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MINNESOTA DEPARTMENT OF HEALTH

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE DEPARTMENT OF HEALTH CONCERNING FEES FOR THE REGISTRATION OF HOME CARE PROVIDERS, Minnesota Rules, chapter 4667.

STATEMENT OF NEED AND REASONABLENESS

BACKGROUND AND LEGAL AUTHORITY

Minnesota Statutes, sections 144A.43 to 144A.48, establishes a system of licensure for home care providers, including hospice programs, to be administered by the Department of Health. Section 144A.49 provides temporary procedures pending promulgation of licensing rules. Among those procedures is a requirement for the registration of providers, including a registration fee. To establish the one time fee, Minnesota Rules, chapter 4667, is proposed under the authority of M.S. sections 144A.49 and 144.122.

The Department has been registering providers pending adoption of this rule establishing fees. Each registrant has been informed that a fee will be assessed upon adoption of this fee rule.

RULEMAKING PROCESS

Notices

A Notice of Solicitation of Outside Information or Opinions Regarding Proposed Rules Governing the Licensure and Regulation of Home Care Providers and Hospice Programs was published in the State Register, 12 S.R. 2105, on March 21, 1988. A notice of Outside Information or Opinions Sought Regarding Proposed Rules Governing Fees was published in the State Register, 13 S.R. 2102, on February 27, 1989.

Small Business Considerations

PARTICIPATION IN RULEMAKING PROCESS

Minnesota Statutes, section 14.115, requires the Department to consider ways to reduce the impact of a proposed rule on small businesses, and to provide small businesses with an opportunity to participate in the rulemaking process.

Virtually all small businesses that are to be regulated under the home care and hospice licensing statute are registered with the Department, as required by Minnesota Statutes, section 144A.49. Those registrants, business and governmental trade associations, and other interested parties, have been informed of all major steps taken in the development of the rules, and have been provided the opportunity to attend and address Advisory Task Force meetings.

The Notice of Intent to Adopt a Rule Without a Public Hearing includes a statement describing the impact of the rules on small business and encourages comments from those affected.

CONSIDERATION OF EFFECT OF RULE ON SMALL BUSINESS

The Department is mandated by Minnesota Statutes, section 144A.49 and 144.122, to recover the cost of the program in fees. Therefore, the total assessed in fees is established by the actual cost incurred by the Department in establishing the registration and licensure rules and systems.

The Department considered how the registration fees could be distributed to minimize negative impacts on providers, within the strictures of the statute. It is reasonable to conclude that individual providers should be assessed a relatively small fee, both because of the potential that a burdensome fee would cause some individuals to cease doing business, and because current registrations show that individual paraprofessional providers generate relatively small revenues, averaging approximately $10,000 a year. In addition, it is possible that a high fee could become an incentive for small providers to evade registration, thereby defeating the purpose of the licensure law to establish minimum standards to protect the public from substandard services. Hospices generally generate low revenues that yield little or no net earnings. This is true even differentiating between Medicare certified hospices that generate Medicare, Medical Assistance, health insurance, and patient paid revenues, and non-certified "community" hospices that generate few revenues beyond charitable contributions.

RULE PARTS

General

FACTORS

Minnesota Statutes, section 144A.49, states that the registration fee must be based on a consideration of four factors: the number of clients served, the number of employees, the number of services offered, and annual revenues.

During the legislative process developing the licensure law, concerns were raised regarding the amount of the registration fee and the impact that a large fee would have on small providers. Minnesota Statutes, section 16A.128, subdivision 1a, requires that fees provide for the recovery of general fund expenditures. Small providers were concerned that, if funds allocated for the start up costs of the program were simply divided by the number of registrants, smaller agencies would pay the same fee as the larger home care agencies. The factors contained in the legislation were included as a method to more fairly allocate the costs among the various groups of providers.

An analysis of the information obtained through the registrations reveals that the four factors in the statute correlate very highly with each other. That is, as one factor changes, the others tend to change proportionately. Basing fees on one factor effectively bases them on all factors. (The correlations are discussed further under part 4667.0030, below).

The providers can be classified in five proposed licensure classes: Class A (professional agencies); Class B (paraprofessional agencies); Class C (individual paraprofessionals); Class D (hospice programs); and Class E (assisted living services); and three subclasses solely for purposes of computing fees. However, for fee purposes, classes B and E are grouped together in a single category, because of the similarity of their services. In fact, the proposed licensing rule, in its current form, treats class B and E providers nearly identically. These classes are discussed in detail, below.

A statistical analysis of the registration data shows that, to a reasonable statistical certainty, the classes are distinct in revenue levels and therefore are a reasonable grouping of providers. The analysis is discussed further in the discussion of part 4667.0030, below.

CRITERIA

The Department used the following additional criteria in developing a fee structure:

1. Total fees collected for registration should approximate the total costs of the program from the date of enactment of the statute, June 2, 1987, as directed by Minnesota

Statutes, section 144.122, paragraph (a); and, because fees are a method of financing regulation, they should be related to the cost of the regulation;

2. Fees must be based on reliable and comparable information from providers, so as to be fair to all providers and accurate in the assessments;

3. The fee structure should be as simple and understandable as possible; and

4. Fees should be reasonable, and not unduly burdensome to each type of provider, within statutory mandates.

It also is important to note that home care registration is a temporary procedure pending adoption of a licensing rule, which is nearing completion. This fee rule uses a classification system similar to the one that the Department anticipates using in the licensing rule. It is reasonable to use the same classification system for registration and licensure to be consistent, and thereby less confusing, to registrants and prospective licensees.

Specific Rule Parts

4667.0005 AUTHORITY. This part is necessary to inform parties affected by the rule of its function and authority.

4667.0010 DEFINITIONS.

Subpart 1. **Scope.** This part is necessary to specify to which parts the definitions apply.

Subp. 2. **Class A provider.** As required by M.S. 144A.45, subd. 1(f), and recommended by the Home Care Advisory Task Force in its Report of March 15, 1989, the forthcoming home care licensing rule, now in development, will divide providers into licensure classes. It is reasonable to use the same approach in classifying providers for purposes of setting registration fees, so as to simplify the transition from registration to licensure. The Department's experience with over 400 registrations, as well as information from staff research and the Advisory Task Force, reveals that providers can be categorized in functional classes. Class A consists of providers who offer at least one "professional" service (nursing, physical therapy, speech therapy, respiratory therapy, occupational therapy, nutritional services, or medical social services), consists of a somewhat homogenous type of provider, namely providers of those professional services specified in Minnesota Statutes, section 144A.43, subdivision 3, items (1) to (7), (9) and (10). It is reasonable to charge each provider in this class the same fee because of the similarity in services as compared to other provider classes. (See the statistical analysis for part 4667.0030, below).

Subp. 3. **Class A-individual provider.** Although individuals who provide professional services, including occupational therapy, speech therapy, respiratory therapy, and medical social work, may be licensed as class A providers, it is recognized that an individual provider is different from other providers, in that individuals generate less revenue, have fewer resources for the marketing of services, and provide limited services to individual clients. Therefore, it is reasonable to treat individual professionals separately from other class A providers. It is reasonable to charge this type of provider a reduced fee, because of the small size of the businesses.

Subp. 4. **Class B provider.** Under the structure of the anticipated licensure rule, Class B licensees will include home care providers that are not individuals and provide only personal care services, under Minnesota Statutes, section 144A.43, subd. 3, item (2), or home management services, under section 144A.43, subd. 3, item (8). This definition is reasonable because these providers tend to be similar in structure and often similar in size to many class A providers, but are limited to nonprofessional services, principally homemaking and chores, and some personal care. It is reasonable to establish the same fee for all members of this class B because of the similarity of the providers in terms of services and size.

Subp. 5. **Class C provider.** Under the structure of the anticipated licensure rule, Class C licensees will include individuals who provide only personal care services, under section 144A.43, subd. 3, item (2), or home management services, under section 144A.43, subd. 3, item (8). This definition is reasonable because these providers are all individuals who provide limited services to individual clients. The current registration information indicates that persons who fall under this class generate limited revenues, often working on a limited basis for few clients. It is reasonable to charge this type of provider a relatively small fee, because of the small size of the businesses.

Subp. 6. **Class D provider.** Under the structure of the anticipated licensure rule, Class D licensees will include hospice programs, under section 144A.43, subd. 3, item (11) and section 144A.48. Approximately 47 hospice programs currently operate in the state, and provide a similar set of services. It is reasonable to assess a uniform fee for all hospice programs because of the similarity of the providers in size and types of services.

Subp. 7. **Class E provider.** Under the structure of the anticipated licensure rule, Class E licensees will include assisted living services (comprised of personal care services, under Minnesota Statutes, section 144A.43, subd. 3, item (2), or home management services, under section 144A.43, subd. 3, item (8)), provided to residents of residential centers by or under the direction of the management of the residence. It is reasonable to assess a uniform fee for all assisted living

programs and Class B providers because of the similarity of the providers in type of services and the anticipated similarity in regulation.

Subp. 8. **Commissioner.** It is necessary to define "commissioner" to clarify that the Commissioner of the Department of Health, rather than another state department, is being identified.

Subp. 9. **Provider.** It is necessary to define "provider", because its usage in the rule is potentially ambiguous. It is reasonable to make it clear that "provider" means a home care provider required to register under Minnesota Statutes, section 144A.49, because that is how the term is used in the statute.

Subp. 10. **Registrant.** It is necessary to define "registrant", because the term is used in this rule in a precise manner, as meaning a home care provider who has registered with the Commissioner before the effective date of this chapter.

Subp. 11. **Register.** It is necessary to define "register", because it is used here as well as in the statute, but is not defined in the statute, and is potentially subject to different interpretations.

4667.0020 PROCEDURE FOR REGISTRATION FEE.

Subpart 1. **Billing of existing registrants.** It is necessary to establish a billing procedure to inform each current registrant of the amount of the fee. It is reasonable to require the Commissioner to simply bill each registrant to provide that notice, because such a procedure is straightforward, economical, and universally understood.

It should be noted that the Department required registrations of providers pending development and adoption of this fee rule so as not to delay the process of listing providers and in order to obtain the necessary data for developing the fee formula.

Subp. 2. **Payment of fee.** It is necessary to set a time limit within which each current registrant must pay the fee, so as not to allow unreasonable delays. It is reasonable to require payment within 30 days after the billing because 30 days is commonly used in commercial transactions as a payment period, and should be sufficient to allow for processing of fees by registrants.

Subp. 3. **New providers.** It is necessary to provide a procedure for payment of fees by those who register after adoption of this chapter. It is necessary and reasonable to require payment in full with the registration because Minnesota Statutes, section 144A.49 states that "a registration fee must be submitted with the application for registration".

Part 4667.0030 FEE SCHEDULE.

Structure

Under the mandate of Minnesota Statutes, sections 144.122 and 144A.49, it is necessary to establish a schedule of fees that is both reasonable and based on statutory factors.

Other Models

An obvious model for a fee structure is the existing nursing home and hospital rules. Those rules, Minnesota Rules, part 4735.0200, provide a flat base fee for each facility plus an additional fee per each licensed bed. It is clear that such a fee structure is inappropriate for a service license like home care, because home care providers are ever-changing, with constantly varying revenues, staffing, and clientele. In contrast, institutions have fixed capacities that provide a measurable and consistent basis for assessing fees. In addition, the facility fees are based on historical data that provide a method of calculating the time spent by the Department on licensing activities. At this point, there is no similar data for home care licensing activities.

Analysis of Provider Classes

Correlations of Factors

The Department analyzed the registrations of 445 providers that were registered as of November 20, 1989, and reached the following conclusions.

Three of the four statutory factors, annual revenues, number of clients served, and number of employees, all correlate highly with each other, meaning that one factor accurately predicts the others. As expected, revenues do not correlate highly with the fourth factor, number of services offered, since a provider can generate significant revenues with a few services that are provided in high volume or for relatively high price, while another provider might generate low revenues with a large number of services provided in low volumes and low prices.

Specifically:

a. revenue correlates with the number of clients to a factor of .6401;

b. revenue correlates with the number of employees to a factor of .7775;

c. revenue correlates with the number of services to a factor of .2146.

Nature of Data

Although adequate for comparing groups of providers, the revenue figures reported in the registrations are not, by themselves, a good basis for computing fees against individual providers, because:

a. they cover different time periods, and not a uniform reporting period;

b. new or recent providers have no or little revenue history;

c. the figures are self-reported and unaudited;

d. full revenues are not reported in cases of providers who receive in-kind resources (e.g., office space, telephone, secretarial support);

e. revenues reported by many governmental agencies are not entirely comparable to private providers, because of the allocation of tax funds;

f. revenues can vary substantially from time period to time period; and

g. it is extremely difficult to identify the revenues attributed to home care by providers that offer both regulated and non-regulated services (e.g., medical equipment vendors, that provide home care services as only a small part of their principal, non-home care business).

Comparison of Classes

It is statistically valid to group registrants into the four licensure classes.

However, for purposes of analyzing revenues, registrants were divided into six groups, three of which are subgroups of class A, and one is a combination of classes B and E. The three subgroups of class A were defined because of a functional difference in the types of providers, and a hypothesis that the three have distinct revenue levels. Specifically, the three subgroups of class A are: A-nursing (providers that offer nursing plus other services); A-therapies (those that offer various therapy services, but not nursing); and A-DME (vendors of durable medical equipment that provide home care services together with equipment). Classes B and E were combined because they provide virtually identical services, with the only difference being that class E providers only serve an "in house" clientele.

The revenues of the six groups and subgroups, as reported in the registrations, were compared using a statistical test known as the Kruskal and Wallis Test, designed to test whether defined groups of information are distinct to some statistical certainty. (See Appendix for a more detailed discussion of the test's methodology).

The results of the Kruskal and Wallis Test lead to the following conclusions:

1. There is a significant difference in revenues among the six groups of providers.
2. The groups rank, in descending order of revenues, as follows:
    - A. Class A-nursing {highest revenues}
    - B. Class A-DME
    - C. Class A-therapies
    - D. Class B/E (paraprofessional agencies; assisted living)
    - E. Class D (hospice)
    - F. Class C (individual paraprofessionals) {lowest revenues}

The top three rankings are the three subgroups of Class A, which compare fairly closely. However, certain anomalies in some information makes it difficult to interpret the revenue figures. In particular, medical equipment vendors (Class A-DME) reported total business revenues, only a fraction of which is attributable to home care services (the bulk being generated by sales and rental of equipment, a business activity not regulated under the home care law). The close ranking of the three subgroups and the DME anomaly make it reasonable to simply treat the entire Class A as a single group for fee purposes.

Based on this analysis, it is reasonable to base fees on a structure of provider classes, which reflect revenues, numbers of clientele, and staffing levels.

However, it is reasonable to treat one small class A group as a separate fee group. A few class A registrants are individuals who provide a single therapy service, and are not otherwise exempt from licensure. Such therapies include occupational therapy, speech therapy, respiratory therapy, and medical social services. (Individuals exempt from licensure include registered nurses and physical therapists, under Minnesota Statutes, section 144A.46, subd. 2, clauses (1) and (4)). Because such individuals provide limited services and generate comparatively small revenues, it is reasonable to assess individuals a smaller fee. The cost of enforcing licensing rules against such individuals also is likely to be less than against other providers, because individuals will likely not be routinely surveyed, but will be regulated through complaint investigation and spot checking.

Program Costs

The costs of the Department's home care program for the three fiscal years of 1988, 1989, and 1990 (dating from July 1, 1987 through June 30, 1990), were $305,329. (See Appendix 2 for budget information).

Allocation of Fees

The fees in part 4667.0030 were allocated across the five fee classes (including a combined fee class of B and E) in rank order of the classes' mean revenues. The fees were computed by determining the amounts that needed to be generated to recover the program costs, and establishing fees approximately equal to each class' proportionate revenues. Comparing mean revenues of each fee class with total mean revenues, the classes rank proportionately at follows:

Class	Mean revenue/total mean revenues
A	77.8%
A-individual	(no precise data)
B and E	14.3%
C	0.8%
D	7.0%
Total	99.9%

The fee amounts were determined by an iterative process of first multiplying the above percentages of each class by $305,000 and dividing by the estimated number of providers in the respective classes. The results were then adjusted to better equalize the fees and to accommodate a fee from class A-individuals.

Specifically, the fees will generate the following approximate revenues to the Department. Numbers of providers are approximate, because registrations continue to be received by the Department.

CLASS	NUMBER OF PROVIDERS	FEE	TOTAL REVENUE
A	250	$900	$225,000
A-individuals	25	150	3,750
B and E	95	650	61,750
C	72	15	1,080
D	60	250	15,000
TOTALS	503		$306,580

COST RECOVERY GOAL = $305,329

CONCLUSIONS

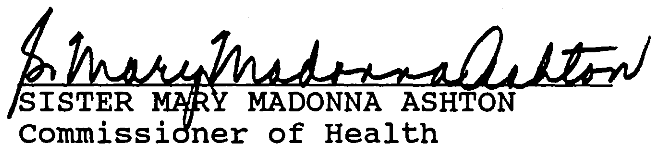
Based on the analysis described above, it is reasonable to assess fees based on each provider's classification under the four proposed license classes, with the exception of a fifth fee class consisting of individual class A providers. The fees as structured in this proposed rule are reasonable because:

1. they meet the criteria discussed above;
2. the groupings of providers for fee purposes are statistically valid; and
3. the fee structure recovers the costs of the program for the last three fiscal years, as required by law.

Expert Witnesses

If a public hearing is held on this rule, the Department does not plan to solicit outside expert witnesses to testify on behalf of the Department. The Department intends to have the following employees testify or be available at the hearing: H. Michael Tripple, Director of the Division of Health Resources, who will testify as to the general background and rationale for the proposed rule, and the Department's costs on which the fees are based; David L. Siegel, Division of Health Resources, who will testify as to the method of computing the proposed fees; and William Tallaksen, Division of Health Resources, who will testify on the statistical methodolgy used to analyze the data on which the proposed fees are based.

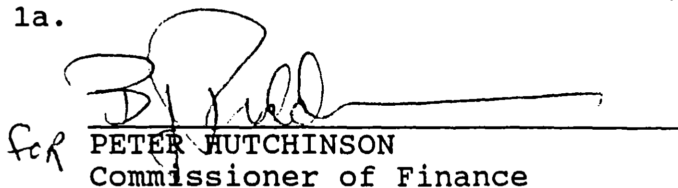
4/19, 1990



SISTER MARY MADONNA ASHTON
Commissioner of Health

Approved by the Department of Finance, under Minnesota Statutes, section 16A.128, subdivision 1a.

May 3, 1990



for PETER HUTCHINSON
Commissioner of Finance

APPENDIX 1

KRUSKAL AND WALLIS' TEST

Description

The Kruskal and Wallis Test is a statistical method for comparing three or more groups of measurements.

The higher the value of the Kruskal Wallis test, the greater the likelihood that the observed differences among the groups do not result from chance, but from genuine differences between the groups.

Group Characteristics

The following six groups were used for analytic purposes:

Group 1 - Hospice (class D)
Group 2 - Individuals (class C)
Group 3 - Those that provide only one or more of the following (classes B and E): home health aide; homemaker; personal care
Group 4 - Those that provide medical equipment together with home care services (class A)
Group 5 - Those that provide professional services other than nursing (class A)
Group 6 - Those that provide professional nursing, and may also provide other services (class A)

Test Results

- - - - - KRUSKAL-WALLIS 1-WAY ANOVA (analysis of variance)

REVENUE BY GROUP

GROUP	1	2	3	4	5	6
NUMBER	55	65	20	23	29	204
MEAN RANKS	156.41	56.45	164.00	243.72	185.62	255.23

			CORRECTED FOR TIES	
CASES	CHI-SQUARE	SIGNIFICANCE	CHI-SQUARE	SIGNIFICANCE
396	163.435	0	163.435	0

- - - - - DESCRIPTIVE STATISTICS BY GROUP

GROUP 1 - Hospice (class D)
=======

MEAN	92237.365	STD ERR	26503.317	STD DEV	196553.863
VARIANCE	.386E+11	KURTOSIS	27.369	SKEWNESS	4.797
MINIMUM	105.000	MAXIMUM	1304183.000	SUM	5073055.100
C.V. PCT	213.096	.95 C.I.	39101.413	TO	145373.318
VALID CASES	55	MISSING CASES	0		

GROUP 2 - Individual paraprofessionals (class C)
=======

MEAN	10496.138	STD ERR	4172.536	STD DEV	33640.063
VARIANCE	.113E+10	KURTOSIS	49.044	SKEWNESS	6.782
MINIMUM	7.000	MAXIMUM	259500.000	SUM	682248.970
C.V. PCT	320.499	.95 C.I.	2160.538	TO	18831.738
VALID CASES	65	MISSING CASES	0		

GROUP 3 - Paraprofessional agency (classes B and E)
========

MEAN	188325.238	STD ERR	85937.368	STD DEV	384323.592
VARIANCE	.148E+12	KURTOSIS	11.429	SKEWNESS	3.229
MINIMUM	955.750	MAXIMUM	1640000.000	SUM	3766504.760
C.V. PCT	204.074	.95 C.I.	8456.260	TO	368194.216
VALID CASES	20	MISSING CASES	0		

GROUP 4 - Medical equipment (class A)
=======

MEAN	345760.440	STD ERR	110111.630	STD DEV	528076.825
VARIANCE	.279E+12	KURTOSIS	11.407	SKEWNESS	3.081
MINIMUM	15654.000	MAXIMUM	2436651.000	SUM	7952490.130
C.V. PCT	152.729	.95 C.I.	117402.896	TO	574117.985
VALID CASES	23	MISSING CASES	0		

GROUP 5 - Professional services other than nursing (class A)
=======

MEAN	177892.100	STD ERR	62848.443	STD DEV	338449.226
VARIANCE	.115E+12	KURTOSIS	9.617	SKEWNESS	3.046
MINIMUM	817.000	MAXIMUM	1521162.000	SUM	5158870.910
C.V. PCT	190.255	.95 C.I.	49152.899	TO	306631.302
VALID CASES	29	MISSING CASES	0		

GROUP 6 - Professional nursing (class A)
=======

MEAN	497994.912	STD ERR	85171.648	STD DEV	1216494.463
VARIANCE	.148E+13	KURTOSIS	77.226	SKEWNESS	7.752
MINIMUM	258.000	MAXIMUM	.140E+08	SUM	.102E+09
C.V. PCT	244.278	.95 C.I.	330060.366	TO	665929.457
VALID CASES	204	MISSING CASES	0		

Conclusion

Based on the computed chi-square value, there is a significant difference ($p < 0.05$) in revenues among these groups. Revenues are lowest in group 2 (individuals), followed by group 1 (hospice), group 3 (paraprofessional agency), group 5 (professional services other than nursing), and group 4 (medical equipment), with the highest revenues occurring in group 6 (professional nursing).

Source

W. H. Kruskal and W. A. Wallis, "Use of Ranks in One-Criterion Analysis of Variance," Journal of the American Statistical Association 47 (1952), 583-621; errata, ibid., 48 (1953), 907-911.

APPENDIX 2

MINNESOTA DEPARTMENT OF HEALTH
HOME HEALTH LICENSURE
START-UP COST

ITEM	1988	1989	1990	TOTAL
HEALTH RESOURCES:				
Public Health Nursing Advisor (Johnston)	25,722	45,083	47,205	118,010
Management Analyst 3 (Cundy)	17,598	35,359	24,278	77,235
Clerk Typist 3 (Paulsen)		16,581	26,703	43,284
Supplies/Expenses				
Purchased Services	1,488	1,066		2,554
Communications-Postage	775	1,760	2,000 (1)	4,535
Communications-Telephone	185	297	300	782
Travel In-State	301	6,967	1,000	8,268
Travel Out-State	548			548
Supplies	2,911	415	500	3,826
Furniture	12,332	1,891		14,223
Equipment	8,752	10,306		19,058
State Registar			6,006 (2)	6,006
Attorney General			3,000 (3)	3,000
Revisor's Office			1,000 (4)	1,000
Administrative Law Judge			3,000 (5)	3,000
TOTAL HEALTH RESOURCES	70,612	119,725	114,992	305,329

(1) Includes two mailings of rules to clientele.
(2) Includes 77 pages @$78/page published twice.
(3) Includes A.G. time to attend public hearings and review rules @ $46/Hr.
(4) Includes drafting rules.
(5) Includes 5 days of hearing time @ $74/Hr.