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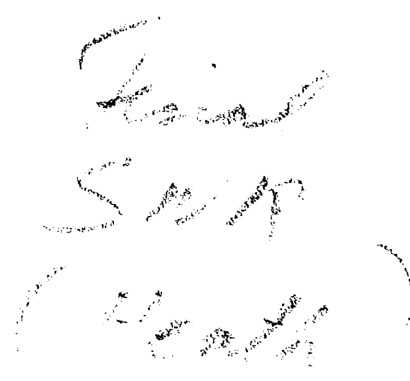


STATE OF MINNESOTA

DEPARTMENT OF HEALTH

IN THE MATTER OF THE PROPOSED
STATEMENT OF NEED AND REASONABLENESS
ADOPTION OF PROPOSED MINNESOTA RULES,
PARTS 4656.0250 TO 4656.0330,
GOVERNING THE ASSESSMENT OF PERSONS
RECEIVING SERVICES AT ICFs/MR AND ASSIGNMENT OF
CLIENT REIMBURSEMENT CLASSIFICATIONS
FOR ICFs/MR.

INTRODUCTION

The Department of Human Services has developed a new Medical Assistance program payment rate system for the care of clients of intermediate care facilities for persons with mental retardation (ICFs/MR). The new payment rate system is referred to as the 'client centered reimbursement system' and is in the form of proposed amendments to Minnesota Rules, Chapter 9553, which is administered by the Minnesota Department of Human Services. The proposed amendments under chapter 9553 establish program payment

rates to be paid according to the level of services needed and received by clients.

Proposed parts 4656.0250 to 4656.0330 establish ways for the Minnesota Department of Health Quality Assurance and Review (QA&R) program to assess and classify services required and received by clients of ICFs/MR to determine which client reimbursement classification under the new system will be assigned to each client.

This statement of need and reasonableness is for parts 4656.0250 to 4656.0330. Parts 4656.0250 to 4656.0330 are closely related to the Department of Human Services rules, parts 9553.0010 to 9553.0080. The client centered reimbursement system is explained in detail in the SNR for parts 9553.0010 to 9553.0080, and it is important to understand that SNR before reading the SNR for parts 4656.0250 to 4656.0330.

CLARIFICATION OF TERMS

* Much of the information collected from assessments for the Inspection of Care (IOC, 42 CFR 456.600 to 456.614) requirement can be used for reimbursement purposes. Therefore, the Quality Assurance and Review Program collects that information simultaneously during its regularly scheduled annual inspections of care. For the purposes of this statement of need and reasonableness, the terms "inspection" and "assessment" will be used as follows:

* "Inspection" refers to the evaluation of care provided to clients in order to make any necessary recommendations for program changes as well as recommendations for level of care changes.

* "Assessment" refers to the evaluation of services provided to clients that is performed to determine client reimbursement classifications under the medical assistance program.

HISTORY AND STATUTORY REQUIREMENTS

In 1985, under Laws of Minnesota, Chapter 9, Article 2, Section 100, the legislature mandated that the Commissioner of human services study alternative "mechanisms" to distribute medical assistance reimbursements to ICFs/MR according the "needs and resource use of the people served by the provider".[1] To study reimbursement mechanisms for program payment rates, the Department of Human Services contracted with Lewin and Associates (experts in reimbursement), Washington, D.C., and with the Human Services Research Institute (experts in the field of mental retardation), Cambridge, Massachusetts. The researchers and DHS staff met regularly with providers, advocates, and legislators to develop and implement the study of reimbursement mechanisms.

The study of reimbursement mechanisms led the researchers to conclude that a client centered reimbursement system would direct resources to clients with the greatest needs. As proposed by the study, the medical assistance reimbursement system for ICFs/MR would consist of three major components: 1) an assessment

instrument used to determine the types and levels of services provided to clients, 2) a system for determining the service need levels based on the assessment, and 3) a schedule of reimbursement rates that corresponds to the service need levels determined by the assessment. Once assessed, services provided by ICFs/MR could be reimbursed according to a "prospective rate per service unit".[2]

Laws of Minnesota, 1988, Chapter 689, Article 2, Section 7, added subdivision 3g to Minnesota Statutes, 1986, section 256B.501. Subdivision 3g requires the Department of Human Services to establish a reimbursement rate based on the types of services provided to ICF/MR clients. Additionally, Quality Assurance and Review is required to assess clients of ICFs/MR using an assessment instrument developed by the Commissioner of Human Services.[3] The information for the major part of the "assessment instrument" that was developed by the Commissioner of Human Services is obtained by a review of the client record and observation of the client to determine the client's level of abilities, the types, frequency, and amounts of intervention that the client needs and that the ICF/MR is providing to meet those needs (see parts 4656.0290 and 4656.0295).

Minnesota Statutes, section 256B.501, subdivision 3g provides the statutory authority for the development and adoption of rules necessary to implement subdivision 3g of section 256B.501.

In 1989 the legislature passed the remaining laws necessary to implement the new ICF/MR reimbursement program. Under laws

of Minnesota, 1989, Article 3, Chapter 282, Section 3, subdivisions 1 through 8 (codified as Minnesota Statutes, section 144.0723), legal authority is given for: 1) the Commissioner of Health to assign client reimbursement classifications (CRC) established by the Commissioner of Human Services; 2) notice of the CRC that was assigned; 3) the client, client's representative or ICF/MR to request that the Commissioner of Health reconsider an assigned CRC 4) the client, client's case manager, or the client's representative to have access to assessment information maintained by the ICF/MR; 5) the Commissioner of Health to require additional information from the ICF/MR when the client or facility requests a reconsideration; 6) the Commissioner of Health to reconsider a CRC that was assigned to a client; 7) audits of assessments; and 8) for the Commissioner of Health to promulgate rules regarding these provisions.[4]

General authority for the Commissioner of Health to inspect or assess the care provided to recipients of medical assistance is under Minnesota Statutes, section 144.072, subdivision 1.[5]

Proposed parts 4656.0250 to 4656.0330 are needed to set uniform standards that can be used to objectively implement the above-cited statutory requirements and are reasonable, in part, because those standards are consistent with the statutory requirements.

To prepare the proposed rules the Commissioner of Health followed the procedures mandated by the Minnesota Administrative Procedures Act and the rules of the Office of Administrative

Hearings. A notice of intent to solicit outside opinion concerning the proposed rules was published in the State Register on Monday, July 24, 1989.

RULE PROVISIONS

The statement of need and reasonableness for parts 4656.0250 through 4656.0330 are as follows:

4656.0250 SCOPE.

Rules affecting the ICF/MR medical assistance reimbursement process are being promulgated by the Minnesota Departments of Human Services and Health at the same time. Therefore this part is needed to clarify which part of the reimbursement system is being implemented by the Minnesota Department of Health. This part is reasonable because the explanation under it is consistent with parts 4656.0250 to 4656.0330.

4656.0260 DEFINITIONS.

Applicability, under subpart 1, and the definitions beginning under subpart 2 are needed to: clarify which parts of Minnesota Rules the definitions apply to; provide consistent terminology for use by persons and organizations interested in medical assistance payments to ICFs/MR; provide a basis for evaluating compliance with Minnesota Statutes, other rules promulgated by the State of Minnesota, and federal laws and regulations; identify and clarify terms used in parts 4656.0250 to 4656.0330; and provide clear

meanings to the provisions in these rules. Words or phrases used in a manner consistent with common usage are not defined.

Subp. 1. Applicability. This subpart is necessary and reasonable because the terms as defined are unique to parts 4656.0250 to 4656.0330 and do not necessarily apply to other parts of Minnesota Rules.

Subp. 2. Assessment. This subpart is needed to clarify and specify the requirements of Minnesota Statutes, section 256B.501, subdivision 3g and to provide an abbreviation for referring to the assessment procedures required by these rules.

Minnesota Statutes, section 256B.501, subdivision 3g requires the assessment instrument developed by the Commissioner of Human Services to "include assessment of the client's behavioral needs, integration into the community, ability to perform activities of daily living, medical and therapeutic needs, and other relevant factors determined by the Commissioner [of Human Services]." Further "the Commissioner [of Human Services] may establish procedures to adjust the program operating costs of facilities based on a comparison of client service characteristics, resource needs, and costs." The Departments of Human Services and Health, together with the Rule 53 (ICF/MR reimbursement rule) advisory committee and the consultants (Lewin and Associates), developed the assessment procedures. The purpose of the assessment is to differentiate between clients with different service needs and to target resources to clients who need the most care. Client

assessments will enable the Department to understand the services needed and received by each client and to compare the service needs and costs of clients with different needs. Research conducted by the Department of Human Services showed that the best method for distinguishing between the service needs of clients is to assess clients according to the types, frequency and amounts of intervention needed by clients (for details on the research, see the SNR for parts 9553.0010 to 9553.0080). It is therefore reasonable to assess clients according to their service needs.

It is reasonable to review the client record because the reviewer needs to examine the client's plans and other documents which show the client's needs and how the provider is meeting those needs. The client record also gives the reviewer an indication of the client's progress and helps in determining the current condition of the client. Federal regulations (42 CFR sections 456.600 to 456.614) mandate QA&R to observe clients for the purpose of completing their inspection of care (IOC). Since QA&R completes client assessments at the same time as the inspection of care, it is reasonable for QA&R to observe clients for assessment purposes also. It is also reasonable to state that clients will be observed "whenever possible" because clients may not always be present at the facility during the QA&R team's visit. This provision clarifies that QA&R should observe clients whenever they are present at the facility but does not place an undue burden on QA&R's staff resources. It is reasonable to specify that assessments can include staff interviews because staff interviews

help in clarifying issues and in understanding the client's condition. QA&R has been assessing ICF/MR clients for the last 13 years and experience has shown that staff interviews help QA&R in making informed decisions. This definition is, therefore, reasonable.

Subp. 3. Assessment form. This term is needed for clarification purposes. By identifying which form must be used to complete an assessment the Commissioner of Health ensures compliance with the requirement under Minnesota Statutes, section 256B.501, subdivision 3g that "the department of health shall assess all residents annually . . . using a uniform assessment instrument developed by the Commissioner [of human services]". To establish uniform client reimbursement classifications throughout the state, it is necessary to use a standard assessment form. This definition is reasonable because it ensures that a standard assessment form will be used.

Subp. 4. Case manager. This definition is needed and reasonable because it is consistent with established rules.

Subp. 5. Client. This definition is needed to clarify the individuals whose service needs are being assessed and classified. Although this is a medical assistance reimbursement program, Minnesota Statutes, section 256B.501, subd. 3g, requires QA&R to assess the services being provided to all persons with mental retardation (including persons whose services are being paid for by non-medical assistance program sources). Therefore, this definition is reasonable.

Subp. 6. Client record. This definition is needed because the documents contained in the client record will be the documents used to complete an assessment. The definition is reasonable because many written records must be maintained according to law. See for example Minnesota Rules Chapter 9525, including parts 9525.0035, subpart 5; 9525.0045; and 9525.0055. Part 9525.0430 "RESIDENT RECORDS" provides the most direct requirement for these records. Title 42, CFR, section 483.410 (c) is the federal certification requirement for client records. It is reasonable to require reviewers to examine the client record because maintaining the client record creates no additional burden on the providers and helps reviewers in determining the services needed and received by clients.

Subp. 7. Client reimbursement classification. This definition is needed to clarify which classifications must be assigned under part 4656.0300. It is reasonable to refer to part 9553.0056, subpart 2 (related human services rule) because Minnesota Statutes, section 144.0723, subdivision 1 requires the Department of Health to assign client reimbursement classifications according to "rules established by the Commissioner of Human Services to set payment rates for ICFs/MR".[6] (For a detailed explanation of the client reimbursement classification, see the SNR for part 9553.0056).

Subp. 8. Department. This definition is necessary and reasonable because it is for identification and clarification purposes only.

Subp. 9. Desk audit. This definition is needed and reasonable because it clarifies a term used in these rules and avoids confusion with the other type of audit used by the Department, the on-site audit.

Desk audit means the audit of an assessment based on the Department's review and analysis of the assessment and the documentation submitted by the provider and the case manager in support of the assessment. Part 4656.0320 gives QA&R the authority to audit assessments performed by case managers. This is reasonable because the Department of Health is responsible for assigning the CRC based on the assessments completed by case managers. This is also reasonable because QA&R has historical experience with the assessment of ICF/MR clients and is well qualified to detect errors in assessments.

Subp. 10. Documentation checklist. The documentation checklist mentions a list of documents including the client's Individual Service Plan (ISP), Individual Habilitation Plan (IHP), Medical Evaluation, Psychological Evaluation, etc. The case manager indicates on this list the documents on which the case manager has based the assessment. QA&R has to know the basis of the case manager's assessment in the event there is a reconsideration or an audit of the assessment. Therefore, it is necessary and reasonable to ask the case manager to sign the documentation checklist.

Subp. 11. Facility or ICF/MR. This definition is needed to clarify which type of facilities are referred to in these rules

and to provide an abbreviation for that facility. The definition is reasonable because it is the same as the definition in the ICF/MR reimbursement rule proposed by the Department of Human Services under part 9553.0020, subpart 19.

Subp. 12. Manual. It is necessary to define manual to explain the meaning of a term used throughout the rule. It is reasonable to use the manual because affected parties can understand the system more clearly when it is explained in a separate manual. The manual contains the details of all assessment procedures which QA&R, providers, and case managers have to follow and has charts and attachments explaining the new reimbursement system in detail. (See exhibit E of the SNR for parts 9553.0010 to 9553.0080).

Subp. 13. On-site audit. This definition is needed and reasonable because it clarifies a term used in these rules and because it prevents confusion with the other type of audit used by the Department, the desk audit. On-site audits enable QA&R to compare the assessment with the documentation on which the assessment was based, and to determine if the assessment form was completed accurately. Since the Department of Health is ultimately responsible for assigning the client reimbursement classification based on the assessment and QA&R is well qualified to detect errors in assessments, it is reasonable to allow QA&R to conduct on-site audits.

Subp. 14. Quality assurance and review. This definition is necessary to inform providers that the QA&R program referred to in

these rules is the program established by the Commissioner under Minnesota Statutes, sections 144.072 to 144.0721. The proposed reimbursement system requires QA&R to conduct annual assessments of clients in ICFs/MR. This is reasonable because it is consistent with Minnesota Statutes, section 256B.501, subd. 3g, which states, "To establish service characteristics of residents, the quality assurance and review teams in the Department of health shall assess all residents annually beginning January 1, 1989,..." It is also reasonable because QA&R has been assessing services provided by ICFs/MR for the last thirteen years and has the necessary training and expertise to complete the assessments with the new assessment form.

Subp. 15. Representative. It is necessary to define this term so interested persons are aware of the unique meaning this term has in this rule. It is reasonable to define representative this way because it is consistent with Minnesota Statutes, section 144.0723, subd. 2.

Subp. 16. Request for classification or RFC. This definition is needed to provide an abbreviation for several forms that must be submitted by the case manager to ask the Department of Health to assign a client reimbursement classification. The Department of Health (MDH) assigns client reimbursement classifications (CRCs) based on assessments completed by case managers. It is reasonable for the case manager to submit a cover letter (transmittal sheet), the assessment form, and a checklist

indicating which documents were reviewed to support the assessment, because MDH needs this information to assign correct CRCs.

Subp. 17. Transmittal sheet. This definition is needed to clarify which form must be submitted as a cover letter with the case manager's request for classification. The transmittal sheet gives the name and address of the case manager in case MDH staff have any questions about the assessment. It also states the number and types of RFCs submitted. This enables MDH staff to inspect the RFC and make sure they have all the relevant documents. It is therefore reasonable to ask the case manager to submit a transmittal sheet.

Subp. 18. Working day. This definition is necessary and reasonable for clarification and identification purposes only.

4656.0280 INSPECTION OF CARE REQUIREMENT.

This part is needed to clarify the authority and procedures for the Quality Assurance and Review Program to conduct inspections of care provided by ICFs/MR. Inspection of care is also necessary because Minnesota Statutes, section 144.072, subdivision 1 requires the Commissioner of health to implement by rule those provisions of the Social Security Amendments of 1972 (Public Law 92-603) required of state health agencies, including rules that establish a plan for the review of the appropriateness and quality of care and services furnished to recipients of medical assistance.

Federal regulatory procedures for conducting reviews of the appropriateness and quality of care of services being provided to

persons receiving the services of ICFs/MR for persons with mental retardation (i.e. inspection of care regulations) are found under Code of Federal Regulations, title 42, sections 456.600 to 456.614. This part is reasonable because it is consistent with the cited laws and regulations.

4656.0290 REQUIREMENTS FOR COMPLETING ASSESSMENTS.

Subpart 1. Quality Assurance and Review assessments. It is necessary for QA&R to assess clients once a year so that the Department of Human Services (DHS) is able to reimburse facilities according to the services needed and received by clients. It is reasonable for QA&R to complete the assessments because QA&R has been assessing ICF/MR clients for the past thirteen years and has extensive experience with such assessments. It is reasonable to provide for annual assessments at the same time as the federal inspection of care of ICFs/MR (required by 42 CFR sections 456.600 to 456.614) because much of the information needed for completing both evaluations is the same. Annual assessments will also reduce the administrative burden on QA&R as well as on providers and the expense for the state Departments of health and human services. This provision is also reasonable because it is consistent with Minnesota Statutes, section 256B.501, subd. 3g.

Assessments reflect the current condition of the client with reference to services needed and received by the client at the time of the assessment. It is necessary to state the time period for which the reviewers will consider documentation in the client

record so that both reviewers and providers know which portion of the client record the annual assessment is based upon. It is reasonable for QA&R to review the record for the past 12 months because that would include all documentation since the last QA&R assessment and would indicate any changes in the client's condition in the past year. If the client's status has changed in the last quarter, reviewers must examine all documents but base their assessments on current observations.

Subp. 2. Case manager assessments. QA&R will assess ICF/MR clients once in a year. It is necessary to provide for re-assessments for situations when a new client enters the facility or the client's needs change between QA&R's annual assessments. This subpart specifies that the case manager shall assess clients 1) who are admitted to facilities; and 2) whose service needs change to such an extent that either the case manager or the provider believe that their client reimbursement classification will change.

It is reasonable to refer to part 9553.0057 because the procedures and timelines for the above assessments are specified in that part. Since all persons governed by parts 4656.0250 to 4656.0330 are also governed by parts 9553.0010 to 9553.0080, this reference eliminates duplicate language and shortens the length of the rule. The reasonableness of the case manager's assessment is in the SNR for part 9553.0057, subparts 3 and 4.

It is necessary to state the time period for which the case manager will consider documentation in the client record so that

both case managers and providers know which portion of the client record the assessment completed under part 9553.0057, subpart 3 or 4 is based upon.

The client record will not usually contain much documentation when the client is recently admitted to a facility. The case manager is required under Minnesota Statutes, part 9525.0105 to convene an interdisciplinary team (IDT) meeting for the client, and this meeting provides the case manager with information upon which the case manager can assess the client's service needs. The findings of the IDT meeting form part of the client record. It is therefore reasonable to base the assessment of a client admitted to a facility (part 9553.0065, subp. 3) on the client record at the time of the IDT meeting.

When a client's status changes the documentation in the client record for the past three months is usually sufficient to establish the change in the client's condition. Therefore, it is reasonable to base the assessment under part 9553.0057, subpart 4 on the client record for the past 3 months.

Subp. 3. Assessment forms. It is necessary to inform QA&R, case managers, and providers that all assessments must be recorded on the assessment form. This requirement is reasonable for the reasons stated in the SNR for part 4656.0260, subpart 3.

4656.0295 AREAS TO BE ASSESSED.

In response to a legislative mandate (Minnesota Statutes, section 256B.501, subdivision 3g) the Commissioner of Human

Services undertook to implement a new payment system for ICFs/MR effective October 1, 1990. The new payment system, also known as the "client centered reimbursement system", reimburses ICFs/MR for program operating costs at varying levels based on client needs and relative resource use (cost of meeting those needs). This system requires ongoing assessments of client service needs and linking of these assessments to the cost of providing care. In this way, client service needs and costs are used to determine program operating cost payment rates and resources are targeted to the client.

The Department of Human Services initiated a major research project to develop the new reimbursement system. The assessment form, specifying the areas in which the client service needs are to be assessed, was developed by researchers along with the staff of the Departments of Health and Human Services, and with the guidance of the Rule 53 (ICF/MR reimbursement rule, part 9553.0010 to 9553.0080) Advisory Committee. (For details on the research background, see the SNR for parts 9553.0010 to 9553.0080).

The research conducted by Lewin and Associates, experts in long term care, sought to understand why program costs varied for different clients. The study confirmed that different client characteristics falling into 4 main domains (activities of daily living; personal interaction, independence, and integration (PIII); challenging behaviors; and, special treatments) substantially contribute to the variations in the need for staff time.

Part 4656.0295 states that a client must be assessed in the

area of PIII, challenging behaviors, ADLs, and special treatments. It is necessary to assess clients to determine the service needs of clients. Based on the assessment, the Department of Health assigns client reimbursement classifications (CRC) for each client. The Department of Human Services then reimburses facilities at a payment rate which corresponds to the CRC of each client. This system of linking assessments to reimbursement helps the State to target resources according to the service intervention needs of clients. It is reasonable to assess clients in the areas of ADLs, challenging behaviors, and special treatments because the research showed that these areas were the best predictors of resource use and explained the maximum variation among clients. It is also reasonable to assess clients in the area of PIII, because the Department wishes to provide an incentive for positive programming in this area. This incentive is provided by linking intensive PIII services to a payment rate that is higher than the payment rate for providing standard community integration services.

Item A. This provision is necessary to inform providers, case managers, and QA&R reviewers how to complete assessments in the area of personal interaction, independence, and integration (PIII). It is reasonable to incorporate section 2.0 of the manual to avoid lengthy rules and to ensure consistency between the manual instructions and the rule.

Assessments are based on services needed and received by clients. Section 2.0 specifies the documents which QA&R and the case manager will review to complete assessments in the PIII area.

This documentation is necessary because a reviewer who goes to the facility just once a year cannot evaluate the provider's services or the client's condition without reviewing the past records. Client records give the reviewer an overview of the client's needs, of any improvements or regressions in the client's condition, of services provided by the facility and of the client's response to those services.

The documentation is also necessary for effective audits and reconsiderations. Audits are conducted by the Department on a routine sampling basis and also if the Department believes that a case manager's assessment is either inaccurate or incomplete. Reconsiderations are conducted by the Department if the provider or the client believe that the assessment completed by QA&R or the case manager is inaccurate. In both processes, (audits and reconsiderations) the Department makes a determination based on the documentation and the information reviewed by the earlier reviewer. It is important to base assessments on some written documentation so that decisions are made objectively, and not just on the subjective judgement of the person completing the assessment. Since the documents required under these rules are also required by other federal and state mandates (see for example, 42 CFR 483.440 (e)) this provision does not create an undue burden on the provider. Therefore, this provision is reasonable.

The manual gives specific documentation requirements to establish that a client needs and receives PIII services. These requirements were developed by the joint efforts of the staff of

the Departments of Health and Human Services, the contractors (Lewin and Associates), and a subcommittee consisting of providers who served on the Rule 53 Advisory Committee.

Lewin and Associates had conducted research which showed that about 20% of the clients were receiving an intensive level of PIII services. When QA&R assessed clients in 1989, their data showed approximately 1% of the clients were receiving intensive PIII services. Staff from both Departments (Human Service and Health) met with the advisory committee to discuss the disparity in the data. The committee determined that the reason for this disparity was that the consultant's research was based on verbal communication with the providers while QA&R's assessment was based on the documentation requirements in the manual. Providers believed that they were providing intensive PIII services but this was not reflected in the QA&R assessment because the services needed and received were not written in the specific documents or in the particular format required by the manual. Providers also believed that another reason for this disparity was that providers were not trained to document services according to the requirements of this rule.

The Department of Human Services agreed to conduct training sessions for providers and case managers and to modify the documentation requirements of the manual. The Department of Human Services formed a documentation subcommittee consisting of staff from both Departments and providers who served on the Rule 53 Advisory Committee. (See attachment 1 for the list of

documentation subcommittee members). The documentation subcommittee revised the documentation requirements in the manual to make them simpler and less stringent.

The documentation requirements for assessments in the PIII area completed in 1989 were different from the ones in the 1990 manual. There were 5 items instead of 3, and providers had to document formal plans and objectives for the client in order to establish that the client needed and was receiving PIII services. The revised requirements specified in items 1 to 3 of section 2.0 were proposed by the documentation subcommittee and accepted by both Departments.

The basic differences between the documentation requirements used in 1989 and the proposed revised requirements are: 1) the reviewer or case manager can accept documentation of the client's need for services in any of the required plans (i.e., the Individual Service Plan, the Individual Habilitation Plan, the Provider Implementation Plan, etc). Earlier, the need for service had to be documented in the Individual Service Plan or the Quarterly Review only; 2) the client record now has to contain a statement defining the team's expectations for the client. Earlier, there had to be a formal plan showing how the provider would meet the client's needs; and 3) the client's record has to contain sufficient documentation to show the service received by the client. Earlier, providers had to show formal documentation of staff intervention, client's response to the intervention, and periodic reassessments of the clients. The 1990 requirements are

different because providers can get credit for providing intensive PIII services if there is sufficient documentation to indicate the frequency and amount of intervention received by the clients even though there may be no formal plans to show the same.

The Department assessed clients at a few facilities on the basis of the new documentation requirements and found facilities to be more amenable to the new requirements. As a result of those assessments the Department believes that the requirements proposed by the documentation subcommittee are practical and realistic, but providers need additional training on effective documentation. The Department of Human Services has issued a request for proposal to develop and implement a comprehensive training program for providers and case managers. The training will focus on the assessment instrument and on techniques for effective and efficient documentation. This will cost DHS $25,000. The Department believes that the proposed documentation requirements, when combined with effective training, will result in accurate assessments. The new requirements will be effective for assessments completed in 1990 and for rates beginning October, 1991. Meanwhile, for the rate year beginning in October of 1990, DHS proposes to reimburse facilities assuming that at least 10% of the clients are receiving intensive PIII services in 1989. This will reduce the disparity for the first year and will give an incentive to facilities to provide these services next year (for a detailed explanation of the 10% formula, see the SNR for part 9553.0053).

The Department of Human Services required PIII assessments not because PIII services were closely related to costs, but because the Department believes that all programs and services for clients should promote independence, productivity, community integration and opportunities in safe, healthful environments. The federal regulations (42 CFR section 483.400) also require that each client should receive a continuous active treatment program so that the client can function with as much self determination and independence as possible. Therefore, the Department wishes to provide an incentive for positive programming in PIII. If future assessments show that despite the easier documentation requirements, the training and the 10% assumption for the first year, few persons are assessed in the intensive PIII category, then this will be because fewer persons are actually receiving these services at the level required for receipt of the incentive. It is not the intent of the assessment to provide additional reimbursement to facilities for services not being provided or for a lesser level of services customarily provided to all clients. The intent is to assess the number of persons receiving intensive PIII services, to provide an incentive to increase this number and to reimburse facilities accordingly. Therefore, this provision is reasonable.

The need and reasonableness for each of the 3 documentation requirements is explained below.

First, for a client to receive a score in any of the 6 areas in the PIII category, the provider must document that the client

needs staff intervention in this category. It is necessary to require that the client's need for staff intervention be documented because the assessment is linked to the reimbursement system and the purpose of the reimbursement system is to pay facilities for services needed and received by the client. The client's service needs are discussed by the interdisciplinary team consisting of the case manager, the client, the client's representative, appropriate facility staff, and professionals who identify the client's needs and design programs to meet those needs. The team reviews the client's record and recommends the client's involvement in different activities, skills, and programs. These recommendations may be recorded in the Individual Service Plan (ISP), the Individual Habilitation Plan (IHP), the Individual Program Plan (IPP), the Provider Implementation Plan (PIP), or periodic reviews. Therefore, it is reasonable for the reviewer to review these documents to determine the client's service needs. This provision is also reasonable because these documents are required by other state and federal regulations (see 42 CFR 483.440(c) for the IPP requirements; Minnesota Statutes, part 9525.0075, subp. 1 for the ISP requirements; Minnesota Statutes, part 9525.0265, subp. 1 for the PIP requirements; and, Minnesota Statutes, part 9525.0105 for the IHP requirements).

In addition to the client's need for PIII, the manual requires the client record to define the team's expectations for the client. This item is necessary because a written statement specifies how the client will be involved and the expected outcome of the

involvement. It is also necessary to have a statement of the team's expectations to ensure consistency between the approaches used by different staff members to provide intervention to the client.

The third requirement that there is documentation to establish the frequency and amount of services being provided to the client is necessary to determine that the client is receiving the necessary services. This requirement for documentation is reasonable because staff already maintain data regarding services so that active treatment may be effectively provided to the client. The new system is based on services needed and received by clients. Research showed that assessments based on both the amount (i.e., quantity of staff intervention, eg., 5 minutes) and the frequency (i.e., how often assistance is provided, eg., once a month) of staff intervention explained more of the variation between resource use of clients than the use of either frequency or amount alone. It is also reasonable to determine the amount and frequency of services provided to clients because assessments are scored and facilities are reimbursed on the basis of these factors. (For a detailed explanation of how assessments are scored based on the amount and frequency of staff intervention, see the SNR for part 9553.0056, item A, steps 2 and 3).

The next three paragraphs of the manual contain general instructions for the case manager and QA&R team on what is contained in items 2.1 to 2.6 of the assessment form and how to complete the assessment form for those areas. It is necessary to

include general instructions in the manual so the case manager and the QA&R team know how the assessments are to be completed. The Department has explained the meaning of each of the six activities to be assessed in the PIII category and has given examples of the skills in each category. Since there may be other skills which are within the definition but not expressly stated as examples under this category, it is reasonable to specify that QA&R and the case manager may assess clients for other skills fitting in the same domain. Each of the skills and objectives within the 6 activities of PIII may need different amounts of staff assistance. It is reasonable to specify that reviewers should estimate the overall amount of time spent by staff in that activity (i.e., the overall amount of time spent in personal choice, or development of social interaction) because this simplifies the assessment process and at the same time results in a fair assessment. The manual further states that if the client's need for services is not documented, the client should receive a score of "0". This is reasonable because if certain skills are not currently being worked on by the client, then the provider should not be providing those services. If the skills are being worked on, then the reviewer must determine both the amount and frequency of staff intervention because both of these factors affect the resource use of clients.

For each activity in the PIII category (e.g., personal choice and initiative, development of social interaction, etc.) scoring is based on 3 levels of amount (i.e., quantity, eg, 5 minutes) of staff intervention and 5 categories of frequency (i.e., how often

eg, once a month) of staff intervention. It is necessary to inform QA&R, providers, and case managers on how to assess clients in the PIII domains because this ensures clarity and consistency and because, ultimately, these scores could affect the payment rate of clients and the revenue of the facility. It is also necessary to score assessments based on the amount and frequency of staff intervention because researchers analyzed that a combination of amount and frequency accounted for more variation in resource use than either one of these variables alone.

It is reasonable to use 3 measures of amount and 5 measures of frequency of staff intervention because this method is simplistic enough for use by all reviewers and also fulfills the researcher's goals of giving a profile of the type of staff intervention that is provided to a client. It is also reasonable because research showed that this method explained the maximum variation in resource use of clients. [For details on the method of scoring 'amount' and 'frequency', and for the need and reasonableness of the methods, see the SNR for part 9553.0056, subp. 1, item A, steps 2 and 3).

Items 2.1 to 2.6 of the manual specify the 6 activities in the PIII domain in which the client must be assessed. It is necessary to assess clients in these 6 categories because the areas of personal choice, social interaction, personal responsibility, community leisure, community integration and community skills are essential to increase the self determination and independence of

the client and the Department wishes to encourage providers to provide programs in these areas.

These assessments focus the attention of reviewers and providers to the client's service needs in the above activities. Further, the new reimbursement system which ties payment to PIII assessments is an incentive for providers to improve the quality of services provided in the PIII domain.

The Departments of Human Services and Health, along with the researchers working on this project, studied various assessment approaches before selecting an assessment instrument. The Department of Human Services also conducted a "mini study" in 20 ICFs/MR in order to understand why program costs varied among clients. It was found that specific client characteristics, falling into 4 main domains, substantially contributed to the variations in need for staff time. One of the domains was the PIII domain. The initial observation from the mini study was further confirmed empirically in a detailed time study conducted by Lewin and Associates. Based on these studies, a panel of technical experts led by experts from the Human Services Research Institute (HSRI) developed an extensive assessment instrument encompassing specific activities in each of the domains which had been identified as important in the earlier studies. A detailed report on the development of this assessment instrument is found in The Minnesota Staff Activities Form: Results of its use in a Survey of 1,000 Persons Residing in ICFs/MR in 1987 (See Exhibit D of the SNR for rules 9553.0010 to 9553.0080).

In the staff activities form (SAF) study, clients were assessed on (among other items) 20 activities of daily living and 6 areas of personal interaction. The SAF contained basic ADL's (i.e., dressing, grooming, bathing, eating, etc.) and instrumental ADL's such as simple money management, preparing meals, dishwashing, using the telephone, etc. The research team then analyzed the scores statistically to see how they related to the cost of care. Since the research team determined that the instrumental ADL's did not explain as high a percentage of variation as the other ADL's, the instrumental ADL's were not included in the ADL domain.

The present PIII area contains a combination of the first 6 items from the SAF personal interaction domain with the instrumental ADL's incorporated as examples of skills or activities in the PIII domain. Based on recommendations of the advisory committee, the Department also added 'community skills acquisition' to this category. The final format of the 6 items in the PIII category was based on the research, expert guidance from the Technical Advisory Panel, and staff from the state Departments of Human Services and Health. The need and reasonableness for scoring assessments in the PIII area is explained in the SNR for part 9553.0056, subp. 1.

Item B. This provision is necessary to inform providers, case managers, and QA&R reviewers how to complete assessments in the area of challenging behavior. The need and reasonableness for incorporating the manual is the same as for item A.

It is necessary to assess clients in the challenging behavior area because research showed that challenging behaviors were very strong predictors of resource use and that clients receiving more behavior intervention were more costly to care for.

Section 3.0 of the manual first specifies the documentation requirements in order to establish that the client needs and is receiving intervention for challenging behaviors. The necessity of the documentation requirements is the same as the necessity of documentation requirements in the PIII area. (See pages 19 and 20 for the SNR for the PIII area).

The documentation requirements originally proposed by the Department (and used for the 1989 assessments) were somewhat different from the ones currently being proposed in the manual. The basic differences between the earlier and the current requirements are: 1) For 1989 assessments the client's need for services had to be documented in a current medical evaluation, and the client's need in this area had to be recorded in the ISP, IPP, IHP, or the quarterly review. According to the current proposal, the client's need for services may be documented in the ISP, IHP, IPP, PIP, periodic review or QMRP monthly review; 2) Earlier, providers had to show a detailed plan for the service intervention for the client. Now the providers only have to show a statement in the record defining the team's expectations from the client. A formal plan is needed only if the client's service needs are complex.

The documentation requirements were modified in response to the concern of some providers on the Advisory Committee who said

that it was difficult to document formal plans and objectives for self adaptive and preventive practices in the challenging behavior domain. The documentation subcommittee which modified the documentation requirements in the PIII area also modified the requirements in the challenging behavior area. The Departments of Health and Human Services accepted these recommendations.

The provider has to show 5 specific items to establish that a client needs and is receiving intervention for challenging behavior services. The reasonableness for each of the 5 items is discussed below.

First, providers must document that a client needs intervention in challenging behaviors. This is reasonable because facilities are reimbursed for providing services only if they can establish the client's need for those services. Since service needs may be documented in the ISP, IHP, IPP, periodic review, or QMRP monthly review, it is also reasonable for reviewers to examine these documents.

It is also reasonable for the record to state the team's expectations for the client because this specifies the intervention that will be performed to meet the client's need. It also ensures that the provider, case manager, and the client's representative agree on the best approach to meeting the client's service needs.

The manual also specifies that if the team's expectations are complex, there should be a plan outlining the procedures necessary to modify or maintain the desired behavior for the client. The difference between a statement and a plan is that the plan analyses

the client's condition and the treatment in more detail than a statement. It is reasonable to require a plan for a client with complex needs because this helps providers focus on the intervention needed for the client and it assures reviewers that the client is receiving the necessary services.

The fourth requirement for documentation of frequency and amount of intervention is reasonable because it is evidence of the fact that the plan is being carried out and services are actually being provided. It is also reasonable to require documentation of implementation because staff already maintain data regarding services provided to the client.

The next requirement for documentation of the client's response to the intervention is reasonable because it helps the reviewer to ascertain the effectiveness of the plan and the intervention. It is also reasonable because documentation of client response to intervention is an established and acceptable method of evaluating services in the industry and facilities already document data concerning services provided to the client. The Department does not require any additional documentation, so there is no undue burden on providers.

The next 3 paragraphs of the manual after the documentation requirements contain general instructions for the case manager and QA&R team on how to complete the assessment form for items 3.1 to 3.8. It is necessary to include general instructions in the manual so the case manager and QA&R teams know how the assessments are to be completed. These instructions are the same as the general

instructions for completing the assessment for PIII services specified in items 2.1 to 2.6. For the reasonableness of the instructions, see the SNR for item A on pages 26 and 27 of this document.

For each domain in the challenging behavior category (eg., self-injurious behavior, unusual or repetitive behavior, etc.) scoring is based on 3 levels of amount of staff intervention and 5 levels of frequency of staff intervention. The "amount" of intervention is multiplied by the "frequency" of intervention to determine the total score of the assessment. It is necessary to inform QA&R, providers, and case managers of how to assess clients in the challenging behavior domains because these scores will affect the payment rates of clients and the revenue of the facility. It is reasonable to consider both the amount and frequency of intervention because research showed that these two variables affected the resource use of the client. (For details on the scoring of challenging behavior assessments and the reasonableness of the scoring methods, see the SNR for part 9553.0056, subp. 1, item A, steps 2 and 3).

The measure for the amount of staff intervention for challenging behaviors domains differs from the measure used for PIII. It is necessary to use three possible amounts of staff intervention measured in <u>"minutes"</u> because the Technical Advisory Committee and the researchers felt that episodes of challenging behaviors requiring staff intervention are more accurately gauged in this manner. Episodes of challenging behavior are less

predictable than staff planned intervention of PIII activities and are therefore better quantified by time segments.

The manual requirements for assessment of amount of staff intervention for challenging behaviors differs from the assessment of amount of staff intervention for the PIII area. In PIII activities, staff supervision of client activities is a means of achieving an objective and helps the client succeed in the PIII activity. Therefore, for PIII activities, supervision is a means for positive programming and the facility should be reimbursed for the service. However, when challenging behaviors occur, the intent is not to create an incentive for staff to simply observe the challenging behavior, but rather, the reimbursement system is designed to encourage preventive practice or corrective action. Further, episodes of challenging behaviors may occur when the staff is supervising the client for some other activity or skill (e.g., assisting the client with ADLs). Reimbursement for supervision in two domains at the same time would result in double payment for facilities. Therefore, staff supervision of the client is not reimbursed separately as a staff intervention for challenging behaviors.

It is necessary to measure the amount of staff intervention to determine how much time is spent in intervention or prevention of challenging behavior. It is reasonable to rate the amount of intervention because staff providing services to the client are

familiar with the client and are able to document the amount of intervention provided for prevention or episodes of challenging behavior.

The need and reasonableness for rating the frequency of staff intervention in the challenging behavior areas is the same as for the PIII area.

The eight items used to assess challenging behaviors on the current assessment form are essentially unchanged from the items also used to assess challenging behavior on the Staff Activity Form (SAF). (See exhibit D of the SNR for parts 9553.0010 to 9553.0080). One item from the SAF, a question asking whether the client was given medications to control behavior, was deleted from the current assessment form. In the field of services to persons with mental retardation current best practice is to modify challenging behaviors with programs instead of using medication which controls the behavior and can have detrimental side effects. The Department, therefore, did not want to encourage medication use by linking it to reimbursement. (See attachment 2 for a comparison of the SAF challenging behavior items and the current assessment instrument challenging behavior items). It is reasonable to use these eight areas to assess challenging behavior because the research indicated these areas were predictive of resource use.

Item C. This provision is necessary to inform providers, case managers, and QA&R reviewers how to complete assessments in the area of activities of daily living (ADLs). It is reasonable to

incorporate section 4.0 of the manual to avoid lengthy rules and to ensure consistency between the manual instructions and the rule.

It is necessary to assess clients in ADLs because this helps to differentiate between low, medium, and high care clients and to target resources to clients with more service needs in ADLs. It is also necessary to assess the service needs of clients in the ADLs and self preservation area because the research conducted by Lewin and Associates shows that the strongest association is between staff time/resources and client ADLs.

It is reasonable to assess service needs in the activities of dressing, grooming, bathing, eating, transferring, mobility, toileting, and self-preservation because these seven activities of daily living and self preservation were considered by the research to be the best predictors of resource use. It is also reasonable to assess the service needs of clients in these eight areas because they were selected after extensive research and analysis by Lewin and Associates. For details on the selection of the seven areas of ADL's and self preservation, see the SNR for part 9553.0056, item A, and exhibits D and F of the SNR for rule parts 9553.0010 to 9553.0080.

The manual states three requirements for documentation to establish the client's needs in the ADL and self preservation area. The need for documentation requirements in the ADL and self preservation area is the same as the need for documentation in the PIII area and is explained in the SNR for section 2.0 (see pages

19 and 20 of this SNR). The need and reasonableness for each documentation requirement is explained below.

First, it is reasonable to require ADLs be assessed based on the medical evaluation, the psychological evaluation, and the adaptive behavior or skills assessment because evaluations will indicate how much assistance the client will need in performing ADLs. It is reasonable to base ADL assessments on these evaluations because this is consistent with 42 CFR 456.610. This is also reasonable because it is consistent with Minnesota Statutes, section 256B.501, subdivision 3g which requires the assessment instrument developed by the Commissioner of Human Services to "...include assessment of the client's...ability to perform activities of daily living...".

The next requirement for the ADL assessment is based on the documentation of the individual habilitation plan (IHP). This requirement is necessary because the IHP contains the objectives and methods used by the provider which are designed to result in the achievement of the annual goals of the individual service plan. Therefore, if the client has a need for supervision, programming, or assistance in ADLs, this need will be documented in the IHP. It is reasonable to require documentation of the client's service needs in the IHP because under the new reimbursement system, facilities will be reimbursed for services provided in the ADL area only if they can prove that the client needs those services. This is reasonable because the documentation is already required by other state regulations (see Minnesota Statutes, part 9525.0105).

The third requirement for documentation of the case manager's approval is necessary to ensure that the case manager has knowledge of and agrees with the plan. It is necessary to require the case manager to complete an annual review of the client's status in order to determine if the status has changed. This provision is also reasonable because it is consistent with Minnesota Statutes, part 9525.0105, subp. 9.

Items 4.1 to 4.8 specify the 8 activities which providers and case managers have to assess in this domain and how the assessments will be completed. The need and reasonableness for assessing the client's needs in these 7 ADLs (dressing, grooming, bathing, eating, transfer, mobility, toileting) and in self-preservation is explained in the SNR for part 9553.0056, subp. 1, item A.

Item D. This provision is necessary to inform providers, case managers, and QA&R reviewers how to complete assessments in the area of special treatments. It is reasonable to assess clients in the area of special treatments because research showed that the need for special medical treatments explained a high percent of variation in the resource use of clients. For the need and reasonableness of the selection of the eight items and the time requirements in the special treatment category (i.e., clinical monitoring, turning and positioning every two hours, tube feeding, etc.), see the SNR for part 9553.0056, subp. 1, item B. The manual states four requirements for documentation to establish the

client's care needs. The need and reasonableness for each is explained below.

The first requirement for the physician's medical evaluation and plan of care is necessary because the physician is the individual qualified to perform this evaluation for the client's service needs in the special treatment domain. This requirement is reasonable because it is consistent with 42 CFR 456.610.

The second requirement, that a licensed nurse assess the client's health needs, is needed and reasonable because facilities employ nurses to perform this function and therefore does not make additional requirements for the facility. The assessment subcommittee chose to require assessments by licensed nurses because most facilities do not have registered nurses on staff regularly.

The third requirement is necessary because the assessment subcommittee believed that the documentation requirements should reflect actual practice and should provide a means for allowing other qualified personnel to implement plans for special treatments, clinical monitoring, and other physician prescribed intervention, in collaboration with the nurse. Documentation helps ensure that the plan is being implemented. It is reasonable to require documentation of implementation of the plan because this reflects actual practice.

The last requirement is for periodic reassessment of the client's health needs and regular communication with the physician. This documentation requirement is necessary in order to determine

changes in the client's condition and to ensure that the physician is made aware of the client's condition. This requirement is reasonable because reassessments are consistent with Minnesota Rules, part 9525.0265.

It is reasonable to incorporate section 5.0 through 5.9 of the manual to avoid lengthy rules and to ensure consistency between the manual instructions and the rule.

4656.0300 ASSIGNMENT OF A CLIENT REIMBURSEMENT CLASSIFICATION.

Subp. 1. Requirement. It is necessary to inform providers, case managers, and QA&R that although assessments are completed by QA&R and by case managers, client reimbursement classifications (CRC) are assigned by the Department of Health. The Department of Health reviews the assessment forms and then assigns client reimbursement classifications according to the specifications of part 9553.0056, subp. 2. The Department of Human Services has established 14 client reimbursement classifications which reflect the variation in resource use of clients. It is reasonable to refer to part 9553.0056, subp. 2, because this prevents duplication of language and lengthy rules. For an explanation of the client reimbursement classifications see the SNR for part 9553.0056, subp. 2.

Item A states that the CRC for a client assessed by QA&R shall be assigned after the assessment form is completed. Since the workplace of the reviewers and the persons assigning the client reimbursement classifications is the same, QA&R simply has to hand

in the completed assessment. The person assigning the CRC knows who the reviewer is and can clarify issues without additional documentation. Therefore, item A is reasonable.

When case managers assess clients, they mail the completed assessment form along with a cover letter and a documentation checklist to the Department of Health. This packet is called the request for classification (RFC). The cover letter (transmittal sheet) is important because it informs the Department of the numbers and types of assessments completed and the name and telephone number of the contact person in case of questions. The documentation checklist tells the case manager which documents to review and also assures the Department of Health that the case manager has examined all relevant documentation. Therefore, it is reasonable to state that client reimbursement classifications for case manager's assessments shall be assigned after the case manager submits the request for classification. It is also reasonable to specify that the case manager must mail the RFC within 5 working days so that the Department can process the assessment form as soon as possible and inform providers, clients, and client's representatives of the CRC. Since the assessment form is completed at the time of assessment and the other two forms are very short, one week is enough time for the case manager to sign and mail the documents.

Subp. 2. Timeframe for assignment of client reimbursement classification. This subpart is needed to assure ICFs/MR of prompt assignment of CRCs. The Department needs time to review the

completed assessment forms and the Department of Health rules which specify how the CRC will be assigned. Therefore, it is reasonable to give the Department 15 days to complete this task. The timeline is also reasonable because it is the same as the timeline for assigning nursing home case mix classifications under part 4656.0050, subp. 2, which has worked well in the past.

Subp. 3. Request for additional information. Case manager's occasionally submit incomplete RFCs (i.e., without the documentation checklist or transmittal sheet) or incomplete or inaccurate assessment forms. It is necessary to allow the Department to ask for additional information to ensure that the CRC is based on a complete and accurate assessment. It is necessary to state how soon this information must be sent to the Department to ensure timely compliance and avoid unnecessary delay in processing the assessment and assigning the CRC. Since the case manager completes the assessment and mails the RFC to the Department, it is reasonable for the Department to make the case manager responsible for the additional information. However, in some cases, the information requested may be in the client record with the facility. In such case, the case manager may ask the facility to send the information to the Department. Five days is reasonable because either the case manager or the facility has the necessary information readily available and can easily submit it to QA&R in that time period. This time frame prevents unnecessary delays in the assignment of the CRC.

Subp. 4. Notice of client reimbursement classification.

The notice required by this item is needed to inform all affected persons of the CRC that was assigned so that those individuals can take further action regarding the classification to the extent such action is authorized or required by laws and rules. It is reasonable to allow 20 days to mail the notice because the Commissioner has 15 days after receiving the request for classification to assign the CRC. The extra five days is sufficient time to prepare multiple mailings and for the notice to be processed within the Department's mailing system. First-class mail is required to ensure prompt notification to affected persons.

It is reasonable for item A to require the name and phone number of the ombudsman for mental health/mental retardation in that area to be included in the notice of classification because the ombudsman can be another source of information and help with understanding or requesting a reconsideration of a classification or other actions pertaining to assessments and classification. Such authority is granted the ombudsman under Minnesota Statutes, section 245.94, subdivision 1, paragraphs (d) and (e) and subdivision 2.

Item B is reasonable because it is required by Minnesota Statutes, section 144.0723, subd. 2. The statutory requirements are repeated here to effectively communicate the requirements to affected persons.

4656.0310 REQUEST FOR RECONSIDERATION OF CLIENT REIMBURSEMENT CLASSIFICATION.

Subpart 1. General requirement. It is necessary to inform clients, their representatives, and facilities of what steps are necessary in order to request the Department to reconsider the assigned client reimbursement classification. It is reasonable to include these provisions because they are the same provisions contained in Minnesota Statutes, section 144.0723, subdivisions 3 to 6.

Subpart 2. Access to information. This subpart is necessary because it is the right of the client, client's representative or the case manager to be able to review any records relating to the client that have been provided to the Department to support the assessment. Since it is important for the client to receive the information as soon as possible, the statute requires the facility to comply with the request within 3 working days. If the facility does not give the documents within 3 days, the Department issues an order asking the facility to comply with the request within 24 hours. If the facility does not give the documents within the 24 hours period, the Department assesses a fine on the facility. This is reasonable because clients need the information as soon as possible to decide if they want reconsideration. This is also reasonable because it is consistent with Minnesota Statutes, section 144.0723, subdivision 4.

Subpart 3. Facility request for classification. It is necessary to give the facility the right to request a

reconsideration because this enables the facility to verify the accuracy of the assessment and to ensure that payment reflects services needed and received by the client. If the facility feels it is not being properly reimbursed because the assessment does not accurately reflect the services needed and received, this subpart provides instructions on how the facility can make a reconsideration request. Items A to C are reasonable because they are consistent with the requirements of Minnesota Statutes, section 144.0723, subdivision 5.

Subpart 4. Process of reconsideration by the Department. It is necessary to inform facilities, clients, and case managers how the Department will determine the client reimbursement classification based on the reconsideration request and how affected persons will be notified of the decision. This subpart is reasonable because it is consistent with Minnesota Statutes, section 144.0723, subdivision 6.

Subpart 5. Additional information required for reconsideration. It is necessary to allow the Department to ask for additional information to ensure that the client reimbursement classification is based on a complete and accurate assessment. It is necessary to state when the facility must submit this information to ensure timely compliance with the request and to avoid unnecessary delay in processing the assessment and assigning the client reimbursement classification. Five days is reasonable because the facility has the necessary information readily

available in the client record and should be able to submit it to QA&R in that time period.

Subpart 6. Notice of reconsideration decision. It is necessary for the Department to notify the client and the facility of the Department's findings and decision regarding the reconsideration request so that the client and facility know the valid client reimbursement classification. It is necessary to state when the notice will be mailed as affected parties need to know if the client reimbursement classification has changed. It is necessary to include information in the notice on how to contact the ombudsman because it is the right of the client to get assistance from the ombudsman if the client wishes. The provisions of subpart 6 are reasonable because they are consistent with the requirements of Minnesota Statute, section 144.0723, subdivision 6.

Subpart 7. Effective dates. It is necessary to inform affected parties of the date when the new CRC takes effect. It is reasonable to refer to the related human services rule, part 9553.0057, subp. 7, item B, because this prevents unnecessary duplication of language and lengthy rules. The reasonableness of the effective date is explained in the SNR for part 9553.0057, subp. 8.

4656.0320 AUDITS OF ASSESSMENTS.

Subpart 1. Audit types. It is necessary to inform facilities and case managers that audits will be performed both at the facility and at the Department to verify the accuracy of assessments completed by the case manager. Since the Department

of Health has the final responsibility to ensure accurate assessments and to assign CRCs, it is reasonable for the Department to have the authority to audit the case manager's assessments. This subpart is also reasonable because it is consistent with Minnesota Statutes, section 144.0723, subdivision 7.

It is necessary that audits be unannounced to prevent altering of the records and to lend validity to the audit process. This provision is reasonable because it is consistent with Minnesota Statutes, section 144.0723, subdivision 7. Since all clients have to be assessed at least once a year and the Department wishes to ensure the accuracy of the assessments, it is also reasonable for the Department to conduct on-site audits of a sample of assessments at least once a year.

Subp. 2. Desk Audits. It is necessary to inform facilities and case managers that the Department may conduct desk audits at its own offices while reviewing the assessment forms. This is reasonable because the Department is responsible for assigning the CRC and it can do so effectively only if the assessment form is accurate. It is also reasonable for the Department to ask the facility or the case manager to submit additional information so the Department has all the relevant information before making a desk audit decision. Three days is sufficient time for the facility or the case manager to send the documents because in most cases the documents are readily available in the client record. This time frame is also reasonable because it is consistent with the time frame for submitting information for reconsideration decisions.

Subp. 3. On Site Audits. Assessments are based not only on a review of the client record but also on interviews with the staff. It is necessary for the Department to go to the facility to review the same records that the case manager reviewed when the case manager conducted their assessment. This ensures that the assessment completed by the case manager is correct. Since the Department of Health is ultimately responsible for assigning CRCs and for reporting accurate assessment to the Department of Human Services for reimbursement purposes, it is reasonable to give QA&R the authority to conduct on-site audits. For the same reason, it is reasonable for QA&R to change the CRC if QA&R believes that the case manager's assessment is inaccurate.

The Department considered various options about the numbers of assessments to be audited by QA&R. It is not possible for QA&R to audit a certain percent of case manager assessments in a given facility (per e.g., 10 percent of a facility) because: 1) case managers complete very few assessments under this rule; 2) it may not be possible to get even a 10 percent sample in facilities with under 6 beds; and 3) it is only possible to get a skewed sample because of the different size of facilities and the varied number of case manager assessments in different facilities.

It is reasonable to state that QA&R shall audit at least 10 percent of the total assessments because this will provide an adequate sample of case manager assessments and assure QA&R that case managers understand the process correctly.

The effective dates for changes in CRC due to audits are specified in the related Human Services rules, parts 9553.0057,

subp. 6. It is reasonable to refer to the Human Services rule to avoid duplication of language and to prevent lengthy rules. The need and reasonableness for the dates is explained in the SNR for part 9553.0057, subp. 6.

Subp. 4. Special audits. This subpart establishes the commissioner's authority to conduct special audits. Special audits are any audits other than routine audits.

The Commissioner may initiate a special audit for a variety of reasons. For example, the Department of Human Services under its authority under chapter 256B, may request the Commissioner to conduct a special audit in an area specified by the Department of Human Services, or the Department may choose to audit an assessment item such as clinical monitoring, and audit facilities that have a higher number of claimed clinical monitoring than other similar facilities. Other examples of unusual circumstances are included in the rule. This is merely an illustrative list and does not include all circumstances which could affect or change the validity of the client CRC.

Special audits are an integral part of the audit process. The Commissioner must be able to audit based on a special identified need. Routine audits alone will not address the goals of the audit process, which are to ensure the integrity of the assessment process and to promote the proper payment level for ICFs/MR. Therefore, this provision is reasonable.

Subp. 5. Access to records. This subpart is needed to clarify that the Department has the authority to access the records during regular business hours. The provision is reasonable because it is impossible to conduct a thorough and

complete audit without access to audit-related documents. Access to records for audit purposes is also consistent with Minnesota Statutes, section 144.0723, subdivision 4.

Subp. 6. Documentation time frame. This subpart is needed to clarify which documents the Commissioner will consider for audits.

The Department selected the documentation time frame keeping in mind that: audits should be based on the same documents that were reviewed to complete the assessment; and assessments are based on the current condition of the client (i.e., the need and services received by the client at the time of the assessment).

The case manager completes the assessment for newly admitted clients after reviewing all the documents at the interdisciplinary team meeting. The assessment is based on those documents and on additional observations made by the provider, case manager, and the client's representative at the meeting. Therefore, it is reasonable to base audits on the documentation that existed up to the time of the assessment.

The case manager completes assessments under part 9553.0057, subpart 4, if the client's condition has changed since the last QA&R assessment. It is not reasonable to review client records for the last year because those documents will not reflect the change in the client's condition. The case manager reviews the last quarter's documents to determine the client's condition at the time of the assessment. Since audits must be based on the same factors as the assessment, it is reasonable for the Department to review documentation from 3 months preceding the assessment up to the date the client was assessed.

Subp. 7. Notice of audit findings. This subpart is necessary to inform clients and facilities when and how they will be notified of the audit findings. It is reasonable to state that the QA&R staff will not discuss preliminary audit findings with facility staff because the auditor has not yet made a final determination of the assessment. It is, therefore, not within the purview of the auditor's authority to state whether or not the CRC will change as a result of the audit. It is also necessary to inform clients and facilities of their right to see the documents that the Department reviewed to make the audit determination, as well as their right to request the Department to reconsider the client reimbursement classification based on the audit. Since the Department conducted the audit and knows of the findings, it is reasonable for the Department to send the notices to the facility. It is also reasonable for the Department to inform affected persons of their legal right if they disagree with the Department's decision. It is reasonable to include information in the notice on how to contact the ombudsman because it is the right of the client to get assistance from the ombudsman if the client wishes to do so. Since the facility knows the name and address of the client, the client's representative, and the case manager, it is reasonable for the facility to distribute the notices. Five working days is enough time to mail notices which already have been prepared by the Department.

4656.0330 DEATH, DISCHARGE AND CHANGE OF PAYMENT SOURCE INFORMATION.

This part is needed to provide the Commissioner with a current list of clients in ICFs/MR. This list is used to generate assessment forms to conduct inspections of care and to complete annual assessments for a facility. Also, this information is used by the Department of Human Services to determine which clients are eligible for medical assistance funds.

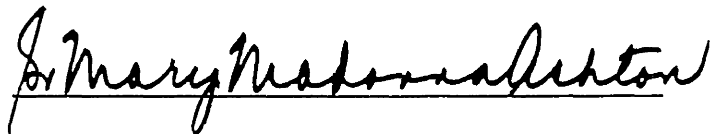
SMALL BUSINESS CONSIDERATIONS

THIS RULE IS EXEMPT FORM SMALL BUSINESS CONSIDERATIONS IN RULEMAKING UNDER MINNESOTA STATUTES, SECTION 14.115, SUBD. 7, PARAGRAPHS (6) AND (7).

EXPERT WITNESSES

THE EXPERT WITNESSES NAMED IN THE SNR FOR Department OF HUMAN SERVICES RULES, PART 9553.0010 TO 9553.0080 WILL ALSO TESTIFY ON BEHALF OF THE Department OF HEALTH. THEY WILL TESTIFY ON THE RESEARCH CONDUCTED FOR THE ASSESSMENT INSTRUMENT, ANALYSIS OF QUALITY ASSURANCE ISSUES, AND THE ROLE OF THE QA&R ASSESSMENT TEAMS AND QA&R ASSESSMENT PROCEDURES.

Date: January 8, 1990



Sister Mary Madonna Ashton

Commissioner of Health

FOOTNOTES

[1]The complete language of Laws of Minnesota, 1985, Chapter 9, Article 2, Section 100 can be found under Appendix A.

[2]See bibliography "1)", pages iii - v.

[3] The complete language of Minnesota Statutes, section 256B.501, subdivision 3g can be found under appendix B.

[4]The complete language of Minnesota Statutes, section 144.0723 can be found under appendix C.

[5]The complete language of Minnesota Statutes, section 144.072, subdivision 1 can be found under Appendix D.

[6]See appendix C.

[7]See appendix D.

[8]See Minnesota Rules, parts 4656.0010 through 4656.0090.

[9]See bibliography "2)", page 69.

BIBLIOGRAPHY

The following documents can be obtained from Marian Lewis, Health Resources Division, Minnesota State Department of Health, at (612) 643 - 2156 or from the long-term care division of the Minnesota state Department of Human Services.

1) Minnesota State Department of Human Services. Department of Human Services Report to the Legislature on the Proposed Rate System for Payments to Intermediate Care Facilities for Persons With Mental Retardation, February, 1989. Long term care division, Minnesota State Department of Human Services, St. Paul, MN.

2) Agosta, John et. al. . The Minnesota Staff Activities Form: Results of Its Use In a Survey of Persons Residing In ICF - MRs. The Human Services Research Institute, Cambridge, MA. January 25, 1988.

3) Recommendations and Rationale for a Proposed Method for Setting Medicaid Reimbursement Rates for ICF/MRs [In Minnesota]: A Summary. Lewin and Associates, Washington, DC.