

Minnesota Attorney General: Administrative Rules Proceedings

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~~1214~~ 08-0009, 0881

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 5-15-86
DATE FOR REVIEW _____
DATE DUE 5-22-86

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

Approved 5/22/86 Disapproved _____ Returned to Agency _____

Resubmitted _____
Approved _____ Disapproved _____ Due _____ Returned to Agency _____

Date filed w/Secretary of State 5-23-86 Revisor approved _____ disapproved _____

✓ Rule as Adopted

✓ Rule as Proposed

✓ Order Adopting 5-15-86 Date Combined w/FF

✓ Notice of Intent to Solicit Outside Opinion S. R. 2/24/86

✓ Order for rulemaking
N/A date of Hearing

NA Certificate of Board's Authorizing Resolution

✓ Notice of rulemaking
✓ Sufficiency

✓ Affidavit of Mailing Notice or rulemaking
3-28-86 At least ~~30~~ 25 days prior to ~~hearing~~/adoption

✓ affid. of additional mailing 3-28-86

✓ Mailing list Certificate affid. of additional mailing 3-28-86

✓ Publication in State Register
3-31-86 At least ~~30/20~~ 25 days prior to ~~hearing~~/adoption

✓ errata publication in S. R. 4-7-86

NA Hearing Examiner's Report

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

✓ Agency's Findings of Fact combined w/FF

NA LCRAR Report or agency Affidavit

✓ Certificate of Board's Resolution Adopting Rules

✓ Order Approving Incorporation by Reference

N/A Statement of Need and Reasonableness

NA 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

✓ Affidavit of Mailing Notice of Submission to Attorney General

✓ Notice of Submission to the Attorney General

~~Order for Publication of Temporary Rules~~

SF-00006-03

STATE MINNESOTA

Office Memorandum

DEPARTMENT ATTORNEY GENERAL

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

DATE: 5/23/86

ATTN: GARY VAN CLEVE
Special Assistant Attorney General

FROM: J. MICHAEL MILES
Assistant Attorney General

PHONE: 296-6555

SUBJECT: In the Matter of the Proposed Adoption of the Department of Human Services' Rules Relating to Nursing Home Payment Rate Determination

The above-referenced rule has been approved as to its legality by the Attorney General on May 22, 1986.

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.

JMM:pmf

Enclosures

cc: Maryanne Hruby
Executive Director
Legislative Commission to Review
Administrative Rules

Duane Harves
Chief Administrative Law Judge
Office of Administrative Hearings

RR1274

AG copy

Department of Human Services

Adopted Temporary Rules Relating to Nursing Home Payment Rate Determination

Rules as Adopted [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 4656.0100 [Temporary].

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 under parts 4656.0010 to 4656.0100 [Temporary] and used for performing resident assessments.

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 nursing 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, and the portion of fringe benefits and payroll taxes allocated to the nursing services cost category in accordance with part 9549.0053 [Temporary].

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Subp. 6. **Case mix score.** "Case mix score" means the case mix index divided by the total number of residents in the nursing 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, and the portion of fringe benefits and payroll taxes allocated to the other care-related cost category, the cost of food, and the dietician consulting fees calculated in accordance with part 9549.0053 [Temporary].

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

Subp. 10. **Productive nursing hours.** "Productive nursing hours" means all on-duty hours of nurses, aides, orderlies, and attendants. This term does not include the on-duty hours of the medical records personnel or the director of nursing for facilities with more than 60 licensed beds. Vacation, holidays, sick leave, and classroom training, are not included in productive nursing hours.

Subp. 11. **Quality assurance and review or QA&R.** "Quality assurance and review" or "QA&R" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. 12. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058 [Temporary].

Subp. 13. **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.

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"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. 14. **Short length of stay facility.** "Short length of stay facility" means a nursing home that is certified to provide a skilled level of care and has an average length of stay of 180 days or less in its skilled level of care. For the purpose of this definition the commissioner shall calculate average length of stay for the nursing home by dividing actual resident days in the skilled level of care for which the nursing home can bill, by the total number of discharges from the skilled level of care during the reporting year.

Subp. 15. **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 2 and 3.

9549.0052 [Temporary] ESTABLISHMENT OF GEOGRAPHIC GROUPS.

Subpart 1. **Classification process.** The commissioner shall classify Minnesota nursing homes according to their geographic location as indicated in subparts 2 to 4.

Subp. 2. **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, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Yellow Medicine, and Wadena counties must be placed in geographic group 1.

Subp. 3. **Group 2.** All nursing homes in counties other than the counties listed under subparts 2 and 4 must be placed in geographic group 2.

Subp. 4. **Group 3.** All nursing homes in Aitkin, Anoka,

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Carlton, Carver, Cook, Dakota, Hennepin, Itasca, Koochiching, Lake, Ramsey, St. Louis, Scott, and Washington counties must be placed in geographic group 3.

9549.0053 [Temporary] DETERMINATION AND ALLOCATION OF FRINGE BENEFITS AND PAYROLL TAXES, FOOD COSTS, AND DIETICIAN CONSULTING FEES.

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.

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.

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.

D. For any nursing home that cannot separately report 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) to (3).

(1) The commissioner shall sum the allowable salaries for all nursing homes separately reporting allowable salaries in each cost category by cost category and in total.

(2) The commissioner shall determine the ratio of the total allowable salaries in each cost category to the total allowable salaries in all cost categories, based on the totals in subitem (1).

(3) The nursing home's total allowable fringe benefits and payroll taxes must be multiplied by each ratio determined in subitem (2) to determine the amount of payroll

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taxes and fringe benefits allocated to each cost category for each nursing home under this item.

Subp. 2. **Determination of food costs.** The commissioner shall determine the costs of food to be included in other care-related costs according to items A and B.

A. For any nursing home separately reporting food costs, food costs shall be the allowable food costs reported under part 9549.0040, subpart 1.

B. For any nursing home that cannot separately report the cost of food under part 9549.0040, subpart 1, the commissioner shall determine the average ratio of food costs to total dietary costs for all nursing homes that separately reported food costs. The nursing home's total allowable dietary costs must be multiplied by the average ratio to determine the food costs for the nursing home.

Subp. 3. **Determination of dietician consulting fees.** The commissioner shall determine the dietician consulting fees to be included in other care-related costs according to items A and B.

A. For any nursing home separately reporting dietician consulting fees, the dietician consulting fees shall be the allowable dietician consulting fees reported under part 9549.0040, subpart 1.

B. For any nursing home that has not separately reported dietician consulting fees, the commissioner shall determine the average cost per licensed bed of allowable dietician consulting fees for all nursing homes that separately reported dietician consulting fees. The nursing home's total number of licensed beds must be multiplied by the average cost per bed to determine the dietician consulting fees for the nursing home.

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

Subpart 1. **Review and adjustment of costs.** The commissioner shall annually review and adjust the operating costs reported by the nursing home during the reporting year

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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.

Subp. 2. **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 I.

A. The commissioner shall select the two most recent QA&R assessments completed prior to April 1, 1985. If only one QA&R assessment is available, the commissioner shall compute the standardized resident days in accordance with item I. Any nursing home whose most recent QA&R assessment completed before April 1, 1985, does not include assessments of nonmedical assistance residents may make a written request to the commissioner to consider a different QA&R assessment to be the most recent if that assessment:

(1) includes nonmedical assistance residents; and

(2) was completed by the Department of Health before July 1, 1985.

The request must be in writing. Written requests must be received by the commissioner by December 31, 1985.

B. For each of the two QA&R 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 QA&R 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 QA&R assessment, the medical assistance case mix score must be the private pay case mix score determined in item F, subitem (1).

D. 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

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medical assistance case mix score and dividing the result by the number of months between the two QA&R 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.

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 QA&R 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 nonmedical assistance residents for each nursing home whose most recent QA&R assessment included assessments of nonmedical assistance 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 QA&R 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 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 QA&R assessment included assessments of nonmedical assistance residents, multiply the nonmedical assistance resident days during the reporting year by the nursing home's private pay case

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mix score as determined in item F, subitem (1). If the nursing home's QA&R 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.

(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 QA&R 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. 3. **Standardized resident days for rate year beginning July 1, 1986.** For the rate year beginning on July 1, 1986, the commissioner shall calculate the nursing home's standardized resident days in accordance with items A to E.

A. The case mix score for a date prior to July 1, 1985, must be determined in accordance with subitems (1) to (4).

(1) Except as provided in subitem (2), the case mix score must be calculated using the most recent QA&R assessment completed prior to April 1, 1985.

(2) A QA&R assessment completed on or after April 1, 1985, may be used if the nursing home's most recent QA&R assessment completed before April 1, 1985, did not include assessments of nonmedical assistance residents and the nursing home has submitted a written request to the commissioner,

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requesting the use of a different QA&R assessment. The nursing home's request to the commissioner to use a different QA&R assessment must have been received by December 31, 1985. The commissioner shall use the requested QA&R assessment to compute standardized resident days if the requested QA&R assessment:

(a) was completed by the Minnesota Department of Health before July 1, 1985; and

(b) nonmedical assistance residents were included in the assessment.

(3) The case mix index for the QA&R assessment selected in subitem (1) or (2) must be the sum of the number of residents in each resident class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

(4) The case mix index determined in subitem (3) must be divided by the total number of residents assessed to compute the case mix score for the QA&R assessment selected in subitem (1) or (2).

B. The case mix score for the period July 1, 1985, to September 30, 1985, must be determined according to subitems (1) to (3).

(1) The resident days in each resident class for the months of July, August, and September 1985 must be multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

(2) The amounts determined in subitem (1) must be summed to determine the nursing home's standardized resident days for the period July 1, 1985, to September 30, 1985.

(3) The standardized resident days determined in subitem (2) must be divided by actual resident days reported for the period July 1, 1985, to September 30, 1985, to determine the case mix score for that period.

C. The average monthly change in the case mix score must be computed by subtracting the case mix score determined in item A from the case mix score determined in item B, and dividing the result by the number of months between the date of the QA&R assessment selected in item A, subitem (1) or (2) and

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August 16, 1985. For the purposes of this item, the commissioner shall count as a full month any period of more than 14 days and shall disregard any period of 14 days or less.

D. The average case mix score must be determined by subtracting the product of the average monthly change in the case mix score times 4.5, from the case mix score determined in item B.

E. The standardized resident days for each nursing home must be computed by multiplying the average case mix score computed in item D by the total number of resident days during the reporting year.

Subp. 4. **Standardized resident days for rate years beginning on or after July 1, 1987.** For rate years beginning on or after July 1, 1987, each nursing home's standardized resident days must be determined in accordance with items A and B.

A. The nursing home's resident days for the reporting year in each resident class must be multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

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

Subp. 5. **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 in the nursing home's reporting year as determined in subpart 2, 3, or 4.

Subp. 6. **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 number of resident days in the nursing home's reporting year.

Subp. 7. **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 number of resident days in the nursing

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home's reporting year.

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 (7).

(1) The components and indices specified in the following table must be used to establish the case mix and other care-related operating cost adjustment factor. These indices are incorporated by reference as specified in subpart 4.

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 index value for calendar year 1983 for each component in subitem (1) must be determined by

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summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for

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the rate year computed in subitem (6), unit (d) by the composite price index for the reporting year computed in subitem (4), unit (d).

B. The annual adjustment factor for the other operating costs must be established according to subitems (1) to (7).

(1) The components and indices specified in the following table must be used to establish the other operating cost adjustment factor. These indices are incorporated by reference as specified in subpart 4.

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

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Miscellaneous Purchases (Commodities)	.0809	Consumer Price Index for maintenance and repair commodities.
TOTAL	1.0000	

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for

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each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (d) by the composite price index for the reporting year computed in subitem (4), unit (d).

Subp. 2. **Base year limits.** For each geographic group established in part 9549.0052 [Temporary] the base year operating costs limits must be determined according to items A to E. No redetermination of the base year 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. For the purpose of establishing operating cost limits, the commissioner shall compute the allowable historical other care-related per diems for the base year 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. An exception to this calculation is made for a short length of stay facility. For a short length of stay facility, the

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allowable historical other care-related operating costs must be divided by the greater of resident days or 80 percent of its number of licensed beds multiplied by the number of days in the reporting period.

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. The total care-related operating cost limit for a short length of stay facility must be 125 percent of the total care-related operating cost limit. 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 is 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 (5). For the purpose of establishing operating costs limits, the commissioner shall compute the allowable historical other operating costs per diems for the base year 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. An exception to this calculation is made for a short length of stay facility. For a short length of stay facility, the allowable historical other operating costs must be divided 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.

(1) For each geographic group in part 9549.0052 [Temporary], the commissioner shall group all hospital attached nursing homes, short length of stay facilities, and nursing homes licensed on May 1, 1983, by the commissioner to provide

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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~~ diems for each nursing home in the group established under subitem (1) in the base year.

(3) The other operating cost limit for all short length of stay facilities, 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).

(5) The other operating cost limit for each group established in 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.

Subp. 3. **Indexed limits.** For a rate year beginning on or after July 1, 1986, the total care-related operating cost limits and the other operating cost limits must be determined in accordance with items A and B.

A. The total care-related operating cost limits must be determined in accordance with subitems (1) and (2).

(1) The composite price index for case mix and other care-related operating costs for the current reporting year as determined in subpart 1, item A, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) The limit for each resident class in subpart 2, item C, must be multiplied by the amount determined in subitem (1) to establish the indexed total care-related operating cost limits.

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B. Each total other operating costs limit must be determined in accordance with subitems (1) and (2).

(1) The composite price index for other operating costs for the current reporting year as determined in subpart 1, item B, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) Each limit in subpart 2, item E must be multiplied by the amount determined in subitem (1) to establish the indexed other operating cost limits.

Subp. 4. **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

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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 5, 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 6, 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, as indexed in part 9549.0055 [Temporary], subpart 3, 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, as indexed in part 9549.0055 [Temporary], subpart 3, 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. If the nursing home is eligible to receive the phase-in in subpart 7, the phase-in reduced by the amount of the efficiency incentive, if any, must be added to

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the adjusted prospective case mix and other care-related payment rate.

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 7, is below the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, as indexed in part 9549.0055 [Temporary], subpart 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 7, is at or above the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, as indexed in part 9549.0055 [Temporary], subpart 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 to E.

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, as indexed in part 9549.0055 [Temporary], subpart 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, as indexed in part 9549.0055 [Temporary], subpart 3, and the nonadjusted other operating cost payment rate in subpart 3, item A, up to a maximum of two dollars per resident day.

B. For any short length of stay facility and any

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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 that 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) as indexed in part 9549.0055 [Temporary], subpart 3, ~~item A,~~ and the nonadjusted other operating cost payment rate in subpart 3, up to a maximum of two dollars.

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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, as indexed in part 9549.0055 [Temporary], subpart 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. If the nursing home is eligible to receive the phase-in in subpart 7, the phase-in must be added to the adjusted prospective other operating cost payment rate.

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

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.

Subp. 6. **One-time adjustment.** Items A to F set forth the procedure to be applied to establish a one-time adjustment to

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the nursing home's case mix operating costs per diem for the period October 1, 1986, to September 30, 1987.

A. To qualify for a one-time adjustment to the case mix operating costs per diem, the nursing home or portion of the nursing home for which the adjustment is requested must be licensed under Minnesota Statutes, chapter 144A and the nursing home must not have received an interim or settle-up payment rate during the reporting year ending September 30, 1985.

B. To apply for the one-time adjustment to case mix operating costs per diem, the nursing home must submit a written request to the commissioner on or before July 31, 1986. The written request must include the information required in subitems (1) to (3).

(1) Documentation indicating that based on the productive nursing hours and standardized resident days for the reporting period, ending September 30, 1985, the nursing home cannot provide a minimum of 0.95 productive nursing hours per standardized resident day by reallocating existing staff and costs and that the nursing home cannot use other available resources, including any efficiency incentives effective July 1, 1986, to increase productive nursing hours to meet the minimum of 0.95 productive nursing hours per standardized resident day.

(2) A list of the number and type of staff positions including annual hours worked and related fringe benefits and payroll taxes, for the reporting years ending September 30, 1984 and September 30, 1985.

(3) A written nursing plan describing how the nursing home will meet the minimum of 0.95 productive nursing hours per standardized resident day if the nursing home receives a one-time adjustment. The plan must include the number and types of staff to be added to the current staff complement and the projected cost of the salary and related fringe benefits and payroll taxes for the additional staff. The plan must also specify any other increases in case mix operating costs.

C. The commissioner of human services and the commissioner of health shall review the documentation submitted

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by the nursing home under item B to determine if the nursing home meets the criteria in subitems (1) to (5).

(1) The nursing home meets the criteria in item A.

(2) The nursing home has submitted the documentation required in item B.

(3) The nursing home provided less than a minimum of 0.95 productive nursing hours per standardized resident day for the reporting period ending September 30, 1985.

(4) The nursing home cannot meet the minimum of 0.95 productive nursing hours per standardized resident day by reallocating staff and costs including efficiency incentives.

(5) The nursing home's allowable historical case mix and other care-related operating cost per diem plus the one-time adjustment is less than the case mix and other care-related operating cost limit.

D. If the request meets the criteria in item C, the commissioner shall make a one-time adjustment to the nursing home's payment rate. The one-time adjustment must be determined according to subitems (1) to (9) and must not exceed the amount computed in subitem (3).

(1) The nursing home's productive nursing hours per standardized resident day for the reporting period ending September 30, 1985, must be subtracted from 0.95 and the result must be multiplied by the nursing home's standardized resident days for the period beginning October 1, 1984, and ending September 30, 1985.

(2) The nursing home's nursing cost per hour must be determined by dividing the nursing home's total allowable historical case mix operating costs by the nursing home's total productive nursing hours for the reporting period ending September 30, 1985.

(3) The amount determined in subitem (1) must be multiplied by the amount determined in subitem (2) to determine the total maximum nursing costs required to meet the minimum of 0.95 productive nursing hours per standardized resident day.

(4) If the amount requested in the nursing hours

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plan submitted under item B is less than the amount in subitem (3) the difference must be subtracted from the amount in subitem (3).

(5) The amount determined in subitem (4) must be divided by the nursing home's standardized resident days for the reporting period ending September 30, 1985, to compute the maximum standardized case mix per diem costs to be allowed under this subpart.

(6) Any efficiency incentive included in the nursing home's total operating ~~costs~~ cost payment on July 1, 1986, must be subtracted from the amounts in subitem (5).

(7) Any further reduction that the commissioner determines would be possible by reallocating the nursing home's staff and costs must be subtracted from the amount computed in subitem (6).

(8) The amount computed in subitem (7) must be multiplied by the weight for each resident class contained in part 9549.0058 [Temporary], subpart 2.

(9) The amount computed in subitem (8) must be added to the adjusted prospective case mix and other care-related payment rates for each corresponding resident class.

E. The one-time adjustment determined in item D, subitem (9) shall be implemented beginning October 1, 1986. No portion of the adjustment may be used to provide services that are not case mix operating costs according to part 9549.0051 [Temporary], subpart 5. The commissioner shall perform a fiscal review of the nursing home's cost report submitted for the reporting period ending September 30, 1987, and of any additional documentation required by the commissioner to determine if the nursing home provided 0.95 productive nursing hours per standardized resident day and to determine whether the nursing home has implemented the provisions of the plan specified in item B. The commissioner shall consult with the commissioner of health to verify compliance with any applicable care-related licensing or certification standards. Based on the results of the fiscal review and the information provided by the

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commissioner of health the commissioner shall implement either subitem (1), (2), or (3).

(1) If the nursing home has failed to implement the plan required in item B, the commissioner shall recover the total amount paid under this subpart in accordance with part 9549.0070, subpart 4 and shall disallow any increases in costs incurred by the nursing home under this subpart in establishing the payment rate for the rate year beginning July 1, 1988.

(2) If the nursing home has implemented or partially implemented the plan specified in item B and the actual case mix operating costs incurred during the reporting year ending September 30, 1987, are below the payment made under this subpart, the commissioner shall reduce the adjustment to the nursing home's payment rate and recover any overpayments in accordance with part 9549.0070, subpart 4. The reduced adjustment to the nursing home's total payment rate shall continue to be paid to the nursing home until June 30, 1988.

(3) If the actual costs of implementing the plan specified in item B, subitem (3) incurred during the reporting period ending September 30, 1987, exceed the payments made under this subpart there shall be no retroactive cost settle-up. The adjustment to the nursing home's total payment rate shall continue to be paid to the nursing home at the same level until June 30, 1988.

F. The nursing home must record the costs associated with this subpart separately from other nursing home costs until the commissioner's fiscal and compliance review under item E establishes that the nursing home has implemented the plan required in item B and has provided at least 0.95 productive nursing hours per standardized resident day during the reporting period ending September 30, 1987. To prevent duplicate payments, the case mix operating costs associated with this subpart are nonallowable until after the commissioner has reviewed and approved the costs under item E. If the commissioner approves the costs, the additional case mix operating costs incurred under this subpart are allowable costs

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and must be included in the computation of the allowable historical case mix operating cost per diem for the rate year beginning July 1, 1988.

Subp. 7. **Phase-in of rates.** Nursing home rate limits shall be phased-in in accordance with Minnesota Statutes, section 256B.431, subdivision 2h.

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

Subpart 1. **Conditions.** 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 2 and 3.

Subp. 2. **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], in effect on March 1, 1986. For the rate year or portion of an interim period beginning on or after July 1, 1986, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 [Temporary], except that:

A. The 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

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care-related operating cost per diem and the allowable historical other operating cost per diem.

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, as indexed in part 9549.0055 [Temporary], subpart 3, and in effect at the beginning of the interim period must be increased by ten percent.

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

G. The phase-in provisions in part 9549.0056 [Temporary], subpart 7, must not apply.

Subp. 3. **Settle-up operating cost payment rate.** The settle-up total operating cost payment rate must be determined according to items A to ~~e~~ D. FFTCF

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, and before July 1, 1986, or whose interim reporting period included a period of time during that period must be determined for the portion of that interim period occurring after June 30, 1985, and before July 1, 1986, as in parts 9549.0050 to 9549.0059 [Temporary] in effect on March 1, 1986.

C. The settle-up operating cost payment rate for a nursing home which commenced construction after June 30, 1986, or whose interim period included a period of time after that date must be determined for the portion of that interim period occurring after June 30, 1986, as in parts 9549.0050 to 9549.0059 [Temporary] except that:

(1) The standardized resident days occurring after June 30, 1986, must be annualized for the interim

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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.

(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 2, item E, must be the limits for the settle-up reporting period occurring after July 1, 1986.

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

(7) The phase-in provisions in part 9549.0056 [Temporary], subpart 7, must not apply.

~~e~~ D. 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, applies.

9549.0058 [Temporary] RESIDENT CLASSES AND CLASS WEIGHTS.

Subpart 1. **Resident classes.** Each resident or applicant must be classified according to items A to E based on the information on the assessment form completed in accordance with part 9549.0059 [Temporary].

A. A 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

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Dressing	2
Grooming	2
Bathing	4
Eating	2
Bed mobility	2
Transferring	2
Walking	2
Toileting	1

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

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

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

(2) the resident or applicant is assessed to require clinical monitoring every day on each shift and the resident is assessed to require one or more of the following special treatments:

(a) oxygen and respiratory therapy;

(b) ostomy/catheter care;

(c) wound or decubitus care;

(d) skin care;

(e) intravenous therapy;

(f) drainage tubes;

(g) blood transfusions;

(h) hyperalimentation;

(i) symptom control for the terminally ill; or

(j) isolation precautions.

D. A resident or applicant must be defined as having a neuromuscular condition if the resident or applicant is

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assessed to have one or more of the diagnoses coded to the categories in subitems (1) to (8) 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. The publication is available through the Minitex interlibrary loan system and is not subject to frequent change.

(1) diseases of nervous system excluding sense organs (320-359 excluding 331.0);

(2) cerebrovascular disease (430-438 excluding 437);

(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);

(7) injury to nerve roots and spinal plexus (953); or

(8) neoplasms of the brain and spine (170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6).

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

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

(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.

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(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.

(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 scoring three or four on the eating ADL in item A and not defined special nursing and defined neuromuscular condition or scoring three or four on behavior.

(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;

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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. The 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 registered nurse 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 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. A resident must not receive more than one assessment per respite care stay.

B. The 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

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requested voluntarily in accordance with Minnesota Statutes, section 256B.091. For purposes of this item, the term "newly admitted resident" includes a resident who moves to a section of the nursing home that is licensed differently than the section from which the resident came or a resident who has been transferred from another nursing home.

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 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. Each assessment that the nursing home is required to perform must be completed by a registered nurse. The 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 QA&R procedures of the Department of Health, including physical observation of the applicant or newly admitted resident and review of available medical records, and must be recorded on the assessment form.

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

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classification within ten working days after admission or after the assessment, whichever is later.

I. The resident class for applicants or newly admitted residents must be effective on the date of the person's 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 QA&R assessment occurred between May 1, 1985, and June 30, 1985, the classification established under part 4656.0030, subpart 3, shall apply.

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 annual assessment by the Department of Health's QA&R team.

B. A registered nurse shall perform the assessment on each resident according to QA&R 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. 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

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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 the information 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 completion of the semiannual assessments.

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 QA&R assessments were performed in October or November 1984.

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

(3) In September 1985, the nursing home must assess all residents whose most recent QA&R 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

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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 QA&R team ~~will~~ must be effective as of the first day of the month following the date of completion of the Department of Health's assessments. FF Tcg

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 must occur no more than five working days after the resident returns to the same nursing home.

~~B. In addition to the assessment required in item A, residents who have returned to the same nursing home after hospital admission must be reassessed by the nursing home no less than 30 days and no more than 35 days after return from the hospital unless the nursing home's annual or semiannual reassessment occurs during the specified time period.~~ FF1

~~C.~~ A registered nurse shall perform the assessment on each resident according to QA&R 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. 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 and the resident's medical plan of care. Upon request, the nursing home must furnish the Department of Health with additional information needed to determine a resident's classification.

~~D~~ C. Any change in resident class due to an assessment provided under item A must be effective on the date

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the resident returns to the nursing home from the hospital. ~~Any change in resident class due to a reassessment provided under item B must be effective as of the first day of the month following the assessment.~~

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 ~~4656.0050~~ 4656.0100 [Temporary] ~~that results in a payment increase for the resident must be effective as of the first day of the month following the date of the Department of Health's classification. Any change in resident class due to a reclassification required by part 4656.0050 [Temporary] that results in a payment decrease for the resident~~ must be retroactive to the effective date of the assessment audited.

Subp. 7. **False information.** If the nursing home knowingly supplies inaccurate or false information in an assessment or a request for reconsideration, the commissioner shall apply the penalties in part 9549.0041, subpart 15.

Subp. 8. **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 4656.0060 is pending.

B. Any change in a resident class due to a reclassification under part 4656.0060 must be effective as of the effective date of the classification established by the original assessment for which a reconsideration was requested.

Subp. 9. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made under part 4656.0060.

Subp. 10. **Resident access to assessments and documentation.** The nursing home must provide access to information regarding rates, assessments, and other

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documentation provided to the Minnesota Department of Health in support of the resident's assessments to each nursing home resident or the resident's authorized representative according to items A to D.

A. The nursing home must post a notice of its current rates for each resident class in a conspicuous place. The rates must be posted no later than five days after receipt by the nursing home. The nursing home may include a notice that the nursing home has chosen to appeal the rates under part 9549.0080.

B. The nursing home must provide written notice to each private paying resident or the person responsible for payment of any increase in the total payment rate established by the commissioner 30 days before the increase takes effect, as required by Minnesota Statutes, section 256B.47, subdivision 2. The notice must specify the current classification of the resident. This item does not apply to adjustments in rates due to a necessary change in the resident's classification as a result of an assessment required in this part.

C. The nursing home must provide each nursing home resident or the person responsible for payment with each classification letter received from the Minnesota Department of Health within five days of the receipt of the classification letter. If the resident's classification has changed, the nursing home must include the current rate for the new classification with the classification letter.

D. 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.

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STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
MAY 23 1986
Joan Anderson Growe
Secretary of State
9:41AM

APPROVED AS TO FORM AND LEGALITY
5/22 19 86
HUBERT H. HUMPHREY, III
ATTORNEY GENERAL
BY _____
ASSISTANT ATTORNEY GENERAL

Department of Human Services

Proposed Temporary Rules Relating to Nursing Home Payment Rate Determination

Rules as Proposed [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~~ 4656.0100 [Temporary].

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,~~ under parts 4656.0010 to 4656.0100 [Temporary] 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 nursing 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, and the portion of fringe benefits and payroll taxes allocated to the nursing services cost category in accordance with part 9549.0053 [Temporary].

Subp. 6. **Case mix score.** "Case mix score" means the case mix index divided by the total number of residents in ~~each~~ the nursing 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, and the portion of fringe benefits and payroll taxes allocated to the other care-related cost category, the cost of food, and the ~~required~~ dietician consulting fees ~~charged-by-a-nonrelated-organization~~ calculated in accordance with part 9549.0053 [Temporary].

Subp. 9. **Other operating costs.** "Other operating costs" means the operating costs listed in part 9549.0040, subparts 1, 2, 3, 4, and 7, excluding the cost of food and dietician consulting fees, 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~~ [Temporary].

Subp. 10. **Productive nursing hours.** "Productive nursing hours" means all on-duty hours of nurses, aides, orderlies, and attendants. This term does not include the on-duty hours of the medical records personnel or the director of nursing for facilities with more than 60 licensed beds. Vacation, holidays, sick leave, and classroom training, are not included in productive nursing hours.

Subp. ~~10.~~ 11. **Quality assurance and review or QA&**

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R. "Quality assurance and review" or "QA&R" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. ~~11.~~ 12. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058 [Temporary].

Subp. ~~12.~~ 13. **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. 14. **Short length of stay facility.** "Short length of stay facility" means a nursing home that is certified to provide a skilled level of care and has an average length of stay of 180 days or less in its skilled level of care. For the purpose of this definition the commissioner shall calculate average length of stay for the nursing home by dividing actual resident days in the skilled level of care for which the nursing home can bill, by the total number of discharges from the skilled level of care during the reporting year.

Subp. ~~13.~~ 15. **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 and 3.

9549.0052 [Temporary] ESTABLISHMENT OF GEOGRAPHIC GROUPS.

Subpart 1. **Classification process.** The commissioner shall classify Minnesota nursing homes according to their geographic location as indicated in subparts ~~1 to 3~~ 2 to 4.

~~Subpart 1.~~ Subp. 2. **Group 1.** All nursing homes in Beltrami, Big Stone, Cass, Chippewa, Clearwater, Cottonwood, Crow Wing, Hubbard, Jackson, Kandiyohi, Lac Qui Parle, Lake of

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the Woods, Lincoln, Lyon, Mahnomen, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Yellow Medicine, and Wadena counties must be placed in geographic group 1.

Subp. ~~2.~~ 3. **Group 2.** All nursing homes in counties other than the counties listed under subparts ~~1 and 3~~ 2 and 4 must be placed in geographic group 2.

Subp. ~~3.~~ 4. **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 [Temporary] DETERMINATION AND ALLOCATION OF FRINGE BENEFITS AND PAYROLL TAXES, FOOD COSTS, AND ~~REQUIRED~~ DIETICIAN CONSULTING FEES.

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.

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.

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.

D. For any nursing home ~~which has not separately reported~~ that cannot separately report 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)~~ to (3).

(1) The commissioner shall ~~determine the ratio of~~ sum the allowable salaries for all nursing homes separately

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reporting 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~~ by cost category and in total.

(2) The commissioner shall determine the ratio of the total allowable salaries in each cost category to the total allowable salaries in all cost categories, based on the totals in subitem (1).

~~(2)~~ (3) The nursing home's total allowable fringe benefits and payroll taxes must be multiplied by each ratio determined in subitem ~~(1)~~ (2) to determine the amount of payroll taxes and fringe benefits allocated to each cost category for each nursing home under this item ~~B~~.

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,~~ The commissioner shall determine the ~~food~~ costs of food to be included in other care-related 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.~~ For any nursing home separately reporting food costs, food costs shall be the allowable food costs reported under part 9549.0040, subpart 1.

B. For any nursing home that cannot separately report the cost of food under part 9549.0040, subpart 1, the commissioner shall determine the average ratio of food costs to total dietary costs for all nursing homes that separately reported food costs. The nursing home's total allowable dietary costs must be multiplied by the average ratio ~~determined in item A~~ to determine the food costs for ~~that~~ the 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 to be included in other care-related costs according to items A ~~to C~~ and B.

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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.~~ For any nursing home separately reporting dietician consulting fees, the dietician consulting fees shall be the allowable dietician consulting fees reported under part 9549.0040, subpart 1.

B. For any nursing home that has not separately reported dietician consulting fees, the commissioner shall determine the average cost per licensed bed of allowable dietician consulting fees for all nursing homes that separately reported dietician consulting fees. The nursing home's total number of licensed beds must be multiplied by the ~~amount determined in item A~~ average cost per bed to determine the ~~required~~ dietician consulting fees for ~~that~~ the nursing home.

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

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

Subpart 1. **Review and adjustment of costs.** The commissioner shall annually review and adjust the operating costs ~~incurred~~ reported 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.

~~Subpart 1.~~ Subp. 2. **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 I.

A. The commissioner shall select the two most recent QA&R assessments completed prior to April 1, 1985. If only one QA&R assessment is available, the commissioner shall compute the standardized resident days in accordance with item I. Any nursing home whose most recent QA&R assessment completed before

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April 1, 1985, does not include assessments of nonmedical assistance residents may make a written request to the commissioner to consider a different QA&R assessment to be the most recent if that assessment:

(1) includes nonmedical assistance residents; and

(2) was completed by the Department of Health before July 1, 1985.

The request must be in writing. Written requests must be received by the commissioner by December 31, 1985.

B. For each of the two QA&R 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 QA&R 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 QA&R assessment, the medical assistance case mix score must be the private pay case mix score determined in item F, subitem (1).

D. 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 QA&R 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.

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 QA&R assessment. For a partial calendar month, the commissioner shall count as a full month the period of more than 14 days, and

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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 nonmedical assistance residents for each nursing home whose most recent QA&R assessment included assessments of nonmedical assistance 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 QA&R 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 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 QA&R assessment included assessments of nonmedical assistance residents, multiply the nonmedical 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 QA&R 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.

(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 QA&R assessment is available, the commissioner shall compute the standardized resident days in

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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.~~ 3. **Standardized resident days for rate year beginning July 1, 1986.** For the rate year beginning on July 1, 1986, ~~each~~ the commissioner shall calculate the nursing home's standardized resident days ~~must be determined~~ in accordance with items A to ~~C~~ E.

~~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.~~

A. The case mix score for a date prior to July 1, 1985, must be determined in accordance with subitems (1) to (4).

(1) Except as provided in subitem (2), the case mix score must be calculated using the most recent QA&R assessment completed prior to April 1, 1985.

(2) A QA&R assessment completed on or after April 1, 1985, may be used if the nursing home's most recent QA&R assessment completed before April 1, 1985, did not include assessments of nonmedical assistance residents and the nursing home has submitted a written request to the commissioner, requesting the use of a different QA&R assessment. The nursing home's request to the commissioner to use a different QA&R

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assessment must have been received by December 31, 1985. The commissioner shall use the requested QA&R assessment to compute standardized resident days if the requested QA&R assessment:

(a) was completed by the Minnesota Department of Health before July 1, 1985; and

(b) nonmedical assistance residents were included in the assessment.

(3) The case mix index for the QA&R assessment selected in subitem (1) or (2) must be the sum of the number of residents in each resident class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

(4) The case mix index determined in subitem (3) must be divided by the total number of residents assessed to compute the case mix score for the QA&R assessment selected in subitem (1) or (2).

B. The case mix score for the period July 1, 1985, to September 30, 1985, must be determined according to subitems (1) to (3).

(1) The resident days in each resident class for the months of July, August, and September 1985 must be multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

(2) The amounts determined in subitem (1) must be summed to determine the nursing home's standardized resident days for the period July 1, 1985, to September 30, 1985.

(3) The standardized resident days determined in subitem (2) must be divided by actual resident days reported for the period July 1, 1985, to September 30, 1985, to determine the case mix score for that period.

C. The average monthly change in the case mix score must be computed by subtracting the case mix score determined in item A from the case mix score determined in item B, and dividing the result by the number of months between the date of the QA&R assessment selected in item A, subitem (1) or (2) and August 16, 1985. For the purposes of this item, the commissioner shall count as a full month any period of more than

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14 days and shall disregard any period of 14 days or less.

D. The average case mix score must be determined by subtracting the product of the average monthly change in the case mix score times 4.5, from the case mix score determined in item B.

E. The standardized resident days for each nursing home must be computed by multiplying the average case mix score computed in item D by the total number of resident days during the reporting year.

Subp. 4. **Standardized resident days for rate years beginning on or after July 1, 1987.** For rate years beginning on or after July 1, 1987, each nursing home's standardized resident days must be determined in accordance with items A and B.

A. The nursing home's resident days for the reporting year in each resident class must be multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

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

Subp. ~~3.~~ 5. **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 in the nursing home's reporting year as determined in subpart ~~1 or~~ 2, 3, or 4.

Subp. ~~4.~~ 6. **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 ~~actual~~ number of resident days in the nursing home's reporting year.

Subp. ~~5.~~ 7. **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 ~~actual~~ number of resident days in the nursing home's reporting year.

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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)~~ (7).

(1) The components and indices ~~for~~ specified in the following table must be used to establish the case mix and other care-related operating ~~costs~~ cost adjustment factor ~~must be as specified in the following table~~. These indices are incorporated by reference as specified in subpart 4.

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). ~~SIC-805 is incorporated by reference.~~
Benefits	.1107	Difference between movements in compensation and wages and salary index components of the Employment Cost Index for Service Workers. ~~This index is incorporated by reference.~~
Supplies and Drugs	.0363	Consumer Price Index for nonprescription medical equipment and supplies. ~~This index is incorporated by reference.~~
Food	.1183	Producer Price Index for consumer foods. ~~This index is incorporated by reference.~~

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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).~~

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined

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by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (d) by the composite price index for the reporting year computed in subitem (4), unit (d).

B. The annual adjustment factor for the other operating costs must be established according to subitems (1) to ~~(4)~~ (7).

(1) The components and indices ~~for~~ specified in the following table must be used to establish the other operating cost adjustment factor ~~must be as specified in the following table~~. These indices are incorporated by reference as specified in subpart 4.

OTHER OPERATING COSTS COMPONENTS AND INDICES

Component	Weight	Index
Utilities	.1099	Producer Price Index for natural gas (80 percent); ~~a~~and Producer Price Index for commercial power in west north central state (20 percent). ~~This index is incorporated by reference.~~

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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 (i) 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~~

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~~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).~~

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80

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percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (d) by the composite price index for the reporting year computed in subitem (4), unit (d).

Subp. 2. Base year limits. For each geographic group established in part 9549.0052 [Temporary] the base year operating costs limits must be determined according to items A to ~~F~~ E. No redetermination of the base year 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. For the purpose of establishing operating cost limits, the commissioner shall compute the allowable historical other care-related per diems for the base year 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. An exception to this calculation is made for a ~~nursing home that is certified to provide a skilled level of care and has an average length of stay of 180 days or less in its skilled level of care. In that case~~ short length of stay facility. For a

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short length of stay facility, the allowable historical other care-related operating costs must be divided by the greater of resident days or 80 percent of its number of licensed beds multiplied by the number of days in the reporting period.

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~~ a short length of stay facility 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~~ is 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 (5). For the purpose of establishing operating costs limits, the commissioner shall compute the allowable historical other operating costs per diems for the base year 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. An exception to this calculation is made for a ~~nursing home that is certified to provide a skilled level of care and has an average length of stay of 180 days or less in its skilled level of care. In that case~~ short length of stay facility. For a short length of stay facility, the allowable historical other operating costs must be divided by the greater of resident days or 80 percent of the

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number of licensed beds multiplied by the number of days in the reporting period.

(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~~ short length of stay facilities, 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~~ short length of stay facilities, 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).

(5) The other operating cost limit for each group established in 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. **Indexed limits.** For a rate year beginning on or after July 1, 1986, the total care-related operating cost limits and the other operating cost limits must be determined in accordance with items A and B.

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A. The total care-related operating cost limits must be determined in accordance with subitems (1) and (2).

(1) The composite price index for case mix and other care-related operating costs for the current reporting year as determined in subpart 1, item A, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) The limit for each resident class in subpart 2, item C, must be multiplied by the amount determined in subitem (1) to establish the indexed total care-related operating cost limits.

B. Each total other operating costs limit must be determined in accordance with subitems (1) and (2).

(1) The composite price index for other operating costs for the current reporting year as determined in subpart 1, item B, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) Each limit in subpart 2, item E must be multiplied by the amount determined in subitem (1) to establish the indexed other operating cost limits.

Subp. ~~3.~~ 4. **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.

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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~~ 5, 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~~ 6, 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, as indexed in part 9549.0055 [Temporary], subpart 3, 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,

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item C, as indexed in part 9549.0055 [Temporary], subpart 3, 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. If the nursing home is eligible to receive the phase-in in subpart 7, the phase-in reduced by the amount of the efficiency incentive, if any, must be added to the adjusted prospective case mix and other care-related payment rate.

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 7, is below the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, as indexed in part 9549.0055 [Temporary], subpart 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 7, is at or above the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, as indexed in part 9549.0055 [Temporary], subpart 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 to ~~C~~ E.

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

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[Temporary], subpart 2, item E, as indexed in part 9549.0055 [Temporary], subpart 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, as indexed in part 9549.0055 [Temporary], subpart 3, and the nonadjusted other operating cost payment rate in subpart 3, item A, up to maximum of two dollars per resident day.

B. For any ~~nursing-home-with-an-average-length-of-stay-of-180-days-or-less-in-its-skilled-nursing-level-of-care~~ short length of stay facility 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~~ that 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) as indexed in part 9549.0055 [Temporary], subpart 3, item A, and the nonadjusted other operating cost payment rate in subpart 3, up to a maximum of two dollars.

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, as indexed in part 9549.0055 [Temporary], subpart 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

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[Temporary], subpart 1, item B.

D. If the nursing home is eligible to receive the phase-in in subpart 7, the phase-in must be added to the adjusted prospective other operating cost payment rate.

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

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.

Subp. 6. **One-time adjustment.** Items A to F set forth the procedure to be applied to establish a one-time adjustment to the nursing home's case mix operating costs per diem for the period October 1, 1986, to September 30, 1987.

A. To qualify for a one-time adjustment to the case mix operating costs per diem, the nursing home or portion of the nursing home for which the adjustment is requested must be licensed under Minnesota Statutes, chapter 144A and the nursing home must not have received an interim or settle-up payment rate during the reporting year ending September 30, 1985.

B. To apply for the one-time adjustment to case mix operating costs per diem, the nursing home must submit a written request to the commissioner on or before July 31, 1986. The written request must include the information required in subitems (1) to (3).

(1) Documentation indicating that based on the productive nursing hours and standardized resident days for the reporting period, ending September 30, 1985, the nursing home cannot provide a minimum of 0.95 productive nursing hours per standardized resident day by reallocating existing staff and costs and that the nursing home cannot use other available resources, including any efficiency incentives effective July 1, 1986, to increase productive nursing hours to meet the minimum of 0.95 productive nursing hours per standardized resident day.

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(2) A list of the number and type of staff positions including annual hours worked and related fringe benefits and payroll taxes, for the reporting years ending September 30, 1984 and September 30, 1985.

(3) A written nursing plan describing how the nursing home will meet the minimum of 0.95 productive nursing hours per standardized resident day if the nursing home receives a one-time adjustment. The plan must include the number and types of staff to be added to the current staff complement and the projected cost of the salary and related fringe benefits and payroll taxes for the additional staff. The plan must also specify any other increases in case mix operating costs.

C. The commissioner of human services and the commissioner of health shall review the documentation submitted by the nursing home under item B to determine if the nursing home meets the criteria in subitems (1) to (5).

(1) The nursing home meets the criteria in item A.

(2) The nursing home has submitted the documentation required in item B.

(3) The nursing home provided less than a minimum of 0.95 productive nursing hours per standardized resident day for the reporting period ending September 30, 1985.

(4) The nursing home cannot meet the minimum of 0.95 productive nursing hours per standardized resident day by reallocating staff and costs including efficiency incentives.

(5) The nursing home's allowable historical case mix and other care-related operating cost per diem plus the one-time adjustment is less than the case mix and other care-related operating cost limit.

D. If the request meets the criteria in item C, the commissioner shall make a one-time adjustment to the nursing home's payment rate. The one-time adjustment must be determined according to subitems (1) to (9) and must not exceed the amount computed in subitem (3).

(1) The nursing home's productive nursing hours per standardized day for the reporting period ending September

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30, 1985, must be subtracted from 0.95 and the result must be multiplied by the nursing home's standardized resident days for the period beginning October 1, 1984, and ending September 30, 1985.

(2) The nursing home's nursing cost per hour must be determined by dividing the nursing home's total allowable historical case mix operating costs by the nursing home's total productive nursing hours for the reporting period ending September 30, 1985.

(3) The amount determined in subitem (1) must be multiplied by the amount determined in subitem (2) to determine the total maximum nursing costs required to meet the minimum of 0.95 productive nursing hours per standardized resident day.

(4) If the amount requested in the nursing hours plan submitted under item B is less than the amount in subitem (3) the difference must be subtracted from the amount in subitem (3).

(5) The amount determined in subitem (4) must be divided by the nursing home's standardized resident days for the reporting period ending September 30, 1985, to compute the maximum standardized case mix per diem costs to be allowed under this subpart.

(6) Any efficiency incentive included in the nursing home's total operating costs payment on July 1, 1986, must be subtracted from the amounts in subitem (5).

(7) Any further reduction that the commissioner determines would be possible by reallocating the nursing home's staff and costs must be subtracted from the amount computed in subitem (6).

(8) The amount computed in subitem (7) must be multiplied by the weight for each resident class contained in part 9549.0058 [Temporary], subpart 2.

(9) The amount computed in subitem (8) must be added to the adjusted prospective case mix and other care-related payment rates for each corresponding resident class.

E. The one-time adjustment determined in item D,

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subitem (9) shall be implemented beginning October 1, 1986. No portion of the adjustment may be used to provide services that are not case mix operating costs according to part 9549.0051 [Temporary], subpart 5. The commissioner shall perform a fiscal review of the nursing home's cost report submitted for the reporting period ending September 30, 1987, and of any additional documentation required by the commissioner to determine if the nursing home provided 0.95 productive nursing hours per standardized resident day and to determine whether the nursing home has implemented the provisions of the plan specified in item B. The commissioner shall consult with the commissioner of health to verify compliance with any applicable care-related licensing or certification standards. Based on the results of the fiscal review and the information provided by the commissioner of health the commissioner shall implement either subitem (1), (2), or (3).

(1) If the nursing home has failed to implement the plan required in item B, the commissioner shall recover the total amount paid under this subpart in accordance with part 9549.0070, subpart 4 and shall disallow any increases in costs incurred by the nursing home under this subpart in establishing the payment rate for the rate year beginning July 1, 1988.

(2) If the nursing home has implemented or partially implemented the plan specified in item B and the actual case mix operating costs incurred during the reporting year ending September 30, 1987, are below the payment made under this subpart, the commissioner shall reduce the adjustment to the nursing home's payment rate and recover any overpayments in accordance with part 9549.0070, subpart 4. The reduced adjustment to the nursing home's total payment rate shall continue to be paid to the nursing home until June 30, 1988.

(3) If the actual costs of implementing the plan specified in item B, subitem (3) incurred during the reporting period ending September 30, 1987, exceed the payments made under this subpart there shall be no retroactive cost settle-up. The adjustment to the nursing home's total payment rate shall

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continue to be paid to the nursing home at the same level until June 30, 1988.

F. The nursing home must record the costs associated with this subpart separately from other nursing home costs until the commissioner's fiscal and compliance review under item E establishes that the nursing home has implemented the plan required in item B and has provided at least 0.95 productive nursing hours per standardized resident day during the reporting period ending September 30, 1987. To prevent duplicate payments, the case mix operating costs associated with this subpart are nonallowable until after the commissioner has reviewed and approved the costs under item E. If the commissioner approves the costs, the additional case mix operating costs incurred under this subpart are allowable costs and must be included in the computation of the allowable historical case mix operating cost per diem for the rate year beginning July 1, 1988.

Subp. 7. **Phase-in of rates.** Nursing home rate limits shall be phased-in in accordance with Minnesota Statutes, section 256B.431, subdivision 2h.

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

Subpart 1. **Conditions.** 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 and 3.

~~Subpart 1.~~ Subp. 2. **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], in effect on March 1, 1986. For the rate year or portion of an interim period beginning on or after July

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1, 1986, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 [Temporary], except that:

A. ~~Each~~ The 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.

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, as indexed in part 9549.0055 [Temporary], subpart 3, and in effect at the beginning of the interim period must be increased by ten percent.

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

G. The phase-in provisions in part 9549.0056 [Temporary], subpart 7, must not apply.

Subp. ~~2.~~ 3. **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

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nursing home which commenced construction after June 30, 1985, and before July 1, 1986, or whose interim reporting period included a period of time ~~after that date~~ during that period must be determined for the portion of that interim period occurring after June 30, 1985, and before July 1, 1986, as in parts 9549.0050 to 9549.0059 [Temporary] in effect on March 1, 1986.

C. The settle-up operating cost payment rate for a nursing home which commenced construction after June 30, 1986, or whose interim period included a period of time after that date must be determined for the portion of that interim period occurring after June 30, 1986, as in parts 9549.0050 to 9549.0059 [Temporary] except that:

(1) The standardized resident days occurring after June 30, ~~1985~~ 1986, 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.

(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~~ 2, item E, must be the limits for the settle-up reporting period occurring after July 1, ~~1985~~ 1986.

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

(7) The phase-in provisions in part 9549.0056 [Temporary], subpart 7, must not apply.

C. For the nine-month period following the settle-up reporting period, the total operating cost payment rate must be

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determined according to item B except that the efficiency incentive in part 9549.0056 [Temporary], subpart 4, item A or B, ~~shall apply~~ applies.

9549.0058 [Temporary] RESIDENT CLASSES AND CLASS WEIGHTS.

Subpart 1. **Resident classes.** Each resident or applicant must be classified according to items A to E based on the ~~assessments performed under~~ information on the assessment form completed in accordance with part 9549.0059 [Temporary] ~~on the assessment form~~.

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

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

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

(2) the resident or applicant is assessed to

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require clinical monitoring ~~including evening and night shifts~~ ~~plus~~ every day on each shift and the resident is assessed to require one or more of the following special treatments ~~on the assessment form~~:

(a) oxygen and respiratory therapy;

(b) ~~ostomy~~ ostomy/catheter care;

(c) ~~care of dressings~~ wound or decubitus care;

(d) skin care;

(e) ~~IV~~ intravenous therapy;

(f) drainage tubes;

(g) blood transfusions; ~~or~~

(h) hyperalimentation;

(i) symptom control for the terminally ill; or

(j) isolation precautions.

D. ~~Each~~ A resident or applicant must be defined as having a neuromuscular condition if the resident or applicant is assessed to have one or more of the diagnoses coded to the ~~following~~ categories in subitems (1) to (8) 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~~ The publication is available through the Minitex interlibrary loan system~~.~~ ~~This~~ and is not subject to frequent change.

(1) diseases of nervous system excluding sense organs (320-359 excluding 331.0);

(2) cerebrovascular disease (430-438 excluding 437);

(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

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injury (806);

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

(7) injury to nerve roots and spinal plexus (953); or

(8) neoplasms of the brain and spine (170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6).

E. ~~Each~~ A resident or applicant must be defined as having a behavioral condition if the resident's or applicant's assessment score is 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). The resident classes must be established based on the definitions in items A to E.

(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.

(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

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not defined neuromuscular condition.

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

(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~~ The 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

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provided in subitems (1) and (2).

(1) The public health nurse of the county preadmission screening team or the ~~RN~~ registered nurse 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 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. ~~However, in no case shall~~ A resident must not receive more than one assessment per respite care stay.

B. ~~Each~~ The 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~~ the term "newly admitted resident" includes a resident who moves to a section of the nursing home ~~which~~ that 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 or who has received a prior preadmission screening, and for whom the assessment required under this subpart has not been performed by the preadmission

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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~~ Each assessment that the nursing home is required to perform must be completed by a registered nurse. The 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 QA&R procedures of the Department of Health, including physical observation of the applicant or newly admitted resident and review of available medical records, 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~~ send the completed assessment form to the Department of Health, and provide a copy to the nursing 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 the person's 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

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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 QA&R assessment occurred between May 1, 1985, and June 30, 1985, the classification established under part 4656.0030, subpart 3, shall apply.

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~~ annual assessment by the Department of Health's QA&R team.

B. A registered nurse shall perform the assessment on each resident according to QA&R 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~~ the information 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 completion of the semiannual

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assessments.

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 QA&R assessments were performed in October or November 1984.

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

(3) In September 1985, the nursing home must assess all residents whose most recent QA&R 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 QA&R team will be effective as of the first day of the month following the date of completion of the Department of Health's assessments.

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~~ must occur no more than five working days

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after the resident returns to the same nursing home.

B. In addition to the assessment required in item A, residents who have returned to the same nursing home after hospital admission must be reassessed by the nursing home no less than 30 days and no more than 35 days after return from the hospital unless the nursing home's annual or semiannual reassessment occurs during the specified time period.

C. A registered nurse shall perform the assessment on each resident according to QA&R 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 and the resident's medical plan of care. Upon request, the nursing home must furnish the Department of Health with ~~further~~ additional information ~~when required in order~~ needed to determine a resident's classification.

~~C.~~ D. Any change in resident class due to an assessment provided under ~~this subpart~~ item A must be effective ~~as of~~ on the date the resident returns to the nursing home from the hospital. Any change in resident class due to a reassessment provided under item B must be effective as of the first day of the month following the assessment.

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 4656.0050 [Temporary] that results in a payment increase for the resident must be effective as of the first day of the month following the date of the Department of Health's classification. Any change in resident class due to a

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reclassification required by part 4656.0050 [Temporary] that results in a payment decrease for the resident must be retroactive to the effective date of the assessment audited.

Subp. 7. **False information.** If the nursing home knowingly supplies inaccurate or false information in an assessment or a request for reconsideration, the commissioner shall apply the penalties in part 9549.0041, subpart 15.

Subp. ~~7.~~ 8. **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 4656.0060 is pending.

B. Any change in a resident class due to a reclassification under part 4656.0060 must be effective as of the effective date of the classification established by the original assessment for which a reconsideration was requested.

Subp. ~~8.~~ 9. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made ~~pursuant to the procedures set forth in~~ under part 4656.0060.

Subp. ~~9.~~ 10. **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~~ access to information regarding rates, assessments, and other documentation provided to the Minnesota Department of Health in support of the resident's assessments to each nursing home resident or the resident's authorized representative according to items A to D.

A. The nursing home must post a notice of its current

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rates for each resident class in a conspicuous place. The rates must be posted no later than five days after receipt by the nursing home. The nursing home may include a notice that the nursing home has chosen to appeal the rates under part 9549.0080.

B. The nursing home must provide written notice to each private paying resident or the person responsible for payment of any increase in the total payment rate established by the commissioner 30 days before the increase takes effect, as required by Minnesota Statutes, section 256B.47, subdivision 2. The notice must specify the current classification of the resident. This item does not apply to adjustments in rates due to a necessary change in the resident's classification as a result of an assessment required in this part.

C. The nursing home must provide each nursing home resident or the person responsible for payment with each classification letter received from the Minnesota Department of Health within five days of the receipt of the classification letter. If the resident's classification has changed, the nursing home must include the current rate for the new classification with the classification letter.

D. 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.

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Proposed Rule

RD911

Agency: Department of Human Services

Division:

Agency Contact: Jane Delage

Minnesota Rules: Parts 9549.0050 to 9549.0059

Title: Proposed Temporary Rules Relating to Nursing Home Payment Rate Determination

Type of Rules: Temporary

Incorporations by Reference: None

Steven C. Cross
Revisor of Statutes

Susan E. Quayle
Assistant Revisor
Phone: 296-0956

Date: March 14, 1986

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF TEMPORARY AMENDMENTS TO RULES RELATING TO NURSING HOME PAYMENT RATE DETERMINATION, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

FINDINGS OF FACT CONCLUSIONS, AND ORDER ADOPTING TEMPORARY AMENDMENTS

Notice of the Commissioner's intent to adopt the above-entitled rules was published in the State Register on March 31, 1986 and was sent by United States mail to all persons on the list maintained by the agency pursuant to Minnesota Statutes, section 14.30 on March 28, 1986.

All persons were given the opportunity to submit written comment on the rule for at least 25 days after notice of proposed rulemaking. The Commissioner has considered all comments received and finds the following:

CHANGES PROPOSED

1. In part 9549.0059 [Temporary], subpart 5, item B, the Commissioner requires that "residents who have returned to the same nursing home after hospital admission must be reassessed by the nursing home no less than 30 days and no more than 35 days after return from the hospital". The Commissioner received comments on this assessment requirement from over 40 commentators. Only two of the commentators supported the requirement, the rest of the commentators stated that this requirement upset the balance established by the case mix system in favor of the residents. The commentators who oppose this requirement assert that because there is not a similiar mechanism to increase the rate for the nursing home when a resident's condition deteriorates but does not require hospitalization, this requirement is unfair.

The Commissioner has considered these comments and has determined that the reassessment process should not be required at this time. The concerns of the commentators will be referred to the Interagency Board for Quality Assurance and further studies of this issue will be undertaken if necessary. To eliminate this requirement, the Commissioner deletes the language in item B and the language relating to this requirement which is found in item D. The Commissioner also changes item C to B and item D to C.

2. In part 9549.0059 [Temporary], subpart 6, the rule establishes the effective date for changes in resident class due to audits of assessments. Under the rule as proposed the effective date is retroactive if the audit results in a decrease in the resident's payment rate and prospective if the audit results in an increase in the resident's payment rate. The Commissioner received comments on this subpart from 38 commentators. All of the commentators opposed the difference in effective dates. The commentators stated that the effective date of the audits should be the same in all situations. The Commissioner agrees that it would be more equitable to make all of the audits effective on the same date and therefore changes this provision so that the effective date of all audits is retroactive to the effective date of the assessment audited.

DISCUSSION OF ISSUES

1. Susan Voigt of MAHCF questions the Department's authority to adopt temporary amendments to parts 9549.0050 to 9549.0059 [Temporary]. According to MAHCF "the Legislature intended that only necessary changes be made to the rules". MAHCF then goes on to define as necessary only those changes in the "operating cost payment rate parts". The Department has reviewed the rulemaking authority found in the statute and finds that all of the amendments proposed fall within the scope of the authority granted by the Legislature. The Legislature did not limit the Department's rulemaking to changes needed to implement rates for 1986, instead they simply extended the Department's authority to promulgate temporary rules governing the case mix reimbursement system. Since amendments fall within the definition of rules found in Minnesota Statutes, section 14.02, the Department is acting in accordance with its statutory authority in adopting the amendments found in these rule parts.

Ms. Voigt goes on to state that the Department proposed changes that were "not even contemplated by the case mix advisory committee". However, the Department did convene the advisory committee prior to publication of the amendments. A meeting of the committee was held on the 28th of February. At that meeting the amendments proposed by the Department were explained and the committee members were given a chance to state their positions on them.

In summary, the Commissioner finds that the Department had the authority to adopt the amendments proposed, had met the requirements of the Administrative Procedures Act, and allowed for public involvement prior to publication of the proposed amendments.

2. In part 9549.0052 [Temporary] geographic groups are established for the purposes of establishing rate limits under part 9549.0055 [Temporary]. Susan Voigt of the Minnesota Association of Health Care Facilities (MAHCF) comments that an exception to the geographic groups should be made for nursing homes located within a five mile radius of the Rochester area. According to MAHCF, these nursing homes should be grouped with the metro area. The change suggested by MAHCF would result in higher limits for the homes in the Rochester area (geographic group 3). In support of the need for higher limits, MAHCF cited higher costs of living in that area.

The temporary rules as proposed include three geographic groups, a change from the previous reimbursement system which divided nursing homes into only two groups. The Rochester area falls into the new middle geographic group. This group was created in response to concerns from providers, including those in the Rochester area, that two geographic groups did not adequately reflect the difference in living costs across the state.

To examine the impact of the move to three rather than two geographic groups on nursing homes in Rochester, the impact of the 1985 rate limits calculated under the temporary rules on the per diem costs of nursing homes in the county in which Rochester is located, was reviewed by the Department. Of the seven nursing homes located in Olmstead County (Rochester area) only one was limited by the other operating cost limits. The per diem costs of the other nursing homes in Olmstead County were well below the limit for their geographic group and these nursing homes

received the appropriate efficiency allowance. All nursing homes in the county were below the care-related limit for resident class A. Only two of the seven were above the care-related limits on some of the other resident classes.

Because so few nursing homes in this area were limited, the Department concluded that the new geographic groups treated providers in the area equitably. Inclusion of the Rochester homes under the geographic group 3 limits would have little impact on the majority of providers in the Rochester area. Based on the Department's recent evaluation of the issue and the fact that the 1986 Legislature mandated further study of the approaches to geographic grouping to be conducted by the State Planning Agency, the Commissioner finds that changing the geographic groupings at this time would be inadvisable.

3. In part 9549.0053 [Temporary] subpart 3, the method of determining the dietician consulting fees to be included in the other care-related costs is established. Commentator Susan Voigt of MAHCF recommends that dietician salaries be included in the other care-related costs and that any nursing home that does not separately report dietician consulting fees be asked to determine those costs and allocate them to the other care-related cost category. MAHCF is concerned that the consulting dietician will not be able to negotiate a contract based on "the facilities requirements for service and ability" unless these changes are made.

The Department has not limited the amount of dietician consulting fees which can be included in the other care-related costs when they are separately reported. Therefore, there should be no restriction on a consulting dietician's ability to negotiate contracts as a result of this provision.

Facilities that have not separately reported dietician fees usually do not do so because they either cannot separate these costs from other dietician costs or because they employ a full-time dietician and have no need of a consulting dietician. Therefore, the Department determines a proportion of dietary costs to be allocated to the other care-related cost category, based on the average consulting dietician's fees reported by the facilities separately reporting consulting dietician. This calculation is done in order to approximate a cost associated with professional nutritional assessments and consultation to meet nutritional needs, for the nursing homes that choose not to separately report these costs. These costs are included in the other care-related costs because they are the dietary costs most closely related to resident care other than raw food. The Commissioner finds that the method of determining dietician consulting fees in this subpart is reasonable and therefore has not made any changes in this subpart.

4. In part 9549.0055 [Temporary], subpart 2, the base year operating cost limits are set. Commentator Susan Voigt of MAHCF recommends that this subpart be amended to provide for rebasing of the base year operating cost limits for errors or appeal resolutions.

Due to administrative complexities and the need for establishing new per diems after correction for error or appeal resolution, the Department believes that changes to the base year limits can only be made in the context of establishing a new base year. Authority for establishing the limits in this subpart is found in Minnesota Statutes, section 256B.431,

Subdivison 2b (d). The statute states that "The limits established under this paragraph remain in effect until the Commissioner establishes a new base period." The only interim adjustment provided for in the statute is the annual adjustment of the limits for inflation. The Commissioner finds that establishing the limits without adjusting for errors or appeal resolutions is consistent with the statute and therefore has not changed this subpart.

5. Susan Voigt of MAHCF recommends the inclusion of an item in part 9549.0055, subpart 2, governing establishment of a new base year. The Department has decided that this provision is unnecessary in the temporary rule parts because there are no plans to rebase during the time that the temporary rule parts will be in effect.

6. In part 9549.0056 [Temporary], subpart 6, the Department establishes a procedure to be used to establish a one-time adjustment to the nursing home's case mix operating cost per diem. Susan Voigt of MAHCF states that the language in this subpart is onerous and burdensome. She also comments that facilities that have already adjusted their staffing to their case mix in expectation of receiving the one-time adjustment should not be excluded from receiving the one-time adjustment.

Minnesota Statutes, section 256B.431 subdivision 2a(d) states that the Commissioner may allow a one-time adjustment when it is determined "that the nursing home is unable to meet minimum standards through reallocation of nursing home costs and efficiency incentives". Therefore, the Commissioner is required to make some determination of the facility's ability to meet care standards by reallocation of resources and efficiency incentives. Because this determination will be made using historical data from the cost reporting periods ending 9/30/84 and 9/30/85 (except for the efficiency incentive available on 7/1/86) it should not interfere with a facility's efforts to improve staffing in anticipation of the adjustments if these efforts take place after the period covered by the cost reports utilized.

The Commissioner finds that the requirements in this subpart are necessary in order for the Commissioner to make an informed decision about the one-time adjustment. The Commissioner also finds that these requirements do not interfere with facility efforts to improve staffing. Therefore, the Commissioner has not changed this subpart.

7. In part 9549.0056 [Temporary], subpart 7, the nursing homes are informed that the phase-in of rates will be conducted in accordance with Minnesota Statutes, section 256B.431, subdivision 2h. Darrell Shreve of the Minnesota Association of Homes for the Aging (MAHA) commented concerning the correctness of the application of the phase-in as provided for in these rule parts. MAHA believes that the phase-in amount should also be inflated by the adjustment factor.

The Department believes that Minnesota Statutes, section 256B.431, subdivision 2h clearly sets out the formula for the computation of the phase-in amounts which are to be used for each rate year in the phase-in period. That formula set forth "...50 percent of the difference between the actual allowable historical operating costs per diem and 105 percent of the limit established by the Commissioner;..." as the amount to be paid under the phase-in. The law does not provide for the inflation factor to be applied to the phase-in amount. In fact, the law specifically states

the computation to be used by the Commissioner shall be "...according to the formula in this subdivision."

Any other interpretation of the statue yields an unreasonable result because the application of the limits established by the Commissioner establishes the per diem amount based on allowable costs. The phase-in provision in the law then sets forth the formula to determine the phase-in amount and does so by specifically using the terms defined by rule. These terms refer to amounts determined before application of the adjustment factor. To inflate the phase-in amount by the adjustment factor would increase the amount of unallowable costs reimbursed. This process would serve to impede implementation of the limits during the phase-in period and would reward facilities whose costs are over the established limits by enabling these facilities to continue to spend further above the limits. Because the method of applying the phase-in proposed by the Department is consistent with the legislative directive given to the Department in Minnesota Statutes, section 256B.431, the Commissioner finds that no changes are needed in these rule parts.

8. In part 9549.0051 [Temporary], subpart 14 the Department defines the term short length of stay facility. Susan Voigt of MAHCF recommended that the Department allow any facility to designate a separate portion of the facility as a short length of stay area.

The Commissioner was required under Laws of Minnesota 1983, chapter 199 and Laws of Minnesota 1984, chapter 641 to consider whether "the fact that a facility has a average length of stay of 180 days of less" should be taken into account in developing the case mix system.

Under the previous rules, facilities which had an average length of stay of 180 days or less were not subject to rate limitations. Under the case mix system these facilities are allowed higher rate limitations than other facilities because of the uncertain impact on quality of further rate reductions in this group of facilities, most of whom were significantly above the rate limits for even hospital-attached facilities. It was assumed that short length of stay facilities were more costly because these facilities experienced rapid tunrover rates.

Because these facilities' average length of stay was short (180 days or less), it was assumed that a high level of occupancy might be difficult to maintain and low occupancy could result in a greater per diem rate than other facilities. For this reason short length of stay facilities were treated differently.

The potential for low occupancy due to rapid turnover is reduced as the number of skilled beds "designated" as short length of stay beds decreases relative to the facility's total beds. Therefore, if the facility were to designate a few skilled beds as a short length of stay unit, the need for higher limits would be minimal. In addition, the higher limits would be applied facility-wide resulting in higher rates for the entire facility, not just for the short length of stay unit.

The Commissioner finds that there is no reason to expand the term short length of stay facility in the manner suggested by the commentator.

9. In part 9549.0058 [Temporary] resident classes and class weights are described. Several commentators expressed concern about the treatment of "behavior" in the resident classification system.

Fran Kaschak of the National Association of Social Workers (NASW) suggests that a major problem of the case mix system is the class categories and behavioral aspects of resident needs. According to Ms. Kaschak "research shows" that extremely physically impaired residents "do not require more time and effort and often require less" than residents with behavioral needs. The Department is unaware of any research which supports this statement. The Department's extensive two-year research project did not support this assertion. Neither did similar research conducted in Connecticut and New York or for any other state case mix system.

In the process of developing the case mix system, the Department researched the time and resources spent on care for 1,883 residents in seventy-seven homes in Minnesota. Four hundred and seventy-five nurses and nursing assistants were interviewed.

Seven hundred and forty-three, or about forty percent of the sample scored two or more on behavior (dependent) on the QA & R assessment form. About thirty-eight per cent of the residents in these facilities who were not in the sample scored two or more on behavior.

In addition to data on assistance to residents with Activities of Daily Living (ADLS) nursing services, data was collected from nurses and aides on the time spent on each resident in areas directly related to the psychosocial or behavioral needs. The areas identified were:

* Asessment/monitoring due to behavioral or emotional problems (eg. talking with depressed, agitated residents)
* Talk to social worker or psychologist
* Visit/talk to family
* Revise plan of care
* Other social/emotional care or supervision (eg. retrieving wanderers, dealing with combative behavior, reassuring the confused).
* Run personal errands for the residents
* Special communication needs

Each question was designed and/or reviewed by a technical advisory committee including nurses and social workers from Minnesota. The committee emphasized the importance of the presence of behavioral needs in the time spent in caring for certain residents.

The data clearly indicated that the presence of a behavioral condition (score of 2 or more in behavior on the QA & R assessment) significantly increases the time spent with a resident. This is consistent with the observations of virtually all of the nurses interviewed in the development of the system. However, the research did not support the NASW contention that physically impaired residents do not require more time and effort than residents with behavioral needs.

The research conducted by the Department found that the time and resources needed to care for residents was linked to the number of Activities of

Daily Living (ADLs) in which they were dependent as well as special nursing and behavioral needs. Residents with few dependencies and behavioral problems do take much more time than residents with few dependencies and no behavioral needs. However, residents with few dependencies and behavioral needs take less time than residents with many dependencies as well as behavioral needs. In addition, some residents with higher levels of dependencies and special nursing needs take more time than some residents with behavioral needs because these residents can do so little for themselves.

The classification system includes four classes based on behavior. Each of these classes is weighted from 28 to 51 percent higher than a class for a person with similar ADL needs but without behavioral conditions. The weights are based on average Resource Use Scores for residents in each class. The weights were derived directly from the research. It is not possible to adjust the weight of one class without having an impact on the other classes. Therefore, higher weights for class "B" residents, for instance, would mean more nursing costs would be allocated to class "B" residents but proportionately less would be allocated to residents in higher classes. This would result in higher rates for class "B" residents but rates for classes C - K would be lower than before. The Department is reluctant to make such arbitrary adjustments at this time. The Department agrees that repeating the research in the future may be valuable in order to validate the present weights. However, it is premature to repeat a research project of this magnitude after only five months of experience. This issue was carefully considered and all parties had considerable involvement in this issue in the design of the classification system. The Department has now included behavioral scores of three or four as a criterion for inclusion in class J which expands the classes based on behavioral needs from three to four. This change was suggested by the Case Mix Advisory Committee in response to discussion of the behavioral issue. The Commissioner finds that no further changes should be made at this time.

10. In part 9549.0055 [Temporary], subpart 2, hospital attached nursing homes are grouped with short length of stay facilities and nursing homes licensed under parts 9570.2000 to 9570.3600 for the purposes of developing operating cost limits. Commentator Susan Voigt of MAHCF questions this grouping process in her comments. MAHCF states that the hospital attached facilities (C&NCs) should be grouped with all other facilities in the "other operating cost" category.

During the development of the temporary rules, several questions arose regarding the reasons for the higher other operating costs identified for C&NCs. In recognition of these high costs, Lewin and Associates recommended separate limits on other operating costs for hospital attached nursing homes. Therefore, hospital attached nursing homes were grouped separately within each geographic region to determine other operating cost limits under the temporary rules. This resulted in higher limits for these facilities than for freestanding homes.

The Interagency Board for Quality Assurance recommended further study of this area. Therefore the Department reviewed the effects of combining the C&NCs with the freestanding nursing homes on the other operating limits in each geopraphic area. At least 75 per cent of the C&NCs would receive substantial rate limits under this method. An additional 29

freestanding homes costs would be under these new limits. In addition, because of efficiency incentives gained by freestanding nursing homes, combining the C&NCs with the freestanding nursing homes for the purpose of setting limits would actually be slightly more costly than arraying them separately. Because of the detrimental effects on the C&NCs and the additional costs to the system that would be incurred if the change proposed by MAHCF was incorporated, the Commissioner finds that this provision should not be changed.

TECHNICAL CORRECTIONS

In reviewing the proposed rules the following technical corrections were found to be needed.

a. In part 9549.0055, [Temporary], Subpart 2, item E, subitem 2, an "s" should be added to the term per diem.

b. In part 9549.0056, [Temporary], Subpart 4, item A, an "a" should be inserted between "to" and "maximum".

c. In part 9549.0056, [Temporary], Subpart 4, item B, in the reference to part 9549.0055 [Temporary], Subpart 3, item A, the phrase "item A" should be deleted.

d. In part 9549.0056 [Temporary], Subpart 6, item D, subitem 1, "resident" should be inserted between "standardized" and "day" to make the language consistent with the language used throughout the rule.

e. In part 9549.0056 [Temporary], Subpart 6, item D, subitem 6, the "s" on "costs" should be deleted.

f. In part 9549.0057 [Temporary], Subpart 3, the lead sentence should be changed from "according to item A to C" to "according to items A to D". In addition, the second item C in this subpart should be changed to item D.

g. In part 9549.0059 [Temporary], Subpart 4, the "will" should be "must".

CONCLUSIONS

I hereby conclude that:

1. The Commissioner has statutory authority to promulgate these amendments.

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

3. The modifications made to the proposed temporary amendments are supported by the Findings of Fact and are not substantial changes.

4. Any duplication in these rules of language contained in Minnesota Statutes is crucial to the ability of persons affected by the rules to comprehend their meaning and effect.

5. The temporary amendments, as modified, are necessary and reasonable.

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

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

Dated: May 15, 1986

NOW, THEREFORE, IT IS ORDERED that the rule identified as parts 9549.0050 to 9549.0059 [Temporary] as modified is adopted this 15 day of May, 1986, pursuant to authority vested in me by Minnesota Statutes, sections 256B.41, subdivision 1 and 256B.431, subdivision 6.

Leonard W. Levine
Commissioner of Human Services

Department of Human Services

Outside Opinion Sought Concerning Proposed Rules Governing Adult Foster Care Services

Notice is hereby given that the Minnesota Department of Human Services is considering a permanent rule governing the administration and provision of adult foster care services to functionally-impaired adults by local county human service agencies.

The rule parts are authorized by Minnesota Statutes, 256.01, subdivision 2,(3); 256.03, subdivision 2 D and C; 256.E.05, subdivisions 1 and 3; and 256.E08, subdivision 1.

The purpose of the rule parts is to ensure that a functionally-impaired adult has access to adult foster homes as a living arrangement; that the adult receives services when selecting an adult foster home; that individualized service and placement plans are developed and carried out; and that community, social and health care services are arranged for in accordance with the individual service and placement plans.

The rule parts set forth the agency's responsibility for foster home development, staffing, training, adult placements, development of the individual resident placement plan, social service requirements and complaints.

All interested or affected persons or groups are requested to participate. Statements of information and comment may be made orally or in writing. Written statements of information and comment may be addressed to:

Gwen Wildermuth
Social Services Division
Department of Human Services
4th Floor, Centennial Building
658 Cedar Street
St. Paul, Minnesota 55155
Telephone: 612/296-0311 (regular business hours)

All statements of information and comment shall be accepted until further notice. All written material received by the Department shall become part of the rule record.

Department of Human Services

Outside Opinion Sought Concerning Rules Relating to Nursing Home Operating Cost Payment Rate Determination

Notice is hereby given that the Minnesota Department of Human Services plans to promulgate amendments to Temporary Rule parts 9549.0050 to 9549.0059 relating to determination of operating cost payment rates 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. Promulgation of these amendments is dependent on passage of legislation which has been introduced in the legislature to extend temporary rule parts 9549.0050 to 9549.0059. If the legislation does not pass, the department will discontinue the amendment process and continue the permanent rulemaking process.

Rule parts 9549.0050 to 9549.0059 are authorized by Minnesota Statutes, section 256B.431, subdivision 6. The department is considering amendments to these rules to clarify the operating cost rate determination process to be used to determine rates for fiscal year 1987 and to update the resident classification system as used in determining operating cost payment rates.

All interested persons or groups are requested to participate. Statements of information and comment may be addressed to:

Jane M. Delage
Rules Unit, Department of Human Services
4th Floor, Centennial Office Building
658 Cedar Street
St. Paul, MN 55105

Oral statements of information and comment will be received during regular business hours over the telephone at (612) 297-4302. All statements of information and comment will be received until March 10. Any written material received by the Department will become part of the hearing record.

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO DEPARTMENT OF HUMAN SERVICES RULES GOVERNING NURSING HOME OPERATING COST PAYMENT RATE DETERMINATION, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

ORDER FOR PUBLICATION OF TEMPORARY RULES

IT IS ORDERED THIS 21st day of March, 1986, 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 ADOPTION OF AMENDMENTS TO DEPARTMENT OF HUMAN SERVICES RULES GOVERNING NURSING HOME OPERATING COST PAYMENT RATE DETERMINATION, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

NOTICE OF PROPOSED ADOPTION OF TEMPORARY RULE AMENDMENTS

Notice is hereby given that the State Department of Human Services proposes to adopt amendments to the above-entitled temporary rule. The statutory authority to adopt the temporary rule is contained in Minnesota Statutes, sections 256B.41, subdivision 1 and 256B.431, subdivision 6. The agency, in adopting the rule, is following the procedures set forth in the Administrative Procedure Act for adopting emergency rules in Minnesota Statutes, sections 14.29 to 14.36.

All persons have 25 days (or until 4:30 p.m. on April 25, 1986) after publication to submit data and views on the proposed temporary rule or any part or subpart of the rule in writing. Any comments must be submitted to:

Jane M. Delage
Department of Human Services
4th Floor, Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Minnesota Rules, parts 9549.0050 to 9549.0059 [Temporary] affect the operating cost payment rate for nursing homes licensed under Minnesota Statutes, chapter 144A or boarding care facilities under Minnesota Statutes, section 144.50 to 144.58 participating in the Medical Assistance Program. The effective period for these rules was extended until June 30, 1987, in Laws of Minnesota 1986, chapter 316. The proposed amendments are necessary to clarify the operating cost rate determination process to be used to determine rates for fiscal year 1987, to update the resident classification system used in determining operating cost payment rates, and to implement the one-time adjustment permitted in Minnesota Statutes, section 256B.431, subdivision 2. The following rule parts are to be amended:

1. Part 9549.0050 [Temporary] Scope
2. Part 9549.0051 [Temporary] Definitions
3. Part 9549.0052 [Temporary] Establishment of Geographic Groups (editing changes only)
4. Part 9549.0053 [Temporary] Determination and Allocation of Fringe Benefits and Payroll Taxes, Food Costs and Dietician Consulting Fees
5. Part 9549.0054 [Temporary] Determination of Allowable Historical Operating Cost Per Diems
6. Part 9549.0055 [Temporary] Determination of the Operating Cost Adjustment Factors and Limits
7. Part 9549.0056 [Temporary] Determination of the Operating Cost Payment Rate
8. Part 9549.0057 [Temporary] Determination of the Interim and Settle-up Operating Cost Payment Rates

9. Part 9549.0058 [Temporary] Resident Classes and Class Weights
10. Part 9549.0059 [Temporary] Resident Assessment

These amendments are being promulgated in conjunction with amendments to parts 4656.0010 to 4656.0100 [Temporary], which govern procedures for assessment and classification of residents by the Department of Health. All references to parts 4656.0010 to 4656.0100 [Temporary] found in these rule parts are references to rules as amended.

A free copy of the proposed temporary rule is available by contacting Mary Ann Bredeson, Department of Human Services, Space Center, 444 Lafayette Road, 6th Floor, St. Paul, Minnesota 55101. (5)

The proposed temporary rule may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed temporary rule as noticed. (6)

Upon adoption of the temporary rule by the agency, the temporary rule as adopted and its supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of this submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Jane M. Delage. (7)

The temporary rule will take effect five working days after approval by the Attorney General and will be effective until June 30, 1987, according to the Laws of Minnesota 1986, chapter 316. (8)

The system established under these rule amendments is approximately budget neutral. The rule amendments will not result in additional state or county spending beyond the amount appropriated by the Legislature. (9)

STATE OF MINNESOTA

3-21-86
Date

LEONARD W. LEVINE, Commissioner
Department of Human Services

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO DEPARTMENT OF HUMAN SERVICES RULES GOVERNING NURSING HOME OPERATING COST PAYMENT RATE DETERMINATION, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

AFFIDAVIT OF MAILING

Nancy Storelee, being first duly sworn, deposes and says:

That on the 28th day of March, 1986, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached notice of proposed adoption of temporary rule amendments by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, to 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 hearing by this Department.

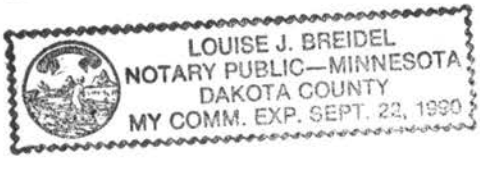
Nancy Storelee

Subscribed and sworn to before me

this 28 day of March, 1986.

Louise J. Breidel





STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO DEPARTMENT OF HUMAN SERVICES RULES GOVERNING NURSING HOME OPERATING COST PAYMENT RATE DETERMINATION, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

NOTICE OF PROPOSED ADOPTION OF TEMPORARY RULE AMENDMENTS

Notice is hereby given that the State Department of Human Services proposes to adopt amendments to the above-entitled temporary rule. The statutory authority to adopt the temporary rule is contained in Minnesota Statutes, sections 256B.41, subdivision 1 and 256B.431, subdivision 6. The agency, in adopting the rule, is following the procedures set forth in the Administrative Procedure Act for adopting emergency rules in Minnesota Statutes, sections 14.29 to 14.36.

All persons have 25 days (or until 4:30 p.m. on April 25, 1986) after publication to submit data and views on the proposed temporary rule or any part or subpart of the rule in writing. Any comments must be submitted to:

Jane M. Delage
Department of Human Services
4th Floor, Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Minnesota Rules, parts 9549.0050 to 9549.0059 [Temporary] affect the operating cost payment rate for nursing homes licensed under Minnesota Statutes, chapter 144A or boarding care facilities under Minnesota Statutes, section 144.50 to 144.58 participating in the Medical Assistance Program. The effective period for these rules was extended until June 30, 1987, in Laws of Minnesota 1986, chapter 316. The proposed amendments are necessary to clarify the operating cost rate determination process to be used to determine rates for fiscal year 1987, to update the resident classification system used in determining operating cost payment rates, and to implement the one-time adjustment permitted in Minnesota Statutes, section 256B.431, subdivision 2. The following rule parts are to be amended:

1. Part 9549.0050 [Temporary] Scope
2. Part 9549.0051 [Temporary] Definitions
3. Part 9549.0052 [Temporary] Establishment of Geographic Groups (editing changes only)
4. Part 9549.0053 [Temporary] Determination and Allocation of Fringe Benefits and Payroll Taxes, Food Costs and Dietician Consulting Fees
5. Part 9549.0054 [Temporary] Determination of Allowable Historical Operating Cost Per Diems
6. Part 9549.0055 [Temporary] Determination of the Operating Cost Adjustment Factors and Limits
7. Part 9549.0056 [Temporary] Determination of the Operating Cost Payment Rate
8. Part 9549.0057 [Temporary] Determination of the Interim and Settle-up Operating Cost Payment Rates

9. Part 9549.0058 [Temporary] Resident Classes and Class Weights
10. Part 9549.0059 [Temporary] Resident Assessment

These amendments are being promulgated in conjunction with amendments to parts 4656.0010 to 4656.0100 [Temporary], which govern procedures for assessment and classification of residents by the Department of Health. All references to parts 4656.0010 to 4656.0100 [Temporary] found in these rule parts are references to rules as amended.

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

The proposed temporary rule may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed temporary rule as noticed.

Upon adoption of the temporary rule by the agency, the temporary rule as adopted and its supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of this submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Jane M. Delage.

The temporary rule will take effect five working days after approval by the Attorney General and will be effective until June 30, 1987, according to the Laws of Minnesota 1986, chapter 316.

The system established under these rule amendments is approximately budget neutral. The rule amendments will not result in additional state or county spending beyond the amount appropriated by the Legislature.

STATE OF MINNESOTA

3-21-86
Date

LEONARD W. LEVINE, Commissioner
Department of Human Services

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO THE DEPARTMENT OF HUMAN SERVICES RULES GOVERNING NURSING HOME OPERATING COST PAYMENT RATE DETERMINATION, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

AFFIDAVIT OF ADDITIONAL MAILING

Nancy Storelie being first duly sworn, deposes and says:

That on the 28th day of March 1986, at the City of St. Paul, County of Ramsey, State of Minnesota, in addition to mailing the attached notice of proposed adoption of temporary rule amendments to persons and associations who have requested that their names be placed on file for the purpose of receiving notice of hearing by this Department, I also mailed 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 all of the agencies that received the Notice of Hearing.

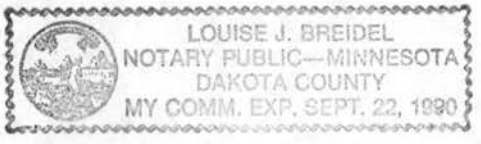
.The 87 Minnesota County Human Services Agencies

Nancy Storelie

Subscribed and sworn to before me

this 28 day of March, 1986.

Louise J. Breidel



STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO DEPARTMENT OF HUMAN SERVICES RULES GOVERNING NURSING HOME OPERATING COST PAYMENT RATE DETERMINATION, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

NOTICE OF PROPOSED ADOPTION OF TEMPORARY RULE AMENDMENTS

Notice is hereby given that the State Department of Human Services proposes to adopt amendments to the above-entitled temporary rule. The statutory authority to adopt the temporary rule is contained in Minnesota Statutes, sections 256B.41, subdivision 1 and 256B.431, subdivision 6. The agency, in adopting the rule, is following the procedures set forth in the Administrative Procedure Act for adopting emergency rules in Minnesota Statutes, sections 14.29 to 14.36.

All persons have 25 days (or until 4:30 p.m. on April 25, 1986) after publication to submit data and views on the proposed temporary rule or any part or subpart of the rule in writing. Any comments must be submitted to:

Jane M. Delage
Department of Human Services
4th Floor, Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Minnesota Rules, parts 9549.0050 to 9549.0059 [Temporary] affect the operating cost payment rate for nursing homes licensed under Minnesota Statutes, chapter 144A or boarding care facilities under Minnesota Statutes, section 144.50 to 144.58 participating in the Medical Assistance Program. The effective period for these rules was extended until June 30, 1987, in Laws of Minnesota 1986, chapter 316. The proposed amendments are necessary to clarify the operating cost rate determination process to be used to determine rates for fiscal year 1987, to update the resident classification system used in determining operating cost payment rates, and to implement the one-time adjustment permitted in Minnesota Statutes, section 256B.431, subdivision 2. The following rule parts are to be amended:

1. Part 9549.0050 [Temporary] Scope
2. Part 9549.0051 [Temporary] Definitions
3. Part 9549.0052 [Temporary] Establishment of Geographic Groups (editing changes only)
4. Part 9549.0053 [Temporary] Determination and Allocation of Fringe Benefits and Payroll Taxes, Food Costs and Dietician Consulting Fees
5. Part 9549.0054 [Temporary] Determination of Allowable Historical Operating Cost Per Diems
6. Part 9549.0055 [Temporary] Determination of the Operating Cost Adjustment Factors and Limits
7. Part 9549.0056 [Temporary] Determination of the Operating Cost Payment Rate
8. Part 9549.0057 [Temporary] Determination of the Interim and Settle-up Operating Cost Payment Rates

9. Part 9549.0058 [Temporary] Resident Classes and Class Weights
10. Part 9549.0059 [Temporary] Resident Assessment

These amendments are being promulgated in conjunction with amendments to parts 4656.0010 to 4656.0100 [Temporary], which govern procedures for assessment and classification of residents by the Department of Health. All references to parts 4656.0010 to 4656.0100 [Temporary] found in these rule parts are references to rules as amended.

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

The proposed temporary rule may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed temporary rule as noticed.

Upon adoption of the temporary rule by the agency, the temporary rule as adopted and its supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of this submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Jane M. Delage.

The temporary rule will take effect five working days after approval by the Attorney General and will be effective until June 30, 1987, according to the Laws of Minnesota 1986, chapter 316.

The system established under these rule amendments is approximately budget neutral. The rule amendments will not result in additional state or county spending beyond the amount appropriated by the Legislature.

STATE OF MINNESOTA

3-21-86
Date

LEONARD W. LEVINE, Commissioner
Department of Human Services

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO THE DEPARTMENT OF HUMAN SERVICES RULES GOVERNING NURSING HOME OPERATING COST PAYMENT RATE DETERMINATION, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

AFFIDAVIT OF ADDITIONAL MAILING

Pamela Parker, being first duly sworn, deposes and says:

That on the 28th day of March 1986, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed 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 groups:

- .The Advisory Committee
- .The list of accountants for nursing homes
- .Nursing Homes
- .Interagency board for Quality Assurance mailing list

Pamela J. Parker

Subscribed and sworn to before me

this 28 day of March, 1986.

Claudia A. Eliason

CLAUDIA A. ELIASON
NOTARY PUBLIC-MINNESOTA
WASHINGTON COUNTY
MY COMMISSION EXPIRES NOVEMBER 15, 1990

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO DEPARTMENT OF HUMAN SERVICES RULES GOVERNING NURSING HOME OPERATING COST PAYMENT RATE DETERMINATION, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

NOTICE OF PROPOSED ADOPTION OF TEMPORARY RULE AMENDMENTS

Notice is hereby given that the State Department of Human Services proposes to adopt amendments to the above-entitled temporary rule. The statutory authority to adopt the temporary rule is contained in Minnesota Statutes, sections 256B.41, subdivision 1 and 256B.431, subdivision 6. The agency, in adopting the rule, is following the procedures set forth in the Administrative Procedure Act for adopting emergency rules in Minnesota Statutes, sections 14.29 to 14.36.

All persons have 25 days (or until 4:30 p.m. on April 25, 1986) after publication to submit data and views on the proposed temporary rule or any part or subpart of the rule in writing. Any comments must be submitted to:

Jane M. Delage
Department of Human Services
4th Floor, Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Minnesota Rules, parts 9549.0050 to 9549.0059 [Temporary] affect the operating cost payment rate for nursing homes licensed under Minnesota Statutes, chapter 144A or boarding care facilities under Minnesota Statutes, section 144.50 to 144.58 participating in the Medical Assistance Program. The effective period for these rules was extended until June 30, 1987, in Laws of Minnesota 1986, chapter 316. The proposed amendments are necessary to clarify the operating cost rate determination process to be used to determine rates for fiscal year 1987, to update the resident classification system used in determining operating cost payment rates, and to implement the one-time adjustment permitted in Minnesota Statutes, section 256B.431, subdivision 2. The following rule parts are to be amended:

1. Part 9549.0050 [Temporary] Scope
2. Part 9549.0051 [Temporary] Definitions
3. Part 9549.0052 [Temporary] Establishment of Geographic Groups (editing changes only)
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7. Part 9549.0056 [Temporary] Determination of the Operating Cost Payment Rate
8. Part 9549.0057 [Temporary] Determination of the Interim and Settle-up Operating Cost Payment Rates

9. Part 9549.0058 [Temporary] Resident Classes and Class Weights
10. Part 9549.0059 [Temporary] Resident Assessment

These amendments are being promulgated in conjunction with amendments to parts 4656.0010 to 4656.0100 [Temporary], which govern procedures for assessment and classification of residents by the Department of Health. All references to parts 4656.0010 to 4656.0100 [Temporary] found in these rule parts are references to rules as amended.

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

The proposed temporary rule may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed temporary rule as noticed.

Upon adoption of the temporary rule by the agency, the temporary rule as adopted and its supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of this submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Jane M. Delage.

The temporary rule will take effect five working days after approval by the Attorney General and will be effective until June 30, 1987, according to the Laws of Minnesota 1986, chapter 316.

The system established under these rule amendments is approximately budget neutral. The rule amendments will not result in additional state or county spending beyond the amount appropriated by the Legislature.

STATE OF MINNESOTA

3-21-86
Date

LEONARD W. LEVINE, Commissioner
Department of Human Services

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO DEPARTMENT OF HUMAN SERVICES RULES GOVERNING NURSING HOME OPERATING COST PAYMENT RATE DETERMINATION, MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

CERTIFICATE

I hereby certify that the list of persons, associations and other interested groups who have requested, pursuant to Minnesota Statutes, section 14.14, subdivision 1a, and 14.22 or 14.30, that their names be placed on the state Department of Human Services rulemaking mailing list is accurate, complete, and current as of this 28th day of March, 1986.

Nancy Stoelee

4656.0100 [Temporary] AUDITS OF ASSESSMENTS OF NURSING HOME RESIDENTS.

Subpart 1. **Audits required.** The department shall audit the accuracy of resident assessments performed under parts 9549.0050 to 9549.0059 [Temporary] through desk audits and on-site reviews of residents and their records. The department shall reclassify a resident it determines to have been incorrectly assessed.

Subp. 2. **Audit reclassification.** Within 15 working days of a reclassification required by subpart 1, the department shall mail a written notice to the resident and the nursing home or boarding care home of the resident's classification, the opportunity to review the Department of Health's documents supporting the classification, and the right of the resident, the resident's authorized representative, or the facility to request reconsideration of the classification.

Department of Human Services

Proposed Temporary Rules Relating to Nursing Home Payment Rate Determination

Notice of Proposed Adoption of Temporary Rule Amendments

Notice is hereby given that the State Department of Human Services proposes to adopt amendments to the above-entitled temporary rule. The statutory authority to adopt the temporary rule is contained in Minnesota Statutes, sections 256B.41, subdivision 1 and 256B.431, subdivision 6. The agency, in adopting the rule, is following the procedures set forth in the Administrative Procedure Act for adopting emergency rules in Minnesota Statutes, sections 14.29 to 14.36.

All persons have 25 days (or until 4:30 p.m. on April 25, 1986) after publication to submit data and views on the proposed temporary rule or any part or subpart of the rule in writing. Any comments must be submitted to:

Jane M. Delage
Department of Human Services
4th Floor, Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Minnesota Rules, parts 9549.0050 to 9549.0059 [Temporary] affect the operating cost payment rate for nursing homes licensed under Minnesota Statutes, chapter 144A or boarding care facilities under Minnesota Statutes, section 144.50 to 144.58 participating in the Medical Assistance Program. The effective period for these rules was extended until June 30, 1987, in Laws of Minnesota 1986, chapter 316. The proposed amendments are necessary to clarify the operating cost rate determination process to be used to determine rates for fiscal year 1987, to update the resident classification system used in determining operating cost payment rates, and to implement the one-time adjustment permitted in Minnesota Statutes, section 256B.431, subdivision 2. The following rule parts are to be amended:

1. Part 9549.0050 [Temporary] Scope
2. Part 9549.0051 [Temporary] Definitions
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6. Part 9549.0055 [Temporary] Determination of the Operating Cost Adjustment Factors and Limits
7. Part 9459.0056 [Temporary] Determination of the Operating Cost Payment Rate
8. Part 9549.0057 [Temporary] Determination of the Interim and Settle-up Operating Cost Payment Rates
9. Part 9549.0058 [Temporary] Resident Classes and Class Weights
10. Part 9549.0059 [Temporary] Resident Assessment

These amendments are being promulgated in conjunction with amendments to parts 4656.0010 to 4656.0100 [Temporary], which govern procedures for assessment and classification of residents by the Department of Health. All references to parts 4656.0010 to 4656.0100 [Temporary] found in these rule parts are references to rules as amended.

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

The proposed temporary rule may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed temporary rule as noticed.

Upon adoption of the temporary rule by the agency, the temporary rule as adopted and its supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of this submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Jane M. Delage.

The temporary rule will take effect five working days after approval by the Attorney General and will be effective until June 30, 1987, according to the Laws of Minnesota 1986, chapter 316.

The system established under these rule amendments is approximately budget neutral. The rule amendments will not result in additional state or county spending beyond the amount appropriated by the Legislature.

March 21, 1986

Leonard W. Levine, Commissioner
Department of Human Services

Rules as Proposed [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~~ 4656.0100 [Temporary].

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,~~ under parts 4656.0010 to 4656.0100 [Temporary] 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 nursing 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, and the portion of fringe benefits and payroll taxes allocated to the nursing services cost category in accordance with part 9549.0053 [Temporary].

Subp. 6. **Case mix score.** "Case mix score" means the case mix index divided by the total number of residents in ~~each~~ the nursing 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, and the portion of fringe benefits and payroll taxes allocated to the other care-related cost category, the cost of food, and the ~~required~~ dietician consulting fees ~~charged by a nonrelated organization~~ calculated in accordance with part 9549.0053 [Temporary].

Subp. 9. **Other operating costs.** "Other operating costs" means the operating costs listed in part 9549.0040, subparts 1, 2, 3, 4, and 7, excluding the cost of food and dietician consulting fees, 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~~ [Temporary].

Subp. 10. **Productive nursing hours.** "Productive nursing hours" means all on-duty hours of nurses, aides, orderlies, and attendants. This term does not include the on-duty hours of the medical records personnel or the director of nursing for facilities with more than 60 licensed beds. Vacation, holidays, sick leave, and classroom training, are not included in productive nursing hours.

Subp. ~~10.~~ 11. **Quality assurance and review or QA&R.** "Quality assurance and review" or "AQ&R" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

Subp. ~~11.~~ 12. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058 [Temporary].

shall determine the average ratio of food costs to total dietary costs for all nursing homes that separately reported food costs. The nursing home's total allowable dietary costs must be multiplied by the average ratio ~~determined in item A~~ to determine the food costs for ~~that~~ the 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 to be included in other care-related costs according to items A ~~to C~~ and B.

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.~~ For any nursing home separately reporting dietician consulting fees, the dietician consulting fees shall be the allowable dietician consulting fees reported under part 9549.0040, subpart 1.

B. For any nursing home that has not separately reported dietician consulting fees, the commissioner shall determine the average cost per licensed bed of allowable dietician consulting fees for all nursing homes that separately reported dietician consulting fees. The nursing home's total number of licensed beds must be multiplied by the ~~amount determined in item A~~ average cost per bed to determine the ~~required~~ dietician consulting fees for ~~that~~ the nursing home.

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

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

Subpart 1. **Review and adjustment of costs.** The commissioner shall annually review and adjust the operating costs ~~incurred~~ reported 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.

~~Subpart 1.~~ Subp. 2. **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 I.

A. The commissioner shall select the two most recent QA&R assessments completed prior to April 1, 1985. If only one QA&R assessment is available, the commissioner shall compute the standardized resident days in accordance with item I. Any nursing home whose most recent QA&R assessment completed before April 1, 1985, does not include assessments of nonmedical assistance residents may make a written request to the commissioner to consider a different QA&R assessment to be the most recent if that assessment:

(1) includes nonmedical assistance residents; and

(2) was completed by the Department of Health before July 1, 1985.

The request must be in writing. Written requests must be received by the commissioner by December 31, 1985.

B. For each of the two QA&R 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 QA& R 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 QA&R assessment, the medical assistance case mix score must be the private pay case mix score determined in item F, subitem (1).

D. 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 QA&R 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.

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 QA& R 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 nonmedical assistance residents for each nursing home whose most recent QA&R assessment included assessments of nonmedical assistance 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 QA&R assessment.

Subp. ~~12.~~ 13. **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. 14. **Short length of stay facility.** "Short length of stay facility" means a nursing home that is certified to provide a skilled level of care and has an average length of stay of 180 days or less in its skilled level of care. For the purpose of this definition the commissioner shall calculate average length of stay for the nursing home by dividing actual resident days in the skilled level of care for which the nursing home can bill, by the total number of discharges from the skilled level of care during the reporting year.

Subp. ~~13.~~ 15. **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 and 3.

9549.0052 [Temporary] ESTABLISHMENT OF GEOGRAPHIC GROUPS.

Subpart 1. **Classification process.** The commissioner shall classify Minnesota nursing homes according to their geographic location as indicated in subparts ~~1 to 3~~ 2 to 4.

~~Subpart 1.~~ Subp. 2. **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, Meeker, Morrison, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Todd, Yellow Medicine, and Wadena counties must be placed in geographic group 1.

Subp. ~~2.~~ 3. **Group 2.** All nursing homes in counties other than the counties listed under subparts ~~1 and 3~~ 2 and 4 must be placed in geographic group 2.

Subp. ~~3.~~ 4. **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 [Temporary] DETERMINATION AND ALLOCATION OF FRINGE BENEFITS AND PAYROLL TAXES, FOOD COSTS, AND ~~REQUIRED~~ DIETICIAN CONSULTING FEES.

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.

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.

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.

D. For any nursing home ~~which has not separately reported~~ that cannot separately report 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)~~ to (3).

(1) The commissioner shall ~~determine the ratio of~~ sum the allowable salaries for all nursing homes separately reporting 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~~ by cost category and in total.

(2) The commissioner shall determine the ratio of the total allowable salaries in each cost category to the total allowable salaries in all cost categories, based on the totals in subitem (1).

~~(2)~~ (3) The nursing home's total allowable fringe benefits and payroll taxes must be multiplied by each ratio determined in subitem ~~(1)~~ (2) to determine the amount of payroll taxes and fringe benefits allocated to each cost category for each nursing home under this 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,~~ The commissioner shall determine the ~~food~~ costs of food to be included in other care-related 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.~~ For any nursing home separately reporting food costs, food costs shall be the allowable food costs reported under part 9549.0040, subpart 1.

B. For any nursing home that cannot separately report the cost of food under part 9549.0040, subpart 1, the commissioner

(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 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 QA&R assessment included assessments of nonmedical assistance residents, multiply the nonmedical 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 QA&R 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.

(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 QA&R 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.~~ 3. **Standardized resident days for rate year beginning July 1, 1986.** For the rate year beginning on July 1, 1986, ~~each~~ the commissioner shall calculate the nursing home's standardized resident days ~~must be determined~~ in accordance with items A to ~~C~~ E.

~~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.~~

A. The case mix score for a date prior to July 1, 1985, must be determined in accordance with subitems (1) to (4).

(1) Except as provided in subitem (2), the case mix score must be calculated using the most recent QA&R assessment completed prior to April 1, 1985.

(2) A QA&R assessment completed on or after April 1, 1985, may be used if the nursing home's most recent QA&R assessment completed before April 1, 1985, did not include assessments of nonmedical assistance residents and the nursing home has submitted a written request to the commissioner, requesting the use of a different QA&R assessment. The nursing home's request to the commissioner to use a different QA&R assessment must have been received by December 31, 1985. The commissioner shall use the requested QA&R assessment to compute standardized resident days if the requested QA&R assessment:

(a) was completed by the Minnesota Department of Health before July 1, 1985; and

(b) nonmedical assistance residents were included in the assessment.

(3) The case mix index for the QA&R assessment selected in subitem (1) or (2) must be the sum of the number of residents in each resident class multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

(4) The case mix index determined in subitem (3) must be divided by the total number of residents assessed to compute the case mix score for the QA&R assessment selected in subitem (1) or (2).

B. The case mix score for the period July 1, 1985, to September 30, 1985, must be determined according to subitems (1) to (3).

(1) The resident days in each resident class for the months of July, August, and September 1985 must be multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

(2) The amounts determined in subitem (1) must be summed to determine the nursing home's standardized resident days for the period July 1, 1985, to September 30, 1985.

(3) The standardized resident days determined in subitem (2) must be divided by actual resident days reported for the period July 1, 1985, to September 30, 1985, to determine the case mix score for that period.

C. The average monthly change in the case mix score must be computed by subtracting the case mix score determined in item A from the case mix score determined in item B, and dividing the result by the number of months between the date of the QA&R assessment selected in item A, subitem (1) or (2) and August 16, 1985. For the purposes of this item, the commissioner shall count as a full month any period of more than 14 days and shall disregard any period of 14 days or less.

D. The average case mix score must be determined by subtracting the product of the average monthly change in the case mix score times 4.5, from the case mix score determined in item B.

E. The standardized resident days for each nursing home must be computed by multiplying the average case mix score computed in item D by the total number of resident days during the reporting year.

Subp. 4. **Standardized resident days for rate years beginning on or after July 1, 1987.** For rate years beginning on or after July 1, 1987, each nursing home's standardized resident days must be determined in accordance with items A and B.

A. The nursing home's resident days for the reporting year in each resident class must be multiplied by the weight for that resident class listed in part 9549.0058 [Temporary].

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

Subp. ~~3.~~ 5. **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 in the nursing home's reporting year as determined in subpart ~~1 or~~ 2, 3, or 4.

Subp. ~~4.~~ 6. **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 ~~actual~~ number of resident days in the nursing home's reporting year.

Subp. ~~5.~~ 7. **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 ~~actual~~ number of resident days in the nursing home's reporting year.

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)~~ (7).

(1) The components and indices ~~for~~ specified in the following table must be used to establish the case mix and other care-related operating ~~costs~~ cost adjustment factor ~~must be as specified in the following table~~. These indices are incorporated by reference as specified in subpart 4.

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). ~~SIC 805 is incorporated by reference.~~
Benefits	.1107	Difference between movements in compensation and wages and salary index components of the Employment Cost Index for Service Workers. ~~This index is incorporated by reference.~~
Supplies and Drugs	.0363	Consumer Price Index for nonprescription medical equipment and supplies. ~~This index is 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).~~

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (d) by the composite price index for the reporting year computed in subitem (4), unit (d).

B. The annual adjustment factor for the other operating costs must be established according to subitems (1) to ~~(4)~~ (7).

(1) The components and indices ~~for~~ specified in the following table must be used to establish the other operating cost adjustment factor ~~must be as specified in the following table~~. These indices are incorporated by reference as specified in subpart 4.

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).~~

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1);

(c) summing the results of the calculations in unit (b); and

(d) multiplying the amount calculated in unit (c) by 100.

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (d) by the composite price index for the reporting year computed in subitem (4), unit (d).

Subp. 2. **Base year limits.** For each geographic group established in part 9549.0052 [Temporary] the base year operating costs limits must be determined according to items A to ~~F~~ E. No redetermination of the base year 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. For the purpose of establishing operating cost limits, the commissioner shall compute the allowable historical other care-related per diems for the base year 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. An exception to this calculation is made for a ~~nursing home that is certified to provide a skilled level of care and has an average length of stay of 180 days or less in its skilled level of care. In that case~~ short length of stay facility. For a short length of stay facility, the allowable historical other care-related operating costs must be divided by the greater of resident days or 80 percent of its number of licensed beds multiplied by the number of days in the reporting period.

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~~ a short length of stay facility 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~~ is 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 (5). For the purpose of establishing operating costs limits, the commissioner shall compute the allowable historical other operating costs per diems for the base year 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. An exception to this calculation is made for a ~~nursing home that is certified to provide a skilled level of care and has an average length of stay of 180 days or less in its skilled level of care. In that case~~ short length of stay facility. For a short length of stay facility, the allowable historical other operating costs must be divided 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.

(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~~ short length of stay facilities, 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~~ short length of stay facilities, 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).

(5) The other operating cost limit for each group established in 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. **Indexed limits.** For a rate year beginning on or after July 1, 1986, the total care-related operating cost limits and the other operating cost limits must be determined in accordance with items A and B.

A. The total care-related operating cost limits must be determined in accordance with subitems (1) and (2).

(1) The composite price index for case mix and other care-related operating costs for the current reporting year as determined in subpart 1, item A, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) The limit for each resident class in subpart 2, item C, must be multiplied by the amount determined in subitem (1) to establish the indexed total care-related operating cost limits.

B. Each total other operating costs limit must be determined in accordance with subitems (1) and (2).

(1) The composite price index for other operating costs for the current reporting year as determined in subpart 1, item B, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) Each limit in subpart 2, item E must be multiplied by the amount determined in subitem (1) to establish the indexed other operating cost limits.

Subp. ~~3.~~ 4. **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~~ 5, 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~~ 6, 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, as indexed in part 9549.0055 [Temporary], subpart 3, 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, as indexed in part 9549.0055 [Temporary], subpart 3, 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. If the nursing home is eligible to receive the phase-in in subpart 7, the phase-in reduced by the amount of the efficiency incentive, if any, must be added to the adjusted prospective case mix and other care-related payment rate.

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~~ 7, is below the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, as indexed in part 9549.0055 [Temporary], subpart 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~~ 7, is at or above the limit for that group established in part 9549.0055 [Temporary], subpart 2, item E, as indexed in part 9549.0055 [Temporary], subpart 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 to ~~C~~ E.

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, as indexed in part 9549.0055 [Temporary], subpart 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, as indexed in part 9549.0055 [Temporary], subpart 3, and the nonadjusted other operating cost payment rate in subpart 3, item A, up to maximum of two dollars per resident day.

B. For any ~~nursing home with an average length of stay of 180 days or less in its skilled nursing level of care~~ short length of stay facility 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~~ that 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) as indexed in part 9549.0055 [Temporary], subpart 3, item A, and the nonadjusted other operating cost payment rate in subpart 3, up to a maximum of two dollars.

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, as indexed in part 9549.0055 [Temporary], subpart 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. If the nursing home is eligible to receive the phase-in in subpart 7, the phase-in must be added to the adjusted prospective other operating cost payment rate.

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

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. .

Subp. 6. **One-time adjustment.** Items A to F set forth the procedure to be applied to establish a one-time adjustment to the nursing home's case mix operating costs per diem for the period October 1, 1986, to September 30, 1987.

A. To qualify for a one-time adjustment to the case mix operating costs per diem, the nursing home or portion of the nursing home for which the adjustment is requested must be licensed under Minnesota Statutes, chapter 144A and the nursing home must not have received an interim or settle-up payment rate during the reporting year ending September 30, 1985.

B. To apply for the one-time adjustment to case mix operating costs per diem, the nursing home must submit a written request to the commissioner on or before July 31, 1986. The written request must include the information required in subitems (1) to (3).

(1) Documentation indicating that based on the productive nursing hours and standardized resident days for the reporting period, ending September 30, 1985, the nursing home cannot provide a minimum of 0.95 productive nursing hours per standardized resident day by reallocating existing staff and costs and that the nursing home cannot use other available resources, including any efficiency incentives effective July 1, 1986, to increase productive nursing hours to meet the minimum of 0.95 productive nursing hours per standardized resident day.

(2) A list of the number and type of staff positions including annual hours worked and related fringe benefits and payroll taxes, for the reporting years ending September 30, 1984 and September 30, 1985.

(3) A written nursing plan describing how the nursing home will meet the minimum of 0.95 productive nursing hours per standardized resident day if the nursing home receives a one-time adjustment. The plan must include the number and types of staff to be added to the current staff complement and the projected cost of the salary and related fringe benefits and payroll taxes for the additional staff. The plan must also specify any other increases in case mix operating costs.

C. The commissioner of human services and the commissioner of health shall review the documentation submitted by the nursing home under item B to determine if the nursing home meets the criteria in subitems (1) to (5).

(1) The nursing home meets the criteria in item A.

(2) The nursing home has submitted the documentation required in item B.

(3) The nursing home provided less than a minimum of 0.95 productive nursing hours per standardized resident day for the reporting period ending September 30, 1985.

(4) The nursing home cannot meet the minimum of 0.95 productive nursing hours per standardized resident day by reallocating staff and costs including efficiency incentives.

(5) The nursing home's allowable historical case mix and other care-related operating cost per diem plus the one-time adjustment is less than the case mix and other care-related operating cost limit.

D. If the request meets the criteria in item C, the commissioner shall make a one-time adjustment to the nursing home's payment rate. The one-time adjustment must be determined according to subitems (1) to (9) and must not exceed the amount computed in subitem (3).

(1) The nursing home's productive nursing hours per standardized day for the reporting period ending September 30, 1985, must be subtracted from 0.95 and the result must be multiplied by the nursing home's standardized resident days for the period beginning October 1, 1984, and ending September 30, 1985.

(2) The nursing home's nursing cost per hour must be determined by dividing the nursing home's total allowable historical case mix operating costs by the nursing home's total productive nursing hours for the reporting period ending September 30, 1985.

(3) The amount determined in subitem (1) must be multiplied by the amount determined in subitem (2) to determine the total maximum nursing costs required to meet the minimum of 0.95 productive nursing hours per standardized resident day.

(4) If the amount requested in the nursing hours plan submitted under item B is less than the amount in subitem (3) the difference must be subtracted from the amount in subitem (3).

(5) The amount determined in subitem (4) must be divided by the nursing home's standardized resident days for the reporting period ending September 30, 1985, to compute the maximum standardized case mix per diem costs to be allowed under this subpart.

(6) Any efficiency incentive included in the nursing home's total operating costs payment on July 1, 1986, must be subtracted from the amounts in subitem (5).

(7) Any further reduction that the commissioner determines would be possible by reallocating the nursing home's staff and costs must be subtracted from the amount computed in subitem (6).

(8) The amount computed in subitem (7) must be multiplied by the weight for each resident class contained in part 9549.0058 [Temporary], subpart 2.

(9) The amount computed in subitem (8) must be added to the adjusted prospective case mix and other care-related payment rates for each corresponding resident class.

E. The one-time adjustment determined in item D, subitem (9) shall be implemented beginning October 1, 1986. No portion of the adjustment may be used to provide services that are not case mix operating costs according to part 9549.0051 [Temporary], subpart 5. The commissioner shall perform a fiscal review of the nursing home's cost report submitted for the reporting period ending September 30, 1987, and of any additional documentation required by the commissioner to determine if the nursing home provided 0.95 productive nursing hours per standardized resident day and to determine whether the nursing home has implemented the provisions of the plan specified in item B. The commissioner shall consult with the commissioner of health to verify compliance with any applicable care-related licensing or certification standards. Based on the results of the fiscal review and the information provided by the commissioner of health the commissioner shall implement either subitem (1), (2), or (3).

(1) If the nursing home has failed to implement the plan required in item B, the commissioner shall recover the total amount paid under this subpart in accordance with part 9549.0070, subpart 4 and shall disallow any increases in costs incurred by the nursing home under this subpart in establishing the payment rate for the rate year beginning July 1, 1988.

(2) If the nursing home has implemented or partially implemented the plan specified in item B and the actual case mix operating costs incurred during the reporting year ending September 30, 1987, are below the payment made under this subpart, the commissioner shall reduce the adjustment to the nursing home's payment rate and recover any overpayments in accordance with part 9549.0070, subpart 4. The reduced adjustment to the nursing home's total payment rate shall continue to be paid to the nursing home until June 30, 1988.

(3) If the actual costs of implementing the plan specified in item B, subitem (3) incurred during the reporting period ending September 30, 1987, exceed the payments made under this subpart there shall be no retroactive cost settle-up. The adjustment to the nursing home's total payment rate shall continue to be paid to the nursing home at the same level until June 30, 1988.

F. The nursing home must record the costs associated with this subpart separately from other nursing home costs until the commissioner's fiscal and compliance review under item E establishes that the nursing home has implemented the plan required in item B and has provided at least 0.95 productive nursing hours per standardized resident day during the reporting period ending September 30, 1987. To prevent duplicate payments, the case mix operating costs associated with this subpart are nonallowable until after the commissioner has reviewed and approved the costs under item E. If the commissioner approves the costs, the additional case mix operating costs incurred under this subpart are allowable costs and must be included in the computation of the allowable historical case mix operating cost per diem for the rate year beginning July 1, 1988.

Subp. 7. **Phase-in of rates.** Nursing home rate limits shall be phased-in in accordance with Minnesota Statutes, section 256B.431, subdivision 2h.

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

Subpart 1. **Conditions.** 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 and 3.

~~Subpart 1.~~ Subp. 2. **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], in effect on March 1, 1986. For the rate year or portion of an interim period beginning on or after July 1, 1986, the interim total operating cost payment rate must be determined according to parts 9549.0050 to 9549.0059 [Temporary], except that:

A. ~~Each~~ The 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.

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, as indexed in part 9549.0055 [Temporary], subpart 3, and in effect at the beginning of the interim period must be increased by ten percent.

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

G. The phase-in provisions in part 9549.0056 [Temporary], subpart 7, must not apply.

Subp. ~~2.~~ 3. **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, and before July 1, 1986, or whose interim reporting period included a period of time ~~after that date~~ during that period must be determined for the portion of that interim period occurring after June 30, 1985, and before July 1, 1986, as in parts 9549.0050 to 9549.0059 [Temporary] in effect on March 1, 1986.

C. The settle-up operating cost payment rate for a nursing home which commenced construction after June 30, 1986, or whose interim period included a period of time after that date must be determined for the portion of that interim period occurring after June 30, 1986, as in parts 9549.0050 to 9549.0059 [Temporary] except that:

(1) The standardized resident days occurring after June 30, ~~1985~~ 1986, 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.

(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~~ 2, item E, must be the limits for the settle-up reporting period occurring after July 1, ~~1985~~ 1986.

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

(7) The phase-in provisions in part 9549.0056 [Temporary], subpart 7, 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~~ applies.

9549.0058 [Temporary] RESIDENT CLASSES AND CLASS WEIGHTS.

Subpart 1. **Resident classes.** Each resident or applicant must be classified according to items A to E based on the ~~assessments performed under~~ information on the assessment form completed in accordance with part 9549.0059 [Temporary] ~~on the assessment form~~.

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

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

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

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

(a) oxygen and respiratory therapy;

(b) ~~ostomy~~ ostomy/catheter care;

(c) ~~care of dressings~~ wound or decubitus care;

(d) skin care;

(e) ~~IV~~ intravenous therapy;

(f) drainage tubes;

(g) blood transfusions; ~~or~~

(h) hyperalimentation;

(i) symptom control for the terminally ill; or

(j) isolation precautions.

D. ~~Each~~ A resident or applicant must be defined as having a neuromuscular condition if the resident or applicant is assessed to have one or more of the diagnoses coded to the ~~following~~ categories in subitems (1) to (8) 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~~ The publication is available through the Minitex interlibrary loan system~~.~~ ~~This~~ and is not subject to frequent change.

(1) diseases of nervous system excluding sense organs (320-359 excluding 331.0);

(2) cerebrovascular disease (430-438 excluding 437);

(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); or

(8) neoplasms of the brain and spine (170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6).

E. ~~Each~~ A resident or applicant must be defined as having a behavioral condition if the resident's or applicant's assessment score is 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). The resident classes must be established based on the definitions in items A to E.

(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.

(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 scoring three or four on the eating ADL in item A and not defined special nursing and defined neuromuscular condition~~, and scoring three or four on the eating ADL in item A, and not defined special nursing~~ or scoring three or four on behavior.

(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~~ The 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~~ registered nurse 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 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. ~~However, in no case shall~~ A resident must not receive more than one assessment per respite care stay.

B. ~~Each~~ The 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~~ the term ''newly admitted resident'' includes a resident who moves to a section of the nursing home ~~which~~ that 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 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~~ Each assessment that the nursing home is required to perform must be completed by a registered nurse. The 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 QA&R procedures of the Department of Health, including physical observation of the applicant or newly admitted resident and review of available medical records, 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~~ send the completed assessment form to the Department of Health, and provide a copy to the nursing 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 the person's 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 QA&R assessment occurred between May 1, 1985, and June 30, 1985, the classification established under part 4656.0030, subpart 3, shall apply.

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~~ annual assessment by the Department of Health's QA&R team.

B. A registered nurse shall perform the assessment on each resident according to QA&R 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~~ the information 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 completion of the semiannual assessments.

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 QA&R assessments were performed in October or November 1984.

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

(3) In September 1985, the nursing home must assess all residents whose most recent QA&R 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 QA&R team will be effective as of the first day of the month following the date of completion of the Department of Health's assessments.

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~~ must occur no more than five working days after the resident returns to the same nursing home.

B. In addition to the assessment required in item A, residents who have returned to the same nursing home after hospital admission must be reassessed by the nursing home no less than 30 days and no more than 35 days after return from the hospital unless the nursing home's annual or semiannual reassessment occurs during the specified time period.

C. A registered nurse shall perform the assessment on each resident according to QA&R 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 and the resident's medical plan of care. Upon request, the nursing home must furnish the Department of Health with ~~further~~ additional information ~~when required in order~~ needed to determine a resident's classification.

~~C.~~ D. Any change in resident class due to an assessment provided under ~~this subpart~~ item A must be effective ~~as of~~ on the date the resident returns to the nursing home from the hospital. Any change in resident class due to a reassessment provided under item B must be effective as of the first day of the month following the assessment.

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 4656.0050 [Temporary] that results in a payment increase for the resident must be effective as of the first day of the month following the date of the Department of Health's classification. Any change in resident class due to a reclassification required by part 4656.0050 [Temporary] that results in a payment decrease for the resident must be retroactive to the effective date of the assessment audited.

Subp. 7. **False information.** If the nursing home knowingly supplies inaccurate or false information in an assessment or a request for reconsideration, the commissioner shall apply the penalties in part 9549.0041, subpart 15.

Subp. ~~7.~~ 8. **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 4656.0060 is pending.

B. Any change in a resident class due to a reclassification under part 4656.0060 must be effective as of the effective date of the classification established by the original assessment for which a reconsideration was requested.

Subp. ~~8.~~ 9. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made ~~pursuant to the procedures set forth in~~ under part 4656.0060.

Subp. ~~9.~~ 10. **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~~ access to information regarding rates, assessments, and other documentation provided to the Minnesota Department of Health in support of the resident's assessments to each nursing home resident or the resident's authorized representative according to items A to D.

A. The nursing home must post a notice of its current rates for each resident class in a conspicuous place. The rates must be posted no later than five days after receipt by the nursing home. The nursing home may include a notice that the nursing home has chosen to appeal the rates under part 9549.0080.

B. The nursing home must provide written notice to each private paying resident or the person responsible for payment of any increase in the total payment rate established by the commissioner 30 days before the increase takes effect, as required by Minnesota Statutes, section 256B.47, subdivision 2. The notice must specify the current classification of the resident. This item does not apply to adjustments in rates due to a necessary change in the resident's classification as a result of an assessment required in this part.

C. The nursing home must provide each nursing home resident or the person responsible for payment with each classification letter received from the Minnesota Department of Health within five days of the receipt of the classification letter. If the resident's classification has changed, the nursing home must include the current rate for the new classification with the classification letter.

D. 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.

OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, an agency, in preparing proposed rules, may seek information or opinion from sources outside the agency. Notices of intent to solicit outside opinion must be published in the *State Register* and all interested persons afforded the opportunity to submit data or views on the subject, either orally or in writing.

The *State Register* also publishes other official notices of state agencies, notices of meetings, and matters of public interest.

Agricultural Society Minnesota State Fair

Meeting Notice

The board of managers of the Minnesota State Agricultural Society, governing body of the Minnesota State Fair, will conduct a business meeting at 10:30 a.m., Thursday April 3 at the Administration Building on the fairgrounds, St. Paul.

Department of Energy and Economic Development Community Development Division

Final Statement for 1986 Minnesota Small Cities Development Program

Notice is hereby given that the Department of Energy and Economic Development has prepared and submitted to the U.S. Department of Housing and Urban Development a Final Statement for the 1986 Small Cities Community Development Block Grant Program (CDBG). Comments pertaining to the Final Statement were solicited in the *State Register* on February 3, 1986. A public hearing to receive comments was conducted on February 21, 1986.

10 MCAR § 1.500 Small Cities Community Block Grant Program: General Provisions.

A. Purpose of these rules. Rules 10 MCAR §§ 1.500-1.565 give procedures for evaluating applications for grants and awarding them to eligible applicants by the Department of Energy and Economic Development under United States Code, title 42, sections 5301-5136 (1981), and regulations adopted in Code of Federal Regulations, title 24, part 570.

B. Objective of the program. The primary objective of this program is to develop viable urban communities by providing decent housing and a suitable living environment and by expanding economic opportunities, principally for persons of low and moderate income. Activities funded under this program shall not benefit moderate income persons to the exclusion of low-income persons. All funded activities must be designed to:

1. Benefit low and moderate income persons;

2. Prevent or eliminate slums and blight; or

3. Alleviate urgent community development needs caused by existing conditions which pose a serious and immediate threat to the health or welfare of the community where other financial resources are not available to meet those needs.

C. Definitions. As used in 10 MCAR §§ 1.500-1.565, the following terms have the meanings given them.

1. "Application year" means the federal fiscal year beginning October 1st and ending September 31st.

2. "Community development need" means a demonstrated deficiency in housing stock, public facilities, economic opportunities, or other services which are necessary for developing or maintaining viable communities.

3. "Competitive grant" means a grant application that is evaluated and ranked in comparison to other applications in the same grant category and includes housing, public facilities and comprehensive applications.

4. "Comprehensive program" means a combination of at least two interrelated projects which are designed to address community development needs which by their nature require a coordination of housing, public facilities, or economic development activities. A comprehensive program must be designed to benefit a defined geographic area, otherwise known as a program area.

SUPREME COURT DECISIONS

Decisions Filed Friday, March 28, 1986

Compiled by Wayne O. Tschimperle, Clerk

C9-85-811 Little Earth of United Tribes, Inc., Relator v. County of Hennepin and State of Minnesota. Tax Court.

The Little Earth housing project, which is owned and operated by a private, nonprofit organization, is not "public property used exclusively for a public purpose" under Minn. Const. art. X, § 1, and Minn. Stat. § 272.02, subd. 1(7).

Minn. Stat. §§ 272.02, subd. 1(6), and 273.13, subd. 17, do not violate the supremacy clause of the United States Constitution.

The tax classification for nonprofit, government-subsidized housing projects does not violate the equal protection clause of the United States Constitution, or the uniformity clause of the Minnesota Constitution.

Affirmed. Scott, J.

C6-82-671 In the Matter of the Application for the Discipline of Kenneth R. Pearson, an Attorney of Law of the State of Minnesota. Supreme Court.

Disbarred. Per Curiam.

ERRATA

Department of Human Services

Correction to Notice of Proposed Temporary Rules Relating to Nursing Home Payment Rate Determination

The notice of proposed adoption of temporary rule amendments for Minnesota Rules, parts 9549.0050 to 9549.0059 published in the March 31, 1986 *State Register* on page 2016, (CITE 10 SR 2016), should have also contained the following sentence:

Copies of the proposed rule amendments are available for public review at each county welfare or social services department.

Additionally, the statutory reference on the last line of the third paragraph should have been Minnesota Statutes, section 256B.431 subdivision 2h (not subdivision 2).

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of the Department of Human Services' Rules Relating to Nursing Home Payment Rate Determination, Parts 9549.0050 to 9549.0059 [Temporary]

DECLARATION OF COUNSEL

I, Gary Van Cleve, Special Assistant Attorney General, do hereby declare that I have examined the above-captioned rule, and the supportive rulemaking record, and that, based on my examination, the Administrative Procedure Act and Minnesota Rules, chapter 2000* have been followed. Any exceptions are listed below. For Attorney General billing purposes, the four-digit docket client code is 0881.

May 15, 1986
Date

Gary A. Van Cleve
Special Assistant Attorney General

* In accordance with Minn. Stat. § 256B.431, subd. 6.

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF THE RULE OF THE STATE OF MINNESOTA RELATING TO NURSING HOME PAYMENT RATE DETERMINATION

AFFIDAVIT OF MAILING THE NOTICE OF SUBMISSION OF AMENDMENTS TO A TEMPORARY RULE TO THE ATTORNEY GENERAL

STATE OF MINNESOTA)
)ss.
COUNTY OF RAMSEY)

JANE DELAGE, being sworn says:

That on the 15th day of May, 1986, in the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice of Submission to the Attorney General by depositing in the State of Minnesota Central Mail System for United States mailing, a copy thereof, with postage prepaid, to all persons and associations who requested notice that the rule in the above-entitled matter has been submitted to the Attorney General.

Jane Delage
Jane Delage
Rules Unit

Subscribed and sworn to before me
this 15 day of May, 1986.

CLAUDIA A. ELIASON
NOTARY PUBLIC-MINNESOTA
WASHINGTON COUNTY
MY COMMISSION EXPIRES NOVEMBER 15, 1990

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF TEMPORARY AMENDMENTS TO RULES OF THE STATE OF MINNESOTA RELATING TO NURSING HOME PAYMENT RATE DETERMINATION, PARTS 9549.0050 TO 9549.0059 [TEMPORARY]

NOTICE OF SUBMISSION OF AMENDMENTS TO TEMPORARY RULES TO THE ATTORNEY GENERAL

Pursuant to your request and in accordance with Minnesota Statutes, section 14.32:

PLEASE TAKE NOTICE that the above-captioned rule as adopted has been submitted to the Office of the Attorney General on the date of this notice, May 15, 1986, for review as to legality and form to the extent form relates to legality. The amendments to the temporary rule, the rule as adopted, all the notices, all written comments and other required documents also have been submitted to the Attorney General.

The proposed amendments to the temporary rule which were published in the State Register and made available to the public on March 31, 1986 have been modified. A free copy of the rule as modified as well as the findings of fact, conclusions, and order explaining the amendments and adopting the rule is available upon request from Jane Delage.

The rule must be approved or disapproved by the Attorney General within five working days following date of receipt of the rule. You may submit written comments to the Attorney General. Your comments must address only the issue of legality of the rule or the legality of the specific parts or subparts of the rule. You may receive a copy of the Attorney General decision upon written request to the Attorney General. Your comments or requests for the decision must be directed to:

The Office of the Attorney General
204 Administration Building
50 Sherburne Avenue
St.Paul, Minnesota 55155
Telephone Number: 612/296-1288

Any written comments submitted to the Attorney General should be submitted simultaneously to:

Jane Delage
Department of Human Services
Rules Unit 4th Floor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Statement of the Minnesota Association of Health Care Facilities

TO: Attorney General- Human Services Division

FROM: William J. Hargis, President,
Minnesota Association of Health Care Facilities

DATE: May 22, 1986

RE: Case Mix Rules - Amendments to Minnesota Rules Parts 9549.0050 to 9549.0059 [TEMPORARY] and 4656.0010 to 4656.0100 [TEMPORARY]



MINNESOTA ASSOCIATION OF HEALTH CARE FACILITIES

PUBLIC AFFAIRS

2850 Metro Drive Suite 429
Bloomington, MN 55420
612-854-2844

For further information contact:

On April 25, 1986, the Minnesota Association of Health Care Facilities (MAHCF) submitted formal comments to the Departments of Health and Human Services concerning the proposed amendments to the temporary rules relating to Nursing Home Payment Rate Determination, and the temporary rule relating to Review of Care and Classification of Residents in Facilities Participating in the Medical Assistance Program.

In these comments, MAHCF asserted that the Commissioners of Health and Human Services exceeded their statutory authority in adopting those rule amendments that were not "necessary for the implementation and enforcement of the reimbursement system."

Initially, the Departments of Health and Human Services intended to incorporate the permanent rule proposed amendments into the temporary rules, without allowing MAHCF or other providers an opportunity for public hearing with regard to the changes. MAHCF objected to the several substantive changes that were initially proposed. However, it appears that both departments have changed their initial position in response to MAHCF's objections in the formal comments. The specific changes that MAHCF objected to most strongly have been changed by the departments in the most recent version of the amendments that have been submitted to the Attorney General. These changes are:

1. The 30-35 day assessment of a resident upon return from a hospital in Minnesota Rules Part 9549.0059, subpart 5. This provision has been eliminated, as MAHCF recommended.

2. The QA & R manual now allows a licensed nurse rather than an RN to document, as MAHCF recommended.

3. The "penalty provision" in Minnesota Rules Part 9549.0059, subpart 6, concerning the effective date upon audits of an assessment was changed to read: "any change in resident class due to reclassification must be retroactive to the effective date of the assessment audited." While MAHCF feels that this entire language is unnecessary, it is more fair to require both increases and decreases resulting from reclassification to be retroactive, than to require the previous penalty provision language that was originally proposed.

MAHCF reiterates that the assessment form should be incorporated by reference, and that the QA & R manual should be part of the rules.

MAHCF also asserts that if in the future, agencies are allowed to amend a temporary or emergency rule, it should be authorized legislatively in the enabling legislation, or a legislative authorization should be incorporated into the Minnesota Administrative Procedures Act under Minnesota Statutes Chapter 14.

On the whole, MAHCF is satisfied that the Departments of Health and Human Services have responded to MAHCF's comments by changing the amendments from their initial form. The rule, as currently amended, is workable and reasonable in light of both department's concessions.

Thank you for your consideration in this matter. If you have further questions regarding these comments, please contact Susan M. Voigt at the Minnesota Association of Health Care Facilities at 854-2844.

WJH:SMV/dsw

SF-00006-04

DEPARTMENT : Human Services

STATE OF MINNESOTA

Office Memorandum

PHONE : 297 4302

DATE : May 15, 1986

TO : Judith Wehrwein
Attorney General Administration

FROM : Jane Delage
DHS Rules Unit

SUBJECT : Submittal of DHS Documents/Temporary Amendments to Rule Parts 9549.0050 to 9549.005

The following documents are enclosed for your review:

* temporary rules as adopted (4)
* order adopting (end of findings) (2)
* order for publication (1)
* rules as proposed (1)
* findings of fact and conclusions (2)
* written comments (1 set)
* declaration of counsel
* notice of solicitation and comments received
* notice of proposed adoption (as mailed)
* affidavit of mailing
* affidavit of additional mailing
* certificate of mailing list
* a copy of the rule as published
* notice of submission to the attorney general
* affidavit of mailing of the notice of submission

Please note that these rules were promulgated in accordance with Minnesota Statutes 256B.431, subdivision 6 which states "that any emergency rule adopted ... under this section shall be adopted in accordance with the provisions contained in section 14.29 to 14.36 in effect on March 1, 1984." Because of this requirement, our notice of submission states that these rules will be approved or disapproved by your office within five (5) working days.