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State of Minnesota
Department of Human Services
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155

March 9, 1994

Ms. Maryanne Hruby
Executive Director, LCRAR
55 State Office Building
St. Paul, Minnesota 55155

Dear Ms. Hruby:

Pursuant to Minnesota Statutes, section 14.131, enclosed is a statement of need and reasonableness relating to Payment Rates for All Nursing Facilities Participating in the Medical Assistance Program, Minnesota Rules, parts 9549.0050 to 9549.0059.

If you have any questions on the statement of need and reasonableness, please do not hesitate to contact me at 297-4301.

Sincerely,

Eleanor Weber

Eleanor Weber
Rules Division

Encl.

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF DEPARTMENT OF HUMAN SERVICE RULES GOVERNING PAYMENT RATES FOR ALL NURSING FACILITIES PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM MINNESOTA RULES, PARTS 9549.0050 TO 9549.0059.

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION

Minnesota Rules, Parts 9549.0050 to 9549.0059 and parts 4656.0010 to 4656.0090 establish procedures and instructions for completing case mix assessments. The rules are authorized by Minnesota Statutes, §256B.41, subdivision 1, which permits the Department of Human Services to establish procedures for determining rates for care of residents in nursing homes that qualify as vendors for medical assistance and Minnesota Statutes, §§ 144.0721 and 144.0722 which establish procedures for the assessment of medicaid sponsored and private paying residents in certified nursing homes and boarding care homes. This Statement of Need and Reasonableness is prepared to comply with the requirements of the Administrative Procedure Act, specifically, Minnesota Statutes, §§14.131 and 14.23.

This Statement of Need and Reasonableness (SNR) addresses amendment of Minnesota Rules, parts 9549.0050 to 9549.0059. The Minnesota Department of Health is proposing amendment of Minnesota Rules, parts 4656.0010 to 4656.0090 in a concurrent rule amendment process.

HISTORY OF CASE MIX

Minnesota Laws of 1985 established a reimbursement system for services to residents in nursing homes and boarding care homes certified to participate in the federal Medicaid program. This system is commonly referred to as a "case mix" system. The Minnesota case mix system establishes eleven payment classifications based on residents' care needs. Those needs are identified by assessments conducted at various intervals by the facility, the Department of Health's Quality Assurance and Review Program (QA&R) or by the county pre-admission screening team.

All assessments are based on the Quality Assurance and Review (QA&R) procedures established by the Minnesota Department of Health (MDH) and must be recorded on the forms developed by the QA&R.

In 1989 a Case Mix Technical Advisory Committee to the Commissioner of Health made a series of recommendations for changes to the case mix system. The recommendations were not adopted at that time as the changes and effects of the federal Nursing Home Reform Act (P.L. 100-203, the Omnibus Budget Reconciliation Act (OBRA) of 1987) on the delivery of health care in certified nursing facilities were unknown. Upon directives from the Commissioners of the Department of Human Services and the Department of Health, the Case Mix Technical Advisory Committee was reconvened in 1993. The committee reviewed possible non-controversial rule changes and recommended that these changes be considered as proposed amendments to the rules.

The proposed amended rules, designated as Minnesota Rules, parts 9549.0050 to 9549.0059, are hereby affirmatively presented by the department in accordance with the provisions of the Minnesota Administrative Procedure Act,, Minnesota Statutes, chapter 14, and the rules of the Office of Administrative Hearings.

Part 9549.0051 Definitions.

Subpart 12. As a result of the federal OBRA legislation, the "plan of care" is now defined in the Code of Federal Regulations, title 42, section 483.20 under "Resident Assessment". This section addresses initial and ongoing assessments of the resident(s) and development of the plan of care. As all certified facilities are federally mandated to use these methodologies and definitions, and certified facilities are subject to the case mix system, requiring the case mix rule also to use these methodologies and definitions is reasonable, as nursing facilities will have a single standard. This change will lessen confusion and duplication for facility staff.

This will result in a change in the MDH's document, Facility Manual for Completing Case Mix Requests for Classification, p. 5, "Definitions".

Part 9549.0059 Resident Assessment

Subpart 1. Under the proposed language, facilities will be given the choice of submitting either a medical plan of care or an interagency transfer form with each assessment to the Department of Health. An interagency form is universally used by health care facilities in Minnesota. The interagency transfer form contains a summary of the information needed by QA&R on a single page and is signed by the attending physician. A facility that chooses to use the interagency transfer form may save time and money because facility staff will no longer need to copy the information to a medical plan of care form for submission and then obtain the physicians's signature.

Subpart 2. The QA&R assessment form used by the QA&R team and the facility gives a through and comprehensive profile of the resident and entails completing areas of the form that are unrelated to the case mix system. Some of the information that is obtained during the annual visit of the QA&R team is used for demographic and health care related studies. The form has areas for this data to be recorded.

The information submitted by the facility for the resident's semi-annual assessment is not used for studies, but rather for determining the resident's classification for reimbursement purposes. This amendment proposes to eliminate the collection of certain assessment items that are not used for establishing the resident classification. Not requiring the facility's registered nurses to complete the entire form, but only the case mix related items, is reasonable because it may result in improved efficiency for the facility, as staff can use the time saved to devote to the residents.

The assessment needs to be signed on the date of completion as it is designed to reflect the status of the resident on the day the assessment is completed. The reconsideration process, as set forth in Minnesota Statutes, section 144.0722, subdivision 3 and Minnesota Rules, part 9549.0059, subpart 8 B, is limited to documentation establishing the needs of the resident at the time of assessment. Therefore, it is important that the date of completion is correctly documented on the form.

Subpart 3. Resident admissions, transfers, hospital returns, and discharges often occur during the annual visit by the QA&R team. In these situations under the current rule, the QA&R team must establish a classification, frequently based only on the limited information available to QA&R on that day. A classification established by QA&R is effective the first day of the month following the exit date of the team. The rule also requires the facility to complete an assessment of the resident, and permits facilities a period of from five to ten days, depending on the situation, to complete the assessment. A classification established by the facility is effective on the date the resident is admitted to, is transferred to, or returned from the hospital to the facility.

When these instances occur, two classifications are established and two classification letters are sent to residents and/or their families. The two classification letters often have different classification effective dates, and possibly establish different classifications (if, for example, actual services needed and received in the long term care setting substantially differ from those projected on the interagency transfer form). In this circumstance, residents, families, and the facility have difficulty determining which classification is correct and which effective date should be used.

This amendment is needed to eliminate the QA&R classification for those residents who experience an admission, transfer, hospital return, or discharge during the QA&R team visit. This should lessen the confusion caused by conflicting effective dates and classifications.

It is reasonable to use the assessments completed by the facility for establishing the classifications, rather than QA&R's assessment because the facility can use the five or ten day time period permitted in the rule to assess the resident's status and establish necessary services. By the end of the applicable time period, the resident's needs and services will probably be better defined, allowing for a more accurate assessment to be completed.

It is reasonable for QA&R to eliminate the establishment of a classification for residents who are discharged during the QA&R team visit because the resident no longer resides in the facility and a payment rate does not need to be determined.

Subpart 4. C. This proposed change would allow the facility to use either the resident's medical plan of care or an interagency transfer form. The rationale is the same as the proposed change discussed in subpart 1 of this SNR.

Small Business Consideration in Rulemaking Under Minnesota Statutes, section 14.115, subdivision 7, clause (3), the small business consideration in rulemaking does not apply to service businesses regulated by government bodies, for standards and costs, such as nursing facilities. Since the proposed amendments govern nursing facilities, the requirements under Minnesota Statutes, section 14.115 do not apply to this rule.

Impact on Agricultural Lands Minnesota Statutes, section 14.11, subdivision 2, requires agencies proposing rules that have a direct and substantial adverse impact on agricultural land in this state to comply with additional statutory requirements. The amendments of the rule governing payment for nursing facilities have no impact on agricultural land, and therefore the additional statutory provisions do not apply.

Statement of Fiscal Impact

The amendments to these rule parts are not anticipated to result in any increases in Medical Assistance costs. These amendments likely will result in a streamlining in processes, both for nursing facilities and for the Minnesota Department of Health, Quality Assurance and Review.

The time saved through streamlining these processes will be small and widely distributed. These amendments alone will not result in direct cost savings. The more likely result will be small amounts of additional time for professional facility nursing staff throughout the work week which can be directed toward additional direct patient care, thus improving quality.

There will be minor reductions in paperwork and processing for the Minnesota Department of Health, Quality Assurance and Review, which will create greater efficiency in operation. However these reductions in paperwork and processing will be small and widely distributed.

Date 2/22/94

Maria R. Gomez
Commissioner of Human Services

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of the Amendments to Rules of the State Department of Human Services Governing Payment Rates for All Nursing Facilities Participating in the Medical Assistance Program, Minnesota Rules, parts 9549.0050 to 9549.0059

NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING

The Department of Human Services intends to adopt amendments to permanent rules without a public hearing following the procedures set forth in the Administrative Procedure Act, Minnesota Statutes, sections 14.22 to 14.28. You have 30 days to submit written comments on the proposed rule and may also submit a written request that a hearing be held on the rule.

Agency Contact Person. Comments or questions on the rule and written requests for a public hearing on the rule must be submitted to:

Eleanor Weber, Minnesota Department of Human Services, 444 Lafayette Rd., St. Paul, MN 55155-3816, telephone (612) 297-4301, fax number (612) 297-3173.

Subject of Rule and Statutory Authority. The statutory authority to adopt this rule is in Minnesota Statutes, section 256B.41, subdivision 1 which permits the Department of Human Services to establish procedures for determining rates for care of residents in nursing homes that qualify as vendors for medical assistance. A copy of the proposed rule is published in the State Register. The proposed rules will amend: Minnesota Rules, part 9549.0051, subpart 12 which defines "Resident Plan of Care"; part 9549.0059, subpart 1, to permit submission of a medical plan of care or an interagency transfer form; part 9549.0059, subpart 2, during the semi-annual assessment, to eliminate the collection of specific information that is not necessary for establishing resident classifications and to clarify the date on which the form should be signed; part 9549.0059, subpart 3, to provide that the Minnesota Department of Health, Quality Assurance and Review (QA&R) shall not establish classifications for residents who experience an admission, transfer, hospital return, or discharge occurring during the QA&R team visit, and part 9549.0059, subpart 4 to permit the facility to submit either the medical plan of care or an interagency transfer form.

The Minnesota Department of Health is in a parallel rule amendment process proposing amendment to rule parts 4656.0010 to 4656.0090. These rule parts establish procedures and instructions for completing case mix assessments.

Department of Human Services

Proposed Permanent Rules Relating to Nursing Homes Payment Rate Determinations

Rules as Proposed

9549.0051 DEFINITIONS.

[For text of subps 1 to 11, see M.R.]

Subp. 12. **Resident plan of care.** "Resident plan of care" for residents of nursing facilities ~~not licensed as boarding care homes~~ means the ~~patient care plan specified in part 4655.6000. "Resident plan of care" for residents of nursing facilities licensed as boarding care homes means the overall plan of~~ comprehensive care plan as ~~defined~~ set forth in Code of Federal Regulations, title 42, section ~~442.319~~ 483.20, paragraph (d), as amended through ~~December 31, 1984~~ October 1, 1992.

[For text of subps 13 and 14, see M.R.]

9549.0059 RESIDENT ASSESSMENT.

Subpart 1. **Assessment of nursing facility applicants and newly admitted residents.** Each nursing facility applicant or newly admitted resident must be assessed for the purpose of determining the applicant's or newly admitted resident's class. The assessment must be conducted according to the procedures in items A to I.

[For text of items A to G, see M.R.]

H. Except as provided in item D, each assessment completed under items A to G and a completed medical plan of care or interagency transfer form must be submitted to the Department of Health by the nursing facility as a request for classification within ten working days after admission or after the assessment, whichever is later.

[For text of item I, see M.R.]

Subp. 2. **Semiannual assessment by nursing facilities.** Semiannual assessments of residents by the nursing facility must

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be completed in accordance with items A to D.

[For text of item A, see M.R.]

B. A registered nurse shall assess 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 Physician's Statement of General Condition (item 10), Individual Dependencies (items 21 to 24 and 28), Medications (items 31 to 34), and Primary, Secondary, and Tertiary Diagnoses (on the back of the form) do not require completion. The registered nurse performing the assessment shall sign the assessment form on the day the assessment is completed.

[For text of items C and D, see M.R.]

Subp. 3. **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. QA&R shall not establish classifications for residents who experience an admission, transfer, hospital return, or discharge occurring during the QA&R team visit.

Subp. 4. **Assessment upon return to the nursing facility from a hospital.** Residents returning to a nursing facility after hospitalization must be assessed according to items A to D.

[For text of items A and B, see M.R.]

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 assessment, the nursing facility must forward to the Department of Health a request for a classification for any resident assessed upon return to the

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nursing facility after a hospital admission. This request must include the assessment form and the resident's medical plan of care or interagency transfer form. Upon request, the nursing facility must furnish the Department of Health with additional information needed to determine a resident's classification.

[For text of item D, see M.R.]

[For text of subps 5 to 9, see M.R.]

Approved by Revisor _____

Office of the Revisor of Statutes

Administrative Rules

TITLE: Proposed Permanent Rules Relating to Nursing Homes Payment Rate Determinations

AGENCY: Department of Human Services

MINNESOTA RULES: Chapter 9549

The attached rules are approved for publication in the State Register

Philip J. Olfelt
Assistant Revisor