional state or county spending in excess of $100,000 annually beyond the amount of funds appropriated by the legislature.

A free copy of the proposed temporary rule may be obtained by contacting Mary Ann Bredesen, Department of Human Services, Space Center, 444 Lafayette Road, 6th Floor, St. Paul, Minnesota 55101.

Dated: March 25, 1985



LEONARD W. LEVINE
Commissioner of Human Services

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED
TEMPORARY RULES GOVERNING NURSING
HOME PAYMENT RATES, MINNESOTA RULES,
PARTS 9549.0050 TO 9549.0059
[TEMPORARY]

AFFIDAVIT OF
ADDITIONAL MAILING

Ann M. Berg, being first duly sworn, deposes and says:

That on the 4th day of April, 1985, at the City of St. Paul, County of Ramsey, State of Minnesota, in addition to serving the attached Notice of Intent to Adopt Temporary Rules to all persons and associations who have requested that their names be placed on file for the purpose of receiving notice of the proposed adoption of rules by this Department, she also served the attached Notice by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, to the following agencies:

-the Case Mix Advisory Committee;
-approxminately 450 nursing homes in Minnesota;
-approximately 120 nursing home accountants; and
-approximately 200 advocates and other interested parties.

Ann M. Berg

Subscribed and sworn to before me

this 4 day of April, 1985.

Margaret Holt

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
MY COMMISSION EXPIRES SEPTEMBER 26, 1990

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED TEMPORARY RULES GOVERNING NURSING HOME PAYMENT RATE, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

NOTICE OF INTENT TO ADOPT TEMPORARY RULES

The State Department of Human Services proposes to adopt the above-entitled temporary rules to implement Laws of Minnestoa 1984, chapter 641, section 22, subdivision 6 and Minnesota Statutes, section 256B.431, subdivision 6.

Persons interested in these rules have until 4:30 p.m. on April 29, 1985, to submit written comments. The proposed temporary rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language. Written comments should be sent to:

Rosemary Chapin
Department of Human Services
Sixth Floor, Space Center
444 Lafayette Road
St. Paul, Minnesota 55101

After consideration of all comments received, the Department of Human Services shall submit the temporary rules as published, with any modifications, this notice, and all written comments received to the Attorney General.

The Attorney General shall review the proposed temporary rule, with any modifications, as to its legality, review its form to the extent the form relates to legality and shall approve or disapprove the rule and any modifications within five working days.

The approved rule shall also be certified by the Revisor of Statutes.

The Department of Human Services shall not implement the temporary rules until a report on the proposed rules has been presented to the Senate Health and Human Services Committee and the House of Representatives Health and Welfare Committee. The rules are effective five days after publication in the State Register.

The temporary rules adopted under the provision of Laws of Minnesota, chapter 641, section 22, subdivision 6, and Minnesota Statutes, section 256B.431, subdivision 6, shall have the force and effect of law and remain in effect until June 30, 1986, unless otherwise superseded by rule.

The Department of Human Services' authority for adoption of these rules is found in Laws of Minnesota 1984, chapter 641 and Minnesota Statutes, section 256B.41, 256B.21, 256B.431, subdivisions 1, 2 c, and 6.

The purpose of the proposed rules is to implement a case mix reimbursement system which bases nursing home operating costs payments on the condition and needs of residents in each home. This system entails ongoing assessment of resident needs to determine to which of eleven payment classifications each resident belongs. For purposes of establishing these prospective payment rates, operating costs are divided into two parts; "care related" and "other operating" costs. Separate limitations and incentives are established for each of these two parts.

This rule will impact the operating costs payment rate for nursing homes licensed under Minnesota Statutes, chapter 144A or boarding care facilities licensed under Minnesota Statutes, section 144.50 to 144.58 participating in the Medical Assistance Program.

The rule contains parts including:

-scope;
-definitions;
-establishment of geographic groups;
-allocation of fringe benefits and payroll taxes, and raw food costs;
-determination of the allowable historical operating costs per diems;
-determination of the operating cost adjustment factors and limits;
-determination of the operating cost payment rate;
-determination of the interim and settle-up operating costs payment rates;
-resident classes and class weight; and
-resident assessment.

Procedures for assessment and classification of residents by the Minnesota Department of Health in accordance with parts 9549.0050 to 9549.0059 [Temporary] are found in proposed Minnesota Rules, parts 4656.0001 to 4656.0006 [Temporary].

The fiscal impact of this rule is approximately budget neutral. The rule will not result in additional state or county spending in excess of $100,000 annually beyond the amount of funds appropriated by the legislature.

A free copy of the proposed temporary rule may be obtained by contacting Mary Ann Bredesen, Department of Human Services, Space Center, 444 Lafayette Road, 6th Floor, St. Paul, Minnesota 55101.

Dated: March 25, 1985



LEONARD W. LEVINE
Commissioner of Human Services

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED TEMPORARY RULES GOVERNING NURSING HOME PAYMENT RATE, MINNESOTA RULES, PARTS 9549.0059 TO 9549.0059 [TEMPORARY]

CERTIFICATE

I hereby certify that the list of persons, associations, and other interested groups who have requested, pursuant to Minn. Stat. S. 14.14, subd. 1, that their names be placed on file with and maintained by the Department of Human Services for the purpose of receiving notice of the proposed adoption of rules by this Department is accurate and complete as of 4:00, p.m., this 3rd day of April, 1985.

Ann M. Berg

Subp. 3. Summary report. The county relocation committee shall provide a summary report to the commissioner within 60 days after the completion of a facility's relocation. The summary report must include:

A. the number of residents relocated;

B. the medical assistance identification number of each medical assistance recipient relocated;

C. the date each resident was relocated;

D. the new placement of each resident;

E. the status of each resident at the time of the follow-up visit; and

F. the identification of problems met during the relocation process.

Department of Human Services

Proposed Temporary Rules Relating to Nursing Home Payment Rate Determination

Notice of Intent to Adopt Temporary Rules

The State Department of Human Services proposes to adopt the above-entitled temporary rules to implement Laws of Minnesota 1984, chapter 641, section 22, subdivision 6 and Minnesota Statutes, section 256B.431, subdivision 6.

Persons interested in these rules have until 4:30 p.m. on April 29, 1985, to submit written comments. The proposed temporary rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language. Written comments should be sent to:

Rosemary Chapin
Department of Human Services
Sixth Floor, Space Center
444 Lafayette Road
St. Paul, Minnesota 55101

After consideration of all comments received, the Department of Human Services shall submit the temporary rules as published, with any modifications, this notice, and all written comments received to the Attorney General.

The Attorney General shall review the proposed temporary rule, with any modifications, as to its legality, review its form to the extent the form relates to legality and shall approve or disapprove the rule and any modifications within five working days.

The approved rule shall also be certified by the Revisor of Statutes.

The Department of Human Services shall not implement the temporary rules until a report on the proposed rules has been presented to the Senate Health and Human Services Committee and the House of Representatives Health and Welfare Committee. The rules are effective five days after publication in the *State Register*.

The temporary rules adopted under the provision of Laws of Minnesota 1984, chapter 641, section 22, subdivision 6 and Minnesota Statutes, section 256B.431, subdivision 6, shall have the force and effect of law and remain in effect until June 30, 1986, unless otherwise superseded by rule.

The Department of Human Services' authority for adoption of these rules is found in Laws of Minnesota 1984, chapter 641 and Minnesota Statutes, section 256B.41, 256B.21, 256B.431, subdivisions 1, 2 c, and 6.

The purpose of the proposed rules is to implement a case mix reimbursement system which bases nursing home operating costs payments on the condition and needs of residents in each home. This system entails ongoing assessment of resident needs to determine to which of eleven payment classifications each resident belongs. For purposes of establishing these prospective payment rates, operating costs are divided into two parts; "care related" and "other operating" costs. Separate limitations and incentives are established for each of these two parts.

This rule will impact the operating costs payment rate for nursing homes licensed under Minnesota Statutes, chapter 144A or boarding care facilities licensed under Minnesota Statutes, section 144.50 to 144.58 participating in the Medical Assistance Program.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

The rule contains parts including:

— scope;

— definitions;

— establishment of geographic groups;

— allocation of fringe benefits and payroll taxes, and raw food costs;

— determination of the allowable historical operating costs per diems;

— determination of the operating cost adjustment factors and limits;

— determination of the operating cost payment rate;

— determination of the interim and settle-up operating costs payment rates;

— resident classes and class weight; and

— resident assessment.

Procedures for assessment and classification of residents by the Minnesota Department of Health in accordance with parts 9549.0050 to 9549.0059 [Temporary] are found in proposed Minnesota Rules, parts 4656.0001 to 4556.0006 [Temporary].

The fiscal impact of this rule is approximately budget neutral. The rule will not result in additional state or county spending in excess of $100,000 annually beyond the amount of funds appropriated by the legislature.

A free copy of the proposed temporary rule may be obtained by contacting Mary Ann Bredesen, Department of Human Services, Space Center, 444 Lafayette Road, 6th Floor, St. Paul, Minnesota 55101.

March 25, 1985

Leonard W. Levine
Commissioner of Human Services

Temporary Rules as Proposed (all new material)

DEPARTMENT OF HUMAN SERVICES
NURSING HOME PAYMENT RATE DETERMINATION [Temporary]

9549.0050 [Temporary] SCOPE.

Parts 9549.0050 to 9549.0059 [Temporary] establish procedures for determining the operating cost payment rates for all nursing homes participating in the medical assistance program. Parts 9549.0050 to 9549.0059 [Temporary] are effective for rate years beginning on or after July 1, 1985. Procedures for assessment and classification of residents by the Department of Health in accordance with parts 9549.0050 to 9549.0059 [Temporary] are found in parts 4656.0010 to 4656.0070.

9549.0051 [Temporary] DEFINITIONS.

Subpart 1. Applicability. As used in parts 9549.0050 to 9549.0059 [Temporary], the following terms have the meanings given them.

Subp. 2. Assessment form. "Assessment form" means the form developed by the Department of Health Quality Assurance and Review Program which was in effect on March 1, 1984, and used for performing resident assessments. The assessment form is incorporated by reference. It is available at Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155. It is available through Minitex interlibrary loan system. This form is not subject to frequent change.

Subp. 3. Base year. "Base year" means the reporting year ending September 30, 1984.

Subp. 4. Case mix index. "Case mix index" means the sum of the results obtained by multiplying the number of residents in each resident class in each home by the weights listed in part 9549.0058 [Temporary].

Subp. 5. Case mix operating costs. "Case mix operating costs" means the operating costs listed in part 9549.0040, subpart 5, as proposed in *State Register*, Volume 9, page 1716, February 4, 1985, and the portion of fringe benefits and payroll taxes allocated to the nursing services cost category in accordance with part 9549.0053.

Subp. 6. Case mix score. "Case mix score" means the case mix index divided by the total number of residents in each home.

Subp. 7. Medical plan of care. "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatment and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures, and discharge potential.

Subp. 8. Other care related operating costs. "Other care related operating costs" means the operating costs listed in part

9549.0040, subpart 6, as proposed in *State Register*, volume 9, page 1716, February 4, 1985, and the portion of fringe benefits and payroll taxes allocated to the other care related cost category in accordance with part 9549.0053 and the cost of food.

Subp. 9. Other operating costs. "Other operating costs" means the operating costs listed in part 9549.0040, subparts 1, 2, 3, 4, and 7, and the portion of fringe benefits and payroll taxes allocated to each of these operating costs categories in accordance with part 9549.0053, excluding the cost of food.

Subp. 10. Quality assurance and review of QAR. "Quality assurance and review" or "QAR" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. 11. Resident class. "Resident class" means each of the 11 categories established in part 9549.0058 [Temporary].

Subp. 12. Resident plan of care. "Resident plan of care" for residents of nursing homes not licensed as boarding care homes means the patient care plan specified in part 4655.6000. "Resident plan of care" for residents of nursing homes licensed as boarding care homes means the overall plan of care as defined in Code of Federal Regulations, title 42, section 442.319, as amended through December 31, 1984.

Subp. 13. Standardized resident days. "Standardized resident days" means the sum of the number of resident days in the nursing home in each resident class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary]. For the rate years beginning on July 1, 1985, and July 1, 1986, standardized resident days must be determined in accordance with part 9549.0054 [Temporary], subparts 1 and 2.

9549.0052 [Temporary] ESTABLISHMENT OF GEOGRAPHIC GROUPS.

The commissioner shall classify Minnesota nursing homes according to their geographic location as indicated in subparts 1 to 3.

Subpart 1. Group 1. All nursing homes in Beltrami, Big Stone, Cass, Chippewa, Clearwater, Cottonwood, Crow Wing, Hubbard, Jackson, Kandiyohi, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, McLeod, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Yellow Medicine, and Wadena counties must be placed in geographic group 1.

Subp. 2. Group 2. All nursing homes in counties other than the counties listed under subparts 1 and 3 must be placed in geographic group 2.

Subp. 3. Group 3. All nursing homes in Aitkin, Anoka, Carlton, Carver, Cook, Dakota, Hennepin, Itasca, Koochiching, Lake, Ramsey, St. Louis, Scott, and Washington counties must be placed in geographic group 3.

9549.0053 DETERMINATION AND ALLOCATION OF FRINGE BENEFITS AND PAYROLL TAXES, AND FOOD COSTS.

Subpart 1. Fringe benefits and payroll taxes. Fringe benefits and payroll taxes must be allocated to case mix, other care-related costs, and other oeprating costs according to items A to D.

A. Fringe benefits and payroll taxes must be allocated to case mix operating costs in the same proportion to salaries reported under part 9549.0040, subpart 5, as proposed in *State Register*, volume 9, page 1716, February 4, 1985.

B. Fringe benefits and payroll taxes must be allocated to other care-related costs in the same proportion to salaries reported under part 9549.0040, subpart 6, as proposed in *State Register*, volume 9, page 1716, February 4, 1985.

C. Fringe benefits and payroll taxes must be allocated to other operating costs in the same proportion to salaries reported under part 9549.0040, subparts 1, 2, 3, 4, and 7, as proposed in State Register, volume 9, page 1716, February 4, 1985.

D. For any nursing home which has not separately reported each salary component of an operating cost category, the commissioner shall determine the fringe benefits and payroll taxes to be allocated under this subpart according to subitems (1) and (2).

(1) The commissioner shall determine the ratio of allowable salaries in each cost category to total allowable salaries in all cost categories for all nursing homes separately reporting allowable salaries in each cost category.

(2) The nursing home's total allowable fringe benefits and payroll taxes must be multiplied by each ratio determined in subitem (1) to determine the amount of payroll taxes and fringe benefits allocated to each cost category for each nursing home under item D.

Subp. 2. Determination of food costs. For any nursing home which has not separately reported the cost of food under part 9549.0040, subpart 1, as proposed in *State Register*, volume 9, page 1716 (February 4, 1985), the commissioner shall determine the food costs according to items A and B.

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A. The commissioner shall determine the average ratio of food costs to the total dietary costs for all nursing homes that separately reported food costs.

B. The nursing home's total allowable dietary costs must be multiplied by the ratio determined in item A to determine the food costs for that nursing home.

9549.0054 [Temporary] DETERMINATION OF THE ALLOWABLE HISTORICAL OPERATING COSTS PER DIEMS.

The commissioner shall annually review and adjust the operating costs incurred by the nursing home during the reporting year preceding the rate year to determine the nursing home's actual allowable historical operating costs. The review and adjustment must comply with the provisions of parts 9549.0010 to 9549.0080, as proposed in *State Register*, volume 9, page 1716 (February 4, 1985).

Subpart 1. Standardized resident days for rate year beginning July 1, 1985. For the rate year beginning on July 1, 1985, each nursing home's standardized resident days must be determined according to items A to H.

A. The commissioner shall select the two most recent QAR assessments completed prior to April 1, 1985. If only one QAR assessment is available, the commissioner shall compute the standardized resident days in accordance with item I.

B. For each of the two QAR assessments selected in item A, the medical assistance case mix index must be the sum of the number of medical assistance residents in each resident class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

C. The medical assistance case mix index for each QAR assessment determined in item B must be divided by the total number of medical assistance residents in order to compute the medical assistance case mix score.

D. The average monthly change in the medical assistance case mix score must be computed by subtracting the most recent medical assistance case mix score from the previous medical assistance case mix score and dividing the result by the number of months between the two QAR assessments dates. For any partial calendar month, the commissioner shall count as a full month any period of more than 14 days and shall disregard periods of 14 days or less.

E. The average medical assistance case mix score must be determined by subtracting from the most recent medical assistance case mix score, the product of the average monthly change in the medical assistance case mix score times the number of months from April 1, 1984, to the date of the most recent QAR assessment. For a partial calendar month, the commissioner shall count as a full month the period of more than 14 days, and shall disregard periods of 14 days or less.

F. The commissioner shall compute the private pay adjustment ratio in accordance with subitems (1) to (3).

(1) Using the method described in item C, compute the private pay case mix score for private paying residents for each nursing home whose most recent QAR assessment included assessments of private paying residents.

(2) Compute a ratio by dividing the private pay case mix score in subitem (1) by the medical assistance case mix score in item C for that QAR assessment.

(3) Compute the private pay adjustment ratio by determining the average of all ratios determined in subitem (2).

G. The commissioner shall determine the private pay average case mix score for each nursing home by multiplying the private pay adjustment ratio determined in item F, subitem (3) times the average medical assistance case mix score determined in item E.

H. The commissioner shall compute the standardized resident days in accordance with subitems (1) to (3).

(1) Multiply the private pay resident days during the reporting year by the average private pay case mix score as determined in item G.

(2) Multiply the medical assistance resident days during the reporting year by the average medical assistance case mix score as determined in item E.

(3) The standardized resident days must be the sum of subitems (1) and (2).

I. If only one QAR assessment is available, the commissioner shall compute the standardized resident days in accordance with subitems (1) to (3).

(1) The case mix index must be the sum of the number of residents in each class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

(2) The case mix score must be computed by dividing the case mix index in subitem (1) by the total number of residents.

(3) The case mix score must be multiplied by the total number of resident days during the reporting year to determine the standardized resident days.

Subp. 2. Standardized resident days for rate year beginning July 1, 1986. For the rate year beginning on July 1, 1986, each nursing home's standardized resident days must be determined in accordance with items A to C.

A. The resident days in each resident class for the months of July, August, and September 1985, must be multiplied by 3.9674 to determine the annualized resident days.

B. For each resident class, the annualized resident days determined in item A, must be multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

C. The amounts determined in item B must be summed to determine the nursing home's standardized resident days for the reporting year.

Subp 3. Allowable historical case mix operating cost standardized per diem. The allowable historical case mix operating cost standardized per diem must be computed by dividing the allowable historical case mix operating cost by the standardized resident days determined in subpart 1 and 2.

Subp. 4. Allowable historical other care related operating cost per diem. The allowable historical other care related operating cost per diem must be computed by dividing the allowable historical other care related operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period, except that a nursing home that is certified to provide a skilled level of care and that has an average length of stay of 180 days or less in their skilled level of care must divide the allowable historical other care related operating costs by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

Subp. 5. Allowable historical other operating cost per diem. The allowable historical other operating cost per diem must be computed by dividing the allowable historical other operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period, except that a nursing home that is certified to provide a skilled level of care and that has an average length of stay of 180 days or less in their skilled level of care must divide the allowable historical other operating costs by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

9549.0055 [Temporary] DETERMINATION OF THE OPERATING COST ADJUSTMENT FACTORS AND LIMITS.

Subpart 1. Annual adjustment factors. The annual adjustment factors must be determined according to items A and B.

A. The annual adjustment factor for the case mix and other care-related operating costs must be established according to subitems (1) to (4).

(1) The components and indices for the case mix and other care related operating costs adjustment factor must be as specified in the following table.

CASE MIX AND CARE RELATED COMPONENTS AND INDICES

Component	Weight	Index
Salaries	.7347	Average hourly earnings of employees in nursing and personal care facilities (SIC 805).
Benefits	.1107	Difference between movements in compensation and wages and salary index components of the Employment Cost Index for Service Workers.
Supplies and Drugs	.0363	Consumer Price Index for nonprescription medical equipment and supplies
Food	.1183	Producer Price Index for consumer foods.
TOTAL	1.0000	

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(2) The average price index for the reporting year must be computed by multiplying the weight for each component contained in subitem (1) by the average index for that component for the reporting year and adding the products.

(3) The average forecasted price index for the rate year immediately following the reporting year must be computed by multiplying the weight for each component contained in subitem (1) by the average forecasted index for that component for the rate year and adding the products.

(4) The adjustment factor for the case mix and other care related operating costs must be computed by dividing the amount computed in subitem (3) by the amount computed in subitem (2).

B. The annual adjustment factor for the other operating costs must be established according to subitems (1) to (4).

(1) The components and indices for the other operating cost adjustment factor must be as specified in the following table.

OTHER OPERATING COSTS COMPONENTS AND INDICES

Component	Weight	Index
Utilities	.1099	Producer Price Index for natural gas (80 percent); and Producer Price Index for commercial power in west north central state (20 percent). This index is incorporated by reference.
Salaries	.5864	Average hourly earnings of employees in nursing and personal care facilities (SIC 805). This index is incorporated by reference.
Benefits	.0799	Difference between movements in compensation and wages and salaries index components of the Employment Cost Index for Service Workers. This index is incorporated by reference.
Additional Professional Services	.1107	Employment Cost Index for wages and salaries of professional and technical workers. This index is incorporated by reference.
Additional Miscellaneous Service Purchases	.0322	Consumer Price Index for maintenance and repair services. This index is incorporated by reference.
Miscellaneous Purchases (Commodities)	.0809	Consumer Price Index for maintenance and repair commodities. This index is incorporated by reference
TOTAL	1.0000	

(2) The average price index for the reporting year must be computed by multiplying the weight for each component contained in subitem (1) by the average index value for that component for the reporting year and adding the products.

(3) The average forecasted price index for the rate year immediately following the reporting year must be computed by multiplying the weight for each component contained in subitem (1) by the forecasted average index values for that component for the same rate year and adding the products.

(4) The adjustment factor for the other operating costs must be computed by dividing the amount computed in subitem (3) by the amount computed in subitem (2).

Subp. 2. Limits. For each geographic group established in part 9549.0052 [Temporary] the operating costs limits must be determined according to items A to F. No redetermination of the operating costs limits shall be made due to audit adjustments or appeal settlement.

A. The commissioner shall compute 115 percent of the median of the array of the allowable historical case mix related operating cost per diems for the base year.

B. The commissioner shall compute 115 percent of the median of the array of the allowable historical other care related operating cost per diems for the base year.

C. The total care related operating cost limit for each resident class must be determined by multiplying the amount determined in item A by the weight for each resident class and adding the amount determined in item B.

D. The commissioner shall disallow any portion of the general and administrative cost category, exclusive of fringe benefits and payroll taxes that exceeds 15 percent of the allowable expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administrative.

E. The other operating costs limits must be determined in accordance with subitems (1) to (3).

(1) For geographic group in 9549.0052 [Temporary], the commissioner shall group all hospital attached nursing homes, all nursing homes with an average length of stay of 180 days or less in their skilled nursing level of care, and nursing homes licensed on May 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600.

(2) For each geographic group in part 9549.0052 [Temporary], the commissioner shall group all nursing homes not included in subitem (1).

(3) The other operating cost limit for each group established in subitems (1) and (2) must be 105 percent of the median of the array of the allowable historical other operating cost per diems for each nursing home in the group for the base year.

F. The commissioner may establish a different base year once within a five-year period.

Subp. 3. Incorporations by reference. The references for the indices specified in this part are listed in items A to D, and are available through the Minitex interlibrary loan system. The references in items A to D are subject to frequent change.

A. The index for average hourly earnings of employees in nursing and personal care facilities is published monthly in "Employment and Earnings," Bureau of Labor Statistics, United States Department of Labor. (SIC 805) Standard Industrial Code 805 is the code used for employees in nursing and personal care facilities in this publication.

B. The Employment Cost Index for Service Workers and the Employment Cost Index for wages and salaries of professional and technical workers are published monthly in "Current Wage Developments," Bureau of Labor Statistics, United States Department of Labor.

C. The Consumer Price Index for nonprescription medical equipment and supplies and the Consumer Price Index for maintenance and repair commodities are published in the "Monthly Labor Review," Bureau of Labor Statistics, United States Department of Labor.

D. The Producer Price Index for consumer foods, the Producer Price Index for natural gas, and the Producer Price Index for commercial power in west north central states are published monthly in "Producer Prices and Price Indices," Bureau of Labor Statistics, United States Department of Labor.

9549.0056 [Temporary] DETERMINATION OF THE OPERATING COST PAYMENT RATE.

Subpart 1. Nonadjusted case mix and other care related payment rate. For each nursing home, the nonadjusted case mix and other care related payment rate for each resident class must be determined according to items A to D.

A. The nursing home's allowable historical case mix operating cost standardized per diem established in part 9549.0054 [Temporary], subpart 3, must be multiplied by the weight for each resident class listed in part 9549.0058 [Temporary].

B. The allowable historical other care related operating cost per diem established in part 9549.0054 [Temporary], subpart 4, must be added to each weighted per diem established in item A.

C. If the amount determined in item B for each resident class is below the limit for that resident class and group established in part 9549.0055 [Temporary], subpart 2, item C, the nursing home's nonadjusted case mix and other care related payment rate must be the amount determined in item B for each resident class.

D. If the amount determined in item B for each resident class is at or above the limit for that resident class and group established in part 9549.0055 [Temporary], subpart 2, item C, the nursing home's nonadjusted case mix and other care related payment rate must be set at the limit.

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Subp. 2. Adjusted prospective case mix and other care related payment rate. For each nursing home, the adjusted prospective case mix and other care related payment rate for each resident class must be the nonadjusted case mix and other care related payment rate multiplied by the case mix and other care related adjustment factor determined in part 9549.0055 [Temporary], subpart 1, item A.

Subp. 3. Nonadjusted other operating cost payment rate. The nonadjusted other operating cost payment rate must be determined according to items A and B.

A. If the allowable historical other operating cost per diem determined in part 9549.0054 [Temporary], subpart 5, is below the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, subitem (3), the nursing home's nonadjusted other operating cost payment rate must be the allowable historical other operating cost per diem.

B. If the allowable historical other operating cost per diem determined in part 9549.0054 [Temporary], subpart 5, is at or above the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, subitem (3), the nursing home's nonadjusted other operating cost payment rate must be set at that limit.

Subp. 4. Adjusted prospective other operating cost payment rate. The adjusted prospective other operating cost payment rate must be determined according to items A and B.

A. If the nursing home's nonadjusted other operating cost payment rate is below the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, subitem (3), the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item H, multiplied by the other operating cost adjustment factor determined in part 9549.0055 [Temporary], subpart 1, item B, plus an efficiency incentive equal to the difference between the limit in part 9549.0055 [Temporary], subpart 2, item E, subitem (3), and the nonadjusted other operating cost payment rate in subpart 3 up to maximum of two dollars.

B. If the nursing home's nonadjusted other operating cost payment rate is at or above the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, subitem (3), the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item B, multiplied by the other operating cost adjustment factor determined in part 9549.0055 [Temporary], subpart 1, item B.

Subp. 5. Total operating cost payment rate. The nursing home's total operating cost payment rate must be the sum of the adjusted prospective case mix and other care related payment rate determined in subpart 2 and the adjusted other operating cost payment rate determined in subpart 4.

9549.0057 [Temporary] DETERMINATION OF THE INTERIM AND SETTLE-UP OPERATING COST PAYMENT RATES.

To receive an interim payment rate, a nursing home must comply with the requirements and is subject to the conditions of part 9549.0060, subpart 14, items A to C. The commissioner shall determine interim and settle-up operating cost payment rates for a newly constructed nursing home, or one with a capacity increase of 50 percent or more according to subparts 1 and 2.

Subpart 1. Interim operating cost payment rate. For the rate year or portion of an interim period beginning on or after July 1, 1985, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 [Temporary], except that:

A. Each nursing home must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in part 9549.0058 [Temporary] to determine the anticipated standardized resident days for the reporting period.

B. The commissioner shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The commissioner shall use the anticipated resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem. Ninety percent of licensed beds multiplied by the number of days in the reporting period must not be used in determining these per diems.

D. The annual adjustment factors determined in part 9549.0055 [Temporary], subpart 1, must not be applied to the nursing home's allowable historical per diems as provided in part 9549.0056 [Temporary], subparts 2 and 4.

E. The limits established in part 9549.0055 [Temporary], subpart 2, items C and E, must be increased by ten percent.

F. The efficiency incentive in part 9549.0056 [Temporary], subpart 4, item A, must not apply.

Subp. 2. Settle-up operating cost payment rate. The settle-up total operating cost payment rate must be determined according to items A to C.

A. The settle-up operating cost payment rate for a nursing home which commenced construction before July 1, 1985, is determined under 12 MCAR § 2.05014 [Temporary] for the interim period before July 1, 1985.

B. The settle-up operating cost payment rate for a nursing home which commenced construction after June 30, 1985, or whose interim reporting period included a period of time after that date must be determined for the portion of that interim period occurring after June 30, 1985, as in parts 9549.0050 to 9549.0059 [Temporary].

(1) The standardized resident days occurring after July 1, 1985, must be annualized for the interim reporting period.

(2) The commissioner shall use the annualized standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

(3) The commissioner shall use the actual resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem. Ninety percent of licensed beds multiplied by the number of days in the reporting period must not be used in determining these per diems.

(4) The annual adjustment factors determined in part 9549.0055 [Temporary], subpart 1, must not be applied to the nursing home's allowable historical per diems as provided in part 9549.0056 [Temporary], subparts 2 and 4.

(5) The limits established in subpart 1, item E, must be the limits for the settle-up reporting period occurring after July 1, 1985.

(6) The efficiency incentive in part 9549.0056 [Temporary], subpart 4, item A, must not apply.

C. For the nine-month period following the settle-up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive in part 9549.0056 [Temporary], subpart 4, item A, shall apply.

9549.0058 [Temporary] RESIDENT CLASSES AND CLASS WEIGHTS.

Subpart 1. Resident classes. Each resident must be classified according to items A to E based on the assessments performed under part 9549.0059 [Temporary] on the assessment form.

A. Each nursing home resident or applicant must be assessed as dependent in an activity of daily living or ADL according to the following table:

ADL	Dependent if Score At or Above
Dressing	2
Grooming	2
Bathing	4
Eating	2
Bed mobility	2
Transferring	2
Walking	2
Toileting	1

B. Each nursing home resident assessed as dependent in fewer than four of the ADL's in item A must be defined as Low ADL. Each resident assessed as dependent in four through six of the ADL's in item A must be defined as Medium ADL. Each resident assessed as dependent in seven or eight of the ADL's in item A must be defined as High ADL.

C. Each resident must be defined as special nursing according to subitems (1) and (2).

(1) the resident is assessed to require tube feeding; or

(2) the resident is assessed to require clinical monitoring including evening and night shifts plus one or more of the following special treatments on the assessment form:

(a) oxygen and respiratory therapy;

(b) ostomy care;

(c) care of dressings;

(d) skin care;

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(e) IV therapy;

(f) drainage tubes;

(g) blood transfusions; or

(h) hyperalimentation.

D. Each resident must be defined as having a neuromuscular condition if the resident is assessed to have one or more of the diagnoses coded to the following categories according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), as published by the Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Michigan (1978). This publication is incorporated by reference. This is available through the Minitex interlibrary loan system. This is not subject to frequent change.

(1) diseases of nervous system excluding sense organs (320-359);

(2) cerebrovascular disease (430-438);

(3) fracture of skull (800-804), excluding cases without intracranial injury;

(4) intercranial injury, excluding those with skull fracture (850-854);

(5) fracture of vertebral column with spinal cord injury (806);

(6) spinal cord injury without evidence of spinal bone injury (952); or

(7) injury to nerve roots and spinal plexus (953).

E. Each resident must be defined as having a behavioral condition if the resident's assessment score is three or more for behavior on the assessment form.

F. The commissioner shall establish resident classes based on the definitions in items A to E and according to subitems (1) to (11).

(1) Class A. Low ADL, and not defined behavioral condition, and not defined special nursing.

(2) Class B. Low ADL, and defined behavioral condition, and not defined special nursing.

(3) Class C. Low ADL, and defined special nursing.

(4) Class D. Medium ADL, and not defined behavioral condition, and not defined special nursing.

(5) Class E. Medium ADL, and defined behavioral condition, and not defined special nursing.

(6) Class F. Medium ADL, and defined special nursing.

(7) Class G. High ADL, and scoring less than three on the eating ADL in item A, and not defined special nursing, and not defined behavioral condition on assessment form.

(8) Class H. High ADL, and scoring less than three on eating ADL in item A, and defined behavioral condition, and not defined special nursing.

(9) Class I. High ADL, and scoring three or four on eating ADL in item A, and not defined special nursing, and not defined neuromuscular condition.

(10) Class J. High ADL, and defined neuromuscular condition, and scoring three or four on the eating ADL in item A, and not defined special nursing.

(11) Class K. High ADL, and defined special nursing.

Subp. 2. Class weights. The commissioner shall assign weights to each resident class established in subpart 1, item F, according to items A to K.

A. Class A, 1.00;

B. Class B, 1.30;

C. Class C, 1.64;

D. Class D, 1.95;

E. Class E, 2.27;

F. Class F, 2.29;

G. Class G, 2.56;

H. Class H, 3.07;

I. Class I, 3.25;

J. Class J, 3.53;

K. Class K, 4.12.

9549.0059 [Temporary] RESIDENT ASSESSMENT.

Subpart 1. Assessment of nursing home applicants and newly admitted residents. Each nursing home applicant or newly admitted resident shall be assessed for the purpose of determining the applicant's or newly admitted resident's class according to items A to I.

A. Each county preadmission screening team or hospital screening team under contract with the county must assess all nursing home applicants for whom preadmission screening is required by Minnesota Statutes, section 256B.091, and any applicant for whom a preadmission screening is not required but who voluntarily requests such a screening in accordance with Minnesota Statutes, section 256B.091, except as provided in subitems (1) and (2).

(1) The public health nurse of the county preadmission screening team or the RN case manager shall assess a nursing home applicant, if the applicant was previously screened by the county preadmission screening team and the applicant is receiving services under the Alternative Care Grants program defined in part 9505.2340 or under the medical assistance program.

(2) A nursing home applicant whose admission to the nursing home is for the purpose of receiving respite care services under the Alternative Care Grants program or under the medical assistance program need not be reassessed more than once every six months for the purpose of computing resident days under part 9549.0054 [Temporary], subpart 2, if the applicant has been classified by the Department of Health within the prior six-month period. In this case, the resident class established by the Department of Health within the prior six-month period may be the resident class of the applicant.

B. Each nursing home must assess each applicant or newly admitted resident for whom a preadmission screening is not required by Minnesota Statutes, section 256B.091, or is not requested voluntarily in accordance with Minnesota Statutes, section 256B.091. For purposes of this item, a newly admitted resident includes a resident who moves to a section of the nursing home which is licensed differently than the section from which the resident came or a resident who has been transferred from another nursing home. Each assessment must be performed by the registered nurse who signs the assessment form.

C. The assessment required by this subpart must be performed within ten working days before or ten working days after the date the applicant is admitted to the nursing home.

D. The nursing home must perform the assessment for any resident who is required to be assessed by the preadmission screening team under item A and who has received a prior preadmission screening and for whom the assessment required under this subpart has not been performed by the preadmission screening team within ten working days before or ten working days after the date the applicant is admitted to the nursing home. The nursing home must perform the assessment and submit the forms to the Department of Health within 15 working days after admission.

E. A registered nurse performing the assessment must sign the assessment form.

F. The assessment of each applicant or newly admitted resident must be based on the QAR procedures of the Department of Health, and must be recorded on the assessment form defined in part 9549.0051 [Temporary], subpart 2.

G. The preadmission screening team or hospital screening team under contract with the county must provide the completed assessment form to the nursing home, and provide a copy to the Department of Health, within five working days following the assessment.

H. Each assessment completed in accordance with items A to G and a completed medical plan of care must be submitted to the Department of Health by the nursing home as a request for classificiation within ten working days after admission or after the assessment, whichever is later.

I. The resident class for nursing home applicants or newly admitted residents must be effective on the date of admission to the nursing home.

Subp. 2. Assessment of residents for July 1, 1985, rate year. For the July 1, 1985, rate year only, each nursing home must assess each resident whose name does not appear on the Department of Health's May 15, 1985, classification list under the procedures prescribed by subpart 3, item B. The nursing home must submit a request for classification for each resident assessed by

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the nursing home to the Department of Health by June 1, 1985. The request for classification must include the completed assessment form and the resident's plan of care. For any resident admitted after June 1, 1985, the procedure outlined in subpart 1 must be followed.

Subp. 3. Semi-annual assessment by nursing homes. Semiannual assessments of residents by the nursing home must be completed in accordance with items A to E.

A. A nursing home must assess each of its residents no earlier than 170 days and no later than 190 days after the date of the most recent QAR assessment.

B. A registered nurse shall perform the assessment on each resident according to QAR procedures established by the Department of Health including physical observation of the resident, review of the medical plan of care, and review of the resident's care plan, and shall record the assessment on the assessment form defined in part 9549.0051 [Temporary], subpart 2. The registered nurse performing the assessment shall sign the assessment form.

C. Within five working days of the completion of the nursing home's semiannual resident assessments, the nursing home must forward to the Department of Health requests for classification for all residents assessed for the semiannual assessment. These requests must include the assessment forms, the resident plans of care, and the nursing home's daily census for the date on which the assessments were completed including an explanation of any discrepancy between the daily census and the number of assessments submitted. The nursing home must provide further information to the Department of Health if the Department of Health requests it in order to determine a resident's classification.

D. Any change in resident class due to a semi-annual assessment must be effective as of the first day of the month following the date of the Department of Health's classification.

E. For the rate year beginning July 1, 1985, only, a nursing home must assess residents according to subitems (1) to (4).

(1) In July 1985, the nursing home must assess all residents whose most recent QAR assessments were performed in October or November 1984.

(2) In August 1985, the nursing home must assess all residents whose most recent QAR assessments were performed in December 1984, or January 1985.

(3) In September 1985, the nursing home must assess all residents whose most recent QAR assessments were performed in February or March 1985.

(4) For residents assessed according to subitems (1) to (3), the nursing home must submit a request for classification for each resident assessed including the assessment form and a copy of the resident's plan of care to the Department of Health no later than the end of the calendar month when the assessments are required. The nursing home must provide further information to the Department of Health if requested by the Department of Health in order to determine a resident's classification. For each assessment performed in subitems (1) to (3), the resident classification determined by the Department of Health shall remain in effect until an assessment is performed under subpart 4 or 5.

Subp. 4. Change in classification due to annual assessment by Department of Health. Any change in resident class due to an annual assessment by the Department of Health's QAR team will be effective as of the first day of the month following the date of the Department of Health's assessment.

Subp. 5. Assessment upon return to the nursing home from a hospital. Residents returning to a nursing home after hospitalization must be assessed according to items A to C.

A. A nursing home must assess any resident who has returned to the same nursing home after a hospital admission. The assessment shall occur no more than five working days after the resident returns to the same nursing home.

B. A registered nurse shall perform the assessment on each resident according to QAR procedures established by the Department of Health, including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form defined in part 9549.0051 [Temporary], subpart 2. The registered nurse who performs the assessment shall sign the assessment form. Within five working days of the completion of the assessment, the nursing home must forward to the Department of Health a request for a classification for any resident assessed upon return to a nursing home after a hospital admission. This request must include the assessment form, the hospital discharge summary, and the resident's plan of care. Upon request, the nursing home must furnish the Department of Health with further information when required in order to determine a resident's classification.

C. Any change in resident class due to an assessment provided under this subpart must be effective as of the date the resident returns to the nursing home from the hospital.

Subp. 6. Change in resident class due to audits of assessments of nursing home residents. Any change in resident class due to a reclassification required by part 4656.0060 must be effective as of the first day of the month following the date of the Department of Health's classification.

Subp. 7. Change in resident class due to request for reconsideration of resident classification. Any change in a resident class due to a request for reconsideration of the classification must be made in accordance with items A and B.

A. The resident classification established by the Department of Health must be the classification that applies to the resident while any request for reconsideration under part 4546.0060 is pending.

B. Any change in a resident class due to a reclassification under part 4546.0060 must be effective as of the date of the assessment for which a reconsideration was requested.

Subp. 8. Reconsideration of resident classification. Any request for reconsideration of a resident classification must be made pursuant to the procedures set forth in part 4546.0060.

Waste Management Board

Proposed Rules Relating to Development Grants for Waste Processing and Collection Facilities

Notice of Intent to Adopt Rules without a Public Hearing

Notice is hereby given that the Minnesota Waste Management Board proposes to adopt the above-entitled rules without a public hearing. The Waste Management Board has determined that the proposed adoption of these rules will be noncontroversial in nature and has elected to follow the procedures set forth in Minnesota Statutes Sections 14.22 to 14.28.

Persons interested in these rules have 30 days to submit comments in support of or in opposition to the proposed rules. The Board encourages public comment on these proposed rules. Each comment should identify the portion of the proposed rule addressed by the comment, the reason for the comment, and any change that is proposed. The proposed rules may be modified if the modifications are supported by the data and views submitted to the agency and do not result in a substantial change in the proposed language.

If twenty-five (25) or more persons submit written requests for a public hearing on the proposed rules within the 30-day comment period, a public hearing will be held. Persons requesting a hearing are encouraged to identify the reasons for their request, the portion of the proposed rules that the hearing should address, and proposed changes. In the event a public hearing is required, the Board will proceed according to the provisions of Minnesota Statutes Section 14.14 to 14.20.

Persons who wish to submit comments or a written request for a public hearing should submit the comments or request to:

Jerry Johnson
123 Thorson Building
7323 - 58th Avenue North
Crystal, MN 55428
(612) 536-0816

Authority to adopt rules for hazardous waste processing facility grants is contained in Minnesota Statutes Section 115A.06 Subd. 2 and 115A.156. The Board is authorized by these sections to adopt rules for the administration of hazardous waste processing facility grants. The grants are intended to help determine the feasibility of developing and operating specific types of commercial facilities and services for processing hazardous waste. Accordingly, the proposed rules include eligibility criteria, information which shall be included in an application, procedures for initial review of applications, procedures and criteria for evaluating grant applications, provisions related to the awarding of grants and required content of grant agreements.

Authority to adopt rules for hazardous waste processing facility loans is contained in Minnesota Statutes Sections 115A.06 Subd. 2 and 115A.162. The Board is authorized by these sections to adopt rules to administer the certification of hazardous waste processing facility loan applications received by the Minnesota Energy and Economic Development Authority. The loans are intended to fund the construction of hazardous waste processing facilities or services. The proposed rules include provisions for initial application review, evaluation of loan applications and certification of loan applications.

Upon adoption of the final rules without a public hearing, the proposed rules, this notice, all written comments received, and the final rules as adopted will be delivered to the Attorney General for review as to form and legality, including the issue of substantial change. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy

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STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF PROPOSED TEMPORARY RULES FOR DETERMINING OPERATING COST PAYMENT RATES FOR NURSING HOMES PARTS 9549.0050 TO 9549.0059 (TEMPORARY).

FINDINGS OF FACT AND CONCLUSIONS

The Commissioner published notice of the proposed temporary rules on the above entitled matter in the State Register promulgated pursuant to Minnesota Statutes 256B.431, Subdivision 6 on April 8, 1985. Notice was also sent by United States mail to all persons on a list maintained by the Department pursuant to Minnesota Statutes, Section 14.14, Subdivision 1 on April 3, 1985. After affording all interested and affected persons an opportunity to submit comments for 20 days after the notice, and reviewing and considering the comments, I find the following:

1. In Part 9549.0051, Subp. 8, [Temporary] of the 4/10/85 draft of the proposed rule, page 2, lines 15-21, the Department specified that "Other Care Related Operating Costs" means the operating costs listed in Part 9549.0040, Subpart 6, as proposed in the State Register, Volume 9, Page 1716, February 4, 1985, and the portion of fringe benefits and payroll taxes allocated to the other care related cost category in accordance with Part 9549.0053 and the cost of food.". Commenters Margaret Stewart, representing Twin City Consulting Dieticians and Sergei Shvetzoff, representing the Minnesota Association of Health Care Facilities (MAHCF) pointed out that nutritional care provided by consulting dieticians and portions of the time spent by dietary supervisors should be recognized as directly related to resident care and, therefore, should have been included in the other care related portion of the rate. The Commissioner finds that nutritional care provided by consulting dieticians and dietary supervisors should be addressed in the other care related portion of the rate. Inclusion of a portion of these costs in the other care related portion of the rate would be beneficial to care quality. Therefore, the Commissioner clarifies the definition of other care related costs to add

"and the required dietician consulting fees charged by a non-related organization." In addition, the Commissioner adds the following to Part 9549.0053 [Temporary] and amends the title accordingly:

"Subp. 3. Determination of required dietician consulting fees. For any nursing home which has not separately reported required dietician consulting fees charged by a non-related organization, the Commissioner shall determine the required dietician consulting fees according to items A, to C.

A. The Commissioner shall determine the average cost per licensed bed of dietician consulting fees charged by a non-related organization for all nursing homes that separately reported dietician consulting fees.

B. The nursing home's total number of licensed beds must be multiplied by the amount determined in item A to determine the required dietician consulting fees for that nursing home."

C. The amount determined in item B must be subtracted from the total dietary salary cost.

2. Part 9549.0054, Subp. 1, item C, page 5, lines 23-26, specifies that "The Medical Assistance case mix index from each QAR assessment determined in item B must be divided by the total number of Medical Assistance residents in order to compute the Medical Assistance case mix score".

However, the situation could arise that a nursing home may not have any Medical Assistance residents in its most recent QAR assessment. If so, the Medical Assistance case mix score would be inaccurate when computed by this method. Therefore, the Commissioner has made a clarification to the rule to provide for this situation by adding a provision to item C which states:

"If the total number of Medical Assistance residents is equal to 0 in the most recent QAR assessment, the Medical Assistance case mix score must be the private pay case mix score determined in item F, subitem 1)."

.3 In part 9549.0054 [Temporary], Subpart 1, item D, page 5, lines 27-31, the Department specified that "the average monthly change in the Medical Assistance case mix score must be computed by subtracting the most recent Medical Assistance case mix score from the previous Medical Assistance case mix score and dividing the result by the number of months between the two QAR assessments dates". Commenter Kristin Larson, representing Minnesota Association of Homes for the Aging, (MAHA) pointed out that the order of the words "previous" and "most recent" were reversed.
The Commissioner finds that the reversal of the words "previous" and "most recent" in this sentence would impair the correct computation of the case mix score. Therefore, the Commissioner modifies this sentence to read "the average monthly change in the Medical Assistance case mix score must be computed by subtracting the previous Medical Assistance case mix score from the most recent Medical Assistance case mix score and dividing the result by the number of months between the two QAR assessment dates".

4. In Part 9549.0054 [Temporary] Subpart 1, item F, page 6, lines 10-12, the Department specifies procedures for determining the "private pay case mix score for private paying residents for each nursing home whose most recent QAR assessment included assessments of private paying residents". Commenter Joelyn Malone, from Seniors Plus, who is a member of the Rule 50 Task Force, points out that "Private Paying Resident" is specifically defined in Proposed Part 9549.0020, Subp. 35 (Permanent) and that this definition excludes residents whose payment rate is established by Medicare, the Veterans Administration or other third party payors. In addition, the definition would appear to apply to the temporary rule and thus causes confusion with the provision for computing the private pay case mix score which includes information on the case mix of residents whose payment rate is determined by Medicare, the Veterans Administration and other third party payors. The Commissioner has clarified the rule to avoid this confusion. References to "private paying residents" in Part 9549.0054 [Temporary] Subpart 1, items F and H, page 6, lines 10, 12, and 25, have been deleted and replaced with "non-Medical Assistance residents".

5. In Part 9549.0054, Subpart 1, items G, and H, page 6, lines 18-27, the Department specifies procedures for computing and applying the average private pay case mix score. The provision specifies that the average private pay case mix score be applied to all nursing homes. Commenter Joelyn Malone points out that for nursing homes where non-Medical Assistance resident QAR data is available, the private pay case mix score should be based on that home's non-Medical Assistance data rather than applying the average private pay case mix in order to avoid instability of rates from the first year to the second and subsequent years of case mix. The Commissioner finds that, for those nursing homes for which non-

Medical Assistance case mix data is available, the private pay case mix score utilized should be based on that nursing homes non-Medical Assistance data rather than the average private pay case mix score. The Commissioner clarifies Part 9549.0054, Subp. 1, items G and H as follows:

G. The Commissioner shall determine the average private pay case mix score for each nursing home in item F, subitem 1, by multiplying the private pay adjustment ratio determined in item F, subitem (3) times the average Medical Assistance case mix score determined in item E.

H. The Commissioner shall compute the standardized resident days in accordance with subitems (1) to (3).

(1) For each nursing home whose most recent QAR assessment included assessments of non-Medical Assistance residents, multiply the non-Medical Assistance resident days during the reporting year by the nursing home's private pay case mix score as determined in item F, Subitem (1). If the nursing home's QAR assessment does not include assessments of non-Medical Assistance residents, multiply the non-Medical Assistance resident days during the reporting year by the average private pay case mix score determined in item G.

6. In Part 9549.0055 [Temporary], Subpart 2, the Department specified limits for total care related operating costs and other operating costs for each geographic group (page 11, lines 2-36, page 12, lines 1-2). Three commenters, Bob Held, representing Ebenezer Caroline Center, Leroy Peterson, representing MAHA and Aileen Baseman, from Courage Residence pointed out that certain facilities with Rule 80 licenses or average lengths of stay of 180 days or less may be unique and that the new case mix system may not accommodate their programs according to preliminary estimates of the impact of the system on their facilities. The Commissioner concurs that additional study of the criteria for the 180 day length of stay category and the licensing requirements for Rule 80 facilities and their relationship to the case mix system would be beneficial to implementation of the new operating costs rate structure. The Commissioner also finds that the extent to which high costs among these facilities is related to necessary program costs is unknown and that costs among facilities vary widely. Therefore, the Commissioner has clarified the rule to adjust the operating cost limits for nursing homes licensed on May 1, 1983, to provide residential services to the physically handicapped under Parts 9570.2000 - 9570.3600 and for nursing homes having an average length of stay of 180 days or less in their skilled care units as follows:

Insert in part 9549.0055 [Temporary] Subp. 2, item C, page 11, line 21.

"For the rate year beginning July 1, 1985, the total care related

operating cost limit for nursing homes with an average length of stay of 180 days or less in their skilled nursing level of care must be 125 percent of the total care related operating cost limit. For the rate year beginning July 1, 1985, a nursing home licensed on May 1, 1983, by the Commissioner to provide residential service for the physically handicapped under Parts 9570.2000 to 9570.3600 must be exempt from the total care related operating cost limit."

In Item E, page 11, line 36, subitems (2) and (3) have been inserted and the remaining subitems and references have been adjusted accordingly:

(2) The other operating cost limit for hospital attached nursing homes in each geographic group in Part 9549.0052 [Temporary] must be 105 percent of the median of the array of the allowable historical other operating cost per diem for each nursing home in the group established under subitem (1) in the base year.

(3) The other operating cost limit for all nursing homes with an average length of stay of 180 days or less in their skilled nursing level of care, and nursing homes licensed on May 1, 1983, by the Commissioner to provide residential services for the physically handicapped under Parts 9570.2000 to 9570.3600 in each geographic group in Part 9549.0052 [Temporary] must be 105 percent of the limit established in subitem (2).

Another commenter, Sergei Shvetzoff, opposes special treatment of these

facilities. The Commissioner finds that any facility may meet the criteria for a short length of stay facility by having an average length of stay of 180 days or less in their skilled unit. Therefore, access to this category of facilities is open to any facility which chooses to meet this criteria. However, the Commissioner has found that additional study of criteria for Rule 80 and short length of stay facilities is necessary. Provision of the additional limits in the temporary rule delays reduction of costs for these facilities to allow necessary time for such study. The Commissioner has further clarified that the calculation of the efficiency incentive available to short length of stay and Rule 80 facilities be based on the limits which would have been in effect without this adjustment in item E, subitem (3) by adding the following and adjusting the subitems and references accordingly.

Part 9549.0056, subp. 4, item A, page 14, line 14:

"A. Except as provided in item B if"; and

"B. For any nursing home with an average length of stay of 180 days or less in its skilled nursing level of care, and any nursing home licensed on May 1, 1983, by the Commissioner to provide residential services for the physically handicapped under Parts 9570.2000 to 9570.3600 which is under the limits established in 9549.0055 [Temporary], subp. 2, item E, subitem (3) the nursing home's adjusted prospective other operating cost payment rate must be the non-adjusted other operating cost payment rate determined in subp. 3, item A, multiplied by the other operating cost adjustment factor determined in Part 9549.0055 [Temporary] subp. 1, item B,

plus an efficiency incentive equal to the difference between the limit in Part 9549.0055 [Temporary] subp. 2, item E, subitem (2) and the non-adjusted other operating cost payment rate in subp. 3 up to a maximum of two dollars."

7. Part 9549.0056 does not include any provision addressing the impact of future adjustments to the operating costs payment rate which result from field audit findings. Therefore, item D was added on page 14 after line 33 to clarify treatment of these adjustments as follows:

"D. The nursing home's efficiency incentives in item A or B must not be changed as a result of a field audit adjustment."

Since the other operating cost payment rate may have an efficiency incentive associated with it, field audit findings could result in a corresponding increase or decrease in the efficiency incentive. The added provision encourages nursing homes to properly identify and exclude non-allowable costs in its annual cost report so that this would be reflected in their efficiency incentive.

8. In Part 9549.0058 [Temporary], Subpart 1, item E, page 18, line 35, the Department specified "Each resident must be defined as having a behavioral condition if the resident's assessment score is three or more for behavior on the assessment form". Commenters Jeannette Metz representing Ebenezer Society, Colleen Kunzer representing Minn. Nursing Homes Social Workers Association, Bobbie DuChamp representing Minn. Nursing Homes Social Workers Association, Gayle Kvenvold representing Minn. Association of Homes for the Aging, Ronald Fine representing Minn. Association of Health Care Facilities, and Mary Alcorn representing Good

Neighbor Services, Inc., suggested a return to a score of two or more rather than three or more for behavior as a criteria for case mix classifications. The Commissioner finds that use of a score of two or more is consistent with the original case mix research recommendations and the current recommendations of the Interagency Board for Quality Assurance. This change more closely reflects the type of resident likely to require staff time due to behavior needs. Therefore, the Commissioner clarifies the rule to provide for a score of two or more as requested. p. 21

9. Part 9549.0059 [Temporary] Subp. 1, item D, page 21, lines 16-23, specifies that, "The nursing home must perform the assessment for any resident who is required to be assessed by the Preadmission Screening team under item A and who has received a prior preadmission screening and for whom the assessment required under this subpart has not been performed by the Preadmission Screening team within ten working days before or ten working days after the date the applicant is admitted to the nursing home.". The Commissioner finds that a technical change is necessary to clarify that the nursing home performs such assessments for any resident who is required to be assessed by Preadmission Screening only when the Preadmission Screening team has not performed the assessment within the time frame allowed. The nursing home also must assess residents who have received a prior screening but who do not require an additional Preadmission Screening. Therefore, the Commissioner has deleted the word "and" and added the word "or" on page 21, line 18, and has added a comma after "Preadmission Screening" on line 19. p. 23

10. Part 9549.0059 [Temporary] subp. 1, item G, page 21, lines 34 and 35 specifies that the county Preadmission Screening team provide the "completed assessment form to the nursing home, and provide a copy to the Department of Health. The Commissioner finds that a modification is necessary to clarify that the original form must be provided to the Department of Health, and a copy to the nursing home. Therefore, the Commissioner modifies this provision as follows: p. 23, 24

"Completed assessment form to the Department of Health, and provide a copy to the nursing home".

11. Part 9549.0059 [Temporary] subp. 2, page 22, lines 11-12, provides for assessments for residents by the nursing home of "each resident whose name does not appear on the Department of Health's May 15, 1985, classification list". The Commissioner finds that some homes will have annual QAR visits between May 1, 1985 and June 30, 1985 and that this data will not appear on the May 15, 1985 classification list. The Commissioner finds that it is necessary to clarify the rule to ensure that the most current QAR data is utilized in these homes. Therefore, the Commissioner modifies the rule by adding a sentence on line 19 as follows: "For any nursing home whose annual QAR assessment occurred between May 1, 1985 and June 30, 1985, the classification established under Part 4656.0030, subp. 3 shall apply." p. 24

12. In Part 9549.0059, Subpart 3, item D, page 23, line 12, the Department specifies that "Any change in resident class due to a semi-annual

assessment must be effective as of the first day of the month following the date of the Department of Health's classification.". Commenter Mary Alcorn points out that this statement should be revised so that changes in resident classes are effective on the first day of the month following completion of the semi-annual assessments. The Commissioner finds that this change would be consistent with treatment of other similar assessment points in the rule. Therefore, the Commissioner has clarified the rule as follows:

"Any change in resident class due to a semi-annual assessment must be effective as of the first day of the month following the date of the completion of the semi-annual assessment."

13. In Part 9549.0059, Subp. 5, item B, page 24, lines 20-25, the Department specifies "within five working days of the completion of the assessment, the nursing home must forward to the Department of Health a request for classification for any resident assessed upon return to a nursing home after a hospital admission. This request must include the assessment form, the hospital discharge summary, and the resident's plan of care". Commenters Virginia Rootkie and Mary Alcorn point out that it will be difficult to consistently obtain hospital discharge summaries within five working days of hospital discharge. Distance between the hospital and nursing home compounds this difficulty. The Commissioner finds that it may be difficult for nursing homes to obtain the discharge summary within the necessary time frame. However, federal certification regulations and state licensing regulations do require physicians orders upon admission to a nursing home. These required orders, defined as the "Medical Plan

of Care" in the rule, should be available within the necessary five day time frame and are specified as required documentation in other parts of this rule. Therefore, the Commissioner amends the rule to delete the requirement for hospital discharge summaries and to require provision of the Medical Plan of Care instead as follows:

"This request must include the assessment form, and the resident's Medical Plan of Care."

p.26

14. In Part 9549.0059, Subp. 6, page 24, line 34, the Department refers to provisions for audits of assessments contained in temporary rules promulgated by the Department of Health in "Part 4656.0060". The Commissioner finds that the reference provided is incorrect and changes the rule to refer to the correct reference, "Part 4656.0050". p.27

15. Part 9549.0059 [Temporary] does not refer to specific provisions for access to assessment data and documentation for nursing home residents or their authorized representatives. Commenter Stephanie Van Zant suggests that such access be outlined to assure timely availability of this data to nursing home residents for the purposes of submitting a reconsideration request. The Commissioner finds that the Minnesota Resident's Bill of Rights, Minnesota Statutes 144.651, 652, and the Minnesota Data Privacy Act, Minnesota Statutes Chapter 13, provide nursing home residents access to any personal data related to payment or their care. However, the Commissioner concurs that additional provisions in this rule are necessary to clarify that the assessment forms and

accompanying documentation must be readily available to nursing home residents or their authorized representatives so that the resident is able to carry out a request for reconsideration within the time frame allowed. Therefore, the Commissioner has clarified the rule to add Subpart 9 to Part 9549.0059 [Temporary] page 25, line 16, as follows:

"Subpart 9. Resident access to assessments and documentation. The nursing home must provide each nursing home resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the Department of Health in support of the assessment within one working day of receipt of a written or verbal request from the resident or the resident's authorized representative."

p. 27

16. As a result of the Department's review of the comments received and the proposed rules, the Department has made minor changes to correct problems of grammar, references, or lack of clarity, in the proposed rules. Such changes did not change the substance of the rules. These changes are as follows:

Part 9549.0050, subpart 9, page 2, line 24

Part 9549.0054, subpart 1, item D, page 5, line 31

Part 9549.0055, subpart 1, item A, subitem (1), page 8, line 31 and line 36, page 9, line 4 and line 7)

Part 9549.0056, subpart 3, item A, page 14, line 2, Item B, page 14, line 8

Part 9549.0056, subpart 4, page 14, line 13

Part 9549.0056, subpart 4, item A, page 14, line 19 and line 23

Part 9549.0057, subpart 2, item B, page 17, line 2 and item C, page 17, line 6

CONCLUSIONS

I hereby conclude that:

1. The Commissioner has statutory authority to promulgate these temporary rules.

2. Proper notice of the Department's intent to adopt the proposed temporary rules was given as required by law, and all interested persons were afforded an opportunity to submit data and views on the proposed rules.

3. The modifications made to the proposed temporary rules are supported by the Department's Findings and are not substantial changes.

4. The temporary rules are necessary and reasonable.

5. The Department has complied with all applicable provisions of law and rule in the promulgation of these temporary rules.

6. If any finding or part of a finding, above, is properly characterized as a conclusion, it is adopted as a conclusion.

DATED: 5-10-85

STATE OF MINNESOTA

LEONARD W. LEVINE, COMMISSIONER
Department of Human Services

Reply to Comments Regarding Geographic Groups

Part 9549.0052 [Temporary] page 3, lines 10-27, establishes geographic groups utilized for the purpose of arraying costs to determine rate limitations. Minnesota Statutes 256B.431 required the Department to review the current grouping system and consider the use of the Standard Metropolitan Statistical Areas (SMSA) in designing a grouping system under the new case mix reimbursement system for nursing home operating costs. A number of commenters, including Sister Rita Budig, Earl Schillo, Tim Steller, Warren Becker, and Carol Mills questioned the geographic groups proposed in the rule. They proposed several alternatives including grouping nursing homes by county, by SMSA designation, or grouping all nursing homes in the state into one region. As part of the research in developing case mix, the Department's contractors, Lewin and Associates, analyzed average nursing salaries in SMSA designated counties. They found that nursing costs which, on average, comprise approximately 45 percent of the nursing homes operating costs in some non-SMSA counties were actually higher than those in some of the SMSA designated counties. Therefore, the Commissioner, after due consideration, disagrees with the suggestion to group homes by SMSA designation since it would be inequitable for those counties where average nursing costs are higher but who are not designated as SMSA counties. The Commissioner also rejects the suggestion to group homes by individual county. This would create 87 different groups and would be administratively burdensome. The Commissioner also finds that grouping all homes in the state into one group would be inequitable as there would be no recognition of difference in wages and prices across the state. The previous rule grouped all homes into two geographic

regions, metro and non-metro. The Commissioner agrees with the commenters that two geographic regions are inadequate. The proposed rule provides for three geographic groups which include a new region between metro and non-metro areas. These new regions are based on average wages in combined economic development regions. It is recognized that while, on average, wages in these areas are similar, facility specific wage data may vary somewhat within each area. Any geographic grouping system will incorporate this type of variation to some degree. Therefore, the Commissioner finds that the grouping system in the proposed rule is reasonable.

This draft corresponds with the Finding of Fact page #s.

Department of Human Services

Adopted Temporary Rules Relating to Nursing Home Payment Rate Determination

Temporary Rules as Adopted

DEPARTMENT OF HUMAN SERVICES

NURSING HOME PAYMENT RATE DETERMINATION [Temporary]

9549.0050 [Temporary] SCOPE.

Parts 9549.0050 to 9549.0059 [Temporary] establish procedures for determining the operating cost payment rates for all nursing homes participating in the medical assistance program. Parts 9549.0050 to 9549.0059 [Temporary] are effective for rate years beginning on or after July 1, 1985. Procedures for assessment and classification of residents by the Department of Health in accordance with parts 9549.0050 to 9549.0059 [Temporary] are found in parts 4656.0010 to 4656.0070.

9549.0051 [Temporary] DEFINITIONS.

Subpart 1. **Applicability.** As used in parts 9549.0050 to 9549.0059 [Temporary], the following terms have the meanings given them.

Subp. 2. **Assessment form.** "Assessment form" means the form developed by the Department of Health Quality Assurance and Review Program which was in effect on March 1, 1984, and used for performing resident assessments. The assessment form is incorporated by reference. It is available at Ford Law Library, 117 University Avenue, Saint Paul, Minnesota 55155. It is available through Minitex interlibrary loan system. This form is not subject to frequent change.

Subp. 3. **Base year.** "Base year" means the reporting year ending September 30, 1984.

Subp. 4. **Case mix index.** "Case mix index" means the sum of the results obtained by multiplying the number of residents in each resident class in each home by the weights listed in part 9549.0058 [Temporary].

Subp. 5. **Case mix operating costs.** "Case mix operating costs" means the operating costs listed in part 9549.0040, subpart 5, as proposed in State Register, volume 9, page 1716, February 4, 1985, and the portion of fringe benefits and payroll taxes allocated to the nursing services cost category in accordance with part 9549.0053.

Subp. 6. **Case mix score.** "Case mix score" means the case mix index divided by the total number of residents in each home.

Subp. 7. **Medical plan of care.** "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatment and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures, and discharge potential.

Subp. 8. **Other care related operating costs.** "Other care related operating costs" means the operating costs listed in part 9549.0040, subpart 6, as proposed in State Register, volume 9, page 1716, February 4, 1985, and the portion of fringe benefits and payroll taxes allocated to the other care related cost category in accordance with part 9549.0053 and the cost of food.

Subp. 9. **Other operating costs.** "Other operating costs" means the operating costs listed in part 9549.0040, subparts 1, 2, 3, 4, and 7, as proposed in the State Register, volume 9, page 1716, February 4, 1985, and the portion of fringe benefits and payroll taxes allocated to each of these operating costs categories in accordance with part 9549.0053, excluding the cost of food.

Subp. 10. **Quality assurance and review or QAR.** "Quality assurance and review" or "QAR" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. 11. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058 [Temporary].

Subp. 12. **Resident plan of care.** "Resident plan of care" for residents of nursing homes not licensed as boarding care homes means the patient care plan specified in part 4655.6000. "Resident plan of care" for residents of nursing homes licensed as boarding care homes means the overall plan of care as defined

in Code of Federal Regulations, title 42, section 442.319, as amended through December 31, 1984.

Subp. 13. **Standardized resident days.** "Standardized resident days" means the sum of the number of resident days in the nursing home in each resident class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary]. For the rate years beginning on July 1, 1985, and July 1, 1986, standardized resident days must be determined in accordance with part 9549.0054 [Temporary], subparts 1 and 2.

9549.0052 [Temporary] ESTABLISHMENT OF GEOGRAPHIC GROUPS.

The commissioner shall classify Minnesota nursing homes according to their geographic location as indicated in subparts 1 to 3.

Subpart 1. **Group 1.** All nursing homes in Beltrami, Big Stone, Cass, Chippewa, Clearwater, Cottonwood, Crow Wing, Hubbard, Jackson, Kandiyohi, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, McLeod, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Yellow Medicine, and Wadena counties must be placed in geographic group 1.

Subp. 2. **Group 2.** All nursing homes in counties other than the counties listed under subparts 1 and 3 must be placed in geographic group 2.

Subp. 3. **Group 3.** All nursing homes in Aitkin, Anoka, Carlton, Carver, Cook, Dakota, Hennepin, Itasca, Koochiching, Lake, Ramsey, St. Louis, Scott, and Washington counties must be placed in geographic group 3.

9549.0053 DETERMINATION AND ALLOCATION OF FRINGE BENEFITS AND PAYROLL TAXES, AND FOOD COSTS.

Subpart 1. **Fringe benefits and payroll taxes.** Fringe benefits and payroll taxes must be allocated to case mix, other care-related costs, and other operating costs according to items A to D.

A. Fringe benefits and payroll taxes must be allocated to case mix operating costs in the same proportion to

salaries reported under part 9549.0040, subpart 5, as proposed in State Register, volume 9, page 1716, February 4, 1985.

B. Fringe benefits and payroll taxes must be allocated to other care-related costs in the same proportion to salaries reported under part 9549.0040, subpart 6, as proposed in State Register, volume 9, page 1716, February 4, 1985.

C. Fringe benefits and payroll taxes must be allocated to other operating costs in the same proportion to salaries reported under part 9549.0040, subparts 1, 2, 3, 4, and 7, as proposed in State Register, volume 9, page 1716, February 4, 1985.

D. For any nursing home which has not separately reported each salary component of an operating cost category, the commissioner shall determine the fringe benefits and payroll taxes to be allocated under this subpart according to subitems (1) and (2).

(1) The commissioner shall determine the ratio of allowable salaries in each cost category to total allowable salaries in all cost categories for all nursing homes separately reporting allowable salaries in each cost category.

(2) The nursing home's total allowable fringe benefits and payroll taxes must be multiplied by each ratio determined in subitem (1) to determine the amount of payroll taxes and fringe benefits allocated to each cost category for each nursing home under item D.

Subp. 2. **Determination of food costs.** For any nursing home which has not separately reported the cost of food under part 9549.0040, subpart 1, as proposed in State Register, volume 9, page 1716 (February 4, 1985), the commissioner shall determine the food costs according to items A and B.

A. The commissioner shall determine the average ratio of food costs to total dietary costs for all nursing homes that separately reported food costs.

B. The nursing home's total allowable dietary costs must be multiplied by the ratio determined in item A to determine the food costs for that nursing home.

9549.0054 [Temporary] DETERMINATION OF THE ALLOWABLE HISTORICAL OPERATING COSTS PER DIEMS.

The commissioner shall annually review and adjust the operating costs incurred by the nursing home during the reporting year preceding the rate year to determine the nursing home's actual allowable historical operating costs. The review and adjustment must comply with the provisions of parts 9549.0010 to 9549.0080, as proposed in State Register, volume 9, page 1716 (February 4, 1985).

Subpart 1. **Standardized resident days for rate year beginning July 1, 1985.** For the rate year beginning on July 1, 1985, each nursing home's standardized resident days must be determined according to items A to H.

A. The commissioner shall select the two most recent QAR assessments completed prior to April 1, 1985. If only one QAR assessment is available, the commissioner shall compute the standardized resident days in accordance with item I.

B. For each of the two QAR assessments selected in item A, the medical assistance case mix index must be the sum of the number of medical assistance residents in each resident class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

C. The medical assistance case mix index for each QAR assessment determined in item B must be divided by the total number of medical assistance residents in order to compute the medical assistance case mix score.

D. The average monthly change in the medical assistance case mix score must be computed by subtracting the most recent medical assistance case mix score from the previous medical assistance case mix score and dividing the result by the number of months between the two QAR assessments dates. For any partial calendar month, the commissioner shall count as a full month any period of more than 14 days and shall disregard periods of 14 days or less.

E. The average medical assistance case mix score must be determined by subtracting from the most recent medical

assistance case mix score, the product of the average monthly change in the medical assistance case mix score times the number of months from April 1, 1984, to the date of the most recent QAR assessment. For a partial calendar month, the commissioner shall count as a full month the period of more than 14 days, and shall disregard periods of 14 days or less.

F. The commissioner shall compute the private pay adjustment ratio in accordance with subitems (1) to (3).

(1) Using the method described in item C, compute the private pay case mix score for private paying residents for each nursing home whose most recent QAR assessment included assessments of private paying residents.

(2) Compute a ratio by dividing the private pay case mix score in subitem (1) by the medical assistance case mix score in item C for that QAR assessment.

(3) Compute the private pay adjustment ratio by determining the average of all ratios determined in subitem (2).

G. The commissioner shall determine the private pay average case mix score for each nursing home by multiplying the private pay adjustment ratio determined in item F, subitem (3) times the average medical assistance case mix score determined in item E.

H. The commissioner shall compute the standardized resident days in accordance with subitems (1) to (3).

(1) Multiply the private pay resident days during the reporting year by the average private pay case mix score as determined in item G.

(2) Multiply the medical assistance resident days during the reporting year by the average medical assistance case mix score as determined in item E.

(3) The standardized resident days must be the sum of subitems (1) and (2).

I. If only one QAR assessment is available, the commissioner shall compute the standardized resident days in accordance with subitems (1) to (3).

(1) The case mix index must be the sum of the

number of residents in each class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

(2) The case mix score must be computed by dividing the case mix index in subitem (1) by the total number of residents.

(3) The case mix score must be multiplied by the total number of resident days during the reporting year to determine the standardized resident days.

Subp. 2. **Standardized resident days for rate year beginning July 1, 1986.** For the rate year beginning on July 1, 1986, each nursing home's standardized resident days must be determined in accordance with items A to C.

A. The resident days in each resident class for the months of July, August, and September 1985, must be multiplied by 3.9674 to determine the annualized resident days.

B. For each resident class, the annualized resident days determined in item A, must be multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

C. The amounts determined in item B must be summed to determine the nursing home's standardized resident days for the reporting year.

Subp. 3. **Allowable historical case mix operating cost standardized per diem.** The allowable historical case mix operating cost standardized per diem must be computed by dividing the allowable historical case mix operating cost by the standardized resident days determined in subpart 1 or 2.

Subp. 4. **Allowable historical other care related operating cost per diem.** The allowable historical other care related operating cost per diem must be computed by dividing the allowable historical other care related operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period, except that a nursing home that is certified to provide a skilled level of care and that has an average length of stay of 180 days or less in their skilled level of care must divide the allowable historical other care related operating costs by the

greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

Subp. 5. **Allowable historical other operating cost per diem.** The allowable historical other operating cost per diem must be computed by dividing the allowable historical other operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period, except that a nursing home that is certified to provide a skilled level of care and that has an average length of stay of 180 days or less in their skilled level of care must divide the allowable historical other operating costs by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

9549.0055 [Temporary] DETERMINATION OF THE OPERATING COST ADJUSTMENT FACTORS AND LIMITS.

Subpart 1. **Annual adjustment factors.** The annual adjustment factors must be determined according to items A and B.

A. The annual adjustment factor for the case mix and other care-related operating costs must be established according to subitems (1) to (4).

(1) The components and indices for the case mix and other care related operating costs adjustment factor must be as specified in the following table.

CASE MIX AND CARE RELATED COMPONENTS AND INDICES

Component	Weight	Index
Salaries	.7347	Average hourly earnings of employees in nursing and personal care facilities (SIC 805).
Benefits	.1107	Difference between movements in compensation and wages and salary index components of the Employment Cost Index for Service Workers.

Supplies and Drugs	.0363	Consumer Price Index for nonprescription medical equipment and supplies
Food	.1183	Producer Price Index for consumer foods.
TOTAL	1.0000	

(2) The average price index for the reporting year must be computed by multiplying the weight for each component contained in subitem (1) by the average index for that component for the reporting year and adding the products.

(3) The average forecasted price index for the rate year immediately following the reporting year must be computed by multiplying the weight for each component contained in subitem (1) by the average forecasted index for that component for the rate year and adding the products.

(4) The adjustment factor for the case mix and other care related operating costs must be computed by dividing the amount computed in subitem (3) by the amount computed in subitem (2).

B. The annual adjustment factor for the other operating costs must be established according to subitems (1) to (4).

(1) The components and indices for the other operating cost adjustment factor must be as specified in the following table.

OTHER OPERATING COSTS COMPONENTS AND INDICES

Component	Weight	Index
Utilities	.1099	Producer Price Index for natural gas (80 percent); and Producer Price Index for commercial power in west north central state (20 percent). This

		index is incorporated by reference.
Salaries	.5864	Average hourly earnings of employees in nursing and personal care facilities (SIC 805). This index is incorporated by reference.
Benefits	.0799	Difference between movements in compensation and wages and salaries index components of the Employment Cost Index for Service Workers. This index is incorporated by reference.
Additional Professional Services	.1107	Employment Cost Index for wages and salaries of professional and technical workers. This index is incorporated by reference.
Additional Miscellaneous Service Purchases	.0322	Consumer Price Index for maintenance and repair services. This index is incorporated by reference.
Miscellaneous Purchases (Commodities)	.0809	Consumer Price Index for maintenance and repair commodities. This index is incorporated by reference.
TOTAL	1.0000	

(2) The average price index for the reporting year must be computed by multiplying the weight for each component contained in subitem (1) by the average index value for that component for the reporting year and adding the products.

(3) The average forecasted price index for the rate year immediately following the reporting year must be

computed by multiplying the weight for each component contained in subitem (1) by the forecasted average index values for that component for the same rate year and adding the products.

(4) The adjustment factor for the other operating costs must be computed by dividing the amount computed in subitem (3) by the amount computed in subitem (2).

Subp. 2. **Limits.** For each geographic group established in part 9549.0052 [Temporary] the operating costs limits must be determined according to items A to F. No redetermination of the operating costs limits shall be made due to audit adjustments or appeal settlement.

A. The commissioner shall compute 115 percent of the median of the array of the allowable historical case mix related operating cost per diems for the base year.

B. The commissioner shall compute 115 percent of the median of the array of the allowable historical other care related operating cost per diems for the base year.

C. The total care related operating cost limit for each resident class must be determined by multiplying the amount determined in item A by the weight for each resident class and adding the amount determined in item B.

D. The commissioner shall disallow any portion of the general and administrative cost category, exclusive of fringe benefits and payroll taxes that exceeds 15 percent of the allowable expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administrative.

E. The other operating costs limits must be determined in accordance with subitems (1) to (3).

(1) For each geographic group in part 9549.0052 [Temporary], the commissioner shall group all hospital attached nursing homes, all nursing homes with an average length of stay of 180 days or less in their skilled nursing level of care, and nursing homes licensed on May 1, 1983, by the commissioner to provide residential services for the physically handicapped under parts 9570.2000 to 9570.3600.

(2) For each geographic group in part 9549.0052

[Temporary], the commissioner shall group all nursing homes not included in subitem (1).

(3) The other operating cost limit for each group established in subitems (1) and (2) must be 105 percent of the median of the array of the allowable historical other operating cost per diems for each nursing home in the group for the base year.

F. The commissioner may establish a different base year once within a five-year period.

Subp. 3. **Incorporations by reference.** The references for the indices specified in this part are listed in items A to D, and are available through the Minitex interlibrary loan system. The references in items A to D are subject to frequent change.

A. The index for average hourly earnings of employees in nursing and personal care facilities is published monthly in "Employment and Earnings," Bureau of Labor Statistics, United States Department of Labor. (SIC 805) Standard Industrial Code 805 is the code used for employees in nursing and personal care facilities in this publication.

B. The Employment Cost Index for Service Workers and the Employment Cost Index for wages and salaries of professional and technical workers are published monthly in "Current Wage Developments," Bureau of Labor Statistics, United States Department of Labor.

C. The Consumer Price Index for nonprescription medical equipment and supplies and the Consumer Price Index for maintenance and repair commodities are published in the "Monthly Labor Review," Bureau of Labor Statistics, United States Department of Labor.

D. The Producer Price Index for consumer foods, the Producer Price Index for natural gas, and the Producer Price Index for commercial power in west north central states are published monthly in "Producer Prices and Price Indices," Bureau of Labor Statistics, United States Department of Labor.

9549.0056 [Temporary] DETERMINATION OF THE OPERATING COST PAYMENT RATE.

Subpart 1. **Nonadjusted case mix and other care related payment rate.** For each nursing home, the nonadjusted case mix and other care related payment rate for each resident class must be determined according to items A to D.

A. The nursing home's allowable historical case mix operating cost standardized per diem established in part 9549.0054 [Temporary], subpart 3, must be multiplied by the weight for each resident class listed in part 9549.0058 [Temporary].

B. The allowable historical other care related operating cost per diem established in part 9549.0054 [Temporary], subpart 4, must be added to each weighted per diem established in item A.

C. If the amount determined in item B for each resident class is below the limit for that resident class and group established in part 9549.0055 [Temporary], subpart 2, item C, the nursing home's nonadjusted case mix and other care related payment rate must be the amount determined in item B for each resident class.

D. If the amount determined in item B for each resident class is at or above the limit for that resident class and group established in part 9549.0055 [Temporary], subpart 2, item C, the nursing home's nonadjusted case mix and other care related payment rate must be set at the limit.

Subp. 2. **Adjusted prospective case mix and other care related payment rate.** For each nursing home, the adjusted prospective case mix and other care related payment rate for each resident class must be the nonadjusted case mix and other care related payment rate multiplied by the case mix and other care related adjustment factor determined in part 9549.0055 [Temporary], subpart 1, item A.

Subp. 3. **Nonadjusted other operating cost payment rate.** The nonadjusted other operating cost payment rate must be determined according to items A and B.

A. If the allowable historical other operating cost per diem determined in part 9549.0054 [Temporary], subpart 5, is

below the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, subitem (3), the nursing home's nonadjusted other operating cost payment rate must be the allowable historical other operating cost per diem.

B. If the allowable historical other operating cost per diem determined in part 9549.0054 [Temporary], subpart 5, is at or above the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, subitem (3), the nursing home's nonadjusted other operating cost payment rate must be set at that limit.

Subp. 4. **Adjusted prospective other operating cost payment rate.** The adjusted prospective other operating cost payment rate must be determined according to items A and B.

A. If the nursing home's nonadjusted other operating cost payment rate is below the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, subitem (3), the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item H, multiplied by the other operating cost adjustment factor determined in part 9549.0055 [Temporary], subpart 1, item B, plus an efficiency incentive equal to the difference between the limit in part 9549.0055 [Temporary], subpart 2, item E, subitem (3), and the nonadjusted other operating cost payment rate in subpart 3 up to maximum of two dollars.

B. If the nursing home's nonadjusted other operating cost payment rate is at or above the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, subitem (3), the nursing home's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item B, multiplied by the other operating cost adjustment factor determined in part 9549.0055 [Temporary], subpart 1, item B.

Subp. 5. **Total operating cost payment rate.** The nursing home's total operating cost payment rate must be the sum of the adjusted prospective case mix and other care related payment

rate determined in subpart 2 and the adjusted other operating cost payment rate determined in subpart 4.

9549.0057 [Temporary] DETERMINATION OF THE INTERIM AND SETTLE-UP OPERATING COST PAYMENT RATES.

To receive an interim payment rate, a nursing home must comply with the requirements and is subject to the conditions of part 9549.0060, subpart 14, items A to C. The commissioner shall determine interim and settle-up operating cost payment rates for a newly constructed nursing home, or one with a capacity increase of 50 percent or more according to subparts 1 and 2.

Subpart 1. **Interim operating cost payment rate.** For the rate year or portion of an interim period beginning on or after July 1, 1985, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 [Temporary], except that:

A. Each nursing home must project its anticipated resident days for each resident class. The anticipated resident days for each resident class must be multiplied by the weight for that resident class as listed in part 9549.0058 [Temporary] to determine the anticipated standardized resident days for the reporting period.

B. The commissioner shall use anticipated standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

C. The commissioner shall use the anticipated resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem. Ninety percent of licensed beds multiplied by the number of days in the reporting period must not be used in determining these per diems.

D. The annual adjustment factors determined in part 9549.0055 [Temporary], subpart 1, must not be applied to the nursing home's allowable historical per diems as provided in part 9549.0056 [Temporary], subparts 2 and 4.

E. The limits established in part 9549.0055

[Temporary], subpart 2, items C and E, must be increased by ten percent.

F. The efficiency incentive in part 9549.0056 [Temporary], subpart 4, item A, must not apply.

Subp. 2. **Settle-up operating cost payment rate.** The settle-up total operating cost payment rate must be determined according to items A to C.

A. The settle-up operating cost payment rate for a nursing home which commenced construction before July 1, 1985, is determined under 12 MCAR S 2.05014 [Temporary] for the interim period before July 1, 1985.

B. The settle-up operating cost payment rate for a nursing home which commenced construction after June 30, 1985, or whose interim reporting period included a period of time after that date must be determined for the portion of that interim period occurring after June 30, 1985, as in parts 9549.0050 to 9549.0059 [Temporary].

(1) The standardized resident days occurring after July 1, 1985, must be annualized for the interim reporting period.

(2) The commissioner shall use the annualized standardized resident days in determining the allowable historical case mix operating cost standardized per diem.

(3) The commissioner shall use the actual resident days in determining both the allowable historical other care related operating cost per diem and the allowable historical other operating cost per diem. Ninety percent of licensed beds multiplied by the number of days in the reporting period must not be used in determining these per diems.

(4) The annual adjustment factors determined in part 9549.0055 [Temporary], subpart 1, must not be applied to the nursing home's allowable historical per diems as provided in part 9549.0056 [Temporary], subparts 2 and 4.

(5) The limits established in subpart 1, item E, must be the limits for the settle-up reporting period occurring after July 1, 1985.

(6) The efficiency incentive in part 9549.0056 [Temporary], subpart 4, item A, must not apply.

C. For the nine-month period following the settle-up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive in part 9549.0056 [Temporary], subpart 4, item A, shall apply.

9549.0058 [Temporary] RESIDENT CLASSES AND CLASS WEIGHTS.

Subpart 1. **Resident classes.** Each resident must be classified according to items A to E based on the assessments performed under part 9549.0059 [Temporary] on the assessment form.

A. Each nursing home resident or applicant must be assessed as dependent in an activity of daily living or ADL according to the following table:

ADL	Dependent if Score At or Above
Dressing	2
Grooming	2
Bathing	4
Eating	2
Bed mobility	2
Transferring	2
Walking	2
Toileting	1

B. Each nursing home resident assessed as dependent in fewer than four of the ADL's in item A must be defined as Low ADL. Each resident assessed as dependent in four through six of the ADL's in item A must be defined as Medium ADL. Each resident assessed as dependent in seven or eight of the ADL's in item A must be defined as High ADL.

C. Each resident must be defined as special nursing according to subitems (1) and (2).

(1) the resident is assessed to require tube feeding; or

(2) the resident is assessed to require clinical monitoring including evening and night shifts plus one or more of the following special treatments on the assessment form:

(a) oxygen and respiratory therapy;

(b) ostomy care;

(c) care of dressings;

(d) skin care;

(e) IV therapy;

(f) drainage tubes;

(g) blood transfusions; or

(h) hyperalimentation.

D. Each resident must be defined as having a neuromuscular condition if the resident is assessed to have one or more of the diagnoses coded to the following categories according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), as published by the Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Michigan (1978). This publication is incorporated by reference. This is available through the Minitex interlibrary loan system. This is not subject to frequent change.

(1) diseases of nervous system excluding sense organs (320-359);

(2) cerebrovascular disease (430-438);

(3) fracture of skull (800-804), excluding cases without intracranial injury;

(4) intercranial injury, excluding those with skull fracture (850-854);

(5) fracture of vertebral column with spinal cord injury (806);

(6) spinal cord injury without evidence of spinal bone injury (952); or

(7) injury to nerve roots and spinal plexus (953).

E. Each resident must be defined as having a behavioral condition if the resident's assessment score is three or more for behavior on the assessment form.

F. The commissioner shall establish resident classes based on the definitions in items A to E and according to subitems (1) to (11).

(1) Class A. Low ADL, and not defined behavioral condition, and not defined special nursing.

(2) Class B. Low ADL, and defined behavioral condition, and not defined special nursing.

(3) Class C. Low ADL, and defined special nursing.

(4) Class D. Medium ADL, and not defined behavioral condition, and not defined special nursing.

(5) Class E. Medium ADL, and defined behavioral condition, and not defined special nursing.

(6) Class F. Medium ADL, and defined special nursing.

(7) Class G. High ADL, and scoring less than three on the eating ADL in item A, and not defined special nursing, and not defined behavioral condition on assessment form.

(8) Class H. High ADL, and scoring less than three on eating ADL in item A, and defined behavioral condition, and not defined special nursing.

(9) Class I. High ADL, and scoring three or four on eating ADL in item A, and not defined special nursing, and not defined neuromuscular condition.

(10) Class J. High ADL, and defined neuromuscular condition, and scoring three or four on the eating ADL in item A, and not defined special nursing.

(11) Class K. High ADL, and defined special nursing.

Subp. 2. **Class weights.** The commissioner shall assign weights to each resident class established in subpart 1, item F, according to items A to K.

A. Class A, 1.00;

B. Class B, 1.30;

C. Class C, 1.64;

D. Class D, 1.95;

E. Class E, 2.27;

F. Class F, 2.29;

G. Class G, 2.56;

H. Class H, 3.07;

I. Class I, 3.25;

J. Class J, 3.53;

K. Class K, 4.12.

9549.0059 [Temporary] RESIDENT ASSESSMENT.

Subpart 1. **Assessment of nursing home applicants and newly admitted residents.** Each nursing home applicant or newly admitted resident shall be assessed for the purpose of determining the applicant's or newly admitted resident's class according to items A to I.

A. Each county preadmission screening team or hospital screening team under contract with the county must assess all nursing home applicants for whom preadmission screening is required by Minnesota Statutes, section 256B.091, and any applicant for whom a preadmission screening is not required but who voluntarily requests such a screening in accordance with Minnesota Statutes, section 256B.091, except as provided in subitems (1) and (2).

(1) The public health nurse of the county preadmission screening team or the RN case manager shall assess a nursing home applicant, if the applicant was previously screened by the county preadmission screening team and the applicant is receiving services under the Alternative Care Grants program defined in part 9505.2340 or under the medical assistance program.

(2) A nursing home applicant whose admission to the nursing home is for the purpose of receiving respite care services under the Alternative Care Grants program or under the medical assistance program need not be reassessed more than once every six months for the purpose of computing resident days under part 9549.0054 [Temporary], subpart 2, if the applicant has been classified by the Department of Health within the prior six-month period. In this case, the resident class established

by the Department of Health within the prior six-month period may be the resident class of the applicant.

B. Each nursing home must assess each applicant or newly admitted resident for whom a preadmission screening is not required by Minnesota Statutes, section 256B.091, or is not requested voluntarily in accordance with Minnesota Statutes, section 256B.091. For purposes of this item, a newly admitted resident includes a resident who moves to a section of the nursing home which is licensed differently than the section from which the resident came or a resident who has been transferred from another nursing home. Each assessment must be performed by the registered nurse who signs the assessment form.

C. The assessment required by this subpart must be performed within ten working days before or ten working days after the date the applicant is admitted to the nursing home.

D. The nursing home must perform the assessment for any resident who is required to be assessed by the preadmission screening team under item A ~~and~~ or who has received a prior preadmission screening and for whom the assessment required under this subpart has not been performed by the preadmission screening team within ten working days before or ten working days after the date the applicant is admitted to the nursing home. The nursing home must perform the assessment and submit the forms to the Department of Health within 15 working days after admission.

E. A registered nurse performing the assessment must sign the assessment form.

F. The assessment of each applicant or newly admitted resident must be based on the QAR procedures of the Department of Health, and must be recorded on the assessment form defined in part 9549.0051 [Temporary], subpart 2.

G. The preadmission screening team or hospital screening team under contract with the county must provide the completed assessment form to the nursing home, and provide a copy to the Department of Health, within five working days following the assessment.

H. Each assessment completed in accordance with items A to G and a completed medical plan of care must be submitted to the Department of Health by the nursing home as a request for classification within ten working days after admission or after the assessment, whichever is later.

I. The resident class for nursing home applicants or newly admitted residents must be effective on the date of admission to the nursing home.

Subp. 2. **Assessment of residents for July 1, 1985, rate year.** For the July 1, 1985, rate year only, each nursing home must assess each resident whose name does not appear on the Department of Health's May 15, 1985, classification list under the procedures prescribed by subpart 3, item B. The nursing home must submit a request for classification for each resident assessed by the nursing home to the Department of Health by June 1, 1985. The request for classification must include the completed assessment form and the resident's plan of care. For any resident admitted after June 1, 1985, the procedure outlined in subpart 1 must be followed.

Subp. 3. **Semi-annual assessment by nursing homes.** Semiannual assessments of residents by the nursing home must be completed in accordance with items A to E.

A. A nursing home must assess each of its residents no earlier than 170 days and no later than 190 days after the date of the most recent QAR assessment.

B. A registered nurse shall perform the assessment on each resident according to QAR procedures established by the Department of Health including physical observation of the resident, review of the medical plan of care, and review of the resident's care plan, and shall record the assessment on the assessment form defined in part 9549.0051 [Temporary], subpart 2. The registered nurse performing the assessment shall sign the assessment form.

C. Within five working days of the completion of the nursing home's semiannual resident assessments, the nursing home must forward to the Department of Health requests for

classification for all residents assessed for the semiannual assessment. These requests must include the assessment forms, the resident plans of care, and the nursing home's daily census for the date on which the assessments were completed including an explanation of any discrepancy between the daily census and the number of assessments submitted. The nursing home must provide further information to the Department of Health if the Department of Health requests it in order to determine a resident's classification.

D. Any change in resident class due to a semi-annual assessment must be effective as of the first day of the month following the date of the Department of Health's classification.

E. For the rate year beginning July 1, 1985, only, a nursing home must assess residents according to subitems (1) to (4).

(1) In July 1985, the nursing home must assess all residents whose most recent QAR assessments were performed in October or November 1984.

(2) In August 1985, the nursing home must assess all residents whose most recent QAR assessments were performed in December 1984, or January 1985.

(3) In September 1985, the nursing home must assess all residents whose most recent QAR assessments were performed in February or March 1985.

(4) For residents assessed according to subitems (1) to (3), the nursing home must submit a request for classification for each resident assessed including the assessment form and a copy of the resident's plan of care to the Department of Health no later than the end of the calendar month when the assessments are required. The nursing home must provide further information to the Department of Health if requested by the Department of Health in order to determine a resident's classification. For each assessment performed in subitems (1) to (3), the resident classification determined by the Department of Health shall remain in effect until an assessment is performed under subpart 4 or 5.

Subp. 4. **Change in classification due to annual assessment by Department of Health.** Any change in resident class due to an annual assessment by the Department of Health's QAR team will be effective as of the first day of the month following the date of the Department of Health's assessment.

Subp. 5. **Assessment upon return to the nursing home from a hospital.** Residents returning to a nursing home after hospitalization must be assessed according to items A to C.

A. A nursing home must assess any resident who has returned to the same nursing home after a hospital admission. The assessment shall occur no more than five working days after the resident returns to the same nursing home.

B. A registered nurse shall perform the assessment on each resident according to QAR procedures established by the Department of Health, including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form defined in part 9549.0051 [Temporary], subpart 2. The registered nurse who performs the assessment shall sign the assessment form. Within five working days of the completion of the assesssment, the nursing home must forward to the Department of Health a request for a classification for any resident assessed upon return to a nursing home after a hospital admission. This request must include the assessment form, the hospital discharge summary, and the resident's plan of care. Upon request, the nursing home must furnish the Department of Health with further information when required in order to determine a resident's classification.

C. Any change in resident class due to an assessment provided under this subpart must be effective as of the date the resident returns to the nursing home from the hospital.

Subp. 6. **Change in resident class due to audits of assessments of nursing home residents.** Any change in resident class due to a reclassification required by part 4656.0060 must be effective as of the first day of the month following the date of the Department of Health's classification.

Subp. 7. **Change in resident class due to request for reconsideration of resident classification.** Any change in a resident class due to a request for reconsideration of the classification must be made in accordance with items A and B.

A. The resident classification established by the Department of Health must be the classification that applies to the resident while any request for reconsideration under part 4546.0060 is pending.

B. Any change in a resident class due to a reclassification under part 4546.0060 must be effective as of the date of the assessment for which a reconsideration was requested.

Subp. 8. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made pursuant to the procedures set forth in part 4546.0060.

STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

In the Matter of the Proposed Temporary Rules Governing Nursing Home Payment Rate, Minnesota Rules, Parts 9549.0050 to 9549.0059 [Temporary]

STATEMENT OF COMPLIANCE WITH RULEMAKING PROCEDURES

I, Special Assistant Attorney General, ~~Beverly Jones Heydinger~~ GAIL M. OLSON, do hereby declare that I have examined the rules and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedures Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed. Any exceptions are noted below.

Gail M. Olson

~~Beverly Jones Heydinger~~ Special Assistant Attorney General

Dated: