✓ 3

Rule 53
ICF/MRs
MA Payment Rates

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 INTERMEDIATE CARE FACILITIES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM MINNESOTA RULES, PARTS 9553.0010 TO 9553.0080

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION

Minnesota Rules, parts 9553.0010 to 9553.0080 establish procedures for determining the total payment rates for all intermediate care facilities for persons with mental retardation or related conditions (hereinafter referred to as ICFs/MR or facilities) participating in the Medical Assistance program. These rules apply to ICF/MR providers including state operated community-based residential facilities. They do not govern the State's seven Regional Treatment Centers. The authority for the establishment of these procedures is in Minnesota Statutes, section 256B.501, subdivisions 1 to 3.

The current ICF/MR reimbursement system was established in 1985. In 1988, the Minnesota Legislature authorized implementation of a new payment system beginning October 1, 1990. The purpose of the new reimbursement system is to target resources (payment) according to the services needed and received by clients.

A. Background

The 1985 Minnesota Legislature mandated that the Commissioner of Human Services study alternative mechanisms for reimbursement of providers of services for persons with mental retardation in ICFs/MR. The project was to determine whether an alternative system could help the state better target resources where need was greatest. Lack of targeting can result in access problems for clients with heavy service needs, nonequitable payment to facilities, exacerbate quality of care problems, and complicate cost containment efforts.

Under the current ICF/MR reimbursement system in Minnesota, payments may not be targeted to where the need is greatest because there is no uniform assessment of client service needs and resource use information available for determining which clients require the most costly services. People with more

significant service needs moving from regional treatment centers and nursing homes into ICFs/MR encounter access problems because ICFs/MR are reluctant to take clients whose greater costs of service are not recognized in rate increases or changes.

In order to comply with this legislative mandate, the Department of Human Services (DHS) contracted with Lewin and Associates, experts in reimbursement, and the Human Services Research Institute, Cambridge, MA, experts in the field of mental retardation, to conduct the mandated study, to research reimbursement mechanisms, and to make recommendations to the state on implementation of a new reimbursement system.

Dr. Rosemary Chapin, research coordinator for the Long-Term Care Management Division of the DHS was project coordinator for the study. Ms. Lisa Rotegard was assigned from the Mental Retardation Division of the DHS to help implement the project. Overall supervision of the project was provided by Ms. Pamela J. Parker, Long-Term Care Management Division.

This study was an integral part of the continuing effort of the state to maximize quality of care and access to care for persons with mental retardation given the constraints of available resources. Minnesota was the first state in the nation to use the Medicaid ICF/MR program as part of an aggressive plan to deinstitutionalize persons with mental retardation and to create community-based residential and service alternatives. The Department of Human Services adopted Rule 52 (Minnesota Rules, parts 9510.0500 to 9510.0890), which was consistent with Federal Medicaid provisions, in order to centralize the rate setting process for community-based ICF/MR programs at the state level.

In Minnesota, the focus of residential care for persons with mental retardation has shifted from regional treatment centers (RTCs) to Intermediate Care Facilities for the Mentally Retarded or ICFs/MR. During the 1960s, over 6,000 persons with mental retardation lived in Minnesota's RTCs. At the end of 1984, the RTC population was under 2,100. A consent decree emanating from the case known as Welsch v. Levine, No. 4-72-451 (D. Minnesota September 15, 1980), required further reduction in RTC populations. To meet this mandate, DHS stressed transferring RTC clients to ICFs/MR and encouraged development of new ICFs/MR. In 1988, the RTC population with mental retardation was approximately 1,500.
Over the past decade, Minnesota has been in the forefront of innovative efforts to provide dignified care and habilitative services for persons with mental retardation. In addition to ICF/MR residential services, the state supports a variety of community-based services including semi-independent living services (SILS), families subsidies, day training and habilitative services, waivered services, and various work activity and educational programs.

The cost of these programs is high. In 1988 the Medicaid costs for ICF/MR services alone was $110.9 million. This is because of both high use of ICF/MR services and very high rates.

The policy consensus at both the federal and state level is that the limited resources must be targeted to an array of services to provide quality care for persons with mental retardation in the least restrictive environment

consistent with their service needs. Therefore, the State must target public investments in ICF/MR services carefully so as to achieve maximum benefit to the clients within the constraints imposed by limited resources. State reimbursement rules are major tools for allocating resources and for cost containment.

B. Reimbursement History

DHS Rule 52 was the initial rule which defined the process and formula for setting per diem rates for Medicaid recipients in intermediate care facilities for the mentally retarded. This rule was adopted in 1973 and went through a number of revisions before it was replaced with 12 MCAR §§ 2.0530 to 2.05315 (Rule 53 [Temporary]), in 1984. Under Rule 52, each provider's per diem rate for the upcoming year was based upon a determination of actual allowable costs from the previous year plus projections for known or anticipated cost changes. The reimbursement procedures developed in Rule 52 came under criticism from both providers and the Legislature. Providers complained about its lack of clarity. The Report of the Legislative Auditor also documented the rule deficiencies and the resulting increase of expenses.

Given this background, and in response to a 1983 legislative mandate, the department began work on first a temporary and then a permanent rule to replace Rule 52. The temporary rule (12 MCAR §§ 2.0530 to 2.05315) became effective on January 1, 1984. The rule introduced measures to contain property costs such as elimination of rebasing of assets on sales, interest rate limits, incentives to renegotiate high interest loans, and a 20 percent down payment requirement for acquisition of new capital assets. The rule also required facilities to put aside depreciation payments in a funded depreciation account so that, in the future, when the principal payments on the provider's mortgage increased, money would be available to meet these obligations. Major changes in operating cost reimbursement under 12 MCAR §§ 2.0530 to 2.05315, were that known cost changes were eliminated and replaced with straight indexing, top management compensation was limited, and incentives for efficient management were included.

Permanent Rule 53 (Minnesota Rules, parts 9553.0010 to 9553.0080), which became effective January 1, 1986, built on the foundation of the temporary rule. The first step in moving to a reimbursement system more directly related to client care is clear identification of costs so that their relationship to client care can be established. This need was addressed in permanent Rule 53.

C. Goals of client centered reimbursement

The kind of payment system to be implemented for ICFs/MR effective October 1, 1990, is referred to as a "client centered reimbursement system."

Client centered reimbursement is a broad concept being used in this project to describe long-term care payment systems which reimburse operating costs at varying levels based upon client needs and relative resource use. These systems require ongoing assessments of client service needs and linking of these assessments to a measurement of resource use or cost of providing care to determine a payment rate. In this way resource use or cost of providing care is used to determine a payment rate and resources are targeted to the

client. Targeting state resources properly is crucial to maintaining quality care. Even though total state payment to ICFs/MR may be adequate, the absence of a mechanism for adjustment and redistribution of payments over time could lead to erosion of effective service in facilities where client care needs are increasing or which are admitting clients with more significant care needs, as is the case with many people moving from Regional Treatment Centers into ICFs/MR. Additionally, if reimbursement rates do not increase to cover increased cost of persons with greater and more costly care needs, there is a disincentive to provide services to such people. A system which more closely relates service costs to rates creates greater equity for both providers and clients.

Any new system developed must conform to Medicaid regulations or rely on other funding sources. Medicaid regulations limit flexibility in achieving program goals. For example, Medicaid only pays for fixed units of service in ICFs/MR, so that unbundling these services (paying for two days a week in an ICF/MR or one-half day habilitation) is not possible. Medicaid regulations also specify that ICF/MR reimbursement systems must provide rates which are reasonable and adequate to pay the costs which must be incurred by economically and efficiently operated facilities.

General goals of the client-centered reimbursement system are to:

-Target state resources according to service needs of clients;

-Promote access to care;

-Ensure manageable state costs;

-Promote quality of care in the most appropriate environment;

-Promote equity for clients and providers; and

-Be administratively feasible.

These goals must be achieved within the constraints of Medicaid regulations.

Since a payment system affects not only the costs of long-term care, but also the quality of care and access to care for different types of clients, it is difficult, if not impossible, to minimize costs while simultaneously maximizing access and quality. Pursuit of any one objective may be limited by administrative resources, and one objective (e.g., quality) may have to be sacrificed to a degree for another (e.g., limited costs or increased access). It is important to note, however, that such sacrifices do not mean abandonment of particular goals. Rather, they shift the burden of achieving particular goals (such as quality) to other policy mechanisms, such as licensure, standards, and quality enforcement. Similarly, a strong quality enforcement program means there is less need to burden the reimbursement formula with that task.

D. The Research

Research Background

Lewin and Associates, the Washington, D.C. based firm chosen to conduct the ICF/MR payment rate study, assembled a research team of nationally known long-term care experts. The team was directed by Dr. Robert Derzson and managed by Dr. Barbara Manard. Other team members included economist, Dr. William Scanlon and sociologist, Dr. Judith Feder of the Georgetown University School of Medicine; Attorney Eugene Tillman of the Washington, D.C. law firm of Pearson, Ball, and Dowd; Dr. Jay Greenberg of Brandeis University; Dr. Steven Clausen of System Metrics Incorporated. Lewin and Associates also contracted Human Services Research Institute of Cambridge, Massachusetts, a firm nationally known for expertise in the field of mental retardation. Valerie Bradley, president of Human Services Research Institute had principal responsibility for the development of the client assessment instrument, management of the survey process, and analysis of quality assurance issues. John Ashbaugh and John Agosta, Ph.D., were the senior analysts on the project.

Long-Term Care Management staff used a team approach from the initiation of this project. Assistant Commissioner Maria Gomez, staff of the Developmental Disabilities Program Division of the Department, and staff from the Minnesota Department of Health have been integrally involved in the development of the project. In this way, the Department developed a consensus about how the reimbursement system could support programmatic goals.

Additionally, staff from the Developmental Disabilities Council and the Department of Finance have been involved in the study. This interagency approach, fostered a wide base of support and understanding of the project.

Lewin and Associates used an incremental decision-making process which involved public guidance from advisory committee members, legislators, and department officials during each step of the research process. This approach was found to be most effective in developing the case-mix reimbursement system for nursing homes. Ongoing education and involvement of key actors in the research process via the activities described below was integral to successful use of such a process.

The director of Long-Term Care Management for DHS appointed an advisory committee consisting of advocates, providers, county directors, case managers, legislators, and other professionals in the field to assist the department in the development of the project. (See Exhibit A for list of advisory committee members.)

The committee charge was:

To review research documents, attend presentations, and provide feedback to the Long-Term Care staff of the Minnesota DHS concerning the study of alternative reimbursement methods for providers of services for persons with mental retardation in intermediate care facilities, day treatment centers, and waivered services.

The committee met regularly with the consultants and staff from DHS to hear presentations on the research and to discuss issues arising from the study. DHS staff has formed a list of persons interested in the project and informed them of committee meetings and other rule developments. (See Exhibit B for list of interested persons.) Some of the committee meetings had over 60 interested citizens in attendance. The committee continued to meet throughout the project to provide feedback at major points in the research during the rule-making process.

Further, the contractors and DHS staff interviewed over 40 "key actors" including advocates, counties, providers, state officials, and professionals in the field and made numerous presentations to interested groups such as the Association for Residential Resources in Minnesota (ARRM), the County Director's Association, the County Social Service Director's Association, and advocate groups throughout the project.

Project Accomplishments

There were five basic tasks to be accomplished in completion of the research for this project. They were:

Task 1. Refine understanding of the goals and objectives for the system and possible approaches. Develop initial options.

Task 2. Select and/or develop an assessment instrument and design a resource use survey.

Task 3. Complete the client assessment and resource use survey on ICF/MR clients.

Task 4. Identify the client service levels and develop resource use system.

Task 5. Develop final recommendations.

Task One: Develop Initial Options

The initial task was to refine the committee's understanding of the goals and objectives of the system and to develop initial options.

In completing Task 1, the contractors first:

- Conducted extensive review of state reimbursement program and licensing rules; other pertinent regulations; federal, state, and county correspondence; and other documentation regarding state programs for persons with mental retardation. A review and analysis of other states' methods (and proposed methods) for setting ICF/MR rates revealed that six states had systems linking the assessed needs of clients to reimbursement. None was deemed suitable for Minnesota because they were either based primarily on "point" systems borrowed from the state's geriatric case-mix system or tied the reimbursement rate too closely to "prices" based on questionable methodologies.

- Interviewed over 40 key actors in the field of mental retardation, including public officials, service providers, advocacy groups, and state and county program personnel.

- Made initial site visits to ICFs/MR.

- Held a consultant team project meeting in Washington D.C., to discuss the design of an alternative case-mix reimbursement system. Participants included representatives from Human Services Research Institute, Brandeis University, the Georgetown Center for Health Policy Studies, and Lewin and Associates.

- Held numerous meetings with the Mental Retardation Program Division and the Long-Term Care Management Division of the Department of Human Services to discuss issues related to the design of a client-based reimbursement system.

- Held extensive discussions with an Advisory Group made up of advocates, providers, legislators, and Department program staff about system goals and the role of reimbursement. Considerable interest was evidenced at various points in tying reimbursement to client outcomes (e.g., learning a skill). This approach was rejected because the study of the relationship between staff effort and expected outcomes is in its infancy: at present, we do not know how to "price" a set of "achievements." A very modest proposal to tie just two percent of reimbursement to outcomes was rejected.

- Completed an analysis of 1984 Minnesota Department of Health Quality Assurance and Review assessment data and ICF/MR cost report information to describe and try to explain cost variations among ICFs/MR. This study found extremely wide variations among facilities in every cost component and very little to explain those variations, except that (as expected) facilities with more staff had higher costs. It was found the most facilities had at least a comfortable profit margin. In fact, 20 percent of the facilities had a 12 percent or greater profit margin on allowable costs in fiscal year (FY) 1984. The facilities having the highest profits tended to be for profit facilities. However, there were also wide variations in profit margins. Approximately 16 percent of the facilities appeared to be operating at a loss. Although this research was not designed to address property costs, this analysis included property costs because it was important to establish whether rate limitations in recent years had severely restricted providers' ability to respond to the more complex care needs of a changing ICF/MR population. It seems that in most cases, reimbursement rates have been such that providers have had sufficient reimbursement to adjust to changing populations.

In order to refine their understanding of the system, as well as to help inform service providers about the project, the contractors, made presentations to the advisory committee and also introduced the project at the monthly meeting of the County Social Service Directors' Meeting, and The Minnesota Association of Counties. Additionally they held an open door seminar on the design of a client-based reimbursement system at the annual legislative conference of the Association of Residential Resources in Minnesota (ARRM) and made a presentation and discussed issues involved in the design of a reimbursement system for persons with mental retardation to ICF/MR providers including members of ARRM and MAHCF (Minnesota Association of Health Care Facilities). The Department also conducted a "mini-study" in twenty ICF/MRs in order to understand why program costs varied and to determine whether it was feasible to proceed with efforts to design a reimbursement system related to assessed client needs and services given by providers. In that study, providers at ten high costs and ten low cost facilities were interviewed. It was found that there was general agreement that specific client characteristics, falling into four basic domains, substantially contributed to variations in need for staff time. These domains were:

-- Extraordinary/disabling physical conditions,

-- Need for help with activities of daily living,

-- Degree of work with personal interaction/community integration,

-- Challenging behaviors.

There were expected differences in the numbers of staff working in facilities with different types of clients. In general, the facilities with lesser staff served higher functioning clients with fewer medical complications and fewer clients with challenging behaviors. But distinct differences were also found in the types of activities in which staff spent their time. Staff in facilities with more severely disabled clients spent most of their time providing basic care and in the development of skills in the area of activities of daily living. Staff in facilities with less severely disabled clients spent more time working with clients in the community and developing independent living skills.

The basis for case-mix reimbursement in geriatric nursing homes (and similarly, case-weighted hospital reimbursement systems like Medicare's DRG system) is provided by a relatively stable set of client characteristics that predict the relative amount of time and effort required to assist different groups of clients or patients. Payments can be varied to reflect the relative difference in effort (or cost) required to assist different groups. The results of the initial "mini-study" raised a difference between resource use and clients of ICFs/MR, and resource use and other studied groups. The study showed that we

should expect to find less predictable associations between resource use (staff time) and measurable characteristics of ICF/MR clients because the "need" for or "capacity to consume" active treatment is, like all educational programs, essentially boundless.

The initial observation from the mini-study was further confirmed empirically in the detailed time study, subsequently conducted. As a result, the system developed was not a "case-mix" reimbursement system in the classical sense. Rather, the system of assessments, groups, and weights emphasis services needed and received.

As part of the analysis of the ICF/MR service system, Human Services Research Institute reviewed the quality assurance activities for services to persons with mental retardation in Minnesota. Their review contained recommendations for improving quality assurance in ICFs/MR and included recommendations for using assessment data collected for the new payment system to develop ways of measuring service and program outcome. (See Exhibit 'C', Review of Quality Assurance Activities for Services to Persons with Mental Retardation in Minnesota for a complete report of their findings.

Task 2: Develop Assessment Instrument and Resource Use Survey

Methodological Considerations

When designing a reimbursement system which bases reimbursement on individual needs and resource use of people served by the provider, it must be determined what makes some clients more costly to serve than others. In order to make this determination, an assessment must be made of the characteristics and needs of clients and a resource use survey must be conducted to determine resource use level related to individual needs. There is agreement that, other things being equal, a person who:

- has severe medical needs; or
- is unable to perform basic activities of daily living (ADLs) such as toileting, bathing, or eating; or
- is under 18 (children require more staff supervision than adults);

may be more costly to care for than clients who do not exhibit these characteristics. Types of habilitation programs which a client participates, challenging behaviors, and family/community support systems may also influence cost of care. At present, there is disagreement among professionals in the field as to what constitutes an adequate habilitation program given a specific set of client needs and the goal of helping the client live in the least restrictive environment possible.

An assessment which is valid, reliable, and which accurately assesses those factors which are most strongly related to cost of client services, must be identified or developed. The object of the resource use survey component of this process was to determine how much staff time (by type of personnel) is devoted to particular clients. The primary methods of determining resource use are time and motion studies (which are prohibitively expense), staff diaries, interviews, and questionnaires.

Val Bradley and John Agosta from Human Services Research Institute (HSRI) developed a Technical Advisory Panel to assist them in determining the utility and practicality of particular assessment approaches. This panel was made up of experts in the field of mental retardation in Minnesota. HSRI also contracted with Dr. Larry Irvin, of the Oregon Research Institute, to review and analyze six possible assessment instruments. Staff from Lewin and Associates, HSRI, and the DHS met with the technical advisory panel to discuss the selection of the instrument. Dr. Irwin presented his analysis of the instruments and issues related to the final selection of an instrument. The panel also discussed the implications for designing a client-based reimbursement system.

The panel of technical experts reviewed existing assessment instruments and decided none of them contained the positive programming elements they considered necessary. Therefore, an extensive assessment instrument was developed by the consultants, encompassing multiple items in each of the domains identified as important in the mini-study.

A relative resource use survey to determine the total amount of staff time spent with each client by each of six categories of staff was also developed by Barbara Manard of Lewin and Associates.

Task 3: Complete the Client Service Needs Assessment and Resource Use Survey on ICF/MR Clients.

The next step in the project was an empirical study of the relationship between staff time and types, and intensity of staff assistance with ICF/MR clients. The assessment instrument was completed on 913 clients in a stratified random sample of 65 ICFs/MR. (A detailed report on the reasons for developing a new assessment instrument, and on the development, testing, and results of the use of this instrument is found in John Agosta, Marsha Langer, Val Bradley, and Kathleen Moore, The Minnesota Staff Activities Form: Results of Its Use in a Survey of 1,000 Persons Residing in ICFs/MR, November 1987, See Exhibit 'D'.) Staff at the sample facilities were also asked to record the amount of time spent with each study client over two days (one work day and one weekend day), on a special logging form, filled out by each staff person at the end of each shift.

Task 4: Identify the Client Service Levels and Develop Resource Use System

A "relative resource use score" (RRU) was constructed in the following manner:

- The total amount of staff time spent with the client by each of six categories of staff was computed.

- The time of each category of staff was weighted by a wage factor, derived from analysis of salary scales for comparable personnel in Regional Treatment Centers.

- The total weighted-cost time for each staff category was summed for each client.

In order to identify client service levels and develop the resource use system, it was necessary to link each client's relative resource use (RRU) score to his or her assessment data. The relationship between each item on the assessment instrument and the relative amount of staff time (the RRU score) was analyzed. In brief, the contractors found:

- The best predictor of the amount of staff time a person receives is the specific facility in which he or she lives.

- The characteristics captured by the assessment instrument do explain a reasonable, though modest amount of the variation in staff resources used by clients. The proposed model explains approximately 30 percent of the variation.

- In every domain (medical needs, disabling physical conditions, ADLs, challenging behaviors, personal/community interaction), the association between staff time/resources and client characteristics/services are in the predicted direction.

- But the strongest associations are between staff time/resources and client ADLs -- particularly the "Basic" ADLs (bathing, eating, toileting, grooming, dressing).

Based on analysis of the linked assessment and resource use data, a client reimbursement classification system was developed. Each client reimbursement group was given an associated "weight," which was derived from the average RRU score of clients in that service group in the time study. Thus, for example, the average client in the most service intensive group took 2.42 times the weighted staff time as the average client in the least service intensive group. The weights for each group were thus a measure of the relative cost (in terms of program staff) of providing services for persons in the different groups. These weights were used to compute service unit scores for each facility.

Task 5: Recommendations

After the empirical field research was completed, consultants analyzed the data and developed recommendations for a new payment system. Based on the extensive research and discussions with the advisory committee and department staff, consultants developed the proposal outlined below for implementation of the new ICF/MR payment system.

E. Transition Considerations

In order to create a base year for development of the new system which reflected necessary program costs for clients, ICF/MR program rates for 1988 and 1989 were set at the greater of the previous reporting years' program costs plus inflation or previous years' program rates plus inflation. They were also reimbursed for any program expenditures between 102 and 105 percent of their rates in addition to having the expenditures built into their prospective rate. Minnesota currently has no upper limits on program costs.

Since the new reimbursement system provides a method for linking rates to the resource use of clients served, data will now be available to allow us to determine which facilities have low rates per service unit point. Facilities at the bottom (meaning their costs are low relative to client needs) when arranged by rate per service unit point will receive a rate increase up to a minimum point, (20th percentile). This computation is referred to as a base adjustment to the program operating cost of a facility.

Additionally, in order to encourage a strong community program during the transition to the new system, when computing service unit rates for 1989, the assumption will be that only 10 percent of the facility's clients are receiving intensive Personal Interaction, Independence and Community Integration. This will reduce the service units for facilities who are already providing intensive services for more than 10 percent of their clients and increase their rates.

Clients service need assessment data for 1989 must be linked to the ICFs/MR 1989 cost reports to set payment rates for October 1, 1990. Therefore assessments for data collection purposes began in January 1989. Five training sessions were conducted for case managers and three for providers across the state by the Minnesota Department of Health and Department of Human Services staff. Training was also completed for the Minnesota Department of Health QA & R staff. Additional training will also be provided between the hearing and the promulgation of the rule.

The new system will be effective for the rate year beginning October 1, 1990. Beginning in October 1990 a facility's revenues ~~will be partly~~ determined by its service units. Facilities that show increases in the intensity of services above their adjusted service units will receive greater revenues.

F. The Proposed Rate Setting System

In linking the reimbursement system to the resource use findings, several factors had to be considered.

- First, preliminary research confirmed that it was program costs that varied given heavier service needs of clients. The research study targeted program costs and therefore, only the program component of the rate will vary with the resource use of the clients. Rates for property costs will not be affected.

- Second, approximately 83% of the facilities in Minnesota are under 16 beds, and 53% have 10 or fewer beds. It may be difficult for some small facilities to absorb the fluctuation in revenue experienced with a system where the rate is client specific and is subject to change at various assessment points.

- Third, since areas of the assessment which deal with independence and integration do not have as high a reliability but are important none the less, it was decided to use these areas for policy reasons.

The Department initially decided to use facility specific rates which would be the average of the resource use scores of all clients in the facility. Rate changes would be triggered only after threshold was exceeded. It was believed that this would help in avoiding destabilizing fluctuations in revenue and would mitigate the impact of variations not explained by the assessment.

However, after further consideration it became apparent that a facility specific system would have the same revenue fluctuation problems as a client specific system. Only minor fluctuations could be addressed by corridors. The problem of large fluctuations, especially decreases, still remained. Also, additional review by the Audits Division and Appeal Division staff of the Department revealed the following problems in a facility specific system:

- The number of assessments and reconsiderations in conjunction with the thresholds to determine whether a facility's rate should change, and the effective date of that change would create significant computer systems development, maintenance, and storage problems.

- Changes in a facility's rate due to assessments for admissions, hospitalizations, OA&R assessments, and reconsiderations will require the issuance of a new rate notice for each change.

- For each rate notice change, an appeal or "re-appeal" may be required.

- Since rates would change after rate appeals or assessment reconsiderations, the computer would have to develop multiple sets of rates for each effective date with a concommitent tracking system. Further, since rate appeals would be heard by DHS and assessment reconsiderations would be heard by MDH, the appeals relating to rate issues would have to be separated.

- The Department's computer system would have to track too much information for too long a time period.

- Issues of client notification are magnified because the change in one client reimbursement classification could result in rate changes for all clients.

The Department believed that a facility specific system would quickly bog down the reimbursement system with even more paperwork, process, and appeals, and that the additional administration required by such a system would be counter productive. This, coupled with the fact that the revenue fluctuation problem was still unresolved led the Department to propose an individual or client specific system.

The Department then proposed the change along with its rationale, to the Rule 53 Advisory Committee. The Committee discussed the fact that, for the most part, new admissions to facilities would be at the higher levels of care, and the mix of current clients is generally expected to be stable. In those instances where new admissions were of a lower level of care, the Department proposed to postpone the effective date of the rate change by 60 days. (See SNR for Part 9553.0057, subp. 2, item B.) After reviewing this information, the Committee agreed that a client specific system would be more workable.

The advantages of a client specific system are:

- It will be simpler for both providers and the department to administer this system.

- The development and implementation of the computer systems will be feasible and greatly simplified because the system in many important respects will be similar to the Nursing Home case mix system.

- The facilities' array of rates will be established at a set point in time for the rate year, and will not change because of a client's service needs re-assessments. If a client's service need assessment results in a change of classification, that client will merely receive the rate assigned to the new classification on the effective date of the change. This will reduce paper work and computer tracking problems.

- Rates will only change because of rate appeal settlements or audit adjustments as done at present. The tracking of rates and appeal issues will be much less than in the facility specific system.

- Client notification issues will be minimized because all clients' rates will not change when one client reimbursement classification changes.

The Department also proposed that all clients residing in ICFs/MR would have their service needs assessed annually. The Minnesota Department of Health will complete these annual assessments as part of the Quality Assurance and Review (QAR) survey currently conducted in the ICFs/MR. To avoid redundancy and reflect best practices, the existing QAR form was modified to contain the necessary reimbursement questions. It was proposed that the Minnesota Department of Health would assign client reimbursement classifications based on assessments of client service needs and also review requests for reconsideration of client reimbursement classifications. The Minnesota Department of Health has been integrally involved in the development of the new assessment and reimbursement classification process.

New clients will be assessed by case managers either at the time of the interdisciplinary team meeting or within five days after the meeting. The Minnesota Department of Health will then assign the reimbursement classifications as explained below.

Client Reimbursement Classification

Clients will be assigned a client reimbursement classification (CRC) based on the score in the assessment instrument. The assessment instrument was adopted from the much larger assessment instrument used in the time study. Key changes were as follows;

- Only those items necessary for assigning a CRC were maintained.

- The wording of each item, particularly in the area of community/personal interaction was carefully reconsidered and modified where necessary for clarity by a task force subcommittee made up of providers, Minnesota Department of Health staff, advocates, and county case managers. This subcommittee worked intensively on the assessment instruments for several months.

- ADL (Activities of Daily Living) items were rewritten based on the ADL questions on the QAR assessment instrument.

- The refined instrument was then piloted by case managers across the state and modified based on their recommendations.

Clients are assigned CRCs based on their scores on various assessment items. Service needs are grouped according to the level of dependence in activities of daily living as measured by the assessment instrument. They are then subdivided according to the score on the challenging behavior portion of the assessment. Finally the assessed service need group is divided into two categories based on whether the client needs and is receiving standard or intensive personal interaction, independence, and community integration services.

Figure 1 shows the proposed classification system. (See next page.)

FIGURE 1

DEFINITIONS AND WEIGHTS FOR CLIENT REIMBURSEMENT CLASSIFICATIONS

Service/Need Level		ADL's	Challenging Behaviors	Community Integration	Service Unit Weight
1	Standard		Low	S Under 90	1.00
	Intensive	Low	(Under 90)	I = 90+	1.04
2	Standard	(0-1)	High	S Under 90	1.36
	Intensive		(90+)	I = 90+	1.52
3	Standard		Low	S Under 90	1.58
	Intensive	Medium	(Under 90)	I = 90+	1.68
4	Standard	(2-5)	High	S Under 90	1.87
	Intensive		(90+)	I = 90+	2.02
5	Standard		Low	S Under 90	2.09
	Intensive	High	(Under 90)	I = 90+	2.26
6	Standard	(6-9)	High	S Under 90	2.26
	Intensive		(90+)	I = 90+	2.52
7	Standard	NA*	NA*	S Under 90	2.10
	Intensive	Special Treatment		I = 90+	2.37

* Not Applicable

A separate category of clients who are termed medically complex because of their need for special medical treatments was developed. That category is also subdivided by whether the client is receiving standard or intensive personal interaction, independence, and integration services. This classification system results in fourteen possible categories.

Each of the categories has been assigned a weight based on the resource use level of clients in that category. The person who is independent in ADLs, does not present significant challenging behavior and is not receiving intensive programming in the areas of personal interaction, independence and integration, is assigned a weight of one (1). The person who scores high in dependence on the ADL scale, high on the challenging behavior scale, and receives intensive personal and community services is assigned a weight of 2.52. These were reported to be the most resource use intensive people in the ICFs/MR according to the research. Clients needing Special Treatment Services (level 7) will have this service need assigned a service unit weight in one of the other six service need levels. In these cases, the service unit weights for the two service need levels will be compared and the higher service unit will be assigned.

Linking Reimbursement to the Classification System

Once service classifications reflecting relative cost of care were determined, researchers had to decide how to price care. The two principle mechanisms for linking resource use to prices or payments were the historical cost-case mix adjustment methods (which Minnesota has adopted for its non-ICF/MR nursing home reimbursement system) and an "exogenous" pricing system. With a historical cost-case mix adjustment method, each facility's own historical costs are initially allocated among the service levels as determined by the initial client assessment. This results in various payment rates. As the needs of the persons served change, or as new clients come in to the facility, the facility's total payment also changes. By contrast, the exogenous pricing system typically involves identifying the number and type of services and staff hours required by each client or groups of clients and setting a price for those service levels based on average wage rates across facilities.

With either method, it is necessary to measure the relative amount of staff time and other resources which are received by different clients. There are two fundamentally different approaches to this. First, one can measure "what is" and second, one can attempt to determine what "ought to be" delivered. However, it is difficult to specify what ought to be delivered in an area which is undergoing such dramatic change in treatment philosophy as is the mental retardation field. A system which builds on what is and creates room for innovation without prescribing specific treatment, may have the most merit in a state where average rates and staffing levels are already relatively high as is the case in Minnesota.

All other states that employ a client-centered reimbursement system use an exogenous pricing system or staff times wages model of reimbursement. Price for care is determined based either on expert opinion or survey of current costs for services. Then a fixed price is paid to everyone for that level of service. However, when this approach is adopted, those providers who have costs which are above this price are not reimbursed for those costs. Where those higher costs reflect inefficiency, this is a desirable outcome. However, where those higher costs reflect a higher quality of care, this is undesirable. Given the current undeveloped "state of the art" of measuring and pricing program quality, a fixed price approach could seriously erode service. Moreover, those providers who are currently providing client services at a cost lower than the fixed price, will receive a windfall profit which will not necessarily result in any better or more service being provided. In fact, such a system will reward low cost, low quality facilities.

The staff times wages model could cause great disruption in a system where there is wide unexplained variation in existing program costs. Even with the most refined measures of client resource needs, unexplained variations among program costs will remain. As a result, a reimbursement system similar to the staff

times average industry wages model used in all other states with client-centered ICF/MR payment systems would cause considerable disruption in Minnesota. Therefore, Minnesota developed a system which links client service needs to facility specific historical program costs.

Minnesota's reimbursement system envisages recommended that classifications based on 1989 assessments of clients service needs in each ICF/MR be used to compute service units for each facility. The number of client days for each client at each client reimbursement classification (CRC) will be multiplied by the weight corresponding to that classification to determine service units at each CRC. The "service units" are then summed to get the facility's total service units. Total service units are divided into the facility's program costs as reported on their 1989 cost report. The result is the facility program cost per service unit.

For the first rate year only, i.e., for rate year beginning October 1, 1990, the facility's total service units will be calculated assuming that at least 10% of the clients are receiving intensive Personal interaction, integration and independence services (PIII). For this computation, the facility's minimum service units are calculated first (assuming all clients are receiving standard PIII). Then the maximum service units are calculated (assuming all clients are receiving intensive PIII) and the difference is multiplied by 10%. This amount is added to the minimum service units. The greater of the adjusted service units (difference x 10% + minimum service units) or actual service units will be the facility's service units for the first year. (See Figure 2). This ensures that at least 10% of the clients are receiving intensive PIII services in the first year. (For the need and reasonableness of this calculation see the SNR for part 9553.0053.)

SCENARIO 1 Figure

WEIGHTS FOR CLIENT SERVICE LEVELS

1S	1.00	5S	2.09
1I	1.04	5I	2.26
2S	1.36	6S	2.26
2I	1.52	6I	2.52
3S	1.58	7S	2.10
3I	1.68	7I	2.37
4S	1.87		
4I	2.02		

ORKSHEET IS
LLUSTRATION
OSES ONLY

OF CLIENTS= 6
ORTING YEAR= 12/31/89
CILITY SIZE= 6 BEDS
AL NEED $'s= $12,428
OGRAM COSTS= $91,561
L PRGM. $'s= $103,989
H INFLATION= 9.33%
). PER DIEM= $29.71
BOTTOM UP)

	A CLIENT REIMB. CLASS	B CLIENT CLASSIFICATION WEIGHTS	C CLIENT DAYS	D FACILITY'S SERVICE UNITS	E MINIMUM SERVICE UNITS ALL STANDARD	F MAXIMUM SERVICE UNITS ALL INTENSIVE	G DIFFERENCE MULTIPLIED BY 10% (F-E*10%)	H FACILITY'S SERVICE UNITS AFTER ADJUSTMENT (>E+G; or D)	I FACILITY'S PROGRAM OPERATING COST PER DIEM (TOTAL PROGRAM COSTS / H)
	1I	1.04	365	380	365	380			
	2S	1.36	365	496	496	555			
	5S	2.09	365	763	763	825			
	2S	1.36	365	496	496	555			
	3S	1.58	365	577	577	613			
	4S	1.87	365	683	683	737			
LIENT DAYS	=		2190						BASE
ERVICE UNITS	=			3395	3380	3665	28	3408	PER DIEM = $30.51

CLASS	WEIGHTS	PROGRAM PER DIEMS (BASE PER DIEM X WEIGHT) EFFECTIVE 10/1/90	PROGRAM PYMT RATES (PER DIEM X INFLATION) EFFECTIVE 10/1/90	PROGRAM PER DIEMS (> BASE PER DIEM or ADJ. BASE PER DIEM X WEIGHT) 1/1/91	PROGRAM PYMT RATES (PER DIEM X INFLATION) EFFECTIVE 1/1/91
1S	1.00	$30.51	$33.36	$30.51	$33.36
1I	1.04	$31.73	$34.69	$31.73	$34.69
2S	1.36	$41.49	$45.36	$41.49	$45.36
2I	1.52	$46.38	$50.70	$46.38	$50.70
3S	1.58	$48.21	$52.70	$48.21	$52.70
3I	1.68	$51.26	$56.04	$51.26	$56.04
4S	1.87	$57.05	$62.38	$57.05	$62.38
4I	2.02	$61.63	$67.38	$61.63	$67.38
5S	2.09	$63.77	$69.72	$63.77	$69.72
5I	2.26	$68.95	$75.39	$68.95	$75.39
6S	2.26	$68.95	$75.39	$68.95	$75.39
6I	2.52	$76.88	$84.06	$76.88	$84.06
7S	2.10	$64.07	$70.05	$64.07	$70.05
7I	2.37	$72.31	$79.05	$72.31	$79.05

CILITY'S
ROGRAM
ERATING
COST
R DIEMS
AND
ENT RATES
OR EACH
CLIENT
ERVICE
LEVEL

One of the objectives of the new system was also to increase the program rates of facilities which were providing services of very low cost. Therefore, the first rate year, the Department will give additional revenue as a base adjustment to the program operating cost of certain facilities. Facilities will be arrayed by the Department and all facilities falling below the 20th percentile will be given an additional amount to increase their program operating cost to reach the 20th percentile. (Figure 3 for the calculation of the program operating cost per diem with the base adjustment).

Figure 3 (See next page) is the same as figure 1 except that in figure 3, the special needs dollars was reduced from $12,428 to $0 and one of the 25 clients was changed to a 2I client. These changes were done to illustrate the impact of "bring-up-the-bottom" computation as well as to show the alternative computation of the facility's service units if it were to have a PIII of more than 10 percent.

SCENARIO 2 Figure

WEIGHTS FOR CLIENT SERVICE LEVELS

1S	1.00	5S	2.09
1I	1.04	5I	2.26
2S	1.36	6S	2.26
2I	1.52	6I	2.52
3S	1.58	7S	2.10
3I	1.68	7I	2.37
4S	1.87		
4I	2.02		

KSHEET IS
USTRATION
ES ONLY

F CLIENTS= 6
CTING YEAR= 12/31/89
LITY SIZE= 6 BEDS
. NEED $'s= $0
RAM COSTS= $91,561
PRGM. $'s= $91,561
INFLATION= 9.33%
PER DIEM= $29.71
OTTOM UP)

	A CLIENT REIMB. CLASS	B CLIENT CLASSIFICATION WEIGHTS	C CLIENT DAYS	D FACILITY'S SERVICE UNITS	E MINIMUM SERVICE UNITS ALL STANDARD	F MAXIMUM SERVICE UNITS ALL INTENSIVE	G DIFFERENCE MULTIPLIED BY 10% (F-E*10%)	H FACILITY'S SERVICE UNITS AFTER ADJUSTMENT (>E+G; or D)	I FACILITY'S PROGRAM OPERATING COST PER DIEM (TOTAL PROGRAM COSTS / H)
	1I	1.04	365	380	365	380			
	2I	1.52	365	555	496	555			
	5S	2.09	365	763	763	825			
	2S	1.36	365	496	496	555			
	3S	1.58	365	577	577	613			
	4S	1.87	365	683	683	737			
ENT DAYS	=		2190						BASE PER DIEM =
VICE UNITS	=			3453	3380	3665	28	3453	$26.52

	CLASS	WEIGHTS	PROGRAM PER DIEMS (BASE PER DIEM X WEIGHT) EFFECTIVE 10/1/90	PROGRAM PYMT RATES (PER DIEM X INFLATION) EFFECTIVE 10/1/90	PROGRAM PER DIEMS (> BASE PER DIEM or ADJ. BASE PER DIEM X WEIGHT) 1/1/91	PROGRAM PYMT RATES (PER DIEM X INFLATION) EFFECTIVE 1/1/91
	1S	1.00	$26.52	$28.99	$29.71	$32.48
LITY'S	1I	1.04	$27.58	$30.15	$30.90	$33.78
GRAM	2S	1.36	$36.06	$39.43	$40.41	$44.18
RATING	2I	1.52	$40.31	$44.07	$45.16	$49.37
OST	3S	1.58	$41.90	$45.81	$46.94	$51.32
DIEMS	3I	1.68	$44.55	$48.71	$49.91	$54.57
ND	4S	1.87	$49.59	$54.21	$55.56	$60.74
NT RATES	4I	2.02	$53.56	$58.56	$60.01	$65.61
R EACH	5S	2.09	$55.42	$60.59	$62.09	$67.89
LIENT	5I	2.26	$59.93	$65.52	$67.14	$73.41
RVICE	6S	2.26	$59.93	$65.52	$67.14	$73.41
EVEL	6I	2.52	$66.82	$73.06	$74.87	$81.85
	7S	2.10	$55.69	$60.88	$62.39	$68.21
	7I	2.37	$62.85	$68.71	$70.41	$76.98

G. Status of rulemaking and description of proposed rule

The Advisory Committee on Client-Centered Reimbursement which worked closely with DHS staff and consultants since the inception of this research continued to work with DHS staff in the development of the rule. The committee met six times during 1988 to provide input as the proposed system developed. The assessment subcommittee met six additional times to help fine tune the assessment instrument. Additionally, the original Rule 53 Advisory Committee was merged with the Client-Centered Reimbursement Advisory Committee to form the combined Rule 53 Advisory Committee to work on the rule. This committee met regularly to develop the content of the new rule parts. (See Exhibit A for list of combined Rule 53 Advisory Committee.) There are 42 members on the combined committee and an additional 45 people who receive meeting notices and information about the process of the committee.

Currently, Minnesota Rules, part 9553.0050 to 9553.0080 establish methods for determining operating costs payment rates, including program payment rate, without regard to client service needs. The new system is based on findings from a major research effort. The Department proposes to amend these rules and to implement a new payment system so that program payment rates will be based on client service needs. The proposed amendments include provisions on: assessment of client service needs; client reimbursement classifications and weights; determination of program payment rate; reconsideration of client reimbursement classifications; initial adjustment of program operating cost payment rate; client access to assessments and documentation; and, payment rates for new facilities.

The proposed amended rules, designated as Minnesota Rules, parts 9553.0010 to 9553.0080, are hereby affirmatively presented by the Department as required by Minnesota Statutes, section 256B.501, subdivision 3, and in accordance with the provisions of the Minnesota Administrative Procedures Act, Minnesota Statutes, chapter 14, and the rules of the Office of Administrative Hearings.

PART 9553.0010. SCOPE

It is necessary to amend the scope of the rule to inform providers that the reimbursement of facilities providing state operated community services (SOCS) will be governed by these rules. This is reasonable because Minnesota Statutes, section 252.50, subdivision 6, requires all state operated community-based programs that meet the definition of "facility" under part 9553.0020, must be reimbursed consistent with parts 9553.0010 to 9553.0080.

It is also necessary and reasonable to delete the term "state owned hospitals" and to insert "regional treatment centers" instead because state owned hospitals are now referred to as regional treatment centers (RTCs). The Minnesota Statutes citation has to be updated because the old definition of state hospitals has been deleted and been replaced by the definition of RTCs instead.

Parts 4656.0250 to 4656.0030 are Minnesota Department of Health (MDH) rules governing assessment of services needed and received by individuals residing in ICFs/MR. It is necessary to refer to these rules because the reimbursement rules cannot be read apart from the assessment rules. This is reasonable because the assessment is the foundation of the new client centered reimbursement system. Payment rates governed by Rule 53 are based on assessments conducted by MDH and both rules have to be read consistently for effective administration of the new system.

PART 9553.0020. DEFINITIONS

Subp. 1a. Active Treatment. This definition is necessary to clarify the meaning of a term used in the rule. It is reasonable because it is consistent with the federal definition of active treatment (42 C.F.R. 483.440). The state medical assistance rules have to be consistent with federal regulations for the state to receive federal financial participation as required under Minnesota Statutes, section 256B.04, subd. 4.

Subp.3a. Assessment. The new reimbursement system is based on an assessment of services needed and received by clients. The department can target resources to clients only after it has determined the characteristics and needs of different clients and the costs associated with the services provided to each individual client.

It is necessary to define this term to clarify its meaning in the context of this rule. It is reasonable to refer to Minnesota Department of Health (MDH) rules because assessments are conducted by MDH and the procedures governing assessments are established in parts 4656.0260 to 4645.0330. This definition ensures consistency between the rules and makes the rules shorter by avoiding unnecessary duplication.

Subp.3b. Assessment form. It is necessary to define assessment form because this term is used throughout the rule. The assessment form, developed jointly by the Departments of Health and Human Services, is to be used by the Quality Assurance and Review team (QAR) to evaluate services needed by clients and the frequency and time spent by staff to provide the services. Since assessments are to be conducted by the QAR team of the Department of Health, the assessment form was developed in conjunction with Department of Health. The Department also received expert guidance from the consultants, Lewin & Associates and Human Services Research Institute, a technical advisory panel, and the advisory committee in the development of the assessment form.

The goal of the new reimbursement system is to reimburse operating costs at varying levels based on client needs and relative resource use (costs). This system requires ongoing assessment of client needs and linking of these assessments to the cost of providing care.

It is reasonable for the Department to use an assessment form because this helps the Department to evaluate the service needs of individual clients and to determine the relative cost of care for clients with varying needs. It is also reasonable to perform client assessments according to the assessment

form because Minnesota Statutes, section 256B.501, subd.3g requires the quality assurance and review team to assess all clients using a uniform assessment instrument developed by the commissioner. Further, this is consistent with the requirement of Minnesota Statutes, section 256B.04, subd. 2, which mandates uniform statewide administration of medical assistance rules.

Subp. 7a. Case Manager. This definition is necessary to explain the meaning of a term used in the rule. It is reasonable to refer to the definition in part 9525.0015, because this ensures consistency in the Department's interpretation of the same term. Further, most providers and case managers who are governed by this rule are also governed by the case management rule (parts 9525.0015 to 9525.0165) and are already familiar with the meaning of terms used in that rule. This definition avoids confusion and eliminates duplication.

Subp. 9a. Client. The present rule refers to persons receiving services in an ICF/MR as "residents". The Department proposes to use the term "client" instead. It is necessary to define client to explain the meaning of a term used throughout the rule. It is reasonable to change from resident to client because the term "client" is consistent with the term used in the federal regulations (see 42 C.F.R. 483), in the related Department of Health rule (parts 4656.0250 to 4656.0330) and in the assessment form. It is also reasonable to clarify that the word client has the same meaning as the word resident used in Minnesota Statutes, section 256B.501, because the enabling statute uses the term "resident" to refer to persons receiving services in an ICF/MR.

Subp. 9b. Client Reimbursement Classification. It is necessary to define the term client reimbursement classification because this classification is an important part of the new reimbursement formula and an understanding of the term is essential to the understanding of the rule. It is reasonable to define the term by referring to the rule part in which the categories are established to avoid unnecessary duplication of language. (For a detailed explanation for the client reimbursement classification, see the statement of need and reasonableness for part 9553.0056).

Subp.20a. Foster care services. This definition is necessary because it explains the meaning of a term used in the rule. It is reasonable to refer to the definition in the DHS foster care rules because this ensures consistency in the department's interpretation of the same term. It is also reasonable to refer to both adult and child foster care services because ICFs/MR serve either adults or children and one of the two rules will be appropriate.

Subp.24a. Home and community-based services. It is necessary to define home and community based services to explain the meaning of a term used in the rule. It is reasonable to refer to the definition in the waivered services rule (parts 9525.1800 to 9525.1930) because this ensures consistency in the Department's interpretation of the same term. Since most providers

and case managers are already familiar with the waivered services rule, this definition is also reasonable because it avoids confusion and eliminates duplication.

Subp.28a. Least restrictive environment. This definition is necessary to explain the meaning of a term used in the rule. It is reasonable to refer to the definition in part 9525.0015, because this ensures consistency in the Department's interpretation of the same term. Further, most providers and case managers who are governed by this rule are also governed by the case management rule (parts 9525.0015 to 9525.0165) and are already familiar with the meaning of terms used in that rule. This definition avoids confusion and eliminates duplication.

Subp.28b. Manual. It is necessary to define manual to explain the meaning of a term used throughout the rule. The manual explains the procedures for assessing clients, adding their scores, and assigning client reimbursement classifications based on client's scores. The manual contains many details which are procedurally important to implement the system but are not policies that are necessary to the rule. However, the Department has incorporated the manual procedures which should be part of 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 QAR, providers and case managers have to follow and has charts and attachments explaining the new reimbursement system in detail. It is reasonable to incorporate relevant parts of the manual because this prevents duplication of language and ensures consistency of procedures followed by all parties. (See Exhibit 'E', ICF/MR Reimbursement and QAR Procedures Manual, 1990).

Subp.30a. Nursing home. This definition is necessary to explain the meaning of a term used in the rule. It is reasonable because it ensures consistency in the Department's interpretation of the same term.

Subp. 46. Program. The proposed amendment is necessary to update the citation relating to federal conditions of participation for ICFs/MR. This amendment is reasonable because it does not change the substance of the rule; it only makes the rule more current.

Subp.37a. Quality assurance and review or QAR. This definition is necessary to inform providers that the quality assurance and review program referred to in these rules is the program established by the commissioner of health under Minnesota Statutes, sections 144.072 and 144.0721. The proposed reimbursement system requires QAR 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 conduct the assessments with the new assessment form.

Subp.38a. Regional treatment center or RTC. It is necessary to define RTC to explain the meaning of a term used throughout the rule. This definition is reasonable because it is consistent with Minnesota Statutes, section 252.025.

Subp.42a. Representative. Representative means the client's legal representative as defined in the case management rule (part 9525.0015, subpart 18), the person authorized to pay the client's facility's expenses or any other individual designated by the client. It is necessary to define this term because it has a meaning peculiar to this rule. This definition is reasonable because it is consistent with the related assessment rule, part 4656.0260, and with Minnesota Statutes, section 144.0723, subd. 2.

Subp.42b. Semi-independent living services. This definition is necessary to explain the meaning of a term used in the rule. It is reasonable to refer to part 9525.0500, because this ensures consistency in the Department's interpretation of the same term.

Subp. 43. Client day. This amendment proposes to substitute the word client for the word resident. The proposed amendment is necessary and reasonable for the reasons stated in the statement of need and reasonableness of subp. 9a. The amendment is for technical purposes only.

Subp.59. Temporary care. It is necessary to change the term "respite" to "temporary" because federal ICF/MR regulations do not recognize "respite" care as a part of ICF/MR service. The term "respite" implies that a client is residing in a facility on an impermanent basis and is essentially "taking a break" with no programming. However, it is recognized that some clients requiring active treatment may have a short term stay in an ICF/MR. Because emphasis in the federal ICF/MR regulations is on active treatment it is reasonable to use the term "temporary care" to describe a client receiving services at a facility for less than 30 days. It is necessary to specify the amount of time that is considered to be temporary care. It is reasonable to use 30 consecutive days because this is the time frame the Department has used to distinguish short term from long term care clients. This distinction has worked well over the past years and the Advisory Committee agrees with this length of time.

PART 9553.0035. DETERMINATION OF ALLOWABLE COSTS

Subp.13. Temporary care. This amendment replaces the word "respite" with the word "temporary". It is necessary to inform providers that the Department is changing the terminology in the rule. This is reasonable for the reasons stated in the SNR for part 9553.0020, subpart 59. The amendment is also reasonable because it does not change the substance of this provision; it only changes the terms used.

Subp.17. Special needs rate exception payments. This provision states that the amount of money approved by the commissioner for the most recent twelve month period under the special needs rate exception rule (Rule parts 9510.1020 to 9510.1140) will be included in the allowable program costs of the facility for the reporting year 1989. This means that special needs rate exception payments will be included in the historical costs of the facility when the department sets the 1990 rates under the new reimbursement system.

This subpart is necessary to reimburse providers for operating costs which are not currently considered as allowable costs under this rule. The department approves special needs rate exception payments for short term needs of clients. However, some clients have required a special needs rate exception payment for twelve or more months signifying long term needs for intensive services. Under the new reimbursement system, all clients receiving intensive services reimbursed with special needs payments will be assessed as needing and receiving such services and will be assigned a payment rate corresponding to their level of care. Since clients will be assessed in 1989 and these assessments will be the basis of the new payment rates, it is reasonable to include the 1989 special needs payments in the historical costs of the facility.

Item A is necessary to distinguish between the short term needs of clients which are reimbursed under rule parts 9510.1020 to 9510.1140, and the long term needs of clients which will be part of the rule parts 9553.0010 to 9553.0080 payment rate. Since costs reimbursed under rule parts 9553.0010 to 9553.0080 will always be included in the historical costs of the facility and will be the basis for future payment rates of the facility, it is reasonable to reimburse only long term costs under this rule. The department's experience has been that clients approved for special needs payments for twelve or more months are usually clients with long term needs. Therefore, it is reasonable to state that this provision will apply only if the amount was approved for at least a 12 month period.

It is necessary to clarify that if approvals are within 30 days of each other the amount of the approval is an allowable cost under this rule. The department only approves special needs rate exceptions for short periods, and providers seeking additional payment for the same client have to apply for extension of the same. Since applications are approved within 10 days of their receipt by the Department, it is reasonable to assume that the payment for a client with a continuous need will be approved within thirty days.

Item B is necessary to inform providers that only the costs of additional staff, staff training and staff consultation will be reimbursed under this rule. This is reasonable because staff costs are costs related directly to the care of the client and are considered as program costs. The special needs payment rule (rule parts 9510.1020 to 9510.1140) also reimburses providers for other costs (eg., equipment) which are not included in the reimbursement system in parts 9553.0010 to 9553.0080.

Item C is necessary because it shows that the client for whom the costs were incurred through a special needs rate exception is still a client of the facility and that the provider is still incurring expenses for that client. Since special needs costs are costs associated with a particular client, it is reasonable for the Department to confirm that the client is still being served by the provider. The April 30, 1990, date is reasonable as it is the last day to submit a cost report for the period to which these costs apply.

Item D requires the special needs rate exception approval to have been in effect any time during 1989 including the time of the 1989 QAR assessment. This is reasonable because the department will use the assessments and cost reports for calendar year 1989 to determine the 1990 payment rates. If the special needs rate exception payment was not approved for 1989, then any

earlier payments should not be included in the 1989 historical costs. Similarly, if the client is not receiving special needs rate exception services during QAR's assessment, then the assessment will reflect a lower level of service needed and received by the client. This means that the 1990 payment rates which correspond to the client's 1989 assessment will be lower than what they would be if the client was receiving special needs services at the time of the QAR assessment. This item reduces the possibility of including special needs payments in the historical cost when those costs are not reflected in the payment rate.

This amendment also informs providers that if the special needs payments are included in allowable historical costs under this rule, then they will not be paid under the provisions of the special needs rate exception (Rule parts 9510.1020 to 9510.1140) rule. Payments allowed under parts 9553.0010 to 9553.0080 form part of the historical cost and will be used in establishing all future payment rates for the facility. This provision is reasonable because it avoids making payments to providers under two different rules, a circumstance that might result in double payments for the same service.

PART 9553.0036. NONALLOWABLE COSTS

Item AA. Part 9553.0036 gives a list of costs that are not to be considered for the purposes of establishing total payment rates under this rule. Item AA of the present rule states that costs incurred in providing services to very dependent persons with special needs under Rule 186 shall not be allowed for purposes of establishing total payment rates.

The proposed amendment makes an exception for special needs costs which are now considered as allowable costs under part 9553.0035, subpart 17. The amendment is necessary to make the this provision consistent with the provision on allowable costs (part 9553.0035). It is reasonable for the reasons stated in the SNR for part 9553.0035, subpart 17.

PART 9553.0040. REPORTING BY COST CATEGORY

Subp.1, item L. Program operating costs. This part groups related costs together and requires common reporting of all costs that fall into that category. Subpart 1 requires the provider to report all program costs in the program operating cost category.

The cost of providing services reimbursed under parts 9510.1020 to 9510.1140 are not currently considered by the department when establishing the total payment rate of the facility. However, the proposed amendments to part 9553.0035, subpart 17, include some of these costs as allowable costs for determining the payment rate for rate years beginning October 1, 1990.

It is necessary to require the provider to report these costs so that the department has all relevant financial information before determining the payment rates. It is reasonable to include the special needs costs in the program operating cost category because these costs which are necessary to provide the client's care have a direct impact on the provider's program costs. This is also reasonable because there are no limits in the program operating cost category while all other categories are subject to limitations.

Subp 2. item D, subitem (6). Maintenance operating costs. This provision states that direct costs of plant operations and maintenence services include licensing and permit fees except for the license fees listed in the special operating cost category.

The proposed amendment simply corrects the citation for the license fees listed in the special operating cost category. The correct citation is subpart 6, item B, and not subpart 5, item F, as stated in the present rule. This amendment is necessary and reasonable because it is only a technical change; it does not change the substance of the rule.

PART 9553.0050. DETERMINATION OF TOTAL OPERATING COST PAYMENT RATE.

This part describes the mathematical formula for determining the total operating cost payment rate. The formula first uses the facility's cost and statistical data to establish allowable costs, then subjects these costs to certain limitations, establishes historical per diems, and finally adjusts the per diems for inflation to establish the facility's payment rates for the rate year.

The objective of the proposed amendments is to establish the rate setting methodology for rate years beginning on or after October 1, 1990. The amendments also simplify the reading of the rule by deleting provisions which referred to rate years before October 1, 1990, clarify the provisions of the present rule, and make the rule consistent with the statutory changes made by the Legislature in 1989.

Subp.1. Establishment of allowable historical operating cost per diem.

Item A, subitem (1). This amendment changes the effective date for the limits on administrative allowable historical operating costs. The proposed effective date is October 1, 1989. The amendment is necessary because this subitem refers to units (a) to (g) which will relate to rate years after October 1, 1989 only. The present provisions apply to rate years after October 1, 1986, but some of these provisions are inconsistent with the new client centered reimbursement system and are proposed to be deleted. This amendment is reasonable for the reasons stated in the SNR for units (c) to (g) of this subitem.

The proposed amendment to unit (c) changes the adjustment of the administrative cost per licensed bed limit from 105 percent to the 75th percentile of the array of each group. This amendment is necessary to clarify that the administrative cost per licensed bed will be limited for future rate years according to the 75th percentile. It is reasonable because it is the same as that specified in Minnesota Statutes, section 256B.501, subd. 3d.

It is necessary to delete unit (d) because its provisions regarding certified audit costs were only applicable for the rate year October 1, 1986, and are no longer applicable to rate setting for periods after October 1, 1989. The amendment is reasonable because the rule is intended to be prospective from October 1, 1990, and the elimination of unnecessary language will help to avoid confusion.

The change in dates in the new unit (d) [old unit (e)] is necessary because it establishes effective dates for the computation described therein. The limits in the present rule are for rate years 1986 and 1987 only. The amendment will use these same limits for rate years after October 1, 1990. There is no substantive change to this provision. The inclusion of the phrase "for the facility's group" is necessary and reasonable for the purpose of clarity and represents no change from the Department's current practice.

New unit (e) is necessary to establish the process for adjusting the administrative cost per bed limits in subsequent rate years. The provision is reasonable because it is consistent with Minnesota Statutes, section 256B.501, subd. 3d.

Unit (f) contained the prior method for adjusting the administrative cost per bed limit for inflation. The 1989 Legislature changed the inflation index for rates set after September 30, 1989. It is therefore, necessary and reasonable to delete this provision to avoid confusion about the applicable index.

In new unit (f) [old unit (g)] the phrase "and the average cost of a certified audit" is proposed to be deleted for the same reasons that old unit (d) is deleted; it does not apply to rates that will be set under this rule after October 1, 1990. This deletion is necessary because providers have to know what costs will not be adjusted as a result of field audits, appeals and amendments. It is reasonable because the rule is prospective and the elimination of unnecessary language will help avoid confusion.

Item A, subitem (2). This provision sets limits for the maintenance operating cost category. The present rule states that for the rate years beginning October 1, 1986 and 1987, the maximum allowable historical operating costs will be the operating cost payment rate for the maintenance operating cost category during the reporting year multiplied by the client days in the same reporting year. The rule then rebases the maximum allowable historical operating costs in the maintenance operating cost category for the period January 1, 1988 to September 30, 1988. The costs from the reporting year ending December 31, 1986 were used as a base to calculate the maximum limit in the future years. For all rate years on or after October 1, 1988, the maximum allowable historical operating cost in the maintenance cost category is the amount determined from January to September 1988 increased by inflation.

The proposed amendment deletes the limits stated for the rate years beginning October 1, 1986 and October 1, 1987. This is necessary and reasonable because this provision was for a limited period and is no longer required. It also avoids confusion about the limits and removes redundant language. The amendment also substitutes the year 1990 for 1988 in the rate year calculations. The change in dates does not change the substance of the rule, - it only makes the rule more current. All persons interested in knowing the limits in effect for rate years before October 1, 1989, can refer to the rule provisions which were in effect for those years.

The proposed amendment deletes references to the old index used for inflation and refers to the "appropriate index" specified in subpart 2, item A of this part. It is necessary to refer to subpart 2, item A, because that provision incorporates the index which the Legislature directed the Department to use.

This composite index must be used instead of the CPI-U index mentioned in the present rule. It is reasonable to use the new index since this index is the same as the one in Minnesota Statutes, section 256B.501, subd.3d.

Item A, subitem (3). The present rule states that for rate years beginning on or after October 1, 1987, the administrative limits stated in this provision shall only apply for the purposes of calculating the efficiency incentive.

The proposed amendment simply restructures the language of this provision without making any substantive change. It is necessary and reasonable because it removes redundant language (i.e., reference to rate years that will not be covered by this rule as is proposed to be amended) and clarifies the language in the rule.

Item A, subitem (4), units (a) to (c). These provisions explain how to reclassify costs and separate them into program, maintenance, special, and administrative cost payment rates. It is necessary to delete these provisions because they applied for rate years beginning October 1, 1986 and 1987 only, and are no longer relevant. Before 1986, providers did not separate the costs into the cost categories established under the present rule. The Department established the cost categories for the rate years beginning in 1986 and identified a method by which providers could break their payment rates into program, maintenance, special, and administrative cost components. Since then providers have carried out the necessary adjustments and now report their costs in the different categories Therefore, it is reasonable to delete this provision as it is no longer applicable to future rate setting.

The last part of subitem (4) specifies how to compute the total limits for the efficiency incentive. The present rule uses prorated client days as part of the calculation because of the fact that payment rates which are in effect during a reporting year are different at various points in the year. It is necessary to add the last sentence to subitem (4) to accommodate the fact that the new client based reimbursement system has up to 14 program payment rates that may be in effect during a facility's reporting year. The new computation is essentially the same as the computation before 1989 except that client days will be reported according to the actual number of client days in each client reimbursement classification. This is reasonable because it results in an accurate reflection of the facility's program revenues and is consistent with the goals of the new system.

Item B. The present method of calculating the allowable program historical operating costs per diem is to divide the total costs in that category by the greater of the total number of client days or 85 percent of capacity days. However, this method essentially provides an average program per diem for all clients of the facility and does not differentiate between the more and less intensive care clients. The new formula for calculating allowable program historical operating costs per diem is different from the one used at present. It provides for different program per diems for clients depending on their reimbursement classification level. ICF/MR may provide care for clients in 14 different reimbursement classification levels and thus receive 14 different payment rates.

It is necessary to delete the present formula because the proposed new reimbursement system is different from the present one. It is reasonable to create a separate part for the new formula to avoid confusion in the calculation of the program rates. Part 9553.0052 contains all the different computations necessary to calculate the program per diems. The need and reasonableness for part 9553.0052 is stated in the SNR for that part.

Item E (old). It is necessary to delete this item because the cost of a certified audit was an allowable cost as a separate payment (outside of the administrative cost category) only for the rate year beginning October 1, 1986. This amendment is reasonable because it removes redundant language and avoids confusion about the requirements of the rule.

Subpart 2. Establishment of total operating cost payment rate.

Item A. The present item A contains provisions for adjusting facility per diems for rate periods prior to October 1, 1989. These provisions are no longer relevant for future rate setting because the 1989 Legislature changed the method of adjusting facility per diems. It is reasonable to delete the present provisions to avoid confusion and enhance the clarity of the rule.

The new item A specifies that a facility's allowable historical cost per diems in the program, administrative, and maintenance categories as computed in subpart 1 shall be adjusted for inflation by the composite index in Minnesota Statutes, section 256B.501, subdivision 3c. This is necessary because we have a prospective rate setting system and must account for the time lag between reporting years and rate years. The time lag occurs between the period for which costs are incurred (the reporting year) and the following period for which rates are established (the rate year). The period of time between the reporting year and the beginning of the following rate year is nine months.

It is necessary to inform providers of the new index which will be used to adjust costs for inflation. The present rule uses the all urban consumer price index (CPI-U)for Minneapolis-St.Paul to update the historical per diems in the program, administrative and maintenance cost categories. However, though the CPI-U reflects cost changes in consumer goods, it does not explicitly recognize cost changes for wages or cost changes in ICF/MRs or other health care related facilities.

The proposed amendment updates allowable historical operating costs by using the statewide composite forecasted index prescribed in the statute referenced above. This index specifically takes into account economic trends and conditions for wages of health care workers. The Data Resources Inc. forecast of the Standard Industrial Code (SIC) 805, that is used to create the statewide composite index, relates to the average wages of health care workers in long term care facilities (these workers include nursing staff). The CPI-U is used for indexing all other operating costs. The composite index is created by developing statewide proportions of wages to non-wage operating costs, and applying these proportions to the two forecasted indices. A composite index is then created when the two proportioned indices are combined. It is reasonable to use the statewide composite index because this is more comprehensive than the present CPI-U index. It is also reasonable to amend this provision to be the same as Minnesota Statutes, section 256B.501, subd.3c, which specifies that the state shall use this statewide composite forecasted index for ICFs/MR rate setting.

Item E. It is necessary to delete the first sentence in item E as this provision no longer applies to rate setting for rate years beginning on or after October 1, 1990. Similarly, portions of the second sentence have been edited to make it clear that the provisions regarding computation of a facility efficiency incentive are applicable to rates set after September 30, 1990. This is reasonable to provide uniformity with other provisions being amended, and to avoid confusion about effective dates.

The Department, in its review of this provision, noted that the references to subpart 1, item A, subitems (2) and (3) are erroneous as they refer to maintenance and administrative costs, and are not program costs. It is necessary and reasonable to delete these references as this clarifies the rule without making any changes to Department policy and practice.

Item F. This provision specifies that the total operating cost payment rate for facilities is the sum of the adjusted program, maintenance and administrative operating cost payment rates and the efficiency incentive. The total operating cost payment rate for rate years before October 1, 1990 will be calculated according to the present rule.

It is necessary to inform providers that the Department will use amended items B to E for computing payment rates beginning October 1, 1990. This provision is reasonable because the new reimbursement system changes the method for calculating the program operating costs per diem and the index for adjusting the program, maintenance and administrative costs. These changes will result in different payment rates from October 1, 1990 forward.

It is also necessary to delete the present provision relating to the allowable certified audit cost per diem, because this is no longer relevant for rate setting after October 1, 1990. It is reasonable because it removes redundant language and helps avoid confusion about the rule.

Subpart 3. One time adjustments to program operating cost payment rate.

Item A. Subitems (1) and (2) apply to situations when there is a change in the licensing or the medicaid certification rules, requiring providers to increase program staff. Facilities are cited and required to pay fines if they do not meet licensing or certification standards. The present rule states that a facility is eligible for a one time adjustment if the commissioner of human services or health, or the federal government has issued a deficiency order under the licensing or medicaid certification rules.

The proposed amendments specify that a facility shall be eligible for the one time adjustment only if the facility is issued a correction or deficiency order during one of the two years following the adoption of the new provision.

The objective of the one time adjustment is to allow additional funding when the facility's existing resources are not sufficient to meet the requirements of new regulations or rules. The purpose of the amendment is to limit the frequency with which an ICF/MR can apply for a one time rate adjustment. The Department believes that it is appropriate to adjust the facility's payment rates when deficiency or correction orders result from new or revised regulations that require added staff and consequently increase program

operating costs. However, once the rule or regulation has been adopted and the facility has not been cited for noncompliance with these rules, it is the facility's obligation to remain in compliance. Therefore, it is reasonable for the Department to declare facilities ineligible for one time program adjustments if the correction or deficiency orders occurred after a review which found the facility to be in compliance with the new or revised rule or regulation.

It is reasonable to permit this adjustment for up to two surveys following the enactment or promulgation of new regulations or rules so that both providers and surveyors have enough time to become familiar with the provisions and expectations of new regulations. Two years of non citation establish that the provider is in compliance with the new regulations, and after that, it is the responsibility of the provider to continue to comply with the same. It is necessary to inform that these limitations do not apply to the one time adjustment in item H. This is the role of the commissioner. These limitations apply only when providers have to comply with new rules or regulations. Item H is broader and applies to a change in application of any rule, which is explained in the SNR of that part.

This subitem also adds the term "commissioner of health". This amendment is necessary and reasonable because in addition to the federal government, the commissioner of health is also authorized to issue orders regarding the number and type of program staff necessary for the facility to comply with medicaid certification requirements. This amendment clarifies that the facility will be eligible to receive a one time adjustment regardless of who issues the deficiency order.

Item A, subitem (2) is also proposed to be amended by deleting the phrase "as amended through October 1, 1986". This is necessary to specify that the one time adjustment will apply to any future changes the federal government makes to its regulations governing ICFs/MR. The State's medical assistance program providers must comply with Federal Regulations to remain eligible for federal financial participation. Therefore, it is reasonable to expand this provision so that future changes made by the federal government which require additional program costs can be incorporated into the facility's program payment rate.

The present subitem (3) provides for program adjustments based on need determinations. The proposed amendment makes this provision inoperative after October 1, 1990. The change is necessary because it is consistent with the new client based reimbursement system. The original purpose of this provision was to address the situation in which the ICFs/MR proposed to admit clients with greater needs than those leaving the facility. Since the rate was an average rate, and would not automatically change by admission of a significantly different client, this provision provided the necessary program rate adjustments for such admissions. The proposed system on the other hand, is client specific. This means that whenever the facility admits clients requiring more intensive care, the facility receives a higher payment rate which corresponds to the service needs of that client. Since the new rate setting system allows the facility to get these additional resources in its payment rate, it is reasonable to eliminate the one time adjustment for such situations.

Subitem (4) updates the citation of the federal regulations and deletes the phrase "as amended through October 1, 1986". This amendment is necessary and reasonable because it makes no substantive change to the rule; it only makes the references more current.

Subitem (5) specifies that the facility is eligible for a one time adjustment if the facility is issued a citation under the Federal Fair Labor Standards Practices Act. The federal law requires facilities to pay extra wages for some staff who sleep in the facilities. Many facilities have been cited under this provision and have had to pay extra wages for overtime or additional staff. Since ICF/MR rates are based on historical costs, it is necessary and reasonable to adjust provider's rates for costs which are not already considered while establishing the rates. That is why it is also reasonable to give this adjustment only once. Once rates are adjusted, the historical cost base for the next reporting year already includes the cost of complying with the federal labor requirements. The base for future years is then adequate to support the services necessary to meet these federal standards. It is also reasonable to allow only the cost of salaries, taxes and fringe benefits, because these are program costs directly related to the care of the client.

Item F. These amendments clarify that the one time adjustment will be paid for at least a twelve month period which must include one full reporting year. It is necessary to specify the length of time for a one time adjustment so that providers understand how the settle up will work. This amendment is reasonable because it reflects current Department practice and both providers and the Department agree on the length of time.

Item H. The present rule limits payments under subpart 3 of part 9553.0050, by stating that facilities can get one time adjustments only once in three years.

The proposed amendment is necessary to inform providers that they may receive payments more often than once in 3 years if they are eligible for the one time adjustment under part 9553.0050, subpart 3, items A to G. This amendment is also necessary to inform providers that they may receive payments for more than one one time adjustment simultaneously. For example, if a provider is eligible for a one time adjustment under item A, subitem (1), and also under item A, subitem (5), at the same time, the provider may receive both adjustments in the same year if the provider meets all the other conditions specified in the rule. The deletion was made at the request of the providers, although the amendment increases the documentation and the accounting required from both the providers and the Department.

This amendment is reasonable because there may be a few situations when the one time adjustment is needed more often than once in three years. It is also reasonable because all the five conditions for the one time adjustment (stated in part 9553.0050, item A, subitems 1 to 5) relate to different circumstances and it may be possible for a provider to need adjustments for more than one condition simultaneously.

Part 9553.0052. Determination of the allowable historical program operating cost service unit per diem.

The purpose of this part is to compute the facility's program operating cost per diems using the new client based reimbursement system. The program per diems calculated in this part are used in part 9553.0050, subpart 1, item B, and in subpart 2, item B, to ultimately develop the facility's program operating cost payment rates for rate years beginning on or after October 1, 1990.

Subparts 1 (Service units for rate years beginning on or after October 1, 1990) and 2 (allowable historical program operating cost service unit per diem). These provisions are necessary to compute each facility's per diem for the client reimbursement level "1S". It is necessary to first determine the facility's total service units by multiplying the client days in each client class by the weight for that class. The sum of each of these products gives the facility's total service units for the reporting year. In subpart 2, the facility's program service unit per diem is computed for client reimbursement level 1S by dividing the facility's allowable program operating costs by the facility's total service units. These computations are reasonable because they assign approximate "costs" to the lowest level of care that may be offered by the facility. The costs for other levels of care are then compared with these costs.

Subp.3. Base adjustment to allowable historical program operating cost service unit per diem. This subpart adds an additional step for the initial rate year beginning October 1, 1990. One of the goals of the new reimbursement system is to promote equity for clients' providers. The purpose of this provision is to adjust the program costs for those facilities whose per diem per service unit is below the 20th percentile of an array of all facilities. This will help in raising the reimbursements of providers whose costs are low compared to the service needs of their clients.

The 1987 legislature appropriated an amount of $5MM to be used to implement the new client-based reimbursement system. One hundred thousand was to be set aside for the Department's added administrative cost. The remaining $4.9MM was to be used to adjust the lowest cost facilities program rates, and to include other additional cost changes to the reimbursement system. The other additional costs identified by the Department include $87,000 for the anticipated cost of the habilitation incentive in subpart 5, $2,881,197 for the anticipated cost of increased persons receiving PIII services, and $354,640 for potential cost of Department of Labor one-time adjustments. The remaining amount of $1,577,163 was identified by the Department to adjust the lowest cost facilities.(See Attachment 1 for the Department's computations of these costs.)

The Department estimates which facilities will be eligible for the base first year adjustment by using the steps outlined in subpart 3 and using the assessment and cost information for the reporting year 1989. The Department then establishes the percentile based on the array of these facilities. (Attachment 1 shows that by using this methodology, the Department established the 20th percentile.) This methodology is reasonable because the Department used the most recent information available to it from provider cost reports and assessments of ICFs/MR. The result is the best approximation of the percentile possible.

The new client centered reimbursement system is based on the Department's belief that it is necessary to link a facility's program operating costs to its client's needs. This was done in item A of subpart 3 through arraying facilities by their allowable historical program operating cost service unit per diem. This is a reasonable method to rank the facilities because the ranking takes into account both the facility's most recent level of program expenditures, as well as its mix of clients using the newly developed client assessment system. This method also provides uniformity in classification of providers through the standardization of facility per diems achieved by using client weights. All facilities below the percentile are considered as comparatively low cost facilities and will be given a base adjustment to bring up their program rates in the first year.

The base adjustment to program operating cost is effective January 1, 1991. This is necessary and reasonable so that the effective date corresponds with the beginning of the facility's reporting year. This also provides the Department with the ability to ensure that these additional program revenues will be expended on program costs as explained in the SNR for item F below.

Item A is necessary to inform providers that the commissioner will indicate on the facility's rate notice if the provider is eligible for a base adjustment and the maximum amount of additional program money available to eligible providers. This is reasonable because it ensures that providers are aware of potential program adjustment and can plan services and budget for them accordingly.

Items B and C are necessary to inform providers who will qualify for the base adjustment. The first condition is that the facility must be licensed and certified throughout the 1989 reporting year. This is reasonable because medical assistance payments are allowed only for licensed and certified ICFs/MR . It is reasonable to refer to the 1989 reporting year because the Department uses the 1989 cost report to establish the array in item A. This ensures that the array is based on the most recent information. This is also reasonable because 1989 is the first year in which clients are assessed under the new client assessment process.

The second condition for qualifying is that facilities must not have received an interim or settle up payment in 1989. New facilities establish their rates based on projected/budgeted costs, and facilities that are closing establish their rates based on actual costs. Since new facilities can anticipate additional costs for clients and facilities that are closing do not need an increase in rates, it is not reasonable to permit them to be eligible for this adjustment.

Item C sets forth the application procedures for providers. It is necessary to identify the Department's expectations so that eligible providers can prepare the required documents for their application. Each eligible provider must submit a budget explaining how and where the added revenues in the program operating cost category will be spent. This is reasonable because it enables the Department to review the provider's expected expenses before giving additional money for program costs. The budget will also provide an affirmative statement of the provider's intentions and the provider's understanding of the purpose of the added revenues. Since budgets generally set forth the details mentioned in subitem (2), it will not be an extra burden on the provider to give this information in the budget. The additional revenue is given to providers to allow them to spend more money on

program operating costs. It is reasonable to ask providers to submit a written affidavit because this gives the Department some basic assurance that the money will be spent appropriately. It is also reasonable for the commissioner to prepare the form of the affidavit because this ensures that all providers sign a standard document and they include in the affidavit all the assurances required by the commissioner. Minnesota Statutes, section 256B.04, subd. 2, mandates the Department of Human Services to ensure that the medical assistance system is administered uniformly throughout the state. It also makes it easier for the provider to complete, and the Department to process the application. Sixty days is a reasonable amount of time for the provider to estimate the additional costs, prepare the budget, and sign the affidavit. The Department must receive the affidavit by October 31, because it needs the month of November to review these amounts and to compute the appropriate rate adjustments that are to be effective January 1, 1991.

Item D is necessary to establish the per diem amount to be included in the facility's payment rate. The purpose of this adjustment is to give the provider additional money to be spent on program costs. The adjustment is not to be applied to any other expenses or or solved at a later date. Therefore, if the provider's budget shows that the provider will spend less than the amount available, it is reasonable to give the provider this lesser amount of money. This provision also states that there will be no recalculation of these amounts or redetermination of the array for any subsequent rate recomputations. The recalculations would require additional documentation and reviews, perhaps several times, once for each recomputation of rates. Similarly, if the Department changed one facility's rank in the array, this would lead to all other facilities having a new ranking in the array. This would mean new rate calculations and notices each time there was a change in the array. This part is reasonable since it reduces the administrative complexity of the rate setting process.

Item E provides for a fiscal review of the cost report for the reporting year ending December 31, 1991. Since the purpose of the base adjustment is to increase the program services provided by low cost facilities, the review is necessary to assure the Department that amounts paid to the provider were indeed expended on program operating costs. A substantial share of reimbursement is made through federal money. The State has to meet the federal requirements of spending imposed by the Health Care Financing Administration (HCFA) of the Federal Department of Health and Human Services (HHS). HCFA requires the state's reimbursement system be cost related. Therefore, it is reasonable for the state to review the cost report to be able to assure HCFA that the payments are related to actual costs.

The review process proposed by the Department is the same as that required by the Legislature for the reporting year 1989. The threshholds established in item E are identical to those established by the Legislature for a similar review for calendar years 1988 and 1989. These are reasonable because they allow facilities to operate within a reasonable margin of budget error. They are also reasonable because they are consistent with Minnesota Statutes, section 256B.501, subdivision 3b.

Item F and G provide the mechanism for determining the repayment of any under spending beyond the limits established in item E. It is necessary to inform providers that the Department will identify any underspending in the program operating cost areas and will recover amounts which were included in the facility's payment rate for the period January 1, 1991, to September 30, 1992. This is reasonable because the money was given on the understanding that it would be spent on program areas. The period for recovery is reasonable because it is for this period that the amounts were included as base adjustments to the program operating costs of the facility. The method used for calculating repayments is reasonable because it is based on the same formula as the one used for calculating the base adjustments.

Subp.4. Program operating cost per diem. This subpart describes the computation necessary to determine a facility's program per diems. Each facility's base per diem is multiplied by each of the classification weights so that a complete array of 14 per diems is created for the facility. Since during the first rate year, some facilities will be benefiting from the "base adjustment" computation, it is necessary and reasonable to recognize that fact, and avoid potential confusion over the matter.

Subpart 5. Habilitation incentive for certain discharges. This subpart is necessary to encourage, facilitate, and reward facilities which are able to discharge clients to non institutional service settings. In general, a client's program objectives and goals should be developed with the underlying overall objective of getting clients to achieve their potential in the least restrictive environment. One way of doing this is to move clients from institutional to non institutional settings.

This distinction between institutional and non institutional settings is necessary to identify which type of discharge the Department considers desirable from the program point of view and the situations in which the provider will be rewarded. The distinction is reasonable because semi independant living services, home and community based services, foster care and family placement are generally believed to be more beneficial for the client than ICFs/MR, nursing homes or hospitals. While some could argue that discharges to smaller ICFs/MR may be programmatically good and may be beneficial to the client, the fact remains that the client continues to be in the same kind of setting and is still considered institutionalized under the federal regulations. Therefore, the Department believes that discharges to other ICFs/MR should not be considered as eligible for a habilitation incentive.

Item A. Subitem (1) establishes the length of stay requirement. The long length of stay (365 days) is necessary and reasonable because this assures the Department that: (1) the admission was not contrived; (2) the client's plans of care (IHP and ISP) have been fully developed and implemented; (3) the services offered by the facility have benefited the client resulting in the client's habilitation to a less restrictive setting; and (4) the discharge was primarily the result of the facility's efforts. The limitation that the discharge date should be on or after October 1, 1990 is reasonable because this date corresponds with the date of implementation of the new client based reimbursement system. The new rule provisions apply from the rate year beginning October 1, 1990.

Subitem (2) is necessary to inform providers that they will not receive money if the discharge is due to the death of a client. This is reasonable because it is consistent with the purpose of the habilitation incentive. A client's death is not regarded as beneficial or as a discharge to a less restrictive setting.

Subitem (3) establishes the necessity that the client discharged be eligible for Medical Assistance. This is reasonable since the habilitation incentive is paid from medical assistance funds and only services to medical assistance eligibles may be paid through Medical Assistance funds.

Subitem (4) is necessary to inform providers that the habilitation incentive will be paid for one client only once. It is possible for a case manager or a provider to determine that clients' needs are not being met in a less restrictive setting and that the client should return to an ICF/MR. Since this payment is an incentive to improve the client's condition permanently, this provision is reasonable.

Subitem (5) requires the case manager to certify that the client discharge meets the conditions necessary for the facility to receive a habilitation incentive. The case manager's involvement is necessary because it is the case manager's responsibility to see that clients are served appropriately according to their plans of care. The case manager is familiar with the client's case and can assure the commissioner that the discharge meets the requirements of this subpart. Since all non institutional settings are not necessarily less restrictive (for eg., a discharge from an ICF/MR to home and community based services can be more restrictive depending on the program services received), it is important for the case manager to certify that the discharge is to a less restrictive setting. A client may also be discharged for reasons other than the treatment provided by the facility. Since the habilitation incentive is a reward for the facility's efforts, it is also important for the case manager to agree that the discharge is the result of active treatment provided by the facility. The above provisions are therefore, reasonable.

It is also reasonable to make this certification a part of the annual cost report because this will reduce the paper work for counties and for the department. It will also make the Department's review more efficient if it is done at the same time and on the same document as the cost report. Minnesota Rules, part 9553.0041 give the department the authority to collect information on the cost report.

Subitem (6) is necessary to inform providers that facilities receiving interim or settle-up payment rates cannot receive the habilitation incentive for their clients. Since these facilities already have special rate setting procedures, and their program rates are either budgeted or are settled-up based upon actual costs, the Department believes they should be excluded from receiving the habilitation incentive.

Item B. This provision sets forth the commissioner's review and rate setting requirements under this subpart. The rates under parts 9553.0010 to 9553.0080 are established on September 1st of each year. The commissioner has to review, verify, and compute the eligible facility's habilitation incentive before setting rates for the next year. It is therefore reasonable to allow the commissioner 4 months time to conduct the review and establish the habilitation rate.

Item B, subitem (1) informs the provider which payment rate will be used to compute the habilitation incentive. It is reasonable to use the client's payment rate in effect at the time the client was discharged because this was the rate paid for the services rendered while the client was a resident of the facility. It is also reasonable to exclude the amount of one time adjustments or other habilitation incentives as these amounts do not reflect care or services given to the discharged client. The habilitation incentive thus rewards the provider's efforts, but does not overcompensate the provider. Like the provisions of subpart 3 above, the expected cost of implementing this provision must be within the overall amount appropriated by the Legislature. Taking into account all the other increases required by the rule, the Department believes that multiplying the rate by 5 is reasonable. The cost will not unduly burden the system and the amount will reward a provider's efforts to habilitate the client.

Subitem (2) is necessary to sum the amounts for a facility with more than one discharge during the reporting year. Summation is a reasonable means to minimize the number of adjustments which might apply to a provider's rates.

Subitem (3) is necessary to establish the facilities habilitation incentive per diem. To do this it is necessary to divide the amount summed in subitem (2) by the facility's total client days for the reporting year. This is reasonable because the reimbursement system is based on per diems and it will be easier to calculate the habilitation incentive after calculating the per diem payment. It is reasonable to use the client days for the reporting year preceding the Commissioner's review because that is the most recent client day information available at the time of the review.

Subitem (4) is necessary to identify which set of payment rates will be adjusted. The Department's rate setting system will more readily accept prospective rate adjustments that are based on the reporting year to which the adjustment relates. It is reasonable to adjust the payment rates for the rate year following the commissioner's review because this is the most practical and efficient method of adjusting the facility's payment rates.

This provision also informs providers of the first reporting year in which the habilitation incentive review is required. It is reasonable to use the reporting year ending December 31, 1990, as this is the year during which the new client based system begins, i.e. October 1, 1990.

PART 9553.0053. COMPUTATION OF TOTAL SERVICE UNITS FOR THE FIRST RATE YEAR.

This part applies only for the first rate year. The purpose of this part is to adjust the first rate year's total service units for the fact that the results of the research identified approximately 20 percent of the clients in the sampled facilities as receiving Intensive Personal Interaction, Independence, and Integration (PIII) services, while the actual results of assessments conducted to date indicate that less than 1 percent of clients received these services.

Items A to F are necessary because they explain and establish the mathematical computations used to adjust the first reporting year's total service units. Item A merely states that the facility's actual total service units are to be computed in the same way as they will be for all future

reporting years. This is reasonable because it provides a standard way of calculating service units according to the service needs of clients at each facility.

Items B and C compute the minimum and maximum total services units of the facility by assuming first, that all clients receive standard PIII services (item B), and then that all clients receive intensive PIII services(item C).

Item D subtracts the amount in item B from item C and multiplies the result by 10 percent. In item E, the amount in item B is added to 10 percent of the difference between the facility's maximum and minimum total service units. The effect of the computations in items B to E is to determine what the facility's total service units would have been if the facility had provided Intensive PIII to at least 10% of its clients. These are called the adjusted service units. Item F specifies that for calculating rates in the first year, the Department will use the greater of the facility's actual or adjusted service units.

It is necessary to adjust a facility's total service units when its actual total service units for reporting year 1989 are less than the adjusted total service units (assuming a 10 percent PIII) because this compensates for the great difference between what the research showed (19.8% PIII) and what the actual 1989 assessments reveal (.03% PIII). Both providers and the department believe that PIII is occurring at a level significantly higher than .03 percent indicated by current assessments. The Department believes the difference is due to the fact that the Quality Assurance and Review teams at MDH require formal documentation while the consultant based her research on verbal communication with the provider. It is also due to the fact that providers are not trained on how to document services to meet the rule requirements. The advisory committee formed a subcommittee to study the documentation requirements with the staff at MDH and DHS. The subcommittee drew up less stringent documentation requirements and providers felt that assessments under the new requirements would identify more clients receiving intensive PIII services. The Department also offered to train providers on how to fill out the forms and meet the documentation requirements of the rule.

It is reasonable to seek to minimize the potential fiscal impact that could be generated as a result of the Department's clarification of the documentation requirements and training steps. If no steps are taken in the first year the providers will be able to increase their program revenues in future years by simply meeting the new documentation requirements without providing any more services. The Department's estimate of the fiscal impact for future years without any adjustment this year is approximately $11 MM. If the Department assumes that at least 10% of people receive intensive PIII, then the fiscal impact will be $2,881,197. It is therefore reasonable to assume that 10% of people will receive intensive PIII services in the first year.

Item F is an effort to minimize the the potential fiscal impact. It is reasonable to use the adjusted total service units when a facility's actual total service units are less because this enables the Department to include the rate for 10% of intensive PIII clients in the first year instead of being faced with a sudden increase next year. Since the research indicated that on average 20% of the clients were receiving intensive PIII services, it is also reasonable to expect providers to provide at least 10 percent PIII after the documentation requirements are clarified and training is provided.

It is also reasonable not to use the adjusted total services units when a facility's actual total service units are greater because to do so would provide such facilities with an automatic program revenue increase without any change in their level of program services. Such an action would only require a further reduction in the amount which can be used to give a base adjustment to the program operating costs of low cost facilities in part 9553.0052, subpart 3. Requiring the use of their actual total service units does not financially harm the facility if it maintains the same level of PIII next year. Therefore, the Department believes that using adjusted total service units for providers whose actual total service units are greater is neither necessary nor reasonable. This will only serve to harm other providers by further reducing the amount of the legislative appropriation allotted and used for other necessary changes.

PART 9553.0054. INTERIM PROGRAM OPERATING COST PAYMENT RATE SETTLE-UP.

The purpose of this part is to establish a settle-up payment rate for newly constructed facilities. The interim rates continue to be established under part 9553.0075. However, the rule provisions governing settle-up will depend on whether the settle-up is for the interim period occurring before or after October 1, 1990. Payment rates will be fair and accurate only if all providers are required to establish client specific rates at the same time, i.e., October 1, 1990. It will also be easier for the Department's computer systems to establish payment rates for all facilities at the same time. Therefore, it is reasonable to require new facilities to use the new system from October 1, 1990.

Item A is necessary to clarify that settle-up for interim periods before October 1, 1990 will be governed by the present rule provisions. This is reasonable because it is consistent with the legislative mandate that the reimbursement system become effective only after October 1, 1990. (See Minnesota Statutes, section 256B.501, subdivision 3(g).)

Item B, subitems (1) to (3) are necessary to inform providers that service unit per diems for interim rates will be computed in exactly the same way as for the other facilities. The need and reasonableness of these provisions is explained in the SNR for part 9553.0052. Subitem (4) states that the statewide composite index must not be applied to the facility's historical program operating costs. This is necessary and reasonable because the facility's actual allowable costs for the settle-up period are used for the settle-up rates. Therefore, there is no need for an inflation factor during settle-up of interim rates.

Item C is necessary and reasonable to inflate the program rates for the nine month period following the settle-up period because costs are likely to increase with inflation. An adjustment for the length of the settle-up reporting period is necessary to account for the varying lengths of a settle-up cost report (5 to 17 months). This additional adjustment is necessary and reasonable to apportion the inflation factor to account for the time between the midpoints of the settle-up period and the nine month period. It is reasonable to divide the products by 21 because the inflation factor is projected to cover 21 months.

A facility whose rates are established pursuant to Minnesota Statutes, section 252.292, is subject to closure. A facility which is closing down will be reimbursed according to the provisions of the present reimbursement rule. Since such a facility will not be part of the system in the future, it is administratively feasible, and therefore, reasonable, not to subject it to the changes required by the client based reimbursement system.

PART 9553.0056. CLIENT REIMBURSEMENT CLASSIFICATION AND CLASSIFICATION WEIGHTS.

Subp. 1. Scoring the assessment. Subpart 1 prescribes the areas in which assessments are scored. Clients' service needs are assessed in four main categories which were found to be the best predictors of resource use. These are: Activities of Daily Living (ADL's), Challenging Behaviors, Personal Interaction, Independence and Integration (PIII) and Special Treatments. Each of these categories requires different patterns of service, and assessments are scored based on the type, and/or frequency and amount of intervention required and received for each service. Assessments are then assigned to a service group ("Client Reimbursement Classification" or "CRC") based on the score on the assessment form. The different CRCs represent different service need levels of clients. Each client reimbursement classification has a corresponding weight. These weights are used to calculate the client's and the facility's payment rate. The goal of the new client centered reimbursement system is to reimburse facilities for program operating costs at varying levels based on the needs and relative resource use (RRU) of clients. This system of assessing client service needs and then linking these assessments to payment rates is a means to reach that goal.

It is necessary to assess clients' service needs in order to target resources to clients. It is also necessary to inform providers, case managers, and Quality Assurance and Review teams of the areas and the methods for scoring assessments because the assessment determines the client reimbursement classification and the payment rate for the client. This provision is reasonable because the new assessment procedure and its implementing assessment form were developed in response to a Legislative mandate requiring the commissioner of human services to study alternative mechanisms for reimbursement of providers of services for persons with mental retardation or related conditions in ICFs/MR. (See Minnesota Statutes, section 256B.501, subd. 3g).

The Department conducted extensive research to develop an assessment form which would accurately assess client's service needs in those areas of service which were most strongly related to the cost of care. (See the Introduction for the formation of the Technical Advisory Panel, research conducted by the consultants, the detailed time study, and the guidance of the Advisory Committee). Lewin and Associates reviewed and analyzed other states' current methods (and proposed methods) for rate setting in ICFs/MR. The research team found 6 states had systems which linked rates to the assessed service needs of clients. However none was considered suitable for Minnesota. The other systems were either based primarily on "point" systems borrowed from the state's geriatric case-mix system or tied the reimbursement rate too closely to "prices" rather than facility costs.

The proposed system is different from all existing systems and is designed to reimburse providers by linking types of services and cost of care with payment rates. This will reduce access problems for clients with heavy service needs, ensure better quality of care and more equitable payment rates for facilities, and provide the state with a uniform system for comparing costs in different facilities.

Item A. This item states that assessments in the ADL, challenging behavior and PIII areas must be scored according to steps 1 to 3 of Attachment I of the manual (See Exhibit E). It is necessary and reasonable to incorporate Attachment I by reference to avoid lengthy rules and to ensure consistency between the manual instructions and the rules.

Step 1. This step informs QAR, case managers, and providers how to score the assessments in the ADL category. It is necessary to assess and to identify the level of service needed in ADL's because this helps to differentiate between the heavy care and the low care clients and to target resources to clients with more service needs in ADLs. It is also necessary to assess client's ADL service needs because the research (see Exhibit F, "Recommendations and Rationale for a Proposed Method for Setting Medicaid Reimbursement Rates for ICFs/MR: A Summary", also referred to as the Lewin report) shows that the strongest association is between staff time/resources and client ADL's - particularly the "basic" ADL's (bathing, eating, toileting, grooming, dressing). [See Attachments 2 and 3]. It is reasonable to assess service needs in the activities of dressing, grooming, bathing, eating, transferring, mobility, toileting, and self preservation because these eight activities were considered by the research to be the best predictors of resource use.

When the Department conducted its research, clients' service needs were assessed on twenty ADL's using a preliminary assessment tool, the Minnesota Staff Activities Form (SAF) [Exhibit D]. The SAF contained basic ADL's and instrumental activities of daily living (IADL's) such as simple money management, preparing meals, dishwashing, using the telephone, etc. All these activities were scored to reflect the level of supervision or physical assistance needed by clients. The researchers then analyzed the scores statistically to see how they related to the cost of care. It was determined that some of the items, especially the IADL's, did not explain as high a percentage of variance as the other ADL's [see attachment 4]. The IADL's were therefore taken out of the basic ADL domain.

The ADL's on the Staff Activities Form were then compared to the structure of the ADL items on the QAR assessment form. Research showed that there was strong correlation on each ADL item between the QAR scale and the original SAF scale (See Attachments 5&6). Researchers also felt that the Staff Activities Form ADL's were more difficult to score while the ADL's on the QAR assessment was found to be less subjective, more easily documented, and were familiar to the reviewers and the facility staff by merit of use since 1977. Therefore, the research team recommended that the department measure resource use using the QAR ADL scale. A work group from the Rule 53 Advisory Committee, the assessment subcommittee, reviewed and refined the QAR ADL language for the final assessment form.

The ADL items on the QAR assessment form were based on extensive research. Well known assessment scales such as the Katz Index[1], the Barthell Index[2], and the Kenney Self-Care Evaluation[3] were all used in the formation of the QAR assessment form. These items have been used to assess clients service needs in Minnesota since 1977. It is also reasonable to use the QAR ADL items because the use of a rating scale for determining the client's ability to perform ADL's has been common practice in various parts of the country since 1950. Currently, most rehabilitation facilities use some form of ADL schedule.

The criteria and approach taken for determining a client's ability to perform activities of daily living are also very similar to the recommendations made by the National Committee on Vital and Health Statistics (NCVHS) in 1980. The ADL portion of the proposed assessment form resembles the Long-Term Health Care Minimum Data Set, which was promulgated by the NCVHS in 1980 for the U.S. Dept. of Health and Human Services. (See attachment 7). Since the QAR ADL items are based on extensive research and have been used successfully before, it is reasonable to use these items for assessing client service needs.

Self-preservation was originally scored as an independent item in the SAF because the initial research indicated it to be strongly associated with resource use. The researchers later became concerned that this assessment item was subjective and open to various interpretations, which could lead to inconsistent scoring of this item. Therefore, they decided not to score self-preservation in a separate category. However, because self-preservation was consistently highly predictive of costed time, it was included into the ADL area with a score of 2 points while other dependencies received 1 point each. Thus self-preservation is included with the ADL services instead of being a major classification criterion of its own. This approach is reasonable because it recognizes that self preservation is predictive of resource use but does not place undue reliance on an item which is difficult to measure.

Clients are assigned to service groups based on the ADL assessment scores. In each of the 8 activities listed in the ADL category (e.g., dressing, grooming, eating, etc.), a client's service need can be scored from 0 to 4. A score below 2 means that a client needs little help or supervision in those activities. A score between 2 to 4 means that a client needs constant supervision or physical assistance from one or more persons to perform the activity. Since clients with an assessed service need score of 2 to 4 are clients who need a significant amount of staff supervision and assistance, it is reasonable to state that a service need score of 2 to 4 is dependent in ADL's.

[1] Lawton, M. Powell. "The Function Assessment of Elderly People". Journal of the American Geriatrics Society. June, 1981, Volume XIX, Number 6.

[2] "Statistical System for Reporting Public Health Physical and Occupational Therapy Activities", Maryland State Department of Health, Divisions of Physical and Occupational Therapy. July 1, 1967.

[3] Schoening, Herbert A., M.D. et.at. "Numberical Scoring of Self-Care Status of Patients". Archives of Physical Medicine and Rehabilitation. October 1965, Volume 46, Number 10.

A dependency in any of the 7 ADL items is assigned 1 point each and a dependency in self-preservation is assigned 2 points. This is reasonable because the researchers determined self-preservation to be a higher predictor of resource use than any of the individual ADLs.

It is necessary to add the assessment scores on a 1 to 9 scale because this enables the department to differentiate between low, medium, and high ADL services. This in turn helps the department to reimburse facilities according to the service need level of the clients they serve.

Client's assessed service needs in ADLs were grouped into low, medium, and high groups based on (0 to 1 low) (2 to 5 medium) and (6 to 9 high) ADL dependencies because research indicated that this approach explained the greatest variation among resource use scores Additionally, this approach maximized the differences between the mean resource use scores in the high and low ADL groups without creating too many groups (see Attachment 8).

Other means of scoring ADLs did not prove to be feasible. For example, using 9 fine tuned categories to take into account the differences for each client's service needs would make the system far too complex, while a system of 2 broad groupings of ADLs would not catch all the variances. In addition, QAR has been successful in working with a similar system in nursing homes. Therefore, it is reasonable to create three ADL categories.

Steps 2 and 3. The need and reasonableness for steps 2 and 3 are explained together because both steps are very similar. Steps 2 and 3 of Attachment I explain the scoring for the challenging behavior and the PIII areas of the assessment form.

It is necessary to measure client's service needs in the challenging behaviors area because research showed that after ADLs, challenging behaviors were also strong predictors of resource use.

Once clients are assessed on their service needs in challenging behaviors, the assessment is divided into two categories based on whether the client needs and receives standard or intensive personal interaction, independence, and integration (PIII) services. It is necessary to score service needs in the PIII domain because the Department wishes to provide an incentive (targeted reimbursement) for positive programs in this area. However, research showed that assessments in the PIII activities were not closely related to resource use. Though areas of the assessment which deal with PIII do not have as high a reliability as the activities in ADLs, challenging behavior, and special treatments, they are still considered important for policy reasons. Therefore it is reasonable to assess clients service needs in these domains.

Items A to D in step 2 and items A to C in step 3, Attachment I of the manual specify the method for scoring assessments in the challenging behavior and PIII area.

It is necessary to inform QAR, providers, and case managers on how to score assessed service needs in the challenging behaviors and PIII domains because these scores will affect the payment rates of clients and the revenue of facilities. For each activity in the challenging behavior category (eg., self-injurious behavior, unusual or repetitive habits, etc.) and the PIII category (eg., personal choice and initiative, development of social

interaction, etc.) scoring is based on 3 levels of amount of staff intervention and 5 levels of frequency of staff intervention. "Amount" refers to the quantity of staff intervention that is provided (e.g., 5 minutes) and "frequency" means how often the staff intervention is provided (e.g., once a month). The "amount" of intervention is multiplied by the "frequency" of intervention to determine the total score of client's assessed needs. It is reasonable to consider both the amount and frequency of intervention because research was based on these two variables, both of which affected the resource use of the client. This is also reasonable because researchers analyzed that a combination of amount and frequency showed more variance in resource use than either one of these variables alone.

Early research assigned scores for amount and frequency as 1 - 3 and 1 - 5, respectively. To illustrate, a "minimal" amount of intervention (5 minutes or less) scored 1 point, "extensive" intervention (over 15 minutes) scored 3 points. "Rare" frequency of intervention (less than once a month) scored 1 point and a frequency of intervention on an "hourly" basis scored 5 points. However, the Committee felt that service needs in PIII or in challenging behavior occurring "hourly" were "worth" more than five times an activity or behavior that occurs "rarely". The consultants analyzed several alternative models of scoring for challenging behavior and PIII before arriving at the final scoring system (see attachment 9). They finally selected scale #2 on attachment 9 as the scale to be used for scoring both the PIII and the challenging behavior assessment areas. According to this scale, the scores for "frequency" of intervention were not 1 to 5, but were on a scale of 1 to 10 instead. This meant that a "rare" frequency of intervention scored 1 point and a frequency of intervention on an "hourly" basis scored 10 points. This scoring is reasonable because it is based on the researchers' testing of each model by analysis of variance and the expert guidance of QAR reviewers, Department staff, and the Advisory Committee,

Item B in step 2 states that the scores for challenging behavior areas 3.1, 3.4, and 3.6 are doubled. For example, episodes of self-injurious behavior (challenging behavior item 3.1) that require moderate staff intervention (2 points) and occur frequently (6 points) would score 12 points, and this score would then be doubled for a total of 24 points. It is necessary to double the score for these challenging behavior areas because the Advisory Committee determined that the behavior areas of "destruction of property", "hurtful to others", and "self-injurious behavior" require more resources than others. QAR reviewers and facility staff suggested that it would reflect actual practice if the score (ie., the product of the amount multiplied by the frequency) was doubled for these behaviors. This scoring system is reasonable because it is based on extensive research and on the professional judgement of experts on the Advisory Committee.

Once the individual activities in the challenging behavior and PIII areas are scored, these scores are summed. If the client's total assessment score in the challenging behavior or the PIII section is 90 or above, the client's service need level is "high" or "intensive". If the score is below 90, then the client's service needs level is "low" or "standard". It is necessary to group assessments in the "high"/"intensive" or "low"/"standard" categories because these groupings will differentiate between clients according to their relative resource use and will target resources to clients. In the PIII area it is assumed that all clients receive a standard level of programming. The intensive level was developed as an incentive for providers to give a higher than average amount of PIII programming to certain clients. The payment

rate for clients whose services fall in the high/intensive category is slightly higher than the payment rate for those whose service needs are in the low/standard category.

The decision to use 90 as a breakpoint for high and low challenging behavior and for intensive and standard PIII was based on the professional judgement of the Developmental Disabilities (DD) Division of the department. Program staff from the DD division devised a reasonably "intensive" model program from areas in the PIII domain. They based their model program on the number of activities in PIII, and the frequency and degree of intensity that would constitute an "intensive" program of PIII. The DD division determined that a program with a score of 90 would be a strong and positive program and at the same time it would not be too difficult to achieve. Researchers also indicated that a breakpoint of 90 would create incentive for facilities to provide more clients with services in the PIII area, thereby increasing the facility's reimbursement.

In the challenging behavior area, the Department wanted to establish a breakpoint which would clearly separate the high from the low resource use clients. In order to rest the scoring scheme, the staff at one facility, Dakota's Children, Inc., scored the challenging behavior service needs of some of their clients. The scores of these "test" assessments were divided into what appeared to be reasonable classifications of "high" versus "low". The research team reviewed the information from the assessments and concluded a breakpoint of 90 would show the variance between the high and low resource use clients. Researchers also decided that for the sake of simplicity, it was best to use the same breakpoint (90) for both challenging behaviors and PIII. It is therefore reasonable to use 90 as a breakpoint for scoring in the PIII and challenging behavior domains.

Item B. The next consideration in determining client reimbursement classification level is based on the assessment of a client's need for special treatments. Lewin and Associates presented results of a Time/Resources use study at the November, 1987 Advisory Committee meeting (See exhibit G). The study identifies a separate category of services which are termed medically complex because they are special medical treatments which clients need everyday.

The consultants originally collected data on 19 special treatment services received by clients (See exhibit D). The list of special treatments was refined by the assessment subcommittee of the Rule 53 Advisory Committee using the items in the QAR assessment form with which they had historical experience. The assessment subcommittee (which included Registered Nurses) included 13 of the original 19 special treatment items in the final assessment form. The remaining 6 items were not as resource intensive as the other items because they were areas where clients needed routine care rather than a more intense special treatment level of care. (See attachment 10 for a comparison of the SAF Special Treatments and the current special treatments). Medications were included in the original SAF but the Committee decided not to include medications in the reimbursement system because it could create a negative incentive to provide more medications than a client needed. The assessment subcommittee then combined the 13 areas into 8 broad categories. The items finally included in the special treatment category were derived from the QAR assessment form used for completing assessments in ICFs/MR Therefore, there was historical experience with the use of these items.

It is necessary to establish a category measuring resource use in the special treatment area because the research shows clients needing complex nursing services on a daily basis are much more costly to care for than other clients. Special treatments are those services which are in response to an identified need, and which because of the inherent complexity of the service, must be performed directly by or under the direct supervision of professional personnel.

It is reasonable to include the services stated in subitems (1) to (8) in the special treatments category because these are all complex services with some common characteristics. First, there are services considered so inherently complex that they are safely and effectively performed only by, or under the supervision of, professional or technical personnel. It is the responsibility of the physician to identify to re-assess the identified need to determine the appropriateness and adequacy of the services being provided. Additionally, special treatments require a certain level of documentation in the client's record including a written plan.

Subitem (1). It is necessary and reasonable to include clinical monitoring once daily on all 3 shifts as part of the special treatments category because this item was essential in distinguishing between clients who received medical treatments but were less resource intensive than those whose conditions were medically intense. The inclusion of this item assisted in creating homogeneous groups of services for clients with similar needs and reduced the need to create additional groups. It is necessary that clinical monitoring be conducted by a licensed nurse because clinical monitoring requires the use of medical judgement or interpretation by an appropriate medical professional. It is reasonable to assign this responsibility to a nurse because nurses are the medical professionals qualified to perform clinical monitoring.

Subitem (2). It is necessary to include turning and positioning every 2 hours because the assessment subcommittee and the research indicated that this service was resource intensive. It is reasonable to include this item as a special treatment so facilities are reimbursed adequately for services provided to clients.

Subitem (3). It is necessary to include tube feeding in the definition of special treatment in order to recognize the costs of this service. It is reasonable to recognize these costs so facilities are not discouraged from accepting or caring for clients with complex and costly service needs.

Subitem (4). It is necessary to include parenteral therapy because this item is generally recognized as an unusual treatment that requires high resource use. It is reasonable to include parenteral therapy because it is a complex treatment and facilities need to have the cost of this service recognized.

Subitem (5). It is necessary to include tracheostomy care and suctioning 3 times a day because clients requiring these services have demonstrated high resource use. It is reasonable to include these services in special treatments because, although the number of clients receiving tracheostomy care and suctioning is small, the costed time associated with the service is high.

Subitem (6). It is necessary and reasonable to include wound or decubiti care 3 times a day in the list of special treatments because such care can be medically complex and was recommended for inclusion by the researchers.

Subitem (7). It is reasonable to include oxygen and respiratory therapy 3 times a day in the list of special treatment since this was recommended by the contractors based on the research. Oxygen and respiratory care were part of the special treatment items in the research linked to high resource use.

Subitem (8). It is necessary to include physician-prescribed staff observation and intervention 3 times a day because the providers on the assessment subcommittee recommended this category. The subcommittee indicated that special situations exist, outside of the areas listed in the research, where a client receives a high level of care consisting of observation and intervention as ordered by the physician. The inclusion of this item is reasonable because it captures special treatments which clients are receiving which did not fit in the category of client monitoring and are not covered in the research.

It is necessary and reasonable to reference Attachment I of the manual to avoid duplication and unnecessary length in the rule. The manual is the instructional text which outlines procedures for completing assessments. The incorporation of the manual ensures uniformity and consistency in assessments completed throughout the state by case managers and QAR teams.

It is necessary to refer to Step 4 because the scoring for special treatments differs from the other areas. This method of scoring is reasonable because it was found that special treatments were a high predictor of resource use. However, the sample of people receiving special treatments was so small (approximately 38 persons) that it wasn't possible to subdivide this group based on their service needs in the activities of daily living or in the challenging behavior area. Persons receiving special treatments are still assessed according to their service needs in the PIII area because the department wishes to provide an incentive for intensive programming in this area.

Subp. 2 Client reimbursement classification. This subpart establishes 14 different client reimbursement classifications based on the assessed service needs of clients. It is necessary to establish different classifications based on the level of care and the cost of service provided to clients so that each facility's payment rate may reflect the service needs of different clients and the relative cost of serving clients with heavy service needs. The department has used the term client reimbursement classification to describe the different service levels provided to clients because this is the term used in Minnesota Statutes, section 144.0723.

Since there are approximately 5000 ICF/MR clients in the State, it is not administratively feasible to establish a different individual payment classification for all clients. Therefore, it is reasonable to establish uniform payment classifications for clients with similar service needs and costs.

Items A - N. It is necessary to assign a client reimbursement classification to each client to reflect the level of services needed and received, as determined by the assessed service needs recorded on the assessment form.

The research conducted by Lewin and Assoc. confirmed that specific client characteristics falling into four domains (ie., ADL's, challenging behaviors, PIII, and special treatments) substantially contribute to the variance in the need for staff time. It is, therefore, reasonable to use a classification system built on these 4 domains. The researchers' goal was to

develop a classification system that made sense to those who would use it and that was statistically plausible in that it explained a reasonable degree of the variance in costed time.

Based on guidance from the experts (Advisory Committee and researchers) and statistical analysis, the final classification system was developed. Attachment 11 shows how the classification system works by grouping service needs first by level of ADLs, then by whether clients are receiving a low or high challenging behavior program, and finally by whether they are receiving standard or intensive PIII. The weight for each service need level is also indicated on attachment 11. Clients are assigned to "low", "medium", or "high" ADL categories based on their assessed service needs in ADLs. Clients with low ADL service needs are assigned a service need level of 1 or 2; medium ADLs are assigned service need level 3 or 4; and high ADL service needs are assigned service need level 5 or 6. The next step in determining the client reimbursement classification is to review the service needs of clients in the challenging behavior area. Clients with low challenging behavior needs are assigned service need levels 1, 3, or 5, depending on their ADL service need level. Clients with high challenging behavior needs are assigned service need levels 2, 4, or 6 again depending on their ADL service need level. After that each of the service need levels (1 to 6) is subdivided into two groups depending on whether the client is receiving standard or intensive PIII services. This gives twelve different service need levels based on the client's needs in the ADL, challenging behavior and PIII areas. A seventh service need level is created for clients receiving medically complex services. This is also subdivided on the basis of standard and intensive PIII services. Thus, the new system has 14 service need levels which are called "client reimbursement classifications".

Since the research showed a strong association between staff time/resources and ADL's, it is reasonable to use ADL's as the first consideration in assigning the client reimbursement classifications. The next most highly predictive measure of resource use is the challenging behavior domain. The Lewin research showed that clients receiving more behavior intervention are more costly to care for. Therefore it is reasonable to use challenging behavior as the next consideration in assigning the client reimbursement classification. The PIII area of the assessment was not demonstrated to be closely related to resource use but was included as an incentive for positive programs in these areas. It is therefore reasonable to assign a different service need level for clients receiving intensive PIII services. A standard program in PIII has a designation of "S" after the client reimbursement classification level; assessments with intensive PIII programming will have an "I" following the client reimbursement classification level. It is also reasonable to assign service need levels to clients receiving medically complex services because research showed that clients requiring special treatments are more costly to care for.

Research showed that the least resource intensive client is the client without special treatments, low in ADL's needs, low in interventions for challenging behavior, and receiving a standard program in PIII. It is reasonable, therefore, to designate this client reimbursement classification level as "1-S". A client similar in all respects, but receiving intensive PIII is assigned a client reimbursement classification level of "1-I". This is reasonable because the department wants to provide an incentive for positive programming for all clients.

Clients needing an intensive program for challenging behavior are more costly to care for than clients not receiving challenging behavior programs. Therefore, it is reasonable to assign assessments without special treatments, low in ADL dependency, receiving high challenging behavior programming and standard PIII to the next service need level, "2-S". Service needs similar in all respects, but receiving intensive PIII is assigned a client reimbursement classification of "2-I". This is reasonable for the reasons stated above.

Medium levels of dependency in ADLs are assigned a client reimbursement classification of either "3" or "4". In addition to medium ADL needs, if the client receives low challenging behavior and standard PIII programs, the client reimbursement classification is "3-S"; if the client receives low behavior program but intensive PIII, the client reimbursement classification is "3-I". Similarly, clients with are medium ADL service needs, high challenging behavior programs are assigned to client reimbursement classification "4S or "4I", depending on whether they receive standard or intensive PIII services.

Of the three levels of ADL services (low, medium, high), clients with high ADL needs are the most costly to care for. All clients with high levels of ADL dependency are assigned client reimbursement classification of either "5" or "6". If the client receives low challenging behavior and standard PIII services, the client reimbursement classification is "5-S" ; if the client has service needs for low challenging behavior but intensive PIII services, the client reimbursement classification is "5-I". Similarly, clients receiving high ADL services and high challenging behavior services are assigned to the "6S" or"6I" client reimbursement classification depending on whether they are receiving standard or intensive PIII services.

Client receiving special treatments are assigned a client reimbursement classification of "7". As in all of the other classifications, clients receiving standard PIII services are assigned a "7-S", and those receiving an intensive level of PIII programming are assigned a "7-I".

It is reasonable to use the model in Attachment 11 because it meets both tests of making sense to those who will use it and explains a reasonable degree of variance in resource use. For example, a client who needs and receives high ADL, low challenging behavior and standard PIII services (5S) is less resource intensive than the client who receives high ADLs, low challenging behavior, and intensive PIII services (5I). This client reimbursement classification system enables the department to differentiate between the service needs of different clients and to target resources where the need is the greatest. This system is also reasonable because it incorporates 4 domains that research indicated were predictive of variances in need for staff time.

Subpart 3. Classification weights. This provision assigns different weights to each reimbursement classification. The weights are based on the resource use level of clients requiring the level of services in that classification. The person who needs the least services (and whose care is the least expensive) is one who is independent in ADLs, does not present significant challenging behavior and is not receiving intensive programming in the areas of personal interaction, independence, and integration. The weight assigned to this level of service need is 1.00. On the other extreme are assessed service needs high in ADLs, high in the challenging behavior and intensive in PIII serivces. This level is assigned the maximum weight, i.e., 2.52.

It is necessary to assign weights because these weights differentiate between client service needs and help to target resources to clients with different service needs. They serve as a point of comparison between the less expensive and the more expensive service needs. Since these weights are used to calculate the service units and therefore the payment rates, it is necessary to inform providers of the weights assigned to each reimbursement classification. It is reasonable to use the numbers specified in items A - N as weights because each number was arrived at by comparing the relative resource use scores for clients with different service needs.

Attachment 8 demonstrates how the researchers arrived at the weights in attachment 11. The model in attachment 8 shows 13 classification levels. Level number 1 corresponds to the medically complex domain. Levels 2 - 5 are the various levels of "low" ADL's, 6 - 9 are "medium" ADL's, and 10 -13 are "high" ADL's.

The weights in attachment 11 are relative values derived from the mean time-costed scores calculated in attachment 8. Level number 2 of attachment 8 corresponds to the mean time-costed score for client reimbursement classification 1S, a client with service needs of "low" ADL needs, a "low" challenging behavior program, and "standard" programs in the PIII domain. Because level number 2 has the lowest time-costed score (i.e., 26.7967540), it is assigned a service unit weight of "1.00". This is the weight of the least expensive client and is used as a point of comparison to arrive at the weights for other levels of service needs. Level number 3 of attachment 8 corresponds to the mean time-costed score for client reimbursement classification 1I, a client with "low" ADL needs, a "low" challenging behavior program, and an "intensive" program in the PIII domain. The mean time-costed score of level 3 (i.e., 27.9716785) is divided by the lowest score (level number 2) to establish the relative difference. Therefore, the service unit weight for level number 3 is 1.04, (27.9716785/26.7967540=1.04). Each of the remaining mean time-costed scores are similarly divided by the value of level 2 to arrive at a service unit weight.

In the statistical research as indicated in attachment 8, level 10 (mean = 56.14) and level 11 (mean = 47.74) have mean scores that are the reverse of what is expected (i.e., level 11 should be higher than level 10 but is lower instead). The researchers examined the cases in levels 10 to 12. Level 12 contained one clear case of an outlier, the removal of which resulted in a relative weight of 2.26 for level 12. Levels 10 and 11 had no obvious outliers. It was necessary to decide whether to leave the actual statistical weight of level 11 (1.78) as found, thus creating a conceptual anomaly, or whether to adjust the statistic to provide greater conceptual clarity. The decision was made to adjust the statistic, giving levels 11 and 12 the same weight (i.e., 2.26) because it would be easier for people who use the system to understand.

Early research showed that although there were few clients receiving special treatments, those clients were very costly to care for. Since all other service levels were subdivided by whether the client was receiving standard or intensive PIII services, it was decided to subdivide the special treatments service need level in the same way. The mean time costed score for level 7S was 56.15. Researchers decided to add 13 percent to level 7-S to set the weight for level 7-I. This decision is reasonable because 13

percent is the average distance between the PIII categories for levels 5 and 6 (unadjusted). The method for setting weights is reasonable because it is based on extensive statistical analysis and reflects variation in resource use among clients with different service needs.

PART 9553.0057. CLIENT ASSESSMENT.

The assessment system is necessary and reasonable because it differentiates between clients with different service needs and it helps target resources to clients based on the service intervention needs of clients. It also ensures that the payment system is fair to both clients and providers.

Subpart 1. Assessment of clients. It is necessary for QAR to assess each client residing in an ICF/MR to determine the service needs and the relative cost of services for clients. Client service needs are grouped and then assigned client reimbursement classifications and corresponding weights so that the assessment is linked to reimbursement. Facilities are reimbursed for the individual service needs of each client at a payment rate established for each of the client reimbursement classification levels. QAR teams conducting Inspection of Care are required by federal regulations (42 C.F.R. 456.611) to complete a report that includes specific findings about individuals residing in the facility. Since assessments are part of the annual Inspection of Care and QAR has been assessing ICF/MR clients for the past 13 years, it is reasonable for QAR to continue to conduct assessments under this rule. It is also reasonable for QAR to assess clients service needs in ICFs/MR because this is consistent with the requirements of Minnesota Statutes, section 256B.501, subdivision 3g. The QAR program is under the direct authority of the Commissioner of Health. Therefore, Minnesota Department of Health (MDH) rules govern the procedures to be followed by QAR while conducting assessments. It is reasonable to refer to procedures specified in parts 4656.0250 to 4656.0330 because this ensures consistency between the rules and uniformity of procedures followed throughout the state.

It is necessary to state that QAR will assess the service needs of all clients annually, so the client, case manager and provider will know who QAR will assess and how often. It is reasonable that QAR do annual assessments because this is consistent with the federally mandated Inspection of Care requirement. This is also reasonable because biannual or quarterly assessments will unduly burden QAR and the providers. Subpart 4 provides for optional assessments if a client's condition changes after the QAR annual assessment.

It is necessary to inform clients, case managers, and providers of the situations when the case manager will assess client service needs. It is reasonable to refer to subparts 3, 4, and 5 to avoid duplication and unnecessary length in the rule. The need and reasonableness of the case manager's assessments is explained in the SNR for those subparts.

Subp. 2. Change in classification due to annual assessment by QAR. QAR conducts annual assessments ~~of~~ the service needs of all clients in a facility. If the service needs of the client have changed in the past year, the QAR annual assessment will reflect these changes and a new client reimbursement classification may be assigned. It is necessary to change the

client reimbursement classification because this classification affects the payment rate of the client and the revenue of the facility. It is also necessary to inform providers of the effective date of the change to avoid uncertainty about any changes in revenue.

Item A states that the new reimbursement classification (and therefore the new payment rate) will be effective from the first of the month following the assessment. It is necessary to specify the effective dates in order to have a uniform point at which to calculate rates for billing purposes. It is reasonable to make the change prospective (i.e., after the assessment) because QAR cannot know exactly when the client's condition changed. It is also reasonable to use the first day of the month because facilities are paid by the Department based on a calendar month.

If the annual assessment determines that the client's condition has improved so that fewer services are needed and received, the client is assigned a lower reimbursement classification. A lower client reimbursement classification means that the client needs less resources than before, and consequently, the payment rate for the client is reduced. Item B states that if the client is assigned a lower client reimbursement classification because the clients service needs in the ADL, challenging behavior, or special treatment area have been reduced, then the decrease will be effective 2 months after the assessment.

This subpart is necessary because the Department wishes to provide an incentive for facilities if their clients' condition improves due to active treatment programs provided in the facility. The 60 day delay in decrease of rates is reasonable because it gives the facility enough time to redirect resources to other clients and avoids a sudden decrease in revenues.

Subpart 3. Assessment of clients admitted to facilities. Under the proposed client centered reimbursement system, facilities cannot be reimbursed unless the client has been assigned a client reimbursement classification. It is necessary to assess the service needs of all newly admitted clients because payment rates are based on client assessments. It is also necessary to inform case managers and providers that all clients admitted to a facility will be assessed by the case manager. This is reasonable because QAR only assesses the service needs of clients who are residing in the facility when QAR conducts its annual assessments. It is not administratively feasible for QAR to go out and assess every client who is admitted to the facility between the periods of the annual assessments. At the same time, the case manager is required by other rules (Minnesota Rule, parts 9525.0015 - 9525.0165) to screen clients before they are admitted to the ICF/MR. Since the case manager is already familiar with the service needs of the new client, it is reasonable to have the case manager complete the assessment. This is also reasonable because historical data has shown that there are approximately 250 new admissions to all ICFs/MR in the state in one year. Therefore, this requirement does not create a heavy load for the case manager.

Item A. This provision is necessary so that case managers and providers know the time limit within which the assessment must be completed. Minnesota rules, part 9525.0105, subp. 2, requires the case manager to convene the interdisciplinary team meeting (IDT) within 30 days of a client's admission to determine the service needs of the client. Since the case manager is required to be present at the IDT meeting and to review the client's

documents and assess the client's needs at this time, it is reasonable to require the case manager to complete the reimbursement assesment under part 9553.0057 at the same time The case manager also has an additional 5 days after the IDT meeting in which to complete the assessment. This is reasonable because it gives the case manager some extra time to complete assessments and also ensures that the case manager still remembers the client service needs from the review at the meeting.

Item B. It is necessary to base the case manager's assessment on the Minnesota Department of Health's QAR procedures so that assessment procedures are uniform throughout the state and so that client reimbursement classifications can be assigned consistently and fairly for all clients. It is reasonable to use the procedures specified by the Department of Health because these procedures were developed as a result of extensive research and analysis by the Department of Human Services's consultants and the advisory committee who put together an instrument which would be a valid and accurate predictor of resource use. For details on the reasonableness of the assessment procedures, see the SNR for parts 4656.0250 to 4656.330.

Item C. It is necessary to inform QAR, providers, and case managers of who has the responsibility to send the completed assessment forms to the Minnesota Department of Health (MDH) and to indicate the time frame within which the assessment forms must be sent. It is necessary to send the assessment forms to MDH because this enables MDH to: verify that the assessment form was completed by the case manager according to the QAR procedures; process the assessment form; and assign the client reimbursement classification. It is reasonable to require the case manager to send the assessment form to Department of Health because the case manager completes the assessment form and has a copy of the same. Furthermore, it is reasonable for the case manager to send a copy of the assessment to the ICF/MR so that the ICF/MR knows of the assessment and can decide on the ICF/MR it wants. It is also reasonable to require that the original and the copy be sent within 5 working days so that MDH and ICFs/MR can receive the assessment in a timely manner. Both clients and ICFs/MR are anxious to have a client reimbursement classification assigned as soon as possible because this affects their reimbursement. Five working days should provide adequate time for the case manager to mail the assessments to the interested parties.

Item D. It is necessary to inform providers of the date on which the client reimbursement classification will be effective for clients admitted to the facility. This provision is reasonable because the date of admission is the first date when the facility provides services to the client and experiences an increase in costs.

Item E. It is necessary to inform case managers and providers that the service needs of clients admitted for temporary care services will not be assessed by the case manager. Since case managers have to review clients documents and visit the facility to assess client service needs, it is administratively burdensome for them to assess clients residing in the facility for less than thirty days. This provision is reasonable because it reduces the administrative complexity of the assessment process. Since reimbursement is based on assessments, it is necessary to specify the payment rate for a client who has not been assigned a client reimbursement classification. It is reasonable to refer to the rule part for calculating

payment rates because this prevents unnecessary duplication of language. The reasonableness of the payment rate is explained in the SNR for part 9553.0070, subpart 3.

QAR assesses the service needs of all clients who are residing in the facility at the time of the QAR assessment. Therefore, if a temporary care client is at the facility, QAR will complete an assessment of the service needs of the temporary care client in the same way as for all other clients. It is necessary to specify that the Department of Health will not assign a client reimbursement classification based on QAR's assessment of the service needs of the temporary care client. The client reimbursement classification for temporary care clients will be the one which corresponds to the payment rate specified in part 9553.0070, subpart 3. This is reasonable because it establishes a uniform method of assigning client reimbursement classifications for all temporary care clients regardless of whether they are in the facility at the time of the QAR assessment.

Subp. 4. Assessment by case manager when client status changes. This provision gives the facility the option to request the case manager to reassess a client's service needs if the provider believes that the client's service needs have changed. The case manager also has the option to reassess the client's service needs if the case manager believes that the client's condition has changed.

It is necessary to inform facilities and case managers that they have this option for one additional assessment between the QAR annual assessments. This provision is reasonable because the client's needs may change after the QAR annual assessment and the facility may then have to provide additional services not incorporated under the current client reimbursement classification assigned to the client. It may not always be feasible for the facility to wait until the next annual assessment to obtain a change in payment rates.

It is reasonable to give the provider discretion in requesting a reassessment because the provider works with the client and knows whether the change is substantial enough to ask for a reassessment. It is also reasonable to give the case manager authority to reassess a client because the case manager stays in contact with the client and is aware of the client's needs.

Item A specifies that if the provider believes there is a substantial change in the client's condition, then the provider must give the case manager enough evidence to support that there will be a change in the client reimbursement classification of the client. Since a change in the client reimbursement classification will change the provider's payment rate, it is reasonable that the provider should have the burden of proving that the facility needs a higher payment rate. It is also not administratively feasible to have a reassessment every time there is a slight change in the client's condition. Therefore, the case manager can decline to reassess a client if the case manager believes that there is not enough evidence to prove that the client reimbursement classification will change. This is reasonable because it reduces the possibility of frivolous reassessments and prevents an undue burden on the case management system.

Item B is necessary to inform case managers and providers how often case managers can complete assessments under this subpart and the time frame within which case manager assessments must be conducted. It is reasonable to provide for case manager assessments between the third and the ninth month following the QAR annual assessment because this prevents unnecessary duplication and possible overlapping of assessments. It is not feasible to have the case manager assess the client more than once per year because additional assessments would unduly burden the case management system. Therefore, this item is reasonable.

Item C is necessary and reasonable for the reasons stated in the SNR for subpart 2. It is also necessary and reasonable for the ICF/MR to send additional documentation to the Department of Health because the Department of Health has to ensure that the assessment form has been completed accurately and that the new classification reflects the condition of the client and the services provided by the facility.

Subp. 5. Change in client reimbursement classification due to audits of assessments of clients. This subpart is necessary to inform clients and providers of the procedure to be followed when a change in client reimbursement classification is made due to an audit required under parts 4656.0250 to 4656.0330. QAR periodically audits a sample of assessments completed by the case manager. It is necessary to refer to the rule parts governing audit procedures to avoid duplication of language and to ensure consistency between related rules. A change in the client reimbursement classification due to an audit means that the earlier client reimbursement classification is not supported by available evidence and documentation. It is necessary to make the new client reimbursement classification effective retroactively because this acts as a deterrent against careless documentation. This is reasonable because the department has to correct any overpayment or underpayment which may have occured due to an erroneous classification. It is reasonable to refer to Department of Health rules because the Department of Health audits assessments pursuant to it's authority under Minnesota Statutes, section 144.0723.

Subp. 6. Reconsideration of client reimbursement classification. This subpart is necessary to clarify that requests for reconsiderations must be made under parts 4656.0250 to 4656.0330. This is reasonable because Minnesota Statutes, section 144.0723 require the Department of Health to establish procedures governing reconsiderations and assessments. It is also reasonable to refer to MDH rules because this prevents unnecessary duplication of language and possible inconsistencies between two related rules. The need and reasonableness for the reconsideration provisions are stated in the SNR for parts 4656.0250 to 4656.0330.

Subp. 7. Change in client reimbursement classification due to a request for reconsideration of client reimbursement classification. This subpart informs clients, facilities and case managers of the effective dates for a change of client reimbursement classification due to a request for reconsideration.

Item A. This item provides that the client reimbursement classification established by the Department must be the reimbursement classification that applies pending the reconsideration decision. This is necessary so that the facility knows what client reimbursement classification level it will be reimbursed for while the reconsideration request is pending. The facility

needs this information for the purpose of planning the number of staff, special service needs of clients, and making general business decisions. It is reasonable to use the existing client reimbursement classification while the request is pending because assignment of a different client reimbursement classification without review by Department of Health review would be arbitrary and could give the providers an incentive for requesting reconsiderations even if they were not necessary

Item B. This provision states the effective date for changes in client reimbursement classification due to reconsideration. It is necessary to inform providers when they will receive payment for any change in client reimbursement classification due to a reconsideration. The provider or the client submit requests for reconsideration because they believe they have been providing or receiving a different level of services from what is indicated on the assessment form. Consequently, they believe that their costs have been different from the payment rates corresponding to the assigned client reimbursement classification. It is reasonable to make any change in client reimbursement classification retroactive to the date of the original assessment because the providers and the client should be paid for the costs they incur by them while providing or receiving a different level of service. It is also reasonable to use the effective date of the original assessment as the effective date for the reconsideration because the reconsideration is based on evidence of the client's needs at the time of the original assessment.

Subp. 8. Client access to assessments and documentation. This subpart is necessary to clarify the rights of the clients and responsibilities of the facilities. Since the assessment impacts the services received by the client, the client or the client's representative has a right to know what information is provided to the Department of Health in support of the assessment. This requirement is reasonable because it is consistent with the requirements in Minnesota Statutes, section 144.651, which governs the rights of clients in facilities. It is reasonable because the client must have access to all information in order to make an informed decision about whether or not to apply for reconsideration.

Item A. This item is necessary to inform providers that they are responsible for responding to client requests for rate information. It is reasonable to require the facility to provide this information because the facility has knowledge of current rates. Five days is a reasonable amount of time for providers to respond to a request because the rate information is readily available to providers and the 5 day time frame prevents unnecessary delay in the process.

Item B. It is necessary to inform providers that they are responsible for notifying private pay clients, in writing, about the payment rates established by the commissioner. This is reasonable because it enables the private pay client to make a decision about whether to continue to purchase services from the facility. It is not necessary to provide this information to Medical Assistance clients because these clients are not responsible for total payment for services and the amount they are required to pay is not affected by the payment rates established by the commissioner (only the state's costs change).

Item C. This item specifies that the client or the person responsible for payment must be provided with the notice of the client reimbursement classification received by the facility from the Department of Health. This is necessary so that affected parties are aware of the client reimbursement classifications and the corresponding payment rates. Since the department mails all classification notices to the facility it has no way of knowing whether or not the client actually receives the letter. To address this problem, this provision requires the facility to send the notices to the client or the person responsible for the client's payment, within 3 working days of receipt. This time frame is reasonable because it gives the clients or the client's representative sufficient time to review the material and evaluate the appropriateness of a request for reconsideration. Since providers simply distribute the notices to the clients by hand, three days is sufficient time for the facility to notify the client. This provision is also reasonable because it is consistent with Minnesota Statutes, section 144.0722, subdivision 2.

It is necessary to include the current rate for the new client reimbursement classification if the client reimbursement classification has changed so that the client or the person responsible for payment is aware of the financial impact of the change in client reimbursement classification. It is reasonable to include this information to aid the client or the person responsible for payment in making informed decisions about the client's continued stay in the facility.

Item D. This item is necessary to ensure that the client or the client's representative has the information necessary to determine if the client reimbursement classification assigned to the client should be reconsidered. Since assessments reflect the service need level of the client, it is reasonable to give the client information about how or why the client was assigned a particular service need level (client reimbursement classification). It is only by reviewing this information that the client can determine if the client reimbursement classification was appropriate.

It is necessary to indicate the time period by which the facility must provide the requested information to avoid delays in the client or the client's representative receiving the requested information. The request for reconsideration has to be submitted within twenty days of the assignment of the client reimbursement classification. The three day time frame is reasonable because it gives the client or the client's representative enough time to review the documents and to consider requesting a reconsideration. The time frame is also reasonable because it is consistent with Minnesota Statutes, section 144.0722, subd.2.

PART 9553.0061. LIFE SAFETY CODE ADJUSTMENT.

This part was developed and promulgated by the Department to enable it to respond to new federal life safety code requirements adopted by the federal government in 1985.

Subpart 1. Determination of Adjustment.

Title 42 C.F.R. section 442.508 related to life safety code requirements of ICFs/MR physical plants. The amendment is necessary and reasonable because the life safety code requirements are now specified in Title 42 C.F.R., section 483.470 instead. The change in citation is simply a technical

change. The proposed amendment also deletes the phrase "as amended through October 1, 1986." This is necessary to clarify that rate adjustments can be permitted for subsequent changes to this section of the Code of Federal Regulations by the federal government. Adjustments will not be restricted to amendments made through October 1986 only. The amendment is reasonable because it is consistent with the purpose of this part that providers will receive adjustments if their historical rates are not enough to meet the federal requirements.

Subparts 2 (Conditions), 3 (Request for Life Safety Code Adjustment), and 5 (Evaluation of documents submitted). It is necessary and reasonable to change the C.F.R. citations and to delete the phrase "as amended through October 1, 1986" for the reasons stated in the SNR for subpart 1. The addition of the words "or the commissioner of health" in subparts 2, 3 and 5 is necessary and reasonable to recognize the fact that both agencies can require facilities to take action to comply with this life safety code requirement. This amendment is merely a clarification of existing procedures; it is not a substantive change.

PART 9553.0070. DETERMINATION OF TOTAL PAYMENT RATE.

Subpart 3. Respite Care Payment Rate. The definitional change of respite care to temporary care makes it necessary to delete the present subpart 3 and to refer to rules appropriate for temporary care clients instead. It is reasonable to delete the present subpart 3 as respite care is no longer reimbursable under the Medical Assistance (MA) program.

The proposed amendment to subpart 3 is necessary because MA clients who are admitted for short stays and who receive services according to their program plans, goals and objectives should continue to be eligible for MA reimbursement. These clients are called temporary care clients. However, because temporary care clients are admitted to the facility for less than 30 days, it is not administratively feasible to conduct assessments for such clients. Since temporary clients are not assessed, their "true" client reimbursement classification level is unknown, and it is therefore reasonable to establish the payment rate for such clients at, or near, the facility's average payment. The payment rate for such temporary MA clients will be essentially the payment rate which approximates the facility's average payment rate.

It is reasonable to calculate the average payment rate by computing the "average service unit score" and taking the rate just above the average, because the average service unit score represents the point at which the facility's client needs and resources are equalized. By picking the weight which is above the average weight of the facility, the benefit of the doubt will be in the provider's favor. This method of selecting a payment rate from an established scale of rates is also reasonable because it makes implementation easier for the department and it is less confusing for clients, providers and counties.

Subpart 4. Adjustment to Total Payment Rate for Phase In of Common Reporting Year. It is necessary and reasonable to delete the present subpart 4 because it deals with the phase in of payment rates for the rate year 1985. This provision was in effect until Sepatember 1986 and was used to adjust payment rates when the present rate system was adopted in 1985. This provision is no longer required for payment rates starting October 1, 1990.

The proposed amendment to subpart 4 is necessary to establish the payment rate at which the provider may bill for services to a newly admitted client. Since clients are assessed between thirty and thirty-five days of their admission the provider may not know their classification level and the corresponding payment rate for the first month. This provision states that the provider may bill at the 6I payment rate for the first month and that the rate will be adjusted after the client's classification is established. The provision is reasonable because it permits the provider to bill at the highest payment rate established by the commissioner. The provider will never get less than the client's actual payment rate; in almost all cases the initial payment will be more than the client's actual payment rate. It is reasonable to subject the payment to a retroactive adjustment because the state is required to have a cost based reimbursement system and cannot pay the provider more than the actual costs. This provision does not apply to temporary clients as payment rates for such clients are established in subpart 3 above. The reasonableness of subpart 3 is also stated above.

PART 9553.0075. RATE SETTING PROCEDURES FOR NEWLY CONSTRUCTED OR NEWLY ESTABLISHED FACILITIES OR APPROVED CLASS A TO CLASS B CONVERSIONS.

Subpart 1. Interim Payment Rate. The provisions of this part do not apply to providers who are modifying or changing their programs, or transferring the program to a new service site. This subpart establishes rates for new facilities, or those converting more than 50 percent of their licensed beds from Class A to Class B. It is necessary to amend these provisions to make them consistent with the proposed client-based reimbursement system.

The addition of the sentence related to the program operating costs is essential to be clear as to how the interim program rate will be developed when the client-based reimbursement provision is not used. It is reasonable because this is the method used for developing rates at present and this method met the test of reasonableness of the earlier rule hearing.

The amendment to subpart 1 also excludes facilities governed by these interim rate setting provisions from the client-based reimbursement provisions in parts 9553.0052 to 9553.0058. The result is that the program costs for such facilities will be established as at present, i.e., there will be one interim program for all clients instead of separate rates for each client. This is reasonable because if the facilities are new or are converting beds, their rates are based on estimated number of clients and budgeted costs instead of actual historical numbers. Since the proposed system is based on the information in last years cost report, it is not possible to assign client reimbursement classifications or corresponding rates for such facilities under the new system.

Subpart 2. Interim Payment Rate Settle Up. It is necessary and reasonable to delete subpart 2, item A, because it applies only to interim rate settle-ups that were established on or before December 31, 1986. This provision was used to accommodate providers whose interim rates were established under rules before 1985, and is no longer necessary.

The deletion in old item B (new item A) is necessary because according to the present rule, all interim payment rates must now be subject to these settle-up provisions. The amendment is reasonable because it only makes a technical change to this provision.

Subitem (1) is necessary to establish that the settle-up payment rates for program operating costs will now be computed under the client-based reimbursement provisions of the rule. This is reasonable since all the cost and client data will be based on the actual information supplied by the provider in their settle-up cost report. The reasonableness of the program operating cost settle-up payment rates is stated in the SNR for part 9553.0054.

The change in subitem (4) is necessary because the settle-up payment rate for program operating costs will be determined according to the proposed client based reimbursement system explained in part 9553.0054. This is reasonable for the reasons stated in the SNR for that part.

The amendment to subitem (6) is necessary to modify the settle-up payment rate limitation of 5 percent annually. The result of the application of the provision as proposed is that if the facility exceeds the limitation, the excess amount expressed as a per diem will be subtracted from its total payment rates. This is reasonable because it requires the provider to budget fairly and accurately, and to spend within the interim payment rate established initially by the Department. The five percent limitation provides for a limited margin of error within which the provider may manage the facility's expenditures and occupancy.

Subpart 3. Total Payment Rate for Nine-Month Period Following Settle-Up Period. The change to item A, subitem (1), is necessary and reasonable for the same reasons given for subpart 2, item A, subitem (1) above.

Old subitem 4 was deleted in order to insert and use the new inflation factor proposed by the Legislature in Minnesota Statutes section 256B.501, subdivision 3c.

The new subitem (4) is necessary to be able to use the new inflation factors for payment rates for the 9 month period following the settle-up reporting year. This is reasonable as these will be the inflation factors that will be used in future rate years.

Subpart 5. Allowable Historical Maintenance Operating Costs. It is necessary to add Subpart 5 to address the computation of the maintenance operating cost category limitation for newly constructed facilities, or for facilities converting more than 50 percent of their licensed beds from Class A to Class B beds. The limit is necessary for the determination of future efficiency incentive computation because in order to determine whether a facility is efficient, it must have this limit with which to compare its costs.

The maintenance cost limitation is established for these facilities in the same way that it was established for existing facilities. The only difference is that since these facilities did not have rates established from the base period used for existing facilities, a different base period must be used for such facilities. Facilities converting more than 50 percent of their licensed beds from Class A to Class B beds are treated like new facilities under the interim/settle-up rate provisions. They are permitted to budget for expected expenses necessary to meet the needs of new clients moving to Class B beds, as well as additional expenses necessary to upgrade

the physical plant. Therefore, it is necessary to give them the same benefits as new facilities (ie., a maintenance limit based on the new cost structure).

The period for which the maintenance limit will be first applied is for maintenance costs incurred during the reporting year following the interim/settle-up reporting period. The limit is 125 percent of the maintenance operating cost payment rate in effect during that reporting year. This limit is a facility specific limitation and in future reporting years is to be indexed in the same manner as other existing facilities. These limitations are reasonable because the method used for establishing the limits is the same as that used for other providers. The 25 percent threshhold affords the provider some flexibility, and through the computation of the efficiency incentive, the provider may be rewarded for operating efficiently under this limit and the administrative limit in part 9553.0050, subpart 1, item A, subitem (3).

PART 9553.0079. SEVERABLE PROVISIONS.

This part states if any of the rule provisions are invalidated by judicial review or by the federal government during the state plan approval process, the Department has the authority to compute future rates without considering the invalidated provisions. This provision is necessary to forestall invalidations of rule provisions or losses in federal financial participation which may occur if the federal government does not approve a portion of the state's state plan.

The federal government as the major financial contributor (approximately 53 percent) to ICF/MR services provided through the Medical Assistance program scrutinizes state plans carefully before allowing reimbursement. Since the state is potentially subject to significant financial liability for rule provisions not approved by HCFA, it is reasonable for the Department to protect itself from future financial liability. This provision is also reasonable because if the federal government or the judiciary makes decisions which are contrary to state rules, then those decisions will prevail.

Currently, Minnesota's state plan for the rate period January 1, 1988 to September 30, 1988, is the subject of close scrutiny by HCFA because of the inclusion of a program adjustment factor of 2.46 percent (See part 9553.0050, subpart 2, item A of present rule). While the provisions of this part are not retroactive, the Department is concerned about future potential disapprovals of portions of this rule through either judicial review or federal disallowances. Therefore, the Department proposes to include the severable provisions language. The effective date of October 1, 1990, is reasonable because it corresponds to the effective date for payment rates under the new reimbursement system.

SMALL BUSINESS CONSIDERATIONS

This rule is exempt from small business considerations in rulemaking under Minnesota Statutes, section 14.115, subdivision 7, paragraphs (b) and (c).

EXPERT WITNESSES

The following persons will testify on behalf of the Department of Human Services:

Dr. Barbara Manard, Lewin & Assoc., assisted by Eugene Tillman, Attorney, Pearson, Ball, and Dowd

John Ashbaugh and John Agosta, Human Services Research Institute

Dr. William Scanlon, Georgetown University School of Medicine

Dr. Rosemary Chapin, University of Kansas, School of Social Welfare

The above witnesses will testify on the research conducted to develop the client centered reimbursement system, including options considered, data analyzed and recommendations made to the Department. This will include testimony on the development of the client assessment instrument, management of the survey process, analysis of quality assurance issues, the role of the QAR assessment teams and the QAR assessment procedures.

Date 1/5/90

/s/ Ann Wynia
Commissioner