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October 18, 1995

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF DEPARTMENT OF HUMAN SERVICE RULES GOVERNING PAYMENT RATES FOR 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 rate 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 (SOCS). They do not govern the State's Regional Treatment Centers. The authority for the adoption of these rules is in Minnesota Statutes, section 256B.501, subdivision 2.

The current ICF/MR reimbursement system was established in 1985 for rates effective January 1, 1986, and revised in 1988 and 1992.

A. Reimbursement History

Rule 52: Department of Human Services (DHS) Rule 52 was the initial rule that defined the process and formula for setting per diem rates for Medicaid recipients in ICFs/MR. 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 in expenses.

Rule 53: 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 as the principal payments on the provider's mortgage increased, funds would be available to meet these obligations. Major changes in operating cost reimbursement under 12 MCAR § 2.0530 to 2.05315 included elimination of known cost changes and replacement with straight indexing, creation of a general and administrative cost category limit, and incentives for efficient management.

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. Minnesota Statutes, section 256B.501, subd. 3, required that:

> The commissioner shall establish, by rule, procedures for determining rates for care of residents of intermediate care facilities for persons with mental retardation or related conditions. The procedures shall be based on methods and standards that the commissioner finds are adequate to provide for the costs that must be incurred for the care of residents in efficiently and economically operated facilities. In developing the procedures, the commissioner shall include [in part]:
>
> (a) cost containment measures that assure efficient and prudent management of capital assets and operating cost increases which do not exceed increases in other sections of the economy;
>
> (b) limits on the amounts of reimbursement for property, general and administration, and new facilities;
>
> (c) requirements to ensure that the accounting practices of the facilities conform to generally accepted accounting principles;
>
> (d) incentives to reward accumulation of equity;

These areas continue to be necessary features of this rule, and this rule revision continues to support these underlying principles.

Client Centered Reimbursement: In 1985, the Minnesota Legislature mandated that the commissioner of DHS study alternative mechanisms for reimbursement of providers of services for persons with mental retardation or related conditions in ICFs/MR. This project was to determine whether an alternative system could help the state target resources where need is greatest. The department and the legislature believed that a payment system that varies individual payments according to client service characteristics would improve access to community ICF/MR services for clients with the greatest service needs. This type of payment system could also result in more equitable payments to facilities, improved quality of care for clients, and improved cost containment.

In order to comply with this legislative mandate, DHS contracted with Lewin and Associates

and the Human Services Research Institute to conduct the study, to research reimbursement mechanisms, and to make recommendations to the state for implementing a new reimbursement system.

The study resulted in an evaluation instrument that assesses ICF/MR services that are most predictive of staff resource use. Clients receive service classifications that are based on the assessed amount of services they need and receive. These service levels were proposed to be used for targeting reimbursement to facilities.

In 1988, the legislature mandated the Minnesota Department of Health (MDH), Quality Assurance and Review section (QA&R), to assess all residents annually, using a uniform client assessment developed by the commissioner of Human Services. The assessment was required to include the areas which the research showed as most predictive of staff resource use. The areas are: client behavioral needs, integration into the community, ability to perform activities of daily living, and medical and therapeutic needs. The legislature required the commissioner to establish program operating cost rates for care of residents in facilities that take into consideration service characteristics of residents of those facilities. The commissioner was required to adopt rules to implement this system for rate years on or after October 1, 1990. (See Minnesota Statutes 1988, section 256B.501, subdivisions 3g and 3j.)

In 1990, the department brought to hearing a proposal for amendment of Rule 53 that would implement such a system. Referred to as "client centered reimbursement," this case-mix style system would have used the client assessment information collected by MDH to target a facility's reimbursement based on the services needed and received by its ICF/MR residents.

At the rule hearing, ICF/MR providers expressed concerns about the reimbursement mechanism under this system. In response to input received at the hearing, the department elected to withdraw the proposal and postpone implementation of the assessment system. The department sought and obtained legislative approval to postpone implementation until October 1992. The time was used to conduct training and to refine the assessment.

In 1992, implementation was again postponed, this time until October 1993. Postponement saved the state share of implementation costs (approximately $2.5 million dollars). At this point, the department concluded that further discussion of client assessment and case-mix applications should be considered in the context of overall rule changes.

In May 1995, the client assessment process was incorporated into Minnesota Statutes (see Laws of Minnesota 1995, Article 7, section 36.) The legislature adopted this assessment system in order to implement several limits in ICF/MR ratesetting for rates effective October 1, 1995.

This proposed rule also uses the classifications and associated weights determined under Laws of Minnesota 1995, Article 7, section 36. Because the entire assessment process has been adopted into law, it is not necessary to also include it in the rule.

B. Background for Current Rule Revision

In 1990, the legislative auditor completed an assessment of the department's administration of Rule 53. These findings were published in the report, Administration of Reimbursement to Community Facilities for the Mentally Retarded, December 1990 (see exhibit 1.) In this report, the Legislative Auditor found that, although Rule 53 was a good cost containment rule, many providers reported experiencing problems using the rule. The report was critical of the department's administration of the rule. The commissioner responded to the report with clarifications, some corrections of inaccuracies in the report, and detailed discussion of issues raised (see exhibit 2.)

Also in 1990, ICF/MR providers, including the Association of Residential Resources in Minnesota (ARRM) filed a civil action in federal court (no. 4-92-116) against the Minnesota Department of Human Services over the administration of the Medical assistance program as it related to the reimbursement of costs incurred by ICFs/MR. Major issues raised in the complaint included the method used to establish reimbursement rates, audit and appeals procedures, and wage parity between private and state-operated programs.

Negotiations between the department and the plaintiffs resulted in a partial settlement agreement in which the commissioner of Human Services agreed to:

> "...form a rule advisory committee consisting of DHS staff, providers and representatives of other interested parties within 45 days following the effective date of this agreement, to consider revisions to the ICF/MR ratesetting rule." (See exhibit 3.)

The agreement also stipulated [in part]:

> "If consensus is reached on an issue or provision, the group will recommend to the commissioner that it be included in the rule. If no consensus is reached on an issue, dissenting committee members may develop alternative recommendations and forward them to the commissioner for consideration."

In June 1992, this advisory committee was formed. It met approximately every two weeks through February 1993. This group produced the document, Recommendations to the Commissioner, February 1993 (see exhibit 4). This document presented the committee's recommendations in two sections.

Part I consisted of recommendations on which the committee reached overall consensus. These recommendations were presented as a package, which balanced costs and savings, streamlined some requirements of the present rule, and included the necessary elements for maintaining budget neutrality.

Some Part II recommendations consisted of areas that the committee had considered but could not reach consensus. Other Part II areas were not included in the Part I recommendations because they would increase overall MA spending. For areas on which there was not a consensus, the committee's report presented alternative recommendations.

The commissioner considered these recommendations and in March 1993 authorized the Long Term Care Facilities Division to initiate rulemaking for revision of parts 9553.0010 to 9553.0080 (see exhibit 5 [letter from commissioner]) to incorporate the Part I recommendations. In addition to the Part I recommendations for which there was committee consensus, the commissioner also requested that the Part II recommendations for establishing an overall limit and central office allocations be included in rulemaking.

In June 1993, the department began formal rulemaking in accordance with the Administrative Procedures Act.

The department believes that its work with providers and ARRM representatives to develop rule revision recommendations has facilitated communication with the provider industry on rule 53 administration issues. Further, the rule revisions recommended to the commissioner address concerns of the Legislative Auditor in the 1990 report for identifying ways of making the current public-private service delivery system operate more smoothly.

C. Goals of Rule Revision

As part of discussions stemming from the negotiated settlement, members of the department, providers, and ARRM representatives identified factors that should guide rule revision efforts. Many factors were discussed including some pertaining to the total service delivery system for persons with developmental disabilities. As the discussions focused on Rule 53 revision, members of the committee identified the following broad areas with which to evaluate rule revisions:

- Efficiency
- Accessibility
- Simplicity
- Consistency
- Overall budget neutrality
- Accountability
- Quality
- Predictability
- Economy
- Administrative feasibility

The department added that any revisions to the rule must be addressed within the constraints of federal Medicaid regulations.

Although there was little disagreement that each factor was important, the task facing the department was to develop rule revisions which reflected each of the above considerations while striking a balance between factors when necessary. That process of balancing competing

principles proved to be most challenging. Department staff and advisory committee members invested many hours discussing the ramifications of any one goal and its relationship to other areas of concern.

For example, a payment system affects the costs of long term care, the quality of care, and access to care for different clients. It is difficult to minimize costs (promote economy) while simultaneously maximizing access and quality. Initiatives to promote achievement of some goals may add to the complexity of the rule and thus diminish simplicity. Pursuit of any one goal may be limited by administrative resources.

It is important to note, however, that such limitations need not prevent achievement of particular goals. In some cases, the burden of achieving particular goals (such as quality) may be shared with other policy mechanisms, such as licensure standards and quality enforcement. Also, as in the example of quality, some simplicity can be sacrificed in the reimbursement rule by adding features to the reimbursement system, such as one time rate adjustment mechanisms, Special Needs Rate Exceptions, and recognition of client service characteristics.

This high level of critical consideration was maintained throughout rule revision process, beginning with the committee which developed recommendations for the Commissioner of Human Services, and continuing with the public rule advisory committee. In addition, department staff held dozens of internal meetings to contemplate proposed concepts, weighing various alternatives against the broad areas of consideration.

As a result of this level of critical consideration, the department concludes that these proposed rule amendments reflect a balance of the factors identified, comply with relevant statutes, and conform to Medicaid regulations.

D. Status of Rulemaking

A Notice of Solicitation of Outside Opinion for the rulemaking activity was published May 17, 1993, in the State Register and again on June 12, 1995 (see exhibit 6.) The department established a public advisory committee composed of persons representing the industry providing intermediate care for persons with mental retardation or related conditions, related businesses, and the Minnesota Department of Health. The committee met in 1993 on June 23 and 30, July 30, August 20, October 11, and December 6, and also on January 25, 1994 (see exhibit 7.) The format of the meetings allowed both providers and DHS staff to propose both concepts and language to be incorporated into the revised rule.

Drafts of advisory committee meeting minutes and rule revisions were mailed to all interested parties and rule advisory committee members.

E. Statutory Revisions

To accomplish proposed revisions, enabling changes in statute were necessary. The department proposed changes in Minnesota Statutes, section 256B.501, which would authorize the department to incorporate the proposed revisions into the rule. The department shared an outline of the proposed legislation with the public rule advisory committee prior to the legislative session. ARRM and its president testified in support of the proposed bill at the Senate hearing.

The proposed legislation was passed during the 1994 Legislative session but was in the vetoed health and human services bill. The legislation was passed again in 1995 and was signed into law on May 25, 1995 (see exhibit 8).

DHS proceeded to complete and propose these rule amendments pursuant to the requirements of the Administrative Procedure Act.

This Statement of Need and Reasonableness presents the proposed amendments to parts 9553.0010 to 9553.0080 as required by the Administrative Procedure Act, Minnesota Statutes, chapter 14, and authorized under Minnesota Laws , Chapter 207, Article 7, section 34, and Minnesota Statutes, section 256B.501, subdivision 3.

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-based ICFs/MR (SOCS) will be governed by these rules. This is reasonable because Minnesota Statutes, section 252.50, subdivision 6, requires that all state operated community-based programs that meet the definition of "facility" under part 9553.0020, subpart 19, must be reimbursed in accordance with parts 9553.0010 to 9553.0080.

It is also necessary and reasonable to replace the term "state owned hospitals" with "regional treatment centers" because state owned hospitals are now referred to as regional treatment centers (RTCs).

PART 9553.0020 DEFINITIONS

Subp. 2. Addition. In this revision, the term "resident" is deleted and the term "client" is substituted. The term "client" is technically more correct because the Code of Federal Regulations uses the term to refer to those individuals residing in an ICF/MR. Therefore, it is reasonable to substitute the term "client" for resident wherever it appears. This revision, or similar revisions such as "clients" for "residents" or "nonclient" for "nonresident", appear in the following rule parts: 9553.0020, subparts 2, 14, 26, 32, 33, and 34; 9553.0035, subpart 6, 11, 12, 13, 14, and 15; 9553.0036, items D, F, I, M, Q, T, V, and X; 9553.0041, subpart 2, 13, and 14; 9553.0050, subpart 3; 9553.0051; 9553.0060, subparts 1, 4, 5, and 6; 9553.0070,

subparts 2 and 3; and 9553.0075, subparts 1, 2, and 3. These revisions are reasonable to ensure consistency throughout the rule.

Subp 3. Applicable credit. It is necessary and reasonable to amend this definition to include as an applicable credit any portions of negotiated payments which exceed the facility's established payment rate. An example of this type of applicable credit could be services provided in an ICF/MR that are reimbursed through the Community Alternative Care Waiver (CAC). (Note: There are a number of waivered services. Typically, a waivered service for persons with mental retardation or related conditions is a service other than traditionally funded, institutionally based Medicaid service [such as nursing facilities or ICFs/MR] and is approved by the federal government for payment through MA. This approval "waives" many of the usual Medicaid regulations.)

Subp 6. Capital Debt. This amendment is necessary to allow providers to use cash for smaller purchases, with the intention of consolidating these purchases into a single loan during that reporting year. This amendment is reasonable because it provides flexibility for providers who may otherwise opt to finance many individual capital assets and it thereby reduces the burden of negotiating and managing numerous loans. Additionally, a provider may be able to obtain a lower interest rate for larger loans than would be possible for several smaller loans.

Subp. 8. Class A beds. It is necessary and reasonable to delete the reference to parts 9525.0210 -9525.0430 because those rule parts have been revised and are no longer relevant to class A designation.

Subp. 8. Class B beds. It is necessary and reasonable to delete the reference to part 9525.0210 - 9525.0430 because those rule parts have been revised and are no longer relevant to class B designation.

Subp 9a. Client. It is necessary to define client because this term is used throughout the rule. This term is intended to reference a person diagnosed as having mental retardation or a related condition (MR/RC). It is reasonable to use the same definitions currently used under law and other DHS rules affecting persons with mental retardation or related conditions because it assures consistency and avoids confusion.

Subp. 11. Cost categories. It is necessary and reasonable to correct these internal cites so they are consistent with revisions in this rule.

Subp. 15. Depreciation guidelines. The revision of this definition is necessary to indicate that the most current publication of the depreciation guidelines will be used. This definition is reasonable because the types of hospital equipment utilized may be subject to change as technology advances. By using the most recent publication of the depreciation guidelines, newly developed equipment will be listed and asset classifications will be current, and

therefore, most accurate.

Subp. 16a. Direct assignment. It is necessary and reasonable to define direct assignment because the meaning of this term is not evident without a definition. This term is used in relation to assignment of costs in part 9553.0030.

Subp. 17a. Employee. A definition of employee is necessary to clarify its meaning in the rule. The term "employee" is used in the rule in relation to individual compensation limits (part 9553.0035, subpart 14) and allocation of compensation (part 9553.0030.) This definition applies to <u>any</u> individual, including an owner, who is compensated by a facility or provider group for necessary services on an hourly or salaried basis.

Subp. 19a. Facility QMRP. It is reasonable to abbreviate the term rather than provide the full title each time the term is used because it is more concise and because the abbreviation is routinely used by providers and regulators.

Subp. 21a. Full-time. It is necessary to define "full-time" to standardize its use and meaning because employers may have different conceptions as to what constitutes full-time employment. The definition is reasonable because full time is commonly considered to be 2080 compensated hours annually. This includes compensated hours for holiday, vacation and sick leave. For example, the Minnesota Department of Employee Relations (DOER) considers full-time work for state employees as 2088 hours. Time and attendance records are already required by Minnesota Statutes, section 256B.432, subd. 8, so it is reasonable to verify full-time employment by using this existing record source.

Subp. 24 Historical general operating costs. This definition contains a technical amendment that inserts the word "general" in the term "historical operating costs." This revision is necessary and reasonable to clarify in the revised rule that cost categories which were separate have been combined into one general operating cost category. This revision also appears in part 9553.0035, subpart 9; part 9553.0040, subpart 1a; part 9553.0050, subpart 1; part 9553.0060, subpart 6; part 9553.0075, subpart 2 and 3.

Subp. 25. Indirect cost. It is necessary and reasonable to delete this term because it is no longer used in the revised rule.

Subp. 34. Program. It is necessary to delete the citation to 42 Code of Federal Regulations section 442.400, because this section no longer exists.

Subp. 37. Provider Group. It is necessary to clarify this definition because ICF/MR providers are sometimes part of an organization which includes operations other than ICFs/MR. It is necessary to clearly define that the provider group may include any parent corporations,

any subsidiary corporations, partnerships, management organizations, and groups of facilities operated under common ownership or control, irrespective of whether any segment of the provider group incurred costs is shown on the ICF/MR cost report. Defining this term informs providers of the department's position regarding the scope of a provider group. Because such organizations incur costs for a broad range of business types, it is reasonable to use a term which encompasses these organizational realities. This term is used in part 9553.0035 for determination of allowable costs.

Subp. 40 Repair. It is necessary and reasonable to define a repair as the cost of labor provided by a person who is not an employee because the cost of work by an "employee" is categorized differently under the rule.

Subp. 43. Resident day. It is necessary and reasonable to delete this subpart because this term is being revised to be "client day." See the SNR for subpart 9a above.

Subp. 43a. Shared costs. It is necessary to define the term "shared costs" because this term is used in part 9553.0030, subpart 3a, item F to distinguish from directly assigned costs for allocation of costs. It is reasonable to define this term so the reader will understand the specific meaning intended.

Subp. 43b. Site. It is necessary and reasonable to define site to distinguish it from a "provider group" or a "facility." "Site" is a broader term than facility because it includes a provider group's non-MR/RC operations. This distinction is necessary for allocation of costs according to part 9553.0030, subparts 3a and 3b.

Subp. 44. ~~Respite care.~~ 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. While Minnesota contends, and Minnesota Health Department surveys support, that clients receiving respite services are getting the same services as other long-term clients, the term "respite" has led to confusion with federal regulations. 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 may have a short term stay in an ICF/MR and receive all services including active treatment. 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 all required services at a facility, and residing at the 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 historically has used to distinguish short lengths of stay from longer client placements. This distinction has worked well over the past years.

Additionally, in the proposed rule, clients residing in the facility for less than 30 days will not receive a client classification, using the assessment process in Laws of Minnesota 1995, Article

7, section 36. Because client classifications are used for various computations in the rule, it is necessary to identify and track client days for these individuals separately so that computations in the rule that use client classifications can account for temporary care days where there is no established client classification.

Subp. 45 Top Management. It is necessary and reasonable to delete the definition of top management because the proposed rule amendments have eliminated the use of this term.

PART 9553.0030 COST CLASSIFICATION AND ALLOCATION PROCEDURES

One goal of this rule revision is to reduce and simplify the recordkeeping required for cost allocation. Simplifying processes is an objective in the reform of both health care and welfare programs. Through simplified processes, both the state and providers can develop greater efficiencies, while simultaneously improving outcomes. The recordkeeping currently required for direct identification and allocation of shared costs has been a point of contention between providers and the state, and has resulted in numerous audit disallowances and appeals. Department staff began exploring ways to simplify the processes required for cost allocation, both to simplify required recordkeeping, and to make it more objective.

The purpose of cost allocation is to fairly assign shared costs among the various entities, program, services, and businesses. At present, providers either must keep detailed time records for all staff who cannot be directly identified to a single operation ("time-distribution records") or allocate the compensation costs between programs using the ratio of expenses. These records are used to "distribute" the employee's time and compensation across all or part of the organization. Providers often choose to allocate central office staff costs based on the ratio of expenses and require employees working at multiple sites to keep records to directly identify costs to each program, service or business on the basis of time distribution records

Over the years, time distribution recordkeeping requirements have proven to be difficult for both providers and the department. Providers have had difficulty producing records with sufficient information for accurate direct identification. Disputes related to time distribution recordkeeping have resulted in many appeals.

Additionally, a very detailed recordkeeping process that requires employees to judge which operation benefits from a given task can become quite subjective when the task may benefit more than one operation at once. As a result, the desired precision of a system which strives to directly identify all costs is ultimately diminished.

An unacceptable alternative was to permit providers to assign costs to the various business operations based on management's estimation of time and benefit. Because of the interplay of the numerous sources of funding involved in providing services to persons with mental retardation and related conditions, the department was concerned that cost assignment could be

manipulated to maximize reimbursement from all funding sources, resulting in medical assistance or ICF/MR payments unfairly subsidizing other programs.

The challenge facing the department was to provide for simple, objective direct identification and reasonable allocation of the remaining "shared" costs. An alternative to directly identifying all of an employee's time (and associated costs) on the basis of time distribution records is to directly assign the time that clearly is attributable to certain sites, and then to allocate those costs which are most difficult to directly identify and verify. This method is reasonable if the large majority of expenses can be directly identified using objective criteria, leaving a relatively small percentage of costs to be allocated to all or part of the organization. Also, if the costs allocated are more likely those which are assignable across the entire organization, such as an administrator's or a central office employee's salary, then such an allocation system would meet the department's objectives.

Department staff spent many hours meeting with providers to discuss the merits of different allocation structures. Providers and the department initially agreed to develop a mechanism for cost allocation without the requirement of time distribution recordkeeping. (See exhibit 4, Recommendations to the Commissioner, p. 5.) The department developed several variations for directly assigning time and presented them to the advisory committee. However, providers on the advisory committee rejected the department's proposals. Eventually the committee recommended that the department reconsider using time distribution records for directly identifying costs. Providers stated that combining program and administrative cost categories would adequately reduce the complexity of time distribution recordkeeping since records would no longer have to differentiate the nature of the work performed as "program" or "administrative."

Although combining cost classifications will simplify recordkeeping, the department concluded that additional revisions are necessary in direct identification and allocation requirements, both to further simplify recordkeeping requirements and, more importantly, to create more objective standards for direct identification and allocation of shared costs. This increased objectivity will ultimately result in fewer audit adjustments and appeals.

The department rejected the advisory committee's proposal to continue using time distribution records for the following reasons.

1. In theory, time distribution records may provide an accurate means for directly identifying costs. However, department staff have concluded that many time distribution records currently maintained by facilities are not sufficiently accurate. Most providers use a time distribution sample, which was instituted in the present rule to simplify or reduce recordkeeping. This simplicity is achieved at the expense of the greater accuracy provided by year-round records. To achieve needed accuracy, staff would need to keep detailed time distribution records of duties performed on a year-

round basis. Year-round recordkeeping was suggested by providers on the advisory committee as a reasonable method for directly identifying costs. However, this level of detailed recordkeeping is contrary to the objective of simplicity in recordkeeping. Moreover, the department is determined to minimize the burden of detailed recordkeeping for providers.

2. During field audits, time distribution records are often found to be unclear. From a practical viewpoint, an employee who completes time distribution records must sometimes make subjective decisions relating to which facility or facilities benefit from the employee's work. This occurs because the nature of some tasks can benefit more than one facility.

3. In some cases, department auditors have found it impossible to verify costs directly because the records supporting them were missing or incomplete. Under the present rule, if there is not sufficient information to directly identify the costs, the rule allows those costs to be allocated using the ratio of expenses. This provision, which was included to provide flexibility, has also provided an opportunity for manipulation by providers wishing to maximize their reimbursement and has resulted in audit and appeal disagreements. In effect, the present rule permits providers to choose depending, not upon the most accurate method, but on which method results in maximum payment. Therefore, it is necessary to correct this weakness in the present rule.

   Additionally, increasing numbers of provider groups have expanded their scope of service to provide non-ICF/MR and non-MR/RC services. This has resulted in more ICF/MR employees who also work at non-ICF/MR sites and more potential for inequitable allocation under the present rule (as explained above.)

Providers asked that the department allow them to assign costs based on their own knowledge of operations and the duties performed by staff. This option, although simple for providers, does not provide objective criteria and information for auditing. Both the department and providers must be accountable for reasonably accurate assignment of costs based on objective criteria. Without some objective criteria for proper assignment of costs, costs may be inappropriately assigned to non-ICF/MR services and there would be no means for verification and correction.

County Input: When forming the advisory committee, the department contacted the county association and invited county representation on the committee. However there were no obvious issues relating to counties, so no county representatives expressed an interest. During the advisory committee meetings, the allocation of costs between ICF/MR and waivered services was identified as an issue in which counties may have an interest and be able to provide advice and information. Specifically, providers expressed a concern that the

department's proposal for allocation may shift costs currently covered by the ICF/MR rate to the MR/RC waiver. It was thought that counties that negotiate the waivered services price with providers, would be unwilling or unable to cover any increased waiver costs and maintain their required average waiver cost. (Counties are required to keep their average MR/RC waiver costs under a specified cap.) The department scheduled a meeting with representatives of eight counties to discuss this issue. The meeting was held on April 8, 1994.

In general, county social service personnel were not concerned that the proposed rule would shift costs from ICFs/MR to the waiver. One representative stated that the market would continue to dictate the price. In general, county representatives felt that providers had already built in substantial administrative overhead costs into their waivered service bids.

This group indicated that the revised rule appears positive because it establishes more objective, control over how shared costs will be identified, allocated, and paid for.

Based on discussions with providers, counties, and department staff, as described above, and on the clear limitations of the present system for time distribution recordkeeping for direct identification of shared costs, the department concluded that it is necessary to revise the present methods for direct identification and cost allocation. The decision to develop a new method for cost allocation is largely in response to the long history of problems with the current system, the department's desire to improve the system under the amended rule, and the belief that this proposal is an improvement over the present allocation system for both providers and the department.

Additionally, Laws 1995, Chapter 207, Article 7, section 34 directs the commissioner to:

> "(8) develop cost allocation principles which are based on facility expenses."

Therefore, the department is proposing a new process for the direct identification of facility-specific costs and allocation of shared costs, based on facility expenses. This method for direct assignment and allocation of costs permits time spent at a site (i.e. ICF/MR, waiver, SILS) and working for the sole benefit of that site to be directly assigned to that site. In most cases, general time (i.e. leave time, time away from a site, time that benefits more than one site, etc.) will also be deemed as being directly identified to the sites benefiting from that person's work. Persons with little or no time directly identified to sites and central office employees will have their time allocated across the organization.

The following subparts specify the process for direct identification, cost allocation, and required recordkeeping.

Subpart 1. Cost classification. Subpart 1 establishes how costs must be classified and must be

compiled and recorded on the cost report. In this subpart, it is necessary and reasonable to replace the word "identification" with "assignment" because the term "direct assignment" is defined in part 9553.0020, subpart 16a, and better expresses the meaning intended.

It is necessary and reasonable to delete the language under item B because it references the assignment of costs between cost categories. In the revised rule, cost categories are combined, making this provision unnecessary.

It is necessary and reasonable to delete the language under item C because it pertains to time distribution recordkeeping and time distribution time sampling. This rule revision replaces the time distribution recordkeeping requirement with a new process for direct assignment and allocation. Therefore, the language under item C is no longer necessary and has been deleted.

It is necessary and reasonable to delete the language under item D because this rule revision eliminates the administrative cost category and the term "top management," making this provision unnecessary.

Subpart 2. Allocation of personal expenses for owners whose primary residence is in the facility.

Item D. It is necessary and reasonable to delete the term "administrative" because administrative costs are no longer specified separately in the revised rule. Because the rule cannot list all situations where costs must be allocated between the personal expenses of owners and the facility's costs, item D provides that any other costs not specifically identified in items A to C must be allocated based on a reasonable estimate of actual use. This item is reasonable because it eliminates the term "administrative" but still applies the same criteria to these expenses as exists in the present rule, thus continuing present practice.

Subpart 3. Cost allocations for other services. It is necessary and reasonable to delete this subpart because this rule revision establishes a new process for allocating shared costs.

Subpart 4. Central, affiliated, or corporate office costs. It is necessary and reasonable to delete subpart 4 because this provision is being replaced with a new method for allocating these costs. The new process is established under subpart 3a.

Subpart 3a. Assignment and allocation of costs including central, affiliated, or corporate office costs. This subpart establishes a new process for assignment and allocation of costs.

Item A. This item establishes the criteria for what costs must be directly assigned to a site. It specifies that, except for compensation of certain central, affiliated, or corporate office staff, all costs which can be directly assigned to a specific site must be classified to that site, except as

provided in item B. Direct assignment of consultant and employee compensation is permitted only for the time work is performed at specific sites and benefiting exclusively that site, except as provided in subitems (1) to (3). Subitems (1) to (3) specify how time may be directly identified to the specific site, even though the employee is not actually at the site or is (briefly) not benefiting that site. The SNR's introduction to this part discusses the need for a new process for assignment and allocation of costs.

This item directs that central, affiliated, or corporate office staff time must be defined and assigned in accordance with item F.

It is reasonable that when work is performed at a specific site and benefiting solely that site, that the associated time should be directly identified to that site. An employee or consultant who is physically at the specific site, and who reports that his or her work is for the sole benefit of that site is clearly working for that site. Such situations are objective. It is therefore reasonable for that employee's compensation to be directly assigned to that site. By using this method, most compensation for ICF/MR employees will be directly assigned.

Minnesota Statutes, section 256B.432, subdivision 8 already requires time and attendance records, showing service to the organization, to be maintained for all individuals when any portion of their salary is assigned to Minnesota ICFs/MR. This item builds on this existing requirement, adding only that the records indicate:

- the facility in which service was performed and
- whether the service benefits that specific site

(See exhibit 9 for an example of the proposed recordkeeping requirement.) This record will supply the minimum information needed to accurately assign costs for the bulk of ICF/MR employees without complex recordkeeping. Hourly employees who keep a time card with the name of the facility on it will need to declare only whether their time was spent for the sole benefit of that facility. State law already requires an employee to sign his or her time card, verifying the reported time. This provision uses this existing requirement. The method is reasonable because it uses existing records (time cards) to establish service to specific sites and dovetails on the existing requirement for employees to verify their hours by signing their time cards. This method is similar to the method for allocating hourly employees under the present rule. As a result, documenting work that is on-site, for the benefit of that site, requires nothing more than a slightly expanded time and attendance record.

Employees who work on a salaried basis and consultants who work for a fee will also be required to track their time if they wish their time to be directly assigned to the site. Because these persons are already required to keep time and attendance records, the requirement to specify the time work is performed at a specific site and for the benefit of that site requires

very little additional documentation, and substantially less detail than under the present rule.

One desirable feature of this expanded time and attendance recordkeeping is its objectivity. An employee or consultant should have no difficulty determining whether he or she is working at a site doing work solely for that site. Most instances where it is unclear whether work benefited one site or several sites have been eliminated from this recordkeeping requirement. Also, this rule revision combines the program and administrative cost categories, so the records will no longer need to differentiate between "program" and "administrative" work activities. Because the recordkeeping is so objective, there is no need to require staff to supply detailed records of tasks and activities performed or for DHS audit staff to verify the accuracy of detailed work activity records.

Subitem (1) provides for time spent off-site, but with a client from the site, to be directly identified as if it were on-site/ for the benefit of the site. This is necessary and reasonable as staff provide programs and services to facility residents outside of the facility as part of the clients' active treatment. These services directly benefit clients of that facility. Therefore, it is reasonable to directly identify that time to that site.

Subitem (2) provides that time away from the site for shopping or errands, if the shopping or errands benefit solely that site, shall be directly identified to that site. This is needed and reasonable for the same reasons as discussed in subitem (1). Examples of persons affected by this provision include a maintenance person on an errand to the hardware store or a program staff purchasing groceries. These are typical situations of staff who leave the site during the workday, yet continue to perform functions necessary to and for the sole benefit of that site.

Subitem (3) provides that direct assignment can ignore infrequent, brief telephone calls. This is needed because staff who oversee the operation of several sites may be interrupted in their service to one site by a telephone call from another site. It would be burdensome for the employee to subtract the time spent on the telephone each time staff from another facility called. It was also reasoned that the interruptions between facilities would generally be reciprocal, balancing each other out. Therefore, it is reasonable for purposes of direct assignment, to ignore infrequent, brief telephone calls.

Item B. This item establishes that general time (time worked that cannot be classified as on-site/for-site time) is not eligible for direct assignment, and provides specific instances which are considered general time for purposes of allocation. This subitem is necessary to clarify what time is considered to be "general." The allocation of this time is addressed in items C and D.

Subitem (1) classifies work performed at a central, affiliated or corporate office as general time. This is reasonable because the work performed at a central office generally benefits more

than one site. Such work includes personnel functions, payroll, development of training functions, accounting, and administrative functions. These tasks would be difficult to directly identify to specific sites, would require subjective decision making as to the sites benefiting from work performed, and likely would be open to interpretation. Even if certain amounts of work performed at a central office benefit only one particular site, the recordkeeping requirements needed to assign that time to the specific site would be more detailed and time consuming to complete because the records would have to differentiate this time from time spent performing tasks benefitting multiple sites. The nature of the work performed would have to be indicated as well to support subsequent independent verification.

This provision also applies to work performed at a central office when the central office is located at a site. The function of a central office is primarily to serve multiple sites through "centralization" of various functions. This is true regardless of the location of the "central office."

Subitem (2) establishes travel time, except as permitted in item A, subitems (1) and (2), as general time. This is reasonable because travel time involves the time spent between sites, time spent traveling for meetings or training which may benefit multiple sites, and other situations that make it difficult to judge which sites benefit from the travel time. It is reasonable to exclude travel under subitems (1) and (2) from general time because these are specific, objective instances where the travel time can be directly identified for the benefit of a single site.

Subitem (3) establishes compensated leave time as general time. This subitem is reasonable because the expense of compensated leave for an employee who serves multiple sites is an expense of all sites served and should not be assigned to any specific site. Item C below, provides a method for assigning this time to the facilities served and addresses the situations of staff who work only at one site or work at several sites, spending a high proportion of total time for the benefit of only those sites.

Subitem (4) establishes training time as general time. This includes training such as conferences, inservices, classwork conducted away from the site, and training conducted at a site, but not for the sole benefit of that site. This subitem excludes on-site orientation and on-the job-job training (This time may be directly identified to the site under item A provided the training is on-site and for the exclusive benefit of that site). This provision is needed and reasonable because an employee who serves multiple sites would have difficulty directly identifying which facilities benefit from the time spent receiving training. Rather than require the staff person to judge which facilities benefited, or require the staff to prorate time, it is reasonable to include training time as general time, subject to allocation.

Subitem (5) establishes that time spent performing services which benefit more than one site is general time. It does not, however, require the employee to decide which specific sites

benefited. This is needed and reasonable because simplifies recordkeeping and removes the subjectivity of employees arbitrarily guessing the proportion in which various sites may have benefitted from their work.

Subitem (6) provides that time spent performing services at one site which benefits another site is general time. Documenting work performed somewhere other than at the site which benefits from the work is essentially time distribution recordkeeping (the method used under the present rule). The introduction to this SNR rule part provides a lengthy discussion of the difficulties ICF/MR employees have had in directly identifying time to specific sites in the absence of objective criteria. It is reasonable to include time under these circumstances as general time because the types of tasks that can be performed away from a site's clients, employees, client records, and other site specific information are most likely to be more general in nature, and therefore, more difficult to directly identify to any single site.

Subitem (7) establishes that the total time of a consultant or employee whose directly assigned time under item A is less than 15 percent of the total time the consultant or employee worked for the facility or provider group shall be considered general time. This provision is needed and reasonable because individuals who cannot show 15 percent of their total time as spent working at a site(s), for the sole benefit of the specific site, likely have little to do with any of those sites in regard to specific, ongoing operations, and can be assumed to be employees who perform general or organization-wide tasks. These employees are most likely administrators, CEOs, or owners who work out of a central office and have only incidental involvement with the day to day operation of individual facilities. This provision is needed to prevent individuals whose full salary should most appropriately be allocated across the entire organization from skewing the allocation formula simply by reporting incidental time at individual ICFs/MR.

Subitem (7) provides an exception for employees or consultants who work in laundry or dietary services. A member of the advisory committee said that some providers have laundry or dietary staff that work in a building other than the site or sites benefited (i.e. a central kitchen or laundry). By excluding these two classes of staff, their time can be allocated to the sites benefited according to item C, below, rather than across the entire organization.

Item C provides a method for allocating the general time of employees who are able to directly identify a certain proportion of their time as work performed on-site/for-site. Subitem (1) specifies that, for licensed medical professionals, such as psychologists, psychiatrists, RNs, LPNs, and physical therapists who perform clinical services consistent with their professions, general time must be 40% or less of total compensated hours. For all other employees and consultants, subitem (2) specifies that general time must be 25% or less of total compensated hours. If an employee's proportion of general time is equal to or less than the applicable threshold, the employee's general time is allocated only to the sites for which the employee has directly identified time, in that proportion, and not across the organization as a whole.

Direct service staff persons, housekeeping, maintenance personnel, dietary workers, and some on-site supervisors who work at one or more sites will, in most cases, have their general time allocated as described above because at least 75% of their compensated time will be time will be spent working at a site, for the benefit of that site.

To determine what proportion of time could reasonably be considered general time for non-medical personnel, the following assumptions were applied (assumes full time = 2080 hours)

	Hours Annually
• Travel time between sites, central office, and meetings but not including travel from the employee's home to the work site (12 hrs monthly)	144 hrs
• Vacation time (3 weeks annually)	120 hrs
• Holidays (6 paid holidays annually)	48 hrs
• Sick leave (6 days annually)	48 hrs
• Outside meetings/ central office time (10 hrs/month)	120 hrs
*Training/conferences	40 hrs
	520 hrs
	or 25% of the time

(* The ICF/MR licensing rule requires 40 hours training per year. This figure is based on the assumption that the employee obtains the full 40 hours of training away from the site.)

Nurses and other clinical professionals typically spend a portion of their time off-site in an office writing observations, reports, or charting in the client's file. Item C, subitem (1) recognizes that such professionals will incur additional general time and provides a threshold of 40% or less total compensated hours for these professionals. The 40% threshold was suggested by the advisory committee. The department believes this estimate to be reasonable.

The following examples show how an employees hours are calculated for purposes of cost allocation.

Examples

Example #1 A direct service program employee works with the clients at one ICF/MR.

	# of hours on-site, for-site	% of time
ICF/MR #1	1832	88%
General time	248	12%
(includes all compensated leave time)		

In this example, 100 percent of the employee's time, including the 12% general time would be allocated back to the one ICF/MR.

Example #2 Providers also hire direct-service employees who work at more than one site. For example, an employee may be scheduled to work part-time at two or three sites, totaling full-time hours. Also, employees of one site are sometimes scheduled to fill in at other sites for employees who are absent or on leave. Item B permits these employees' general time to be allocated only to the sites that the employee served, rather than across the entire organization.

This illustrates an employee regularly working at two ICFs/MR and one waivered services site. This employee also filled in at a second waivered site two days that year.

	# of directly identified hours	% of time
ICF/MR #1	600	29%
ICF/MR #2	600	29%
Waiver #1	464	22%
Waiver #2	16	1%
	General time	
	400	19%

In this example, 81 percent of the employee's time is directly identified and 19 percent of the time is "general." The 81 percent is directly assigned to the facilities for which the employee can directly identify time, and the 19 percent general time is allocated to the same facilities in proportion to the time directly assigned to each. In this case, of the 400 hours of general time, 36% (29/81) will be allocated to ICF/MR #1, 36% (29/81) to ICF/MR #2, 27% (22/81) to waivered site #1, and 1% (1/81) to waivered site #2 (filling in for an absent employee).

Although general time is not spent at specific sites, it is reasonable to conclude that an employee who spends at least 75% of his or her time working at sites for the benefit of those sites is most likely to be spending the remaining time for the benefit of those same sites too, rather than for the benefit of the entire provider group. Similarly, a medical professional spending 60% or more time at sites for the benefit of sites can be assumed to be spending the remaining general time for the benefit of those same sites. Therefore, it is reasonable in these situations to allocate to those sites directly identified, and in that proportion. This targets the allocation of general time to those facilities that the employee serves and avoids the allocation of wages to other services or businesses for which the employee probably has no responsibility.

An employee who cannot directly identify 75% or more time to specific sites, is likely involved in more duties than just the day-to-day operations of certain sites. For example, assuming equal service between sites, a person who supervises two sites would need to show only 37 1/2% of his or her time as spent at each site, for the benefit of the sites to be eligible for site-specific allocation of general time according to item B. A person supervising three sites,

assuming equal service, would need to show only 25% of his or her time at each site, for the benefit of the site. A person who cannot directly identify this amount of time at the sites is probably performing some general, administrative functions that benefit the entire organization and those general costs should be allocated across the organization as a whole.

Seventy-five percent is a reasonable threshold for permitting allocation to the sites directly identified because it is liberal enough to capture virtually all direct service staff and most program supervisory personnel with day-to-day responsibilities at specific sites without requiring them to change their schedules. In addition to performing direct client activities, it is reasonable to expect that program supervisory employees spend a portion of "office" time at the sites for administration of program related activities. Client program records are maintained at the site, as are time cards, which must be reviewed for completing payroll. A program manager, who must train and supervise on-site staff, performs this duty at the site. Also, staff meetings and interdisciplinary team meetings are usually held at the site while most residents are gone during the day.

Similarly, nursing and other medical/clinical personnel can be expected to spend much of their time working at sites, for the sole benefit of those sites. Client treatments are performed at the site, trips to the doctor's office are included as directly identified time, and clients' medical records, in which nurses document treatments, are often maintained at the site. At the request of the advisory committee, the threshold for allocation based on the proportion of directly assigned time was increased to permit a medical/clinical employee to report up to 40% of his or her time as general, and still have that general time allocated according to item C (1).

Item D provides that employees who are not central, affiliated, or corporate office staff (as described in items A and F) and who have directly identified 15% to 74.9% of their time to sites (or for licensed medical personnel, between 15% and 59.9%) will have their general time assigned to the sites benefiting from the employee's work **based on the ratio of operating expenses of each site benefited.** For these employees, directly identified (on-site/for-site) time is assigned to those sites directly identified; only the general time is allocated based on the ratio of expenses. This provision is most likely to affect program directors, program coordinators/ managers, quality assurance managers, trainers, and similar positions that benefit multiple facilities.

It is reasonable to allocate the general time of staff with more broad responsibilities using a different method than that used for staff who spend most of their time working at sites. Employees that report less than 75% (or less than 60% for medical professionals) of their time working at sites for the benefit of those sites probably spend more time traveling between sites and/or are officed in a location away from a site (such as in a central or regional office). Such persons typically have responsibilities that benefit multiple sites (example: preparing inservice materials for all employees). Because these employees have a smaller proportion of directly identified (on-site/for-site) time, it is less reliable to allocate their general time based on that

time. Therefore, it is reasonable to use a different method for allocating the general time for these employees. Time that can be directly assigned as work on-site, for-site will still be directly assigned, however (provided that at least 15 percent of that employee's time can be directly assigned to one or more sites).

This method addresses advisory committee concerns that the rule have a method for allocating the time of program supervisors, directors and QMRPs who work for more that one site but less than the entire organization. It also supports the legislature's directive on cost allocation (Law of Minnesota 1995, Chapter 207, Article 7, section 34.)

Subitems (1) to (3) are needed to establish the allocation ratios used.

Subitem (1) establishes the numerator of the allocation ratio. This is needed and reasonable because it identifies the total expenses of a single site.

Subitem (2) is needed to establish the denominator for the allocation ratio as the sum of the numerators in subitem (1). This sum provides the total non-property expenses of the provider group. Subitems (1) and (2) establish the ratio of expenses for a facility.

Under Subitem (3), it is necessary that, for all sites except Minnesota ICFs/MR, total operating expenses include nonallowable salary costs when such costs are nonallowable due to failure to maintain time records. It is necessary and reasonable to include nonallowable salary costs for non-ICF/MR sites in order for these facilities' total expenses to be accurately reflected. This will permit accurate allocation without requiring time records for employees working solely at non-ICF/MR sites.

How many staff will be allocated in each of these methods? Department staff asked providers on the advisory committee what percent of their staff would have a portion of compensation costs allocated based on the ratio of expenses. Committee members did not have specific numbers, but said that the allocation formula would only affect a relatively-small percentage of non-central office staff.

To estimate how many ICF/MR staff will continue to be directly identified to the sites they serve or have some portion of their costs allocated based on the ratio of expenses, DHS completed an analysis of total reported hours worked in ICF/MR facilities to estimate the number of positions likely to be affected by the proposed allocation formula. From the 1992 annual cost reports filed by the facilities, the department compiled the following summary of total hours worked, by position type:

	HOURS	%	Direct Care %
Program Director	310,770	3.0	
Program Coordinator	537,221	5.1	

RN	221,489	2.1	
Administrative	335,757	3.2	
LPN*	250,329	2.4	2.4
Other Program Professionals*	1,842,322	17.6	17.6
Other Program*	6,190,339	59.0	59.0
Dietary*	309,737	2.9	2.9
Laundry/housekeeping/maintenance	472,107	4.5	4.5
Therapy*	20,591	.2	.2
Total	10,490,662	100.0%	86.6%

* For purposes of this analysis, these positions were considered direct service workers (employees who work at sites) which we expect will be directly assigned to specific sites. Due to the direct care nature of these positions, it is reasonable to expect these types of positions to have only a minimal amount of general time. Together, these positions account for 86.6% of the total hours reported.

Item E is needed to establish that, when adequate documentation has been maintained, the costs of centrally purchased goods will be assigned to the sites where distributed and consumed. It is reasonable to allow goods to be purchased centrally because larger volume purchasing can be more economical and more efficient for the provider. It is reasonable to assign the costs of these goods based on the sites where the goods are distributed and consumed because this clearly identifies the site where the goods were actually used. It is reasonable that the provider maintain adequate records to identify the goods, the cost of the goods, and the site where the goods were distributed and consumed so that direct assignment can be verified through audit. The advisory committee agreed that these records already are maintained by providers by site and should be available for this purpose.

This item also provides that, when required records are not maintained, that the costs of the goods should be allocated using the formula in item D and F. This provision is needed in the event that a provider has not maintained sufficient records to directly identify costs to specific sites or cannot directly identify all costs to specific sites. It is reasonable to allocate costs in the absence of detailed records, rather than to disallow those costs because, unlike the allocation of compensation costs, there have been very few problems in the past associated with this flexibility. DHS auditors report that some types of purchases are very easy to track based on where they are distributed and used, while other goods are most appropriately allocated based on the ratio of expenses. The ratio of expenses is a reasonable proxy because this ratio reflects the proportion of overall spending for each operation. Also, this relieves the provider from keeping detailed records for costs of centrally purchased goods which are clearly shared costs best allocated using the procedure in item D.

Item F is needed to establish a method for allocating any remaining costs to Minnesota

ICFs/MR. This item provides that all remaining costs must be treated as shared costs and allocated across all sites based on the ratio of expenses.

When developing a process for allocating these costs, the department first considered using three "pools"; a Minnesota ICF/MR pool, a Minnesota MR/RC services pool, and an extended pool that included out of state services and non-MR/RC operations. Costs would be assigned to the correct pool, then allocated within that pool. In order to allocate to the correct pool, time records would need to indicate the entity served for all of time allocated. Because the on-site/for-site time already would have been accounted for, the time remaining would be the time most difficult to objectively and accurately assign. Some tasks may benefit all of a smaller pool and parts of a larger pool. Staff would have to keep records indicating to which pool time should go. This differs little from the time distribution recordkeeping required at present and, in some ways, may be even more problematic because staff would need to understand the types of "pools" for their provider group.

Because most organizations do not have non-MR/RC or out of state operations, it did not seem reasonable to impose a complex recordkeeping system on all organizations in order to accommodate the complex structure of a few organizations. DHS decided that a simpler allocation method with some special provisions for the large organizations would produce the most reasonable method, overall.

The department decided to use only one large pool. Because most providers operate only in Minnesota and only provide MR/RC services, a large pool would work well for allocation of shared costs. In addition, their central offices generally serve the entire organization. The single pool could be used to reasonably allocate the portion of costs not directly identified, across the organization. DHS presented this idea to the advisory committee. The committee stated that this method would work for central office allocation. Their concern mostly centered on a fair allocation for program supervisors/ directors, and QMRPs who work for more than one site but less than the entire organization. To address this concern, the allocation under item D was developed (see SNR item D above.)

The department concluded that it is reasonable to allocate the remaining costs across a single pool, based on the ratio of expenses for several reasons. The remaining costs constitute a small percentage of a facility's total costs and are composed of those costs which cannot be directly identified using the criteria in items A to D. These include costs that are best attributed across the entire organization, such as salaries of central office employees (accounting, payroll, legal, data programmer), training directors and CEOs, and costs of shared goods. Included for allocation under this item are costs that have proven to be difficult or impossible to identify to a specific site or are difficult to reliably document (would require subjective judgment on the part of the employee as to the site(s) benefited and the proportion of that benefit.) By allocating these costs, rather than trying to directly identify them to sites, it is not necessary to require detailed time distribution records in an attempt to judge where to assign those costs.

Subitems (1) to (5) are needed to identify types of employees and consultants whose compensation must be allocated according to this item. These types of employees are designated as central, affiliated, or corporate office staff.

For purposes of item F, a central, affiliated, or corporate office cannot be considered a site because central office costs constitute many of the costs that must be allocated. It would defeat the purpose to allocate a central office's costs back to itself and thus would not be reasonable.

When the allocation concept was presented to the advisory committee, providers expressed concerns that allocation of shared compensation costs across the pool based on the ratio of expenses may unfairly shift costs from the ICF/MR to the waivered services. The department considered this concern and discussed the issue with county personnel who negotiate waivered services contracts. The department concluded that, after applying the criteria to directly identify most costs, allocating the remaining, shared costs would not cause aggregate shifting of costs from the ICF/MR to waivered services. In fact, the on-site/for-site provision for direct identification allows discretion for providers as to where staff serving multiple sites will be "officed." To the extent that providers will choose to office these employees at the ICF/MR, the proportion of allocated costs will shift toward the ICF/MR, rather than to waivered services because these employees will increase their time on site, working for the benefit of the site. And to the extent that clients will benefit from these employees being at the ICF/MR a greater amount of time, rather than at a central or off-site office, some benefits of improved quality or better management oversight may be achieved as well.

Providers and their accountants have also stated that portions of the allocation method proposed in this rule do not conform to Generally Accepted Accounting Principles (GAAP). GAAP refers to the pronouncements of the Financial Accounting Standards Board. It authoritatively resolves questions that arise with respect to financial accounting standards and practices. It is designed to provide direction to accountants in the preparation of financial reports and disclosure statements.

GAAP is directed primarily to the corporate business environment rather than to rate setting and regulatory settings. Under Rule 53, reimbursement reflects policy considerations about appropriate spending and the timing of cost recognition. These standards can differ substantially from GAAP in many instances. For this reason, the revision to Rule 53 continues to give precedence to its own reporting and documentation requirements whenever they may conflict with GAAP. Federal Medicare principles follow this same approach.

For example, GAAP alone does not address our administrative and programmatic concerns to invest in quality programming while controlling costs and developing efficiencies. It is the department's obligation to assure prudent use of public dollars. Therefore, it is reasonable for the rule to supersede GAAP when necessary.

Revised Rule 53 continues to provide that when the rule does not create accounting standards GAAP standards will guide accounting decisions.

Item G. This item is needed so that a governmental or non-profit organization that has a federally approved cost allocation plan may allocate central, affiliated, or corporate office costs based on the federal cost allocation plan. Subitems 1) through 3) are necessary to detail the criteria required for department acceptance of a federally approved cost allocation plan for allocation of central, affiliated, or corporate costs. The provider must document that the federal government has approved the allocation plan and that the plan meets the requirements of subitems (1) to (3).

Some organizations have operations that are required to use a federally approved cost allocation plan. It could be difficult for such a provider to equitably allocate central, affiliated, or corporate office costs if different portions of their operations have different rules for allocating costs. The department prefers the allocation method set forth in this rule but understands the difficulties presented by different government entities requiring different methods of cost allocation. DHS staff examined examples of federally approved cost allocation plans and determined that, if the allocation plan conforms to subitems (1) to (3), the plan would be acceptable in this circumstance. This is a reasonable accommodation.

Subitems (4) and (5) are needed and reasonable to assure that undo costs are not allocated to ICFs/MR and that nonallowable costs are not included.

Subpart 3b. Required time records.

This item is needed to define the time records required for direct identification or allocation of costs.

Item A. This item is necessary because Minnesota Statutes, section 256B.432, subdivision 8, requires all employees to keep time and attendance records. It is reasonable to reference the statute because this reduces the length of the rule. Reference to this statute is included in the rule at the request of the advisory committee, which asked that, to the extent possible, statutory requirements be included in the revised rule. The recordkeeping requirements set forth in the rule will build upon the current statutory time and attendance recordkeeping requirement. Therefore, it is reasonable to reference this statutory requirement and use it as a foundation for the additional recordkeeping requirements under items B and C.

Item B. This item details the information that employees must report in on-site/for site records. This item is needed to establish the records used for calculating directly identified time under subpart 3a, item A. It is reasonable for ICFs/MR to collect these records so that directly assignable time can be determined.

Exhibit 9 gives several examples of the record an employee could keep in order to meet this requirement.

It should be noted that an employee who works only in non-ICF/MR settings (such as a waivered services) and for whom the provider will not claim any portion of that employee's salary for reimbursement under this rule is not required to keep these time records.

Provision of Balance in Allocation: Providers may, however, choose to require certain non-ICF/MR staff to keep these time records in order to balance the allocation formula. The following example will illustrate this feature.

An organization has two program directors, one performing only ICF/MR work and one working only for waivered services. Each works out of a central office and spends less than 15% of the time working for the sole benefit of a site. Therefore, each has all of the work time designated as general time, and as such, allocated across the whole provider group (waivers and ICFs/MR) based on the ratio of expenses. For simplicity's sake, assume that the ICFs/MR and waivered services have equal expenses. As a result, each person will have half his time allocated to ICF/MR and half to waivered services. In order to balance the allocation system, the rule permits the general time of the waivered services program director also to be documented and allocated to the ICF/MR. Even though the waivered services program director did not specifically work for the ICFs/MR, in this example, half of his general time costs can be allocated to the ICFs/MR. This serves to balance the allocation system.

The more typical management structures will not be so segregated as the above example, and generally will have employees who work for both ICFs/MR and non-ICF/MR service sites. However, this example shows that the allocation method is designed to provide balance in allocation for organizations with non-ICF/MR services.

Item C was added to permit the allowable costs of out-of-state employees who perform work for Minnesota ICFs/MR to be included in the pool for allocation. This subitem creates a mechanism for organizations with employees officed outside of Minnesota who do Minnesota ICF/MR work to have this time recognized and included in the pool. This provision is needed because some large provider groups may have staff who spend significant amounts of time performing services for Minnesota ICF/MR operations but have offices in another state.

In addition to the required time and attendance records, all out-of-state (officed out-of-state) employees must keep records showing a minimum of 240 hours of service to Minnesota clients within a reporting period in order to be included in the allocation pool. The records must show when the service was performed and what that service was. After 240 hours have been documented, the detailed recording of work performed benefiting Minnesota facilities can be discontinued for the remainder of the reporting period and the employee's total compensation or fee will be eligible for allocation. Note: These employees must continue to keep the

expanded time and attendance records in order to have their compensation reimbursed under this rule.

The first sentence of item C stipulates that the work performed must benefit Minnesota facilities. Therefore, an employee would keep these records only if a portion of the employee's activities are related to Minnesota ICF/MR services. However, this sentence does not require that all 240 hours of the work must benefit ICFs/MR. The second sentence goes on to explain that the 240 hours of service must benefit Minnesota clients, which can be any individuals with mental retardation or related conditions (MR/RC). Because the allocation method establishes a mechanism for allocating expenses across all service areas, it is reasonable to consider all Minnesota services for persons with MR/RC toward the 240 hour eligibility threshold, as long as some of the time benefits clients in ICFs/MR. This feature provides balance to the allocation method.

The threshold was set at 240 hours because it prevents organizations from including individuals in the pool who have little to do with Minnesota services for persons with MR/RC. It is reasonable to apply a higher standard for out-of-state employees to be included in the allocation pool because these employees, due to their physical location (officed in another state), are least likely to be performing work for Minnesota ICF/MR facilities.

To determine the threshold at 240 hours, the department looked at two examples. An employee would needed to work just under 5 hours a week for Minnesota MR/RC businesses in a given year to meet the threshold. Likewise, a person would need to work as little as six weeks a year if assigned full time to a special project related to Minnesota activities. It is reasonable to recognize these circumstances and allow the time to be allocated to the pool.

For example, a person based in another state who attends a few meetings where Minnesota services are discussed would not be eligible for allocation through the pool unless the person has spent 240 hours during the year doing so. However, a person based in another state who spends 10 hours per 2 week pay period doing payroll for Minnesota ICF/MR and waivered services would be eligible for the pool (10 hours X 26 pay periods).

The advisory committee was concerned that the allocation of out-of-state employees' salaries was not balanced. The committee stated that a Minnesota central office employee's salary would be allocated across the pool; however, an out-of-state employee would have to show 240 hours in order to get in the pool. Department staff explained that once the out-of-state employee demonstrated 240 hours of service to Minnesota facilities, the employee's total compensation would be eligible for the pool. Additionally, an employee officed in Minnesota who performs little or no work for Minnesota facilities also would be eligible for allocation across the pool. And, as mentioned above, the 240 hours are based on services to Minnesota clients, for which some portion must benefit Minnesota ICF/MR facilities.

Item D. This item is needed to specify that records required under items A to C must be maintained in a format specified by the commissioner unless an alternate format is approved in advance. This provision is reasonable because, in the past, providers have had difficulty producing time records that meet the department's specifications. By requiring providers to keep time records according to the format specified by the commissioner, providers have less confusion as to what is expected. Also, some providers have been known to provide more information than the department needs and wants, based on the assumption that "more is better." By specifying a format, employees will be more likely to keep the records that are needed.

This item includes the option for the provider to have an alternative format for recordkeeping approved by the commissioner. This is reasonable because some providers may already have systems for keeping records in place that meet the department's requirements or can meet the requirements with some modification. Rather than require providers to adopt a single format for keeping records, it is reasonable to allow flexibility. In addition, providers may want to track other information that is not specifically required by the department. By allowing providers to have their own formats for keeping records approved, it permits them to integrate their recordkeeping needs with the department's requirements, rather than keeping dual records.

It is reasonable that the alternative recordkeeping format be approved in advance to safeguard providers from completing and submitting records only to discover later that the records do not supply adequate information.

Item E. This item establishes that failure to maintain the documentation in items A to C will result in the disallowance of the compensation. This item is needed to enforce the requirements for recordkeeping. It is reasonable to disallow compensation costs when records have not been maintained, rather than allocating the costs, because the allocation method proposed cannot be implemented without these records. Without disallowances, providers could choose when to keep records and force allocation based on the ratio of expenses depending on which instance would most skew costs to the ICF/MR (see discussion on pages 12-13.)

Subpart 4. Central, affiliated, or corporate office costs.

It is necessary and reasonable to delete this subpart because this rule part sets forth a new method for allocating central, affiliated, and corporate office costs.

Subpart 5. Allocation of costs to related or nonrelated organizations. This subpart is being deleted because new subpart 3a (assignment and allocation of costs including central, affiliated, or corporate office costs) encompasses the substance of this subpart.

Subpart 6. Payroll tax and fringe benefit cost allocation.

Part 9553.0030 subp. 3b Time Records

It is necessary and reasonable to delete this subpart because this rule revision eliminates the payroll and fringe benefit, program, maintenance, and administrative costs categories, thus rendering this provision unnecessary.

PART 9553.0035 DETERMINATION OF ALLOWABLE COSTS

Amendment of this part establishes line item limits and documentation requirements for individual compensation, vehicle mileage, travel, and membership fees.

Subpart 2. Licensure and certification costs. Item A has been deleted because the reference to 42 Code of Federal Regulations section 442.400 is no longer accurate -- that section no longer exists. Item E still requires ICFs/MR to meet licensing standards under federal and state law.

Item B has been amended to correct the citations to department rules that set program standards.

Subp. 3. Service costs. Program, maintenance, administrative, and payroll taxes and fringe benefits cost categories are being combined into one general operating cost category, as discussed in detail in the SNR of part 9553.0040. It is necessary and reasonable to substitute the term "general operating" to reflect the combination of these cost categories. This revision also appears in the following parts: 9553.0035, subpart 3; 9553.0050, subparts 1 and 3; and 9553.0060, subpart 1. These revisions are reasonable to assure consistency throughout the rule.

Subp. 5. Adequate documentation. Item A. (3). This subitem includes technical language changes which better convey the intended meaning of the item. At the end of this item, the words, "and maintain the information in another manner", are added because the intention is for the provider to not only make a good faith attempt to obtain the information, but also if unable to obtain the information in the required manner, to produce and keep the needed information in some other way. This item is needed and reasonable because, without the information, individual costs cannot be determined or justified.

Item C. It is necessary to eliminate the requirement to keep payroll allocation records for all cost categories because payroll expenses are present in only one category -- "general operating cost."

Item D. It is necessary to delete the present method for vehicle mileage documentation and insert the proposed language in order to implement a simpler approach for documenting vehicle costs, while maintaining certain needed cost controls.

The present rule requires the facility to maintain mileage logs for all mileage, except that of

motor vehicles used exclusively for facility business. As a result, comprehensive mileage logs must be maintained for vehicles used primarily for transporting residents and only occasionally used for personal reasons. It is reasonable to require mileage log documentation for vehicles used primarily for resident transportation only when the vehicle is used for personal reasons because it will reduce the amount of recordkeeping and still allow subtraction of reimbursement for personal use of the vehicle.

<u>This criterion for recordkeeping is supported by the advisory committee</u>.

By requiring documentation of the total annual mileage for the reporting year, personal use of a vehicle principally used for resident transportation can be disallowed through a proration of the vehicle's property and operating costs. Therefore, it is a more reasonable and efficient way to disallow the costs of personal usage of vehicles.

It is reasonable to require more stringent documentation for vehicles which are assigned principally to an individual or used by corporate or office staff because in these situations the vehicle is more available for personal or general use. (Subitem (2).) It is reasonable to limit reimbursement for these vehicles to mileage only, as this will encourage prudent acquisition of vehicles which are assigned principally to individuals or office staff. For example, under the IRS reimbursement rate, full reimbursement for the costs of an economy car may be likely. However, it is unlikely that the costs of a luxury vehicle will be fully reimbursed. The department's proposal thus promotes economy.

It is reasonable to reimburse business mileage based on the current IRS reimbursement rate, as the IRS rate is the standard frequently applied to these businesses. (Subitem (3).)

It is reasonable to consider the travel between work and the employee's personal residence as personal use of a vehicle, because this travel is not a part of the employee's job. (Subitem (4).) In most employment situations, an employee's work day begins and compensation commences when he or she arrives at the work site. The time and expense to arrive at the work site is the responsibility of the employee. This concept is reasonable as it parallels federal IRS regulations in regard to similar issues and such time does not directly benefit the client or the facility.

Subp. 8, item B. Capitalization. It is necessary and reasonable to delete the language classifying repairs necessitated by resident behavior as a program expense because this rule amendment proposes to collapse program and maintenance operating cost categories. The combining of categories makes this language unnecessary and, therefore, a reasonable change.

Subp. 10. Retirement contributions. This item is needed to indicate that IRS sections 403 (b) and 408 (k) plans are acceptable under this cost category, as provided under Minnesota Statutes, section 256B.501, subdivision 5a, paragraph (d). It is reasonable that these benefits

designated in statute as allowable be listed with other 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 44. The amendment is also reasonable because it clarifies the terms used.

Subp. 14. Individual Compensation limit. This subpart removes the compensation limit for top management and establishes an individual compensation limit for all ICF/MR employees.

The top management compensation limit under the present rule was created as a maximum compensation for top managers. These individuals (owners, administrators, etc.) are presumed to be the most highly compensated individuals in an organization because they are generally in a position of direct budgetary control. The top management compensation limit was established to prevent individuals with this level of budgetary control from granting themselves excessive compensation levels. The compensation limit under the proposed rule serves the same purpose, but it avoids confusion as to who is "top management." Except for the clinical services exception, the proposed limit acts as a ceiling for compensation whether or not an individual would be considered top management. It is likely that highly compensated individuals (whether full-time or part-time and receiving high compensation for the portion of time compensated for ICF/MR service) will often be the same individuals who are defined as top managers and limited under the current rule.

Amendment of this subpart is needed, pursuant to 1995 Minnesota Laws Chapter 207, Article 7, section 34, which requires rule revisions that:

> "(5) establish compensation limits for employees on the basis of full-time employment and the developmentally disabled client base of a provider group or facility."

The proposed amendments to this subpart are also needed because 1995 Minnesota Laws, Chapter 207, Article 7, section 34, requires rule revisions which combine the program, maintenance, and administrative operation cost categories into one general operating cost category. When cost categories are combined, administrative costs will no longer be segregated from other costs; thus, it will no longer be possible to apply an administrative limit.

The administrative cost category limit served as a deterrent for excessive spending on compensation in the administrative area. Under the administrative limit, providers could pay whatever compensation they negotiated with individuals who were not "top management," but overall compensation levels were limited by the administrative limit. As all administrative tasks had to be accomplished by personnel compensated within the limits established by the administrative cost category, the administrative limit served as a deterrent for excessive administrative compensation for non-top management administrative personnel. Without the

administrative limit, this deterrence will no longer exist.

A limit on individual compensation is a reasonable way to continue to control excessive compensation because it provides a comparable level of control over compensation and is more targeted than the present administrative limit.

Finally, with the combination of administrative and program categories, it is necessary to prevent shifts of dollars from direct client services into excessively high compensation for some individuals. The individual compensation limit prevents providers from shifting dollars spent on direct care of residents into compensation for highly paid individuals by placing a reasonable limit on reimbursement for the compensation of any highly paid individual. This provision is essential because it discourages or prevents highly paid managers from increasing their own salaries by shifting program dollars into salaries. Such shifts could result in a decrease in the quality of direct client services.

It is necessary and reasonable to remove the deleted language in current rule, Subpart 14, items A to F so the rule may be amended to provide a new individual compensation limit structure.

It is reasonable to delete the top management compensation limit language because "top managers" will be limited under the new individual compensation limit. Use of an individual compensation limit, rather than a top management compensation limit is also reasonable because it will eliminate disputes and subsequent appeals regarding what constitutes "top management."

It is reasonable to delete the existing rule language stating that documentation of all necessary service performed must be maintained according to subparts 5 and 6. Subparts 5 and 6 already state this; the reference here is redundant.

The new language in items A to H establishes a limit on allowable annual compensation for any employee of a facility or provider group and for any consultant who is related as defined in part 9553.0020, subpart 39. It is reasonable that this limit is effective beginning after September 30, 1996, because October 1, 1996, is the beginning of the first rate year after the rule is to be adopted. Although this subpart includes related consultants as defined in part 9553.0020, subpart 39, it does not apply to unrelated consultants.

Item A identifies certain individuals that are excluded from the individual compensation limit. The limit does not apply to compensation for clinical services by employees or related consultants who are licensed psychiatrists, psychologists, or physical therapists. Licensed psychiatrists, psychologists, or physical therapists are employees who commonly work part time for a provider and usually receive a high rate of compensation for their part-time work. Because item C requires the individual compensation limit to be prorated for individuals who work less than full time, it is likely that, without an exclusion, the reimbursement for many of

these high level professionals would be limited.

The high level of compensation which these individuals command is dictated largely by the marketplace. Without this exception, a provider may have difficulty obtaining a qualified individual who would charge an amount within the prorated individual compensation limit. By providing an exception to the individual compensation limit for these specialists, the rule will not limit reimbursement for these services. As a result, the availability of these services for clients will not be inhibited as a result of the compensation limit. For these reasons, the inclusion of item A is reasonable.

It should be noted that this exception applies to compensation for clinical services; not to the person who provides the services. Therefore, a person who performs half-time clinical services and half time non-clinical work cannot claim the non-clinical work under this exemption. Additionally, if compensation is determined to be "unreasonable" by the department, it may adjust the compensation as provided in the general cost principles section of the rule.

It also should be noted that many licensed psychiatrists, psychologists, and physical therapists bill Medical assistance directly on a fee for service basis. This provision will not apply to these persons as their compensation will not be reimbursed through payments to the ICF/MR.

Item B specifies the maximum compensation that may be recognized in parts 9553.0010 to 9553.0080 for any individual employed by an organization that provides Minnesota ICF/MR services. These limits are set at levels which are much higher than the compensation presently received by most employees working for a Minnesota ICF/MR, and would likely affect only the highest level employees in a provider group.

The limit varies based on the number of persons with developmental disabilities served and the type of services provided to those clients. This is illustrated in the left hand column on the table in item B.

Subitems (1) through (4): The term "client equivalents" is used to account for the types and amounts of services (ICF/MR, semi-independent living services (SILS), etc.) received by persons with MR/RC served by the organization. This term is used when establishing individual compensation limits. Client equivalents were developed to provide a means for counting persons with MR/RC for whom an employee is responsible by recognizing that different services involve varying levels of staff intervention and associated responsibility. For example, overseeing a 24-hour supervised program requires more time and responsibility than overseeing a SILS client who receives a staff visit once a week.

A client equivalent of 1.0 is assigned for clients who receive 24-hour supervised ICF/MR or waivered services from the provider. A client equivalent of .2 is assigned for each client who receives SILS, non-24-hour supervised waivered services, or day training and habilitation

(DT&H) services. These client equivalents are summed for a client who receives more than one type of service from a provider group, such as DT&H and waivered services. The client equivalents for clients served by the provider group are summed and this number is used to determine the applicable individual compensation limit from the table.

A client equivalent of 1.0 is a reasonable benchmark for clients receiving 24- hour services in an ICF/MR or through waivered services because it relates to the services provided to one (1.0) individual for 24-hour services. For clients receiving less than 24-hour services from a provider or provider group, a client equivalent of less than 1.0 is reasonable. This point was discussed with the advisory committee who made recommendations to the commissioner. The group agreed on a client equivalent of .2 (20%) for clients receiving less than 24-hour services from a provider or provider group. Although the number of hours of services provided daily can vary greatly among persons receiving less than 24-hour services, the group agreed that .2 is a reasonable proxy for an average level of services such as SILS and non-24-hour waivered services.

The department received a written comment suggesting that the term, "24-hour services" be changed to "24-hour plan of care," because many programs require 24-hour staff who can sleep for a portion of those hours. In this subitem, "supervised" is intended to include either awake or asleep staff. If the term was changed to "24-hour plan of care", as the commenter suggested, situations where no staff are at the site, but a "plan" is in place, could be counted as 24-hour services. This is not the intention. Therefore, the department chose to use the term "24-hour services" and to explain in the SNR that 24-hour services specifically includes situations where sleep-over staff are used.

For DT&H services, .2 is also a reasonable figure. While the amount of DT&H services can vary, a DT&H provider operating year round, providing 6 hours of service per day, Monday through Friday, would provide 1560 hours of service per year, or approximately 18% of around-the-clock service.

Subitem (5). Client equivalents shall be counted on the last day of the reporting year. A standard is needed so providers will know when they should count the number of client equivalents in their organization. This point was discussed in advisory committee meetings. The department offered to set the date for counting client equivalents at either the beginning or the end of the year. The department suggested that counting at the end of the year generally may be more beneficial to providers since provider groups seem to be expanding their overall services, rather than reducing them. After some discussion, advisory committee members concluded that provider organizations are tending to serve more, rather than fewer clients. By counting at the end of the reporting year, the growth in clients served will be reflected on the table. Counting client equivalents by taking an average was considered by the department but rejected because it added unnecessary complexity while providing minimal, if any, added benefit. As a result, counting client equivalents at the end of the reporting year was determined

to be the most reasonable alternative.

Subitem (6) Client equivalents establish a measure for the size and complexity of the provider organization. Consideration of the size and complexity of the entire provider group is reasonable because individuals who receive high compensation often have organization-wide responsibility. The table acknowledges the complexity of the provider organization, and therefore, the magnitude of job responsibilities for highly compensated individuals, when determining the applicable individual compensation limit.

It is also reasonable to provide a higher compensation limit for persons working in larger organizations because this allows for increases in compensation for persons assuming broader responsibilities within the organization who assume greater responsibilities. However, it can be expected that, at some point, a person has assumed all the responsibilities of managing a large organization, and there is little difference in management function resulting in additional increases in organization size.

The individual compensation limits in subitem (6) were developed after considerable discussion with the advisory committee. An advisory committee subgroup, consisting primarily of ARRM representatives and DHS staff, developed a maximum compensation scale, based on the size of the organization (number of clients served). The group initially agreed that 15 or fewer clients served would constitute the bottom of the scale. Initially, $38,000 was chosen by the committee as the compensation limit for serving 15 or fewer clients (or client equivalents). However, ARRM received complaints from small providers that would be affected by this limit, so withdrew its support for the $38,000 limit. DHS staff looked for a more objective method for establishing the compensation limit scale.

DHS and ARRM representatives eventually agreed to develop a maximum compensation limit based on the current top wages paid to comparable Regional Treatment Center employees. According to Minnesota Department of Employee Relations, the top salary of a SOCS coordinator (Community Residential Supervisor) overseeing between 6 - 12 beds, is $43,848 per year (see exhibit 10).

The group also agreed that top compensation for managing a large, complex MR/RC service entity including ICF/MR services or a large ICF/MR should be no more than the top compensation paid to a Regional Treatment Center (RTC) Chief Executive Officer (CEO). (See exhibit 11.) RTC-CEOs oversee RTC based ICF/MR services, state operated community based ICFs/MR, and waivered services for several hundred persons with developmental disabilities. The current RTC-CEO top compensation (Chief Executive Officer - Hospital) is $80,680. Therefore, it is reasonable to use this maximum salary to define the maximum compensation limit for similar positions in community ICFs/MR.

The RTC-CEO top compensation amount actually exceeds the ICF/MR top management

compensation limit under the present rule (the 1995 top management compensation limit is $74,994). Thus, the proposed limit is more generous than the previous limit.

The compensation limit table was completed by establishing maximum compensation limits beginning with $44,000 for 1 - 12 client equivalents and ending at $80,500 for 80 or more client equivalents. ARRM members were concerned that individuals serving small organizations may be more subject to salary limitation under this structure than individuals serving large organizations, because the compensation of individuals serving smaller facilities may be closer to the established limits under this model. To address this concern, the table was constructed to increase the limit by $1,000.00 increments for each client equivalent from 12 to 17 beds. The limit increases in $500.00 increments for each client equivalent above 17, until reaching the top compensation for an RTC-CEO.

This model created a threshold of 80 client equivalents or more for the top individual compensation limit. The advisory group agreed that management of as few as 80 beds may involve all the complexities of a large operation. It also is reasonable to assume that the overall management of a facility or provider group will change little if it exceeds 80 client equivalents since a manager who assumes responsibilities exceeding 80 client equivalents likely will delegate some responsibilities. Therefore, it is reasonable that the maximum number of client equivalents on the table should be 80.

In the advisory committee meetings, some cases were presented of employees whose current individual compensation may be higher than the limit. The department recognizes that an individual compensation limit structure that limits no one would need very high limits in order to accommodate the high salaries of every outlier. Such a scale would be essentially useless. As a result, a small number of individuals' compensation may fall above the individual compensation limits proposed in this part.

However, the department recognizes that the intention of this subpart is to establish limits that will contain future growth in compensation once the administrative limit is removed, but not to penalize employees who have been allowed high levels of compensation under the present rule's limits. For this reason, the individual compensation carry-forward provision (item F) was added, so individuals with ICF/MR compensation above the proposed limits defined in item B may continue to receive this level of ICF/MR compensation, up to the maximum limit of $80,500. However, the limits will apply to newly hired employees and to employees who are currently within the proposed limit.

This table does not, nor is it intended to, limit compensation for non-ICF/MR services. The table represents the reimbursable compensation limits for full-time ICF/MR service or the prorated compensation limit for less than full-time service. These rule amendments do not establish any compensation limits for waivered or SILS services because it is the responsibility of counties and providers to negotiate prices for these services. Payment for these services is

outside of the scope of this rule. Providers are not precluded from compensating an ICF/MR employee an amount above the applicable compensation limit. However, the provider can receive reimbursement only for that employee's compensation up to the maximum applicable limit.

It is reasonable for the compensation table to include the total number of client equivalents in the provider group rather than only ICF/MR clients because individuals who work part-time in ICF/MR services and part-time in non-ICF/MR services have their non-ICF/MR services allocated across the organization as set forth in part 9553.0030, subpart 3a. The compensation limits on this table represent full-time compensation. Therefore, it is reasonable to consider the size and complexity of the entire organization prior to applying the allocation method.

For these reasons, and because of the incorporation of exceptions discussed above, the department concludes that the table of individual compensation limits is reasonable.

Item C is needed to establish that the individual compensation limit in item B must be prorated for any individual who works for the facility or provider group on less than a full-time basis. Part 9553.0020, subpart 21a, defines full-time employment as at least 2080 hours annually in accordance with written personnel policies of the facility or provider group as verified by time and attendance records. The individual compensation limit table in item B lists the individual compensation limits for full-time employment. Therefore, if an individual performs less than full-time service for an ICF/MR, it is reasonable to prorate the individual compensation limit.

An issue that received substantial consideration by the department and the advisory committee was whether to provide a mechanism for individuals who work more than 2080 hours per year to count their "overtime" for allocation purposes. In the initial recommendations to the commissioner, the initial advisory group proposed recognizing up to 2600 hours service When final agreement could not be reached on a compensation limit structure and a method for allocating compensation, the proposal for recognizing overtime was reconsidered as part of the total compensation limit amounts and allocation method eventually proposed.

The department has determined that full-time work shall be defined as at least 2080 hours. This is reasonable because highly compensated salaried individuals, both in private and public sectors, often work in excess of 2080 hours. When asked by the department, most provider members of the advisory committee acknowledged that they presently work more than 2080 hours annually. Also, RTC-CEOs are expected to work at least 2080 hours per year and are not routinely compensated for their overtime work (see exhibit 12). The salary limits in the table are limits for high-level individuals who oversee ICF/MR services. Therefore, it is assumed that these individuals may already be working in excess of 2080 hours for their full-time salaries. The compensation limits in the right hand column of the table reflect this assumption.

Item D states that, "individual compensation shall not include fringe benefits unless they are not provided to all or substantially all of the employees of a facility or provider group at the same benefit level." This means that employees who receive fringe benefits that most other employees do not receive will have those fringe benefits counted as compensation. Those fringe benefits shall be included as compensation subject to the limit in items B and C.

This provision is needed to prevent providers from circumventing the compensation limit by creating "perks" for select individuals in lieu of compensation. This provision is a part of the present rule, and appears in the deleted language regarding top management (see part 9553.0035, subpart 14.) If this provision was not retained, providers might lose an incentive to continue to offer fringe benefits to substantially all of their employees, including direct service employees. Alternatively, other forms of compensation of these individuals would flourish, defeating the legislative intent to limit highly compensated individuals.

It is reasonable not to include fringe benefits such as group health, dental insurance, or governmentally required retirement plans in the calculation of total compensation for purposes of the individual compensation limit, because the value of these benefits is not reflected in the compensation limits established in this subpart. Likewise, the RTC-CEO top compensation amount does not include the value of fringe benefits. It also is reasonable to exclude these benefits because, while the cost of these benefits may change, the benefits received may remain unchanged. Therefore, including these benefits under the compensation limit may unduly penalize employees whose benefit costs increase.

Item E establishes controls on salary increases for employees who are owners, administrators, executives, (such as president, vice president, treasurer, comptroller, chief executive office, or chief financial officer), and who are compensated at less than the limit in items B and C.

Some control over salary increases is needed to replace the control which was provided by the former administrative cost category limit. Under the present rule, the administrative limit placed an overall control of spending in the administrative cost category. Under the proposed rule, administrative expenses are combined into a general operating cost category. When these cost categories are combined, the cost control benefit of the administrative cost category limit no longer exists.

Under the new structure, it would be possible for owners or executives with direct budget control to increase their salaries, up to the limit, by shifting dollars formerly designated for direct resident care. Were this to occur, an erosion in program quality would likely result. Therefore, it is reasonable and prudent to prevent this from occurring. By creating a line item limit for those individuals who may have the incentive and the ability to increase their salaries, cost categories can be combined with less risk of shifts in spending from programmatic purposes to unnecessarily high compensation of key managers or owners.

Subitem (1) establishes that for the individuals listed in item E, (owners, executives, or administrators - including, but not limited to president, vice president, treasurer, comptroller, chief financial officer, or financial officer), future compensation increases reimbursable under this rule are restricted to no more than the forecasted index in part 9553.0050, subpart 2, item C, subitem (2) for reporting years subsequent to the reporting year ending December 31, 1995, applied to the compensation for 1995. This provision is reasonable because it discourages individuals from shifting program dollars in order to increase their own salaries. Use of the index in part 9553.0050, subpart 2, item C, subitem (2) is reasonable because it is the same index authorized by the legislature for annual inflation adjustments in ICFs/MR under Minnesota Statutes, section 256B.501, subparts 3c.

It is reasonable to use the compensation level received in 1995 because that is the most current salary level for employees prior to this rule's adoption (in early 1996).

This subitem only applies to those employees listed. Employees that are not owners, executives, or administrators may receive increases in compensation up to the amount of the applicable limitation under items B and C at whatever rate the employer determines. This is reasonable as a provider may have many valid reasons to give an unrelated employee a raise. For example, the employee may receive a promotion, accept greater responsibilities, or assume a greater work load. Also, an employee may acquire new skills or expertise. This provision allows the provider discretion in granting compensation increases to the majority of employees.

This subitem also provides that if the owner, administrator, or executive's compensation is less than the limit in items B and C and below the limit for a 40 bed (meaning 40 client equivalents) facility or provider group, that the allowable increase in compensation for the individual shall be no more than the amount determined in item H. This was included because item H increases the limits on the table by a dollar amount based on the CPI increase to the mid-range (40 client equivalents) of the table in item B. Without this exception, owners, administrators, or executives would have their allowable increases limited to the forecasted inflation index, even though the applicable limit on the compensation table was increasing faster than the inflation index because it is indexed at the mid-point (40 client equivalents) on the table in item B. This provision permits the allowable compensation for these individuals to increase by this amount.

The following examples illustrate this subitem. These examples assume full-time ICF/MR employment (not allocated).

1. An administrator of a 15 bed ICF/MR receives $40,000 per year in compensation. This compensation is below the applicable compensation limit in item B of $47,000. The CPI-U increase is 3%. Item H determines a dollar amount based on the mid-point of the table ($60,500) for the increase, so the resulting indexed amount would be $1,815. This provision allows the administrator of the 15 bed facility also to increase his salary

by $1,815, to $41,815. As a result, this administrator can receive an allowable increase in pay higher than the 3% CPI-U would have provided ($40,000 + 3% = $41,200.)

2. In another example, an administrator of a 100 bed provider group, earning $70,000 can receive an increase in compensation by the full CPI-U increase (example 3%), or $2,100 for total allowable compensation of $72,100. Although the applicable limit on the table would only increase by $1,815 to $82,315, this person is below that limit, so is not affected.

3. If an owner, administrator, or executive is receiving compensation at the applicable limit, that person can receive an allowable increase up to the applicable limit on the table indexed according to item H (in this example, the applicable limit plus $1,815).

This is reasonable because it permits owners, administrators, and executives of smaller facilities to benefit from the progressive indexing of the individual compensation limits resulting from item H.

Subitem (2) was added to recognize situations where an owner, administrator, executive, (such as president, vice president, treasurer, comptroller, chief executive office, or chief financial officer) assumes increased responsibilities. Assuming that this level of employee has organization-wide responsibility, an increase in the number of client equivalents for the provider group serves as an indicator that the person has assumed greater responsibilities. When the organization's total number of client equivalents increases, this subitem allows compensation increases, up to the limit established in items B and C, for any employee, which are proportional to increases in client equivalents for the facility or provider group. This subitem serves as an exception to subitem (1).

For example, if a provider group expanded the number of client equivalents from one reporting year to the next from 30 to 50, the corresponding compensation equivalents from the table are $55,500 and $65,500. The proportional increase in compensation would be $10,000 ($65,500 minus $55,500) divided by $53,000 or 18.01%. This percentage increase would be the maximum increase that could be given.

Allowing increased reimbursement for these highly compensated persons who have generally broad corporate responsibilities and who assume increased responsibilities due to the growth of their provider group is a reasonable policy position. Much of the growth in provider groups is in waivered, SILS, and other non-ICF/MR community based MR/RC services. Without this exception to subitem (1), the employee's ICF/MR allowable compensation may be eroded when the cost allocation formula is applied. By allowing individuals who manage provider groups to receive increased compensation for growth in their provider group, a potential disincentive for expanding these services is removed.

Item F. This item is needed to establish a mechanism to allow individuals whose allowable unallocated compensation is more than the applicable limit to continue to have that amount recognized in the rate setting formula, up to the maximum compensation limit under items B and C. Individuals whose compensation under the present rule exceeds the proposed compensation limits will continue to have that compensation "grandfathered," provided that the conditions in subitems (1) to (5) are met. It is reasonable to use 1995 compensation as the "grandfathered" amount because it is the most recent salary level for employees prior to this rule's adoption (in early 1996).

This provision is reasonable because the purpose of the individual compensation limit is to control future growth in compensation for individuals receiving high compensation in ICFs/MR. The intent of this rule part is not to penalize individuals who are legitimately receiving allowed compensation under the present rule.

Subitem (1). This provision is needed to establish that the carry-forward individual compensation amount (the "grandfathered" amount) cannot exceed the highest limit shown on the table in item B.

It is reasonable to limit the grandfathered compensation amount to no more than $80,500.00 (the RTC-CEO maximum compensation level) for the same reasons as discussed in the SNR of item B above.

It is reasonable that the maximum grandfathered compensation amount should not be indexed for inflation as provided under item H because the "grandfathered" carry-forward is meant to be a static amount. When the compensation limit on the table as adjusted in item H exceeds the grandfathered amount, the compensation carry-forward provision will no longer be necessary because the employee's compensation will no longer exceed the limit.

Subitem (2) is necessary to clarify that the carry-forward amount is based on the assumption of full-time ICF/MR employment and will be adjusted proportionately downward if an individual provides less than full-time ICF/MR employment. It is reasonable to assume that an individual already receiving compensation above the limits established on the table should be performing full-time work for the ICF/MR because the limits on the table are for full-time employment. In cases where the individual works in both ICF/MR and other MR/RC service areas, the allocation formula will be applied to the carry-forward amount to determine the proportionately adjusted ICF/MR carry-forward amount. This application is consistent with the allocation method in part 9553.0030.

Subitem (3) is necessary to allow a grandfathered amount that was adjusted downward because the individual did not work full time, also to be adjusted proportionately upward, to the lesser of the limit in items B and C for the facility or provider group or the actual amount of compensation. This is reasonable because individuals may work greater or lesser proportions of

full time from one year to the next.

Subitem (4) This subitem is needed to explain restrictions to the compensation carry-forward provision. It is necessary to establish that the carry-forward amount, as adjusted, serves as the compensation limit for the individual until the applicable individual compensation limit from the table in item B equals or exceeds the carry-forward amount. This provision clarifies that the carry-forward is an exception to the individual compensation limit, as restricted by units (a) and (b). This item also explains that when the applicable individual compensation limit from the table equals or exceeds the carry-forward amount, the carry-forward exception no longer applies for the individual and henceforth the provisions of subpart 14, items A to E, G, and H (the applicable individual compensation limit) shall apply.

Unit (a) It is necessary and reasonable that the grandfathered amount not be increased for annual inflation changes, because the individual compensation carry-forward is not intended to indefinitely grandfather compensation above the applicable rule-based limit for these individuals. Rather, the individual compensation carry-forward is designed to provide a transition for individuals receiving high compensation during implementation of the new individual compensation limits without incurring financial hardship. It is reasonable that the grandfathered amount remain at that level until the rule-based compensation limit for the applicable number of beds equals or exceeds the grandfathered compensation amount, as this continues the compensation carry-forward provision for as long as is necessary for those individuals affected.

Unit (b) It is necessary and reasonable that the carry-forward amount should not be increased for proportional changes in client base, because any proportional change in clients served will be reflected on the table in item B. If an increase in clients served (client equivalents) is enough to raise the appropriate limit above the grandfathered amount, the individual compensation carry-forward provision is no longer necessary and the applicable provisions under subpart 14, items A to E, G, and H shall apply.

Subitem (5) This subitem is needed to establish that the carry-forward compensation is subject to downward proportional adjustments for decreases in client equivalents. If a facility or provider group reduces its size and complexity as evidenced by a reduction in the number of client equivalents, it is reasonable that the carry-forward amount also be subject to a downward proportional adjustment for the affected employees. This is consistent with the adjustments in the compensation limits under item B that occur with changes in client equivalents.

Examples for Allocating the Carry-forward Individual Compensation Amount

Assumptions:

Applicable compensation limit under proposed Rule 53: $45,000

Maximum compensation limit: $80,500

Base ICF-MR allocation under current rule: 50%
For revised rule ICF/MR allocation: See examples of various levels of compensation.

Current Rule Comp.	Revised Rule Comp.	Current Rule Allocation	Revised Rule Allocation: 20%	50%	80%
$20,000	$20,000	$10,000	$4,000	10,000	16,000
$45,000	$45,000	$22,500	9,000	22,500	36,000
$60,000	$60,000*	$30,000	12,000	30,000	48,000
$70,000**	$70,000*	$35,000	14,000	35,000	56,000
$90,000	$80,500***	$45,000	16,100	40,250	64,400

*Hold Harmless Amount
**Assume that actual compensation was $80,000, but only $70,000 was allowable because of the current Rule 53 top management compensation limit.
***The maximum compensation limit serves as an upper limit on the Hold Harmless.

Item G. This item is needed to establish the allowable compensation for an individual as the lesser of the total compensation as adjusted in items D and E or the individual compensation limit in items B and C, unless the person has a carry-forward compensation amount. This item references the applicable items (items B through E) which are used for establishing an employee's allowable compensation. The applicable amount is subject to allocation in accordance with part 9553.0030, subpart 3a. (See the SNR of part 9553.0030, subpart 3a for the need and reasonableness for allocating shared costs, including individual compensation.)

Item H. It is necessary and reasonable to include this provision so compensation limits in item B will keep pace with inflation. The reporting year ending December 31, 1996 is designated as the first year in which the inflation factor will be applied, and annually thereafter. It is reasonable to begin the inflation index with reporting year 1996 because it is the end of the first cost report year following implementation of the revised rule. It is necessary and reasonable to use the forecasted index in part 9553.0050, subpart 2, item C, subitem (2), as use of this index is required by statute.

It is reasonable to apply the inflation factor by determining the inflation increase for a forty-bed facility and increasing each per bed limit on the table by that amount because forty beds is the mid-point on the table. This method provides the same compensation limit increase across the scale. If the inflation percent increase was applied based on the amount for each per bed limit, the higher end of the table would increase faster than the low end of the table. Over time, the difference between the low end and high end compensation limits on the table would become wider. This method is reasonable because it provides a more equitable way to index compensation limits for inflation for all-sized provider groups. The advisory committee supported this provision.

Subpart 17. Out-of-State, overnight travel costs.
This subpart establishes the maximum allowable out-of-state, overnight travel costs reimbursable under the proposed rule. This limit is necessary because the proposed amendments remove the administrative limit. It is necessary to create alternative ways to limit certain areas that may be subject to excessive utilization without a limit. Creation of line item limits puts strong limitations where needed, while allowing increased discretion in spending in other areas. Out-of-state, overnight travel is an area which, if not controlled, could be abused.

Because Minnesota ICFs/MR are all located within the boundaries of Minnesota, routine travel to Minnesota facilities will not be subject to this limit. Confining this limit to overnight travel allows facility staff near the state borders to travel during daytime working hours into the neighboring state for shopping or other purposes of benefit to the clients and the facility. This limit will primarily affect travel to out-of-state meetings and conferences.

The limits for out-of-state, overnight travel (items A to C) were developed during the initial advisory meetings (the group that provided recommendations to the commissioner). The group tried different methods for calculating the limit. There was agreement to base this limit on the size of the provider group with respect to the number of ICF/MR beds. ARRM leaders consulted with their membership to determine actual out-of-state, overnight travel, before agreeing to the limit proposed.

The group accepted these limits as reasonable and included them in their recommendations to the commissioner. These limits were again reviewed with the full rule advisory committee, which accepted items A to C.

It is reasonable to include the costs of transportation, lodging, and meals in the total limited amount, as this may encourage more prudent spending during out-of-state, overnight trips.

It is reasonable that costs not related to client care should not be reimbursable under the rule because medical assistance funds only can be used for services to clients. This provision is consistent with existing rule policy (see rule part 9553.0036, item F).

Subpart 18. Limit of membership fees and trade association dues.

This subpart allows the cost of facility membership in one Minnesota and one national ICF/MR trade association. It also allows reimbursement for membership in one community/ service or business organization whose activities are of programmatic benefit to the residents.

Line item limits for reimbursement for membership fees and trade association dues are needed because the proposed amendments remove the administrative limit. It is necessary to create alternative ways to limit certain areas which may be subject to excessive use without some

controls.

It is reasonable to limit membership to ICF/MR trade associations and organizations whose activities benefit ICF/MR clients because reimbursement under the rule must relate, either directly or indirectly, to client care.

This subpart was discussed with the initial rule advisory group to develop a reasonable limit. A limit based on a dollar amount was considered but was determined not to be feasible because membership dues can vary greatly. Factoring in the size of the organization was considered, but it was believed that size should not necessarily be a consideration, as both large and small organizations may seek the same kinds of memberships. The group eventually agreed to the limit presented here. This limit was presented to the full rule advisory committee, which offered no objections to this limit as proposed.

This limit in no way prevents facilities or employees from joining additional organizations. It only establishes a maximum number of organizations for which membership can be reimbursed under the rule. It is common, both in public and private sectors, for employees to personally pay for membership in associations.

PART 9553.0036 NONALLOWABLE COSTS

Amendments in this rule part are needed to clarify the special needs rate exception language and establish travel outside the continental USA or Canada as a nonallowable cost.

Subpart 1, Item AA. This item refers to costs incurred for services supported by a special needs rate exception. This technical amendment is needed so that a disallowance for the cost of services supported by a special needs rate exception cannot exceed the amount approved and authorized for payment. The current wording of this item could present problems for providers because it disallows any costs reported or billed as special needs costs. If a provider's reported special needs costs are in excess of what has been approved and authorized for payment, it is possible that these costs would not be paid under special needs, nor allowed as costs for rate-setting. This was not the intention of this item nor is the present wording consistent with the comparative language in the rule governing special needs. It is reasonable to clarify this language so that costs for special needs services would be disallowed up to the authorized amount but costs beyond the authorized amount would be allowable. This provision is consistent with the special needs rate exception rule, part 9510.1130 subpart 1, so that nonallowable amounts cannot exceed those amounts approved and authorized for payment.

<u>Item HH</u>. This item is needed to establish travel outside the continental United States or Canada as a nonallowable cost. This item is reasonable because quality services to clients will rarely, if ever, require overseas travel. Both the initial committee which presented recommendations to the commissioner and the full rule advisory committee support this provision.

PART 9553.0040 REPORTING BY COST CATEGORY

This part combines program, administrative, and maintenance categories into a single, "general operating" cost category. Other categories in the proposed rule are "property related costs" (subpart 5); and "special operating costs" (subpart 6).

Under present Rule 53, facility operating costs are assigned to various cost categories in an effort to differentiate between direct (program) care and indirect (overhead, room and board) costs. Costs which were believed to relate more closely to client care are classified as Program costs and are fully recognized in the prospective rate formulas. Costs in categories which relate to direct care in a more ancillary fashion are subject to limitations which create ceilings on amounts recognized in the rate formulas. These distinctions reflect the belief that these kinds of costs ought to be either discretionary, manageable, or more controllable, and were thought more likely to be subject to abuse. Also, limitations were thought less likely to affect the quality of care. The categories subject to limitation under the current rule are the "Maintenance" and "General and Administrative" cost categories.

These limitations have resulted in some cost containments. The limits also resulted in some disallowed costs. In the 1992 reporting year, approximately $74,000 in maintenance costs and $835,000 in general and administrative costs were, in the aggregate, excluded from the industry's rate. The total Medical assistance budget for this period was about 148 million dollars for this segment of the industry. A constructive effect of these limitations was to discourage providers from spending in these categories whenever it was administratively and managerially possible. Conversely, the lack of limitations in the direct care areas permitted more appropriate programmatic spending.

Unfortunately, the assignment of costs to specified categories has been a source of confusion and controversy from the time Rule 53 was first promulgated. Most of the controversy has centered on whether particular costs should be considered "Program" or "General and Administrative". The disputes most frequently have been about whether managerial and clerical salaries, office supplies and office equipment should be recognized as "Program" costs because of their relationship to the direct care effort or as "General and Administrative" costs because their character and the kinds of activities to which they relate were more akin to overhead. A December 1990 report from the office of the legislative auditor was critical of the program and administrative cost classification structure, citing it as, "perhaps the most problematic area of Rule 53." (See p. 14, Legislative Auditor's Report, exhibit 1).

In an effort to maximize reimbursement, providers have generally taken a more expansive view of the definition of "Program". The Department's staff, in assigning costs, have attempted to protect the initial integrity of the categories. These very different viewpoints have made cost categorization the principal focus of controversy. More than half of the appeals each year involve disputes about classification of cost categories.

Another dispute relates to the assignment of shared expenses between facilities and other

businesses, both MR/RC services and non-MR/RC services, as well as both Minnesota and non-Minnesota.

Resolving the appeals through the negotiation and settlement process has been time consuming and difficult. It has required extensive examination of the structure of individual provider organizations and the facts, when assembled, have not fallen into tidy, objective packages. The results in one case have not been easily transferrable to the next case. These same factors have made appeal resolutions through the hearing process equally unsatisfactory.

The length of time (often years) before rates are finalized and the resulting lack of predictability during the interim have exacerbated the problem. All in all, the rate setting system has not been able to function efficiently from the viewpoint of either providers or the department. In 1990, this led to a provider lawsuit which challenged the department's administration of Rule 53.

Complicating the audit and appeals process further is a recent decision by the federal Office of the Inspector General that the federal share of overpayments to ICFs/MR must be recovered within 60 days of the date a disallowance is made. Until recently, the department did not collect overpayments when a disallowance was first identified but waited until any appeals were resolved. This gave the benefit of the doubt to providers, which were allowed full due process before the department collected any overpayments. Under this new ruling, either providers will be required to pay back the federal share of the disputed amount, possibly causing them a financial burden, or the state will need to carry the federal portion of the payback until a final appeal ruling is made (thus increasing the state's costs). In either case, the impact of this situation will be minimized if the rule can be refined to lessen the number of appealed disallowances by eliminating disputed areas. (See page 43, Audit of Medicaid Costs Claimed by the Minnesota Department of Human Services for Intermediate Care Facilities for the Mentally Retarded, October 1, 1985 through August 31, 1991.)

These disputes need to be eliminated. The department and the industry share this goal. The challenge has been to find a way to curtail unnecessary spending and maintain cost neutrality while simplifying the system and reducing the need for provider documentation as well as subsequent departmental reviews.

A closer examination of audit adjustments and appeals shows that the primary concern has been facility spending which tends to directly benefit owners or those in control. Because cost categories have been a source of disputes resulting in numerous appeals, proposed Rule 53 amendments change the focus from limited cost categories to limits on individual costs through clarified definitions of allowability and limitations on specific line item costs. (See proposed individual limits under part 9553.0035, subpart 14, item B). As a result, separate operating cost categories can be eliminated without sacrificing cost containment.

Subparts 1 to 4. For the reasons discussed above, it is necessary to delete subparts 1 to 4.

Subpart 1a. General Operating Cost Category
This revised subpart combines the program, administrative, maintenance, payroll taxes and fringe benefits categories into a single, general operating cost category. It also transfers two insurance line items from the Special Operating Cost category to the new category. Cost reporting following the new classification structure is proposed to begin with the reporting year ending December 31, 1995. This date is needed and reasonable because it is the end of the last complete reporting year preceding the proposed adoption of the rule amendments. The information from this cost report will be used to set rates under the newly adopted rule, effective October 1, 1996.

Items A to Y list costs under the general operating cost category. Although this list is not exhaustive, it is necessarily expansive to give providers a clear sense of the type of costs that are to be assigned to the general operating cost category.

Program, administrative, and maintenance costs, payroll taxes, and fringe benefits are included within the general operating category. Because these costs are combined, language that differentiates items to a specific category is no longer necessary, and it is reasonable to delete it. For example, it is no longer necessary to specify that maintenance for repairs due to resident behavior be categorized as a program cost, while other repair costs are categorized as maintenance costs. The department believes it is important to keep some level of delineation of cost types for purposes of monitoring and analyzing cost trends, and therefore, it is reasonable to require some detailed expense reporting. The listings in the items are representative of the detail that will be required in the cost report under each item. For example, item A, includes all facility employees, but goes on to list certain employee titles. These titles indicate the level of detail in reporting that the department will require in the cost report.

Items B, E, F, G, H, I, J, M, O, P, Q, R, T, U, V, W, and X appear in the present rule The only change is that these items have been moved into the general operating cost category under the revised rule. This is necessary and reasonable for the reasons discussed in the introduction to this rule part. Because these items appear in the present rule, a detailed discussion of their need and reasonableness is unnecessary.

Some items have wording revisions in the new rule. The need and reasonableness of these items is discussed below.

Item A is needed to indicate facility employee positions that will be included under this cost category. These positions are currently listed under the program, administrative, and maintenance categories in the present rule.

Item C. It is necessary and reasonable to give providers a more clear idea of "consultant

services" with specific examples. Purchased services are not contained in this item because they are purchased from consultants, and therefore, the term is unnecessary.

Item D. It is necessary and reasonable to remove the word program from this item because the general operating cost category includes training costs for all staff.

Item K. This item is included in the current rule. The only difference is that, because of the combining of cost categories, the cite for the exception to this item has changed.

Item L. Travel is itemized as either in Minnesota or outside of Minnesota because travel outside of Minnesota is subject to the line item limit under part 9553.0035, subp. 17, if the travel includes an overnight stay out of Minnesota. The two types of travel will be reported separately on the cost report, so it is reasonable to list them separately in this item also.

Item N. The present rule refers to telephone and telegraph costs. It is necessary to expand this item to include "communication charges" because many providers use communication technologies other than telephones. It is reasonable to delete "telegraph charges" because such charges are necessarily included in the broader category of "communication" charges.

Item S. It is reasonable to allow membership fees, within the proposed limits, for associations and professional organizations because such memberships may increase staffs' professional development and expertise. Also, some organizations, such as community associations, may provide direct benefits to facility clients.

Item Y. It is reasonable to abolish the payroll and fringe benefits cost category because these costs are now included in the general operating cost category.

Item Y (5). This item is needed to incorporate self insurance, as provided under Minnesota Statutes, section 256B.501, subdivision 5a(e)(1), under this cost category. It is reasonable that a provision designated in statute as allowable be listed with other allowable costs.

Item Y (6). This item is needed to indicate that IRS sections 403 (b) and 408 (k) plans are acceptable under this cost category, as provided under Minnesota Statutes, section 256B.501, subdivision 5a, paragraph (d). It is reasonable that these benefits designated in statute as allowable be listed with other allowable costs.

Item Y (7). It is necessary and reasonable to indicate that governmentally required retirement contributions are included under the general operating cost category because the pension plans listed in this item are not all- inclusive.

Subpart 5. Property-related costs. It is necessary to delete payments permitted under part 9553.0036, item BB, from this cost category because such costs are now grouped under subpart

6. It is reasonable to categorize these costs under subpart 6 because subpart 6 includes similar costs.

It is necessary and reasonable to include central, affiliated, or corporate office capital assets used exclusively by the facility under this category because this category includes similar costs. The current rule is silent as to the categorization of these costs. This language clarifies where these costs must be categorized.

Subpart 6. Special operating costs. It is necessary and reasonable to delete real estate insurance and professional liability insurance from this cost category because those costs will now be categorized under item O of the general operating cost category. It is reasonable to include these costs in the general operating cost category because it permits all insurance costs to be included in the same cost category.

It is necessary and reasonable that payments permitted under part 9553.0036, item BB, should be categorized under this subpart because costs in this category are passed through. Therefore, these special situations can be recognized and those costs categorized under the rule.

PART 9553.0041 GENERAL REPORTING REQUIREMENTS

Subpart 16. Reporting real estate taxes, special assessments, and insurance. This part instructs providers and their accountants how to prepare cost reports. Subpart 16 specifies documentation which providers must submit annually to receive reimbursement for certain special operating costs. Because two of the cost items, real estate insurance and professional liability insurance, are included in the general operating cost category, this documentation is no longer required. By combining cost categories, the distinction between these types of insurance and other facility insurance is not needed. Under the current rule, this distinction serves to exempt these two types of insurance from the administrative cost limitation. With one general operating cost category, it is reasonable to no longer exempt and pass-through these costs, but rather classify them in the same way as other insurance. Instead of passing-through these costs, the historical cost will be indexed for inflation. Therefore, it is no longer necessary nor reasonable to require the advance submittal of this documentation.

PART 9553.0050 DETERMINATION OF GENERAL OPERATING COST PAYMENT RATE

Subpart 1. Establishment of allowable historical operating cost per diem. By combining the program, maintenance, and administrative cost categories into one general operating cost category, it will no longer be possible to apply administrative and maintenance cost category limits. Amendments in parts 9553.0010 to 9553.0080 remove the present method for determining administrative and maintenance operating cost disallowances, provide a mechanism to carry forward historic administrative cost adjustments in order to provide funding to continue

"efficiency incentive payments," provide means for facilities to reduce and eventually reconcile their administrative carry-forward, and establish a mechanism for netting the total maintenance disallowance against available efficiency incentive dollars. It is necessary and reasonable to delete applicable language because the old method will no longer apply once the new method is in place.

Item A. The administrative operating cost limit carry-forward. Under the current rule, efficiency incentive payments are funded primarily with savings from disallowed administrative costs that exceed the administrative limit. The bulk of these dollars are returned to the industry each year. Because the proposed rule combines the administrative cost category with other cost categories into one general operating category, the structure for disallowing administrative costs over the limit will no longer exist. But, without savings from disallowed administrative costs, efficiency incentive payments cannot be continued without substantially increasing medical assistance costs. The advisory committee nonetheless recommended that some form of efficiency incentive award be continued.

This provision is necessary and reasonable because, Laws 1995, Chapter 207, Article 7, section 34, requires that the commissioner adopt rules that:

> "(2) eliminate the maintenance and administrative operating cost category limits and account for disallowances under the rule existing on the effective date of this section in the revised rule. If this provision is later invalidated, the total administrative cost disallowance shall be deducted from economical facility payments..."

The commissioner directed that this rule revision not increase costs to the medical assistance budget. Increased costs would require legislative approval and an additional appropriation. But, the legislature has not appropriated additional funds for this purpose. Because continuing to offer incentive payments without this provision would significantly increase medical assistance spending, and the provider industry wants some sort of efficiency incentive, it is necessary to develop a different mechanism for incentive payments within the constraints of budget neutrality. (Subitems (1) to (3), below, discuss the carry-forward mechanism in detail.)

This provision, known as the *administrative operating cost limit carry-forward*, is a reasonable method for continuing to fund incentive payments to providers, thus rewarding economical operation. Without this provision, funds formerly redirected to facilities as efficiency incentives instead would become a windfall for facilities with excessive spending (spending above the limit) in the administrative category. Without this provision, facilities could continue with what has been determined as uneconomical spending, and the formerly limited administrative costs would be reimbursed. A mechanism to encourage economy would be lost.

To fund the new incentive payments, the department proposes that facilities with historical disallowed administrative costs in excess of the administrative limit for reporting year 1994,

carry-forward this disallowed amount.

The advisory committee recommended this proposal. Providers stated that economical facilities should not lose their efficiency incentives to uneconomical providers. The committee also stated its belief that it is the same providers every year who are subject to large disallowances resulting from the administrative limitation.

This proposal was discussed at length with members of the provider association, ARRM, and others during the rule advisory meetings stemming from the lawsuit settlement. They examined data in the 1991 cost report to determine how many providers have disallowances due to the administrative limitation. Based on this data, the group found that approximately one third of all providers had some administrative costs above the limit.

Department data as of March 1, 1994, shows 86 facilities with disallowances resulting from the administrative limit for 1991, totaling $984,961.00. Of facilities with such disallowances, fifteen facilities had disallowances over $10,000.00, totaling $663,275.00 (67% of the total disallowance resulting from the limit). Of those same fifteen providers, ten also had disallowances in 1992, comprising $433,563.00 of the $790,485 in total administrative disallowances resulting from the limit. (Four did not have disallowances, and one was no longer in operation.)

When presented with the option of discontinuing current efficiency incentive awards or creating an administrative disallowance carry-forward, the full rule advisory committee recommended that facilities that exceed the administrative limit carry-forward this disallowance. In light of the rule advisory committee's support for this provision and in order to continue the benefit derived from rewarding facilities for economical operation, the department has determined that the concept of an administrative operating cost limit carry-forward provision is reasonable.

Item A establishes the computation of the carry-forward amount for facilities with administrative limitations. Originally, the reporting year ending December 31, 1992, was selected as the year in which the carry-forward amount would be calculated because, in reporting years after 1992, some providers knew that the department was discussing with the provider association the development of an administrative carry-forward. Providers with knowledge of the proposal may have *temporarily* reduced their administrative spending in years after 1992 in an attempt to reduce their baseline year for the carry-forward amount. However, implementation of this rule was delayed because the authority to make rule revisions was part of the vetoed 1994 Health and Human Services Omnibus bill. It is reasonable that the year in which the carry-forward is established should be as recent as possible so that the carry-forward reflects the most recent facility spending patterns. Therefore, it is reasonable to use reporting year ending December 31, 1995, as the base year for this carry-forward provision.

In addition, the law requires that the new rule account for disallowances under the rule existing on the effective date of this section in the revised rule. Because the statutory language was effective in 1995, administrative disallowances for that year must be used as the carry-forward

amount.

Subitem (1) is needed to specify how the administrative carry-forward may be adjusted annually. It states that if a facility is able to keep its general operating costs below the prior year's general operating costs (on a per diem basis, i.e., costs divided by days) indexed for inflation, the savings shall be deducted from the administrative disallowance carry-forward. This is reasonable because it enables facilities to reconcile the administrative carry-forward through the development of efficiencies and economies. In other words, if the facility can "beat inflation", by controlling the growth of its costs, this amount is deducted from the administrative carry-forward amount. Because the rule combines cost categories, facilities will have more flexibility in their spending and may be better able to develop ways to reduce costs and "beat inflation" without affecting the quality of services.

Subitem (2) describes how the administrative carry-forward will be increased in subsequent years, up to the baseline amount, should the facility spend more than its prior costs plus inflation. This item is needed to prevent facilities from temporarily reducing their costs in order to reduce the administrative carry-forward, then increasing costs the following year. It is reasonable to add back amounts to the administrative carry-forward if the facility does not maintain the efficiencies and economies it developed to reduce administrative costs. The overall budget neutrality of the economical facilities incentive provision (see part 9553.0050, subpart 2, item B) is contingent on the efficiencies and economies netted against the administrative carry-forward being permanent. It is reasonable to only add back the administrative carry-forward up to the baseline amount, as this is the facility's historic amount of disallowance.

Subitem (3) is necessary to establish that once a facility's administrative operating cost limit carry-forward has been reduced to zero, the carry-forward provision will no longer be apply in subsequent years. A facility with a significant carry-forward amount presumably would need several years to bring its carry-forward balance down to zero. Facilities that accomplish this probably have made permanent changes in their spending, through development of efficiencies and economies, so it is reasonable to no longer apply the carry-forward provision. Because a carry-forward will no longer be applied in subsequent years, it is reasonable to discontinue the special tracking of facilities' carry-forward balances, thereby relieving both the department and providers of this recordkeeping requirement.

Subitem (4) is needed to prevent the total economical facility incentive dollars distributed from exceeding the amounts available for distribution in future years. This is accomplished by subtracting the carry-forward balances of facilities that cease operation as ICFs/MR from the total economical facility incentive dollars available.

Under Minnesota's State Plan, which is approved by the federal government's Health Care Financing Agency, the total dollars paid to ICFs/MR must not exceed Medicare upper limits.

This means that the aggregate payments to ICFs/MR must not exceed total allowable ICF/MR costs. The federal government typically views incentive payments as non-cost expenditures. The model used by the state for maintaining federal compliance employs the use of Medicare reimbursement principles. Essentially, the federal compliance test demonstrates through the use of Medicare reimbursement principles that medical assistance rate setting is not more costly than what a Medicare reimbursement system would yield.

A problem may occur when facilities that are carrying administrative carry-forward disallowances leave the ICF/MR program. Because the closed facility's costs and disallowances are no longer represented in the aggregate, total economical facility incentive payments could exceed the amounts collected as carry-forward disallowances. This could cause aggregate payments to exceed total ICF/MR costs, thus jeopardizing the state's federal financial participation (FFP) by violating the approved State Plan. (The federal government participates in the funding of ICFs/MR by funding 55% of the costs. To assure continued federal financial participation, however, the state must adhere to the approved State Plan.) This provision is necessary because it maintains the critical balance by subtracting the administrative carry-forward amounts of facilities that leave the ICF/MR program from the dollars available as economical facility incentive payments. Without this provision, the state would be in technical default in its federal assurances and risk losing federal financial participation.

This subitem includes a provision to net any administrative carry-forward against the total economical facility incentive dollars available for a facility that terminates operations or has entered into a voluntary closure agreement under the Community Conversion Project. Under a voluntary closure agreement, the department may set an interim rate for the facility. Facilities that enter into closure agreements usually receive interim (budget based) rates. It is reasonable to subtract the carry-forward amount of a facility that has signed an agreement for voluntary closure because under subitem (6), the administrative carry-forward will not be applied to any facility with an interim rate as a result of closure agreement. By subtracting the facility's administrative carry-forward from the total economical facility incentive dollars available effective the first rate year after facility enters into a closure agreement, the necessary balance in the equation is preserved. For these reasons, the department believes the provision is necessary and reasonable.

Subitem (5) is needed to explain how to administer the carry-forward provision for facilities undergoing one time rate adjustments (OTRAs), downsizing initiatives, and interim/settle-up rates. These facilities have special rate setting formulas not applicable to other facilities.

This item prevents facilities with OTRAs from using OTRA funding to reconcile their administrative carry-forward. It is reasonable that facilities with an administrative carry-forward are prevented from netting OTRA dollars against the administrative carry-forward, because the OTRA is granted specifically to meet identified client needs. By adjusting the computations in this item to include the OTRA amount for both the current and prior reporting

years, a fair comparison can be made which will prevent providers from using any portion of the OTRA to reduce the carry-forward amount.

This subitem exempts facilities that enter into a voluntary closure agreement in accordance with Minnesota Statutes, section 252.292, from the administrative carry-forward requirements. These facilities are in the process of closing and have received an interim rate from the department to facilitate this process. It is not reasonable to impose an administrative carry-forward on a facility granted an interim rate for the specific purpose of facilitating an organized and planned downsizing resulting in closure, because that facility's rate is based on a negotiated rate with budgeted or estimated costs and client days, and is subject to the settle-up of its actual costs.

This subitem also allows a facility that is in the process of downsizing without closure to complete that project and complete two full reporting years following the downsizing project's completion before applying the carry-forward review process. This provision is reasonable because it allows time for the downsizing project to be completed and the new historic costs established before reinstating the administrative carry-forward review process. This facility would still have past administrative costs offset using the carry-forward provision, if it has a carry-forward. However, it is not practical or possible to do the review during the downsizing period, as the review would have to "hit a moving target". This subitem does not apply to future downsizing activity because it is not possible to anticipate the content of future laws regarding downsizing. However, the department recognizes that some provision would be needed during downsizing. An appropriate action would be to address any future situation as part of any proposed downsizing legislation.

Item B. This item is needed to present the formula for calculating the historical general operating cost per diem. This formula replicates a similar formula in the present rule. The purpose of this formula is to promote efficient operations by discouraging low utilization rates, i.e., below 85%. Setting a utilization rate is reasonable because an efficiently operated facility serves the taxpayers well and encourages providers to be better managers.

Item C. Item C creates a method for addressing the historic maintenance operating cost limit disallowances. This item is necessary because the proposed rule amendments will combine the maintenance category with other costs into one general operating cost category. It will no longer be possible to determine what costs are strictly maintenance nor to apply a maintenance limit. It is necessary to develop a method for reconciling the amount disallowed annually through the former maintenance limit, because the commissioner of human services, in her letter authorizing rule revisions (see Exhibit 5), stated that revisions must not cause increases in medical assistance expenditures. The ARRM/DHS advisory committee and the full committee discussed this issue. The providers stated that facilities with historic maintenance disallowances may incur excessive spending due to unusual, but necessary, spending in one year. For example, a facility may require a major non-capitalized repair in one year. This expenditure

may cause the facility to exceed its limit in the maintenance area.

The advisory committee stated that, unlike the administrative carry-forward, it would not be reasonable to require a facility to carry forward a maintenance disallowance. The committee stated that facilities may have less control over maintenance costs, which, unlike administrative costs, may vary considerably from year to year. The advisory committee and department agreed to reconcile the maintenance disallowance amount by summing the total maintenance operating cost limit disallowances for all facilities, and deducting the amount from the aggregate of all facility efficiency incentive payments as provided in subpart 2. It is reasonable to use report year 1995 as the base year because it reflects a typical year's maintenance disallowances, and is the most current figure available. It also is consistent with Laws 1995, Article 7, section 34.

Item D. This item provides that, if a facility's general operating cost per diem is greater than the respective allowable historical general operating cost payment rate established for the corresponding year, there must be no retroactive cost settlement, unless the difference is due to a field audit or a settle-up payment rate. The purpose of this provision is to establish the ICF/MR reimbursement system as prospective, not subject to retrospective cost settlements except where the rule specifically provides for cost review (audits) and settle-up. Examples are the field audit process which permits the department the ability to review past period costs and to adjust payment rates retroactively. The interim/settle-up rate setting process expressly provides that interim rates are based on budgeted cost and the settle-up is a retroactive review based on actual costs. One-time rate adjustments are handled similarly. The practice is reasonable and prudent: prospective ratesetting is commonly used by other states, permits greater accuracy in budget forecasting, and supports the goal of cost containment.

Item E is necessary because the administrative carry-forward provision is new and untested. Although the rule advisory committee, including ARRM has given its support for using this mechanism to fund economical facility incentive payments, the provision may be challenged by the federal government or individual providers that are required to carry-forward administrative disallowances. Therefore, it is reasonable that, if the carry-forward mechanism is found to be contrary to federal reimbursement principles or is otherwise invalidated, the total administrative cost disallowance for all facilities must be deducted from the economical facility incentive dollars available for distribution for the reasons stated above. It is reasonable that the department reserve the right to reexamine this provision if presented with evidence that the provision is contrary to federal reimbursement principles, and have a method to adjust the incentive payments if the provision is invalidated.

Subpart 2. Establishment of total operating cost payment rate.

It is necessary to delete items A to E in the current rule so that the department can implement a new method for establishing the total operating cost payment rate.

Proposed items A to D of this subpart are necessary to establish the new method of calculating the total operating cost payment rate.

Item A defines a facility's general operating cost payment rate as its allowable historical general operating cost per diem in subpart 1, multiplied by the forecasted index in item C, subitem (1). It is reasonable to have a payment rate that keeps step with inflation. The consumer price index (CPI) is an established index of inflation and its use is authorized by the legislature in Minnesota Statutes, section 256B.501, subd. 3c.

Item A stipulates that, for rate years beginning on or after October 1, 1996, the commissioner shall establish facility maximum overall general operating cost per service unit limits according to subitems (1) to (8). Item A subitems reflect a mathematical formula that combines the facility's general operating cost information, its client days, and the client assessment weights. This item specifies that any increase granted in a facility's general operating cost payment rate (as described above) shall be subject to this overall limit.

Overall limits are needed because Laws 1995, Chapter 207, Article 7, section 34, paragraph (6), requires that the revised rule establish overall limits on a facility's rate of inflation increases. The statute further specifies that the commissioner shall consider groupings of facilities that account for a significant variation in cost.

The department initiated research to develop an overall limit which takes into account the reasons for variation in costs. The objective was to limit facilities that receive an excessive rate in relation to these factors, and to continue to fully reimburse the costs which must be incurred by facilities that are operating efficiently and economically.

The advisory committee questioned the need for an overall limit, stating that the 21 month delay in reimbursement of new costs serves as a type of limit. The 21 month delay is an effective feature for containing cost growth for many facilities. However, this delay does not address the wide variance in rates paid to ICFs/MR in Minnesota. In fact, the delay may contribute to variance in rates paid to ICFs/MR because some providers seem to have difficulty operating under the 21 month delay while others do not. Additionally, the 21 month delay provides no mechanism for comparing facilities and applying a rational, controllable limit. However, without the groups and arrays, as established above, it is difficult to fairly compare facilities to determine which facilities provide the most service for the dollar and which facilities are most expensive, given their structure and services. The department concludes that, when establishing limits, it is reasonable to account for all these factors. Finally, the 21-month delay does not consider the characteristics of facilities that may account for the differences in costs. For these reasons, and because an overall limit is required under Laws 1995, Article 7, section 34, paragraph (6), the department decided that the 21-month delay was inadequate as a sole limit and proceeded to develop an overall limit.

Item A specifies that each facility's allowable historical general operating costs and client assessment information for the reporting year shall be used as the base year for establishing the overall limits.

Laws of Minnesota 1995, Article 7, section 34 (7) requires that the commissioner, "utilize the client assessment information obtained from the application of the provisions in subdivision 3g for the revisions in clauses (3)[economical facility incentive], (4) [best practices awards] and (6) [overall limits]." Therefore, it is necessary and reasonable to use the client assessment process established under Minnesota Statutes, section 256B.501, subd. 3g (as amended by Laws of Minnesota 1995, Article 7, section 36).

It is reasonable to use the data from the same year as the cost reporting data because that data provides the most recent cost and assessment information available.

The last five lines of Item A provide an exemption for facilities that have a proportion of temporary care client days to total client days exceeding 80 percent. Because temporary care clients are not assigned client assessment classifications, a facility with a high proportion of temporary care days will not have sufficient client days at assessed classifications to calculate a meaningful service unit score. Without this information, the facility's cost information cannot be standardized for client service characteristics and arrayed with other facilities. Additionally, it would not be reasonable to require facilities to conduct assessments for temporary care clients. It would be administratively burdensome and costly for a facility with a high level of temporary care clients to continually submit assessments. Furthermore, the validity of assessments conducted for clients residing in the facility for only a few days or weeks would be questionable. Therefore, it is reasonable to exempt a facility with greater than 80 percent temporary care days from the overall limits because such a facility is primarily serving temporary care clients and is unlikely to have client assessment classifications which represent the services provided to their ever-changing population. Department staff are aware of only one facility in the state that will be affected by this provision. That facility serves only temporary care clients. It should be noted that facilities exempted from the overall limits under this provision are also excluded from participating in the economical facility incentive under item B.

This item also provides that the commissioner shall limit such a facility's payment rate to not more than its prior year's payment rate plus the inflation factor as established in item c, subitem (2), plus three percent. This is reasonable because the CPI plus three percent is the statutory limit imposed on facilities above the median in each grouping and array. It is reasonable to apply a similar limit to these facilities.

Subitem (1). This subitem is necessary to explain how each facility's total weighted service units are determined. Weighted service units are necessary for standardizing client days. The standard client days are used to control for the presumably higher costs of caring for more

difficult clients. The units help determine which facilities are high-cost. Laws of Minnesota 1995, Article 7, section 34 (7) require that the commissioner, "utilize the client assessment information obtained from the application of the provisions in subdivision 3g" for this purpose.

Client days are used because they reflect the number of days in which clients' needs were met at specific levels of service. Costs, client days, and assessments used in the calculation are for the same period of time: a reporting year. These factors afford a blending of information for all providers for the same reporting year which makes for a reasonably accurate comparison of facilities.

Subitem (2). This subitem is necessary to define the term "service unit score", a term used in this section of the rule. The service unit score represents the facility's average weighted service units and is an indicator of the average client service characteristics for clients in the facility.

Subitem (3). This subitem is necessary to complete the standardization of costs, client days, and assessment information. The computation is a reasonable method for comparing one facility with another because it accounts for variation in cost. (See the SNR, subitem (4) for a discussion of groupings and arrays which are used to account for variance across facilities.) It is reasonable to use the service unit score in subitem (2) for representing temporary care client days because the service unit score indicates the facility's average.

Subitem (4) establishes groupings of similar facilities. Groupings are needed so that limits may be applied more equitably to similar facilities after accounting for a significant amount of variation in cost. The process for establishing groups, and the underlying reasonableness of the groups is discussed below.

ANALYSIS TO ESTABLISH FACILITY GROUPINGS

Minnesota's 324 community-based ICFs/MR differ considerably with respect to number of beds, geographical location, number of years approved for medical assistance reimbursement, average hourly wage of program staff, average program staff hours per resident day, percent occupancy, average level of supervision and care required by the residents (as measured by the QA&R client assessment classification score), facility class designation (e.g., class A vs. class B) and general operating cost per resident day.

In order to fairly implement limits using the standardized general operating cost, as described in subitems (1) to (3), as the criteria on which all facilities would be compared, it was first necessary to acknowledge these basic differences by creating groups of facilities similar to each other in most significant respects. Stepwise Regression Analysis seemed most suited to achieve this goal. This analytical technique regresses a continuous dependent variable upon a list of independent variables (measured continuously or discretely), and selects in descending order of

predictive power those variables which collectively best predict the value of the dependent variable. This technique seemed especially appropriate for this purpose because it would empirically determine the criteria (e.g., independent variables) that best define the factors that reasonably divide the facilities into homogeneous groups.

The analysis was conducted using data from the 1992 ICFs/MR facility cost report database, client assessment data from the QA&R database, and indicators of geographical location. The Department first had to determine which cost factor it wished to use in determining high-cost facilities (the dependent variable) and then those factors beyond an individual facility's control which account for the most significant differences between groups of facilities (the independent variables). Variables initially considered for inclusion in the stepwise regression analysis were:

FOR THE DEPENDENT VARIABLE:

* Actual general operating cost per client day, OR
* Standardized general operating cost per client day (general operating cost per client day which are "standardized" using client assessment classifications. This standardization is conducted using the procedure in subitem (1) and (2).

FOR THE INDEPENDENT VARIABLES:

* The county in which the facility is located
* The county cluster in which the facility is located
(Three clusters were selected on the basis of the results of the 1992 "Minnesota Salary Survey by Area" conducted by the Minnesota Department of Jobs and Training. The salary data in that report strongly suggested that the wages of service-oriented employees whose jobs were most similar to program staff of ICFs/MR could be clustered within three groups of counties: (1) metro, (2) central & northeast, and (3) rural).
* Percent occupancy
* Number of licensed ICFs/MR beds
* Class ("A" or "B")
* "Impractical Class A"
* average hourly wage of program staff (with and without salary of the program director included)
* average program staff hours per client day
* number of years approved for MA reimbursement
* average case mix score (e.g., average level of staff supervision and care required by residents of the facility)

Selection of the standardized general operating cost per client day as the dependent variable followed extensive analysis of the advantages and disadvantages of incorporating the indicator

of client service characteristics (client assessment score) within the dependent variable. The alternative would have been to allow the average client assessment score (also referred to as "weighted service units") to function as an independent variable and, perhaps, as one of the factors for defining the homogeneous groupings of facilities. The standardized statistic was selected for three reasons:

(1) This selection was most in tune with the intent of identifying a single statistical criterion that would permit comparing facilities within a homogeneous group on a measure that related general operating cost to client need.

(2) From a pragmatic perspective, use of the average client assessment score per facility as an independent variable and a factor in defining the homogeneous groups of facilities would require reducing that continuous variable into two, or perhaps three, discrete categories. This type of statistical manipulation was seen as undesirable because it results in the loss of information and because it requires an empirically-based rationale to justify where the continuum of scores would be interrupted to create the two or three discrete categories. No such rationale was available.

(3) By standardizing operating costs to recognize facility average assessment classifications, more than 25% of the variance in the dependent variable would already be "explained". (See the discussion below about results of analysis relating to client classifications.)

INDEPENDENT VARIABLES:

Two indicators of the potential variation across Minnesota's counties were included in the list of independent variables in the stepwise regression: the county in which the facility was located and which county cluster (metro, central & northeast, or rural) the facility was in. Both indicators were seen as potentially explaining in part variation in the dependent variable because they both measure geographical differences, one more aggregate than the other. Also, both had the potential for contributing to our understanding of the level of general operating costs. Costs would be higher, it was reasoned, in those geographic areas (or those counties) where wages of staff in health-related service occupations were highest, all other factors being equal. For that reason both indicators were included in the equation.

Percent occupancy was included as an independent variable to help detect that any variations in general operating costs that might be attributable to empty beds.

The total number of licensed beds was included in the list of independent variables as a measure of any variation attributable to "economies of scale" that might be associated with larger facilities.
Class A/Class B licensing status was included as an independent variable because it is a

classification used by the Minnesota Department of Health to distinguish between facilities that are and facilities that are not capable of serving residents who are unable to demonstrate self-preservation skills.

A relationship between general operating cost and class A/B status can be expected for several reasons. Clients who are unable to demonstrate self preservation skills must reside in class B facilities. These clients generally have high needs that require more intensive levels of staffing. In fact, the research to develop the Minnesota ICF/MR Client Assessment showed that, of all service areas studied, receiving services due to a lack of self preservation skills was the strongest predictor of staff resource use. Also, facilities which convert from class A to class B to begin serving 50% or more of their population from the Regional Treatment Centers, typically receive an interim rate to increase their staffing to meet the needs of more vulnerable clients. These factors contribute to a strong relationship between class and resource use, both from a reimbursement policy perspective (one time rate adjustment) and from a MDH licensing/ regulatory perspective.

DHS staff initially believed that using the average client assessment score of a facility and the facility's class A or B status would be redundant because both indicate the level of needs and services of the clients. However, a simple correlation coefficient generated to test that assumption suggested otherwise. The correlation coefficient of ±.60 indicated that, while the two are definitely related, they are each to some extent measuring somewhat different aspects of resident need and, perhaps, how administrative policy in Minnesota has been implemented. For that reason, the class A/class B indicator was retained. It was noted that class serves as a rougher determination of client needs in a facility and could serve as a "cut" in determining general groupings. Once grouped, the average client assessment score could be used to more precisely sort facilities within each grouping, with its focus on both "client needs" and "services provided".

DHS staff also examined whether Impractical Class A could explain some of the variation in general operating costs. Facilities designated as Impractical Class A after 1986 were those class A facilities that were serving one or more residents who lacked self preservation skills in the area of fire safety or emergency evacuation and that did not want to be designated as class B facilities. This indicator was included in the list of independent variables at the recommendation of the advisory committee, based on the assumption that general operating costs may be higher for such facilities and, perhaps, equivalent to the costs incurred in class B facilities. It was observed, however, that this indicator was not significant in explaining the variance in the dependent variable and that Impractical Class A facilities (N=44) more closely resembled typical class A facilities rather than class B facilities with respect to (1) the average non-standardized operating cost per resident day, (2) the average standardized operating cost per resident day, and (3) the average case mix score. (See Exhibit 13.) The correlation coefficient indicative of the relationship between class A and Impractical "A" status was ±.26. suggesting a weak relationship biased toward the class A type facility.)

The average hourly wage of program staff without the salary of the program director was included in the original list of independent variables because it was perceived as one of the factors that was most directly related to general operating costs, much like the average number of program staff hours per client day which also was included in the original list. Preliminary examination of the data indicated that the salaries of program directors varied considerably and erratically across facilities and resulted in no clear evidence of association between this independent variable and the dependent variable. For that reason, the program director's salary was deleted. This adjustment had the effect of revealing the expected and logical relationship between the two variables of average hourly wage and standardized general operating costs. (See Exhibit 14. Correlation Coefficient = +.36.)

The number of years that the facility had been approved for medical assistance reimbursement was also selected for the original list of independent variables due to its historical relationship to cost. Because facilities generally can only spend the money that they receive, and the money that they receive is by formula tied to its rate, it follows that the older facilities will generally have lower rates and lower operating costs. Newer facilities, of course, enter the ICF/MR program with higher rates right from the onset (see discussion under A, below.)

Finally, the average client assessment score for each facility initially was considered as an independent variable. Facility residents are assessed at least annually using the Minnesota ICF/MR Client Assessment.

Analysis showed that client assessment classification predicts variation in rates. Given the many factors which can contribute to variation in rates, and the fact that average assessment scores have never been linked to reimbursement, it was encouraging to see a correlation between operating costs and average client assessment classification. It is important from a policy standpoint to consider the service characteristics of a facility's clients as an objective indicator of the services provided in the facility. DHS decided that the facility's average client assessment score should be a factor in the grouping of facilities when establishing an overall limit.

As explained above, it seemed more appropriate to incorporate the client assessment statistic within the dependent variable, thereby creating a statistic that related general operating cost directly to the average level of staff intervention and care needed and received by the clients. This seemed appropriate from an empirical perspective as well because as the correlation between the actual cost (non-standardized general operating cost) and the average case mix score was $\pm.53$. By creating a dependent variable that mathematically reflected the client assessment/operating cost relationship, more than 28% of the variance in the new dependent variable would already be "explained". (Note: the percent of variance explained in the dependent variable is calculated by squaring the correlation coefficient.)

Final selection of the independent variables to be used in the stepwise regression analysis was based on both an analysis of the correlation matrix (Exhibit 15) and on several pragmatic

criteria determined to be reasonable guidelines (as discussed below) for grouping facilities and ultimately arraying costs in relation to client service needs. The variables eliminated from the analysis and the rationale for doing so included:

A. The number of years that the facility had been approved for medical assistance reimbursement. The department decided to include the general operating costs of newer facilities in the arrays with older facilities with the same characteristics even though newer facilities entered the system with higher rates than existing facilities.

Historically, older facilities (facilities that have more years in the MA program) tend to be the facilities with lower costs. This is because the historical rate of a facility drives its ability to spend; a facility generally spends the money it receives. Newer facilities entered the system with higher rates. These higher rates for newer development are a result, in part, of higher costs due to increased property value, higher staffing levels, and costs associated with smaller facility size and a loss of economies of scale. Over time, percentage increases for inflation resulted in newer facilities receiving higher rates than older facilities. This has contributed to a wide difference in rates across facilities. However, the department views this relationship between the number of years a facility has been eligible for medical assistance reimbursement and general operating cost as an undesirable artifact of the current system. From a policy perspective, the number of years of MA certification should have little to do with the operating cost of any facility. Therefore, the department eliminated years of MA certification as a factor for grouping facilities.

B. Impractical Class A status. Because the profile of the residents of Impractical Class A facilities was so similar to the profile of residents in class A facilities, and all such facilities were already classified as class A, it seemed most appropriate to continue grouping them in class A for this analysis. The alternatives would have been to group them with class B facilities or to allow them to define a third classification status for this analysis. The data did not warrant either of these alternatives:

	CLASS A	IMPRACTICAL "A"	CLASS B
Avg. Assessment Score	1.51	1.66	1.96
Avg. Standard Operating Cost	$57.81	$49.45	$ 75.79
Avg. Non-Standard Operating Cost	$86.45	$83.05	$145.56

** Note: Class A statistics above only reflect non-impractical "A's".

The data clearly shows that an Impractical Class A facility, on average, does not serve clients with a level of vulnerability similar to those in a class B facility. An Impractical Class A may have only one resident who lacks the necessary

safety skills, or may be serving many such residents. This may explain the variation in average assessment scores between "impractical A's" and class B's.

Impractical Class "A" facilities have the option of pursuing a class B license. The facility would have to go through the need determination process; however, DHS is promoting the conversion of facilities from class A to class B, and would support conversion requests. The MDH engineering office stated that there should be no additional physical plant adaptation necessary for a class B (ambulatory) license. DHS would not require a facility to undergo a rate adjustment (interim rate process) in order to become a class B. This means that the process for becoming a class B would be fairly simple. Permitting Impractical Class A facilities the option of applying for a class B license is reasonable because it allows the Impractical Class A facility the option of deciding whether it is most advantageous to stay grouped with the class A facilities, or to seek class B designation.

C. Staff wages per hour **AND** Hours per resident day. Inasmuch as the department's purpose in establishing the facility groupings was to array the general operating costs within each group, it seemed reasonable NOT to include variables that, by definition, comprise a large proportion of the operating costs in the criteria that would define the groupings. Staff wages and hours per resident day, in fact, are two major components of the operating cost calculation and expectedly are highly correlated with the non-standardized dependent variables (+.54 and +.47 respectively). To have included them in the stepwise regression analysis, and then very possibly in the criteria for grouping facilities, would have created a situation where facilities that pay high staff wages would be arrayed on operating costs along with other facilities that pay high wages. Likewise, facilities that pay lower wages to staff would be grouped with facilities that have a similar payroll policy. The obvious result would be that some otherwise low cost facilities would be considered high cost facilities within their group. This was not the department's intent. In addition, the department acknowledged that staff wages and hours, unlike other independent variables being considered, are NOT static. They can be increased or decreased in accordance with decisions made by the administrator of the facility. It seemed more reasonable to create criteria for grouping facilities using factors that are static and define facilities within the system (e.g., class, size, geographical location, etc.)

STEPWISE REGRESSION RESULTS

When the dependent variable (standardized general operating cost) was regressed on the final list of independent variables (county of location, metro/urban/rural cluster of counties, percent occupancy, number of licensed beds, and class), three variables emerged as statistically

significant predictors. In their order of entry into the regression equation, they were: (1) THE METRO/URBAN/RURAL CLUSTERS, (2) CLASS, AND (3) THE NUMBER OF LICENSED BEDS. The coefficient of multiple correlation [R] was +.6624 and the coefficient of multiple determination [R squared] was .4388. The metro/urban/rural cluster alone accounted for 23% of the variance in the dependent variable, class an additional 16%, and the number of beds the remaining 5%.

The remaining independent variables (county of location and percent occupancy) were rejected in the analysis due to their statistically less significant relationship with the dependent variable (see exhibit 16).

DEVELOPMENT OF THE GROUPINGS MODEL: As a practical matter, the number of facility groupings to be used to array the general operating costs of the 324 ICFs/MR had to be limited in quantity and had to be structured in a manner that would include a reasonable number of facilities in each group. An array of six to eight groups was perceived as quite manageable.

The three variables selected by the stepwise regression equation clearly provided the foundation for the grouping model. Further refinement was necessary, however, to actually create the groupings and to limit the number of groupings to the desired quantity.

Task #1 was to break the number of licensed beds, a continuous variable, into two or three discrete categories. Task #2 was to assess the advantages and disadvantages of using the metro/urban/rural index in its current form as opposed to reducing the number of geographic categories from three to two. The class variable was perceived to be acceptable in its current form because, with only two categories, it needs no further simplification.

Analysis and discussion by department staff resulted in the decision to develop a groupings model that included eight groups based on the following three dichotomous variables:

* metro/non-metro location
* class A / class B
* small (6 beds or less)/large

This model seemed reasonable and appropriate for a number of reasons. First, from a pragmatic perspective, it provided for a manageable number of groupings each of which had a reasonable number of homogeneous facilities within it. Second, the reduction of the non-dichotomous variables into a dichotomous format was supported empirically. General operating costs and staff wages per hour are more divergent with the metro/non-metro format than with a format that clusters the metro counties with the urban counties and compares them to the remaining rural counties, as indicated by the data below:

	Avg. Operating Cost Per Resident Day	Avg. Staff Wage Per Hour
METRO COUNTIES	$127.79	$9.02
NON-METRO COUNTIES	$ 91.55	$7.50
METRO/URBAN COUNTIES	$116.53	$8.55
RURAL COUNTIES	$ 91.19	$7.49

Finally, the reduction of the continuous facility size variable into the dichotomous categories of "small" and "large" seemed reasonable and appropriate because it reflects the policy and vision of the State of Minnesota with respect to residential services for persons with developmental disabilities. Small (4- to 6-bed) homes in the community are characteristic of new and planned development, and downsizing and closure of institutions and larger facilities have been the core goals of state law and the department's work program for well over 10 years.

Exhibit 17 illustrates the final groupings and the number of facilities which fall into each of the eight discrete groups.

Subitem (5) establishes the method for arraying facilities within each of the eight groupings in subitem (4) by its cost per service unit, as determined in subitem (3). The array is needed for comparing similar facilities and determining which facilities are the most costly when providing comparable services. It is reasonable to array facilities based on each facility's cost per service unit because the method of "standardizing" operating costs by determining the facility's cost per service unit, as described in subitem (3), takes into account research showing which services affect costs the most. While the groupings in subitem (4) allow for comparison of facilities that are similar in size, geography, and service characteristics, arraying by cost per service unit provides a cost comparison of facilities within each group.

Subitem (6) is needed to establish a maximum limit in which higher cost facilities can increase their allowable costs in a year. It is reasonable to limit the cost increase to the lesser of the current year's allowable historical general operating cost per service unit, plus the CPI, increased by three percent, because it is established in Laws 1995, Chapter 207, Article 7, section 37. It is reasonable to include the provision in the rule because the provision is an integral part of the total ratesetting formula.

Subitem (7) This subitem establishes the thresholds for the overall operating cost limit for each group. The department is proposing two overall operating cost limit thresholds.

Unit (a) requires reestablishing the arrays after application of subitem (6). This requirement is reasonable because the application of subitem (6) may change the rankings of facilities within the array.

Unit (b) establishes the thresholds for the two overall limits. The first threshold is set at the 0.5 standard deviation above the median of that array. The second cost per service unit limit is established at 1.0 standard deviation above the median of the array.

These limits are necessary to conform to those established in Laws 1995, Chapter 207, Article 7, section 37, and thus to reflect the legislature's intention. It is reasonable to repeat those limits in the rule because they are an integral part of the rule and provide necessary information for an understanding of the full rate calculation.

A "deviation" is the distance between a given score and the mean of the distribution. The standard deviation is a very useful statistic that measures the dispersion of scores around the mean. On the average, 68 percent of all scores in a sample will be within plus or minus one standard deviation of the mean. Ninety five percent of all scores will be within plus or minus two standard deviations of the mean. The variance is calculated directly from the distribution of raw scores. It is the sum of the squared deviations of each score from the arithmetic mean divided by "n." The standard deviation is simply the square root of the variance.

It is reasonable to set these thresholds at the 0.5 to 1.0 standard deviation and the 1.0 standard deviation above the mean for several reasons. From an analytical perspective, these standard deviations are traditional points where deviation from the mean is noted to differentiate points that are significantly different from the average. In practical terms, the least economical facilities will fall above the first standard deviation for all eight arrays. Since the purpose of the overall limits is to slow the rate of growth in payment rates for the most costly services, it is reasonable to set the thresholds so that the more costly facilities incur an immediate limit. Additionally, the limits will curb future excessive growth.

Unit (c) requires indexing the overall operating cost per service unit limits for inflation annually beginning with the reporting year ending December 31, 1996, using the forecasted index in subpart 2, item C, subitem (2). This unit is necessary to ensure that the limits increase commensurate with inflation. Without this provision, the limits would affect more facilities, as facilities' costs per service units increase for inflation. Also, by establishing the limit as a dollar amount, and indexing that amount forward annually for inflation, facilities will know what the limit is and can strive to reduce spending, serve clients with greater needs, or improve the services presently provided to clients in order to fall below the limits in their array.

Subitem (8) is needed to define the limited amounts. These limits are necessary to conform to those in Laws 1995, Chapter 207, Article 7, section 37. It is reasonable to repeat those limits in the rule because they are an integral part of the rule and provide necessary information so that the reader can understand the full rate calculation.

Furthermore, these limits are reasonable because they are part of a refined structure for controlling overall cost increases. Over time, the limits will tend to compress the array of

facilities, bringing greater rate uniformity and correcting for cost disparities among providers within each group.

Finally, these limits are reasonable because they represent only a small (2-3%) reduction to the total operating cost per diems of the higher cost facilities. The provision permits inflationary increases to continue for all facilities, or their allowed operating costs, as appropriated by the legislature.

Subitem (9) This subitem permits rebasing of overall limit thresholds every three years. This provision is necessary because it is required in Minnesota Laws 1995, Chapter 207, Article 7, section 37. The department does not anticipate the need to rebase the limits frequently. The advisory committee supports less frequent rebasing and was supportive of the provision to limit rebasing to once every three years. The three-year period gives facilities the opportunity to adjust their spending to avoid being affected by the overall limits. The state also benefits because lower rates will cost taxpayers less.

Subitem (10)
This subitem states provides an exemption from subitem (6) for facilities with a one-time rate adjustment settle-up, facilities undergoing closures, or facilities with downsizing projects authorized through legislation. This provision is reasonable because these facilities have been granted a special rate in relation to their special circumstances. A limit on the amount that the facility can spend during this time could circumvent the ratesetting process otherwise set forth in rule or statute for these situations.

Item B. This item establishes the method for calculating a facility's economical facility incentive. A new method for calculating and distributing an efficiency incentive is necessary because eligibility for the current efficiency incentive is based on each individual facility's spending in cost categories that will not exist in the revised rule. Both the department and the advisory committee agree that it is reasonable to create a new method for distributing payments which encourage and reward economical operation.

An economical facility incentive is necessary because Laws 1995, Chapter 207, Article 7, section 34 require the commissioner to:

> (3) establish an economical facility incentive that rewards facilities that provide all appropriate services in a cost-effective manner and penalizes reductions of either direct service wages or standardized hours of care per resident.

The change in terminology from "efficiency" to "economical" is reasonable because "economical" better represents the status of facilities receiving this incentive award. An economical facility can be defined as one that is not "luxurious" or is less costly. The method of evaluation in item B identifies economical facilities. This provision also seeks to encourage

facilities to develop and maintain economical services through incentive payments.

Under this item, facilities that have a percentage of temporary care client days to total client days exceeding 80 percent are not eligible for an economical facilities incentive. The method for determining which facilities are economical uses client assessment classifications but such classification are not established for temporary care clients. As a result, facilities with a high percentage of temporary care clients do not have the information about their client population that would enable calculation of the incentive payment.

In response to provider concerns, item B includes for a transition period between the old and new efficiency incentive methods.

Because the methods that determine eligibility for each of these incentives are different, providers who qualified for an incentive payment under the old method may not receive an incentive payment under the new method. ARRM has stated that members who receive efficiency incentives each year have become reliant on those additional dollars. The department therefore agreed to provide a transition period of three years in which the old efficiency incentive will be phased out and the new economical facility incentive phased in.

Subitem (1) establishes the procedure for determining the total amount available for distribution as economical facility incentives. This subitem is necessary so providers will understand how the total amount of economical facility incentive dollars available for distribution is calculated. It explains the proration between the old and new incentive payments during the transition period. This provision is reasonable because the department and representatives of those stakeholders affected have agreed to this transition. It is also reasonable because it gives providers time to adjust to any potential loss of incentive payments and to change their management practices accordingly.

It is reasonable to use the efficiency incentive per diems in effect on September 1, 1996, because this is the roughly the last date in which rate information under the old method will be available. This information will be used to calculate the prorated efficiency incentive amount to be paid during the transition period.

Units (a) and (b) provide the formula for determining a facility's proportion of economical facility incentive dollars during the three-year phase-in.

Unit (c). It is necessary to subtract the aggregate amount of maintenance operating cost limit disallowances for the same reasons discussed under subpart 1, item C.

Subitem (2) establishes the first of two methods for distributing the economical facility incentive dollars. The first method is specified in units (a) and (b). The second one is specified in subitem (3).

Units (a) and (b) specify the method for distributing all but $40,000 of the dollars available for economical facility incentive payments.

First, it is necessary to use the same method for grouping facilities that is used in item A, subitem (6) in this subpart, because this method of grouping accounts for a significant amount of cost variation, thus permitting the comparison of facilities to determine economical facilities.

Laws of Minnesota 1995, Article 7, section 34 (7) requires that the commissioner, "utilize the client assessment information obtained from the application of the provisions in subdivision 3g for the revisions in clauses (3)[economical facility incentive], (4) [best practices awards] and (6) [overall limits]." Therefore, it is necessary and reasonable to use the client assessment process established under Minnesota Statutes, section 256B.501, subd. 3g (as amended by Laws of Minnesota 1995, Article 7, section 36) when calculating the economical facility incentive. This is achieved by using the arrays in item A subitem (5).

After discussion with advisory committee members, DHS staff determined that the median plus 5 percent was an appropriate point within each of the eight groupings to identify economical facilities. Facilities below this point are economical when compared to higher cost facilities. The objective reflected in the table in unit (a) is to reward facilities further below the threshold (median plus 5%) i.e., at least $5.00 and up to $10.00, at a greater level to encourage economies. The department believes, however, that, at some point, economies may be too great. Therefore, economies below $10.00 are rewarded, but to a lesser degree. The percentages (7%, 15%, 5%), the increments, and the maximum of $2.00 reward economical behavior while managing the cost of this incentive within the dollars available. It is necessary to maintain the total incentive payment distribution within the dollars available to ensure that the state budget is not increased without a legislative appropriation to cover the cost. Likewise, it is reasonable to include the methodology in unit (b) to spend but not exceed the available economical facility incentive dollars.

Subitem (3) establishes the formula for any facility receiving an economical facility incentive.

Subitem (4) This subitem is needed to describe the method that may be used to distribute approximately 5% of economical facility incentive dollars not otherwise distributed in the manner described in subitem (2).

A best practices award system is necessary because Laws 1995, Chapter 207, Article 7, section 34, paragraph (4) requires the commissioner to:

> establish a best practices award system that is based on outcome measures and that rewards quality, innovation, cost effectiveness, and staff retention.

Laws of Minnesota 1995, Article 7, section 34 (7) requires that the commissioner, "utilize the client assessment information obtained from the application of the provisions in subdivision 3g for the revisions in clauses (3)[economical facility incentive], (4) [best practices awards] and (6) [overall limits]." Therefore, it is necessary and reasonable to use the client assessment process established under Minnesota Statutes, section 256B.501, subd. 3g (as amended by Laws of Minnesota 1995, Article 7, section 36) when calculating the Best Practices award.

In discussions of the need for a new mechanism for distributing current efficiency dollars, the department and industry representatives agreed that some redistribution of a small portion of those funds in recognition of exemplary services would be positive and reasonable given all stakeholders' interest in emphasizing service quality and innovation, as well as cost effectiveness. The task force formed a small subcommittee to work out a method by which exemplary service would be recognized. The subcommittee was made up of providers, advocates, and staff from the Departments of Health and Human Services. The department also sought input from the ARRM advisory board, the Developmental Disabilities Council, the University Affiliated Program and the McKnight Foundation.

Subitem (4) is reasonable because it is the culmination of those discussions and because it addresses the subcommittee's primary goals of:

1) recognizing and promoting excellence and
2) focusing on service outcomes and consumer input and evaluation.

It reflects a flexible, permissive process for the department to use in making awards to up to ten providers based on the recommendation and rationale of an expert panel.

The National Accreditation Council on Services for People with Disabilities has implemented an outcomes-based survey that shifts focus from a provider's deficient processes to achievement of outcomes for clients. This survey is one of many examples of private organizations and government focusing on service quality and improvement. (See Oregon's CQI/Best Practices, University Affiliated Program's publications, and Contemporary Long Term Care's Order of Excellence.) This shift in focus coupled with industry and government emphasis on total quality management concepts lends more credence and reasonableness to the Rule 53 task force's efforts to refocus a small portion of available efficiency incentive dollars to service outcomes and innovation.

The subcommittee members felt that although a monetary benefit is desirable, it is not essential in the recognition of exemplary service. Therefore, it is reasonable that discretion be given to the expert panel in determining the number of awards and their amount. It also is reasonable to set the maximum number of awards at ten in order to limit the number of facilities receiving a best practices award to a number that is manageable for the panel and the department, and to truly recognize industry "best practices."

It is necessary to establish timelines for the nomination and awards process so that dollars distributed via this mechanism can be awarded in a timely and predictable manner. Also, by awarding economical facility incentives at the end of a rate year, the amounts can be awarded in a lump sum for that year. The advisory committee urged that the awards be granted in a lump sum, because facilities could use the lump sum for specific or one-time purchases, rather than having the award paid in small amounts throughout the year. A lump sum payment is perceived as a more meaningful award.

Because service on the panel is voluntary, it also is reasonable that the period of time allowed for meeting be kept brief (approximately two months) and be flexible (as often as necessary). Subcommittee members determined that written nominations should not exceed five pages because the short length may encourage nominations and also simplify the volunteer panel's task.

It is reasonable to exclude from eligibility any facility or related facility of a provider serving on the panel to avoid potential conflicts of interest.

Units (a) through (e) establish the procedures for selecting the areas of activity for the awards, announcing the parameters of evaluation, and establishing time frames for making the awards. Dissemination of these parameters is reasonable so that all facilities interested in competing for a best practices award will understand the process for nomination and awards.

Unit (f) is needed so any economical facility incentive funds that are available as best practices awards but are not awarded are available as economical facility incentives under subitem (2). It is reasonable that dollars not awarded be distributed to economical facilities via the mechanism established in subitem (2) so that all efficiency dollars currently earned by providers continue to be awarded under the proposed rules.

Subitem (5) This subitem is necessary to comply with Laws 1995, Chapter 207, Article 7, section 34, paragraph 3. Under this subitem, facilities that reduce the wages paid to employees working at the facility or decrease the number of standardized staff hours are ineligible for an economical facilities incentive. This provision is reasonable because reduction of staff wages or total staff hours, although an easy approach for demonstrating economy, will likely result in a reduction in the quality of services to clients. The department wants to promote economical operation resulting from development of efficiencies and economies. This economy, however, must be balanced with preservation of quality services. Therefore, it is reasonable to make ineligible those facilities that have decreased either total staff hours (standardized) or reduced employee wages. This provision levels the playing field for providers to develop or maintain economic operations and to qualify for an economical facility incentive payment without reducing their direct service staff.

Unit (a) Beginning with the 1995 cost report, providers must indicate that they did not reduce

the wages of any employees for which any portion of time is directly assigned to the facility (worked any portion of time at the site for the sole benefit of the site.) For example, a facility could not reduce a current direct service employee's wages by $1.00 an hour in order to appear more "economical".

This provision will allow facilities to continue to provide stepped wage scales when new employees start at a lower wage and receive increases in compensation at set intervals. (A stepped wage scale assists facilities in retaining their more experienced employees by rewarding longevity of service.) It is unlikely that any provider would fire existing employees in order to qualify for an economical facilities incentive because of the costs for hiring and training new employees. However, if the department could demonstrate, during a field audit, that a provider discharged employees specifically to hire new employees at a lower wage, the provider would be disqualified from eligibility for an economical facility incentive. In this instance, the burden of proof would be on the department.

Unit (b) This unit establishes that facilities that reduce their standardized hours of care per client also shall be ineligible for an economical facilities incentive. This provision is necessary because it is required under Laws 1995, Chapter 207, Article 7, section 34, paragraph 3.

"Standardized hours of care" is a term unique to this unit. A reduction in standardized hours of care occurs when:

-- a facility reduces its total reported direct service staff hours for the most recently reported year when compared to the prior reporting year, and

-- the total direct service staff hours, when standardized by dividing the total direct service staff hours by that year's service unit score, results in a lower number of standardized client hours when compared to the standardized hours of care for the prior year.

The measure of standardized hours of care is intended to identify facilities that have decreased total staff hours, not to penalize facilities that accept and provide services to more service intensive clients. Therefore, it is reasonable to apply the standardized hours of care test only to facilities that have decreased their total direct service staff hours. Without this provision, a facility might admit more service intensive clients and maintain or even increase the number of staffs hours in order to provide additional services, yet show a slightly lower standardized hours of care measure than previously.

Item C is necessary to identify the inflation adjustment factors that will be used to index operating costs and limits. Minnesota Statutes, Section 256B.501, subdivision 3c, specifies the inflation factors the department must use. The index specified is the Consumer Price Index-All Items (U.S. city average), forecast for the department by Data Resources, Inc.

Subitem (1) identifies the time period for which the index is to be forecast (the mid-point of the report year to the mid-point of the following rate year [21 months]), and the point in time at which the index is to be obtained. It is both necessary and reasonable to forecast inflation for this 21-month period because, on average, operating costs incurred during the 12 month reporting year are a proxy for the 12 month period covered by the rate year. Since the rate year lags the report year by 9 months, the forecasted index needs to be 21 months (from the mid-point of the reporting year [6 months] to the end of the reporting year, plus the 9 month time lag to the beginning of the rate year, plus the next 6 months to the mid-point of the rate year). The first quarter of the calendar year in which the rate year begins is the earliest practical quarter in which the forecast can be made available, yet provide facilities with information on predicted cost increases and provide the department with the greater assurance of accuracy.

Similarly, subitem (2) identifies the index for the 12 month period from the mid-point of the reporting year to the mid-point of the immediately preceding reporting year. This time period measures the amount of actual inflation in other sectors of the economy since the prior reporting year. This inflation index is then used to adjust the operating cost limits in Part 9553.0050, subpart 2, item A, subitem (6) (the payment rate growth limits), and 9553.0035, subpart 14, item H (the individual compensation limit). The rationale for the quarter in which the index is obtained is the same as above.

Item D replaces current item F, which sums the operating cost rate components to produce the total operating cost payment rate. This is a necessary step in establishing a facility's total payment rate. The deletions are necessary because they contain the old formula (the sum of items B to E), which is being replaced by a new formula (the sum of items A and B).

Subpart 3. One time adjustment to allowable historical general operating cost payment rate.

It is necessary and reasonable to reword the introductory paragraph in subpart 3 so that the term "program" is no longer used to identify the type of staffing. The term "program staff" is difficult to define. This revision deletes the word "program" and defines "additional staff" as direct service staff required to implement changes in the provider's program to correct the finding of deficiency or need in excess of the number included in the facility's total payment rate during the rate year covering the date of the finding of deficiency or need. This rewording has the same substantive meaning but avoids using the term "program". Deletion of the term program is consistent with the change in the rule which combines the program cost category and other cost categories into one general operating cost category. The intention is to provide additional staff to implement changes in the client's programs. The additional staff typically will be program staff who work directly with the clients and directly implement the clients' individual program plans. In this subpart, direct service staff also may include staff such as a QMRP, if it can be demonstrated that this type of individual is essential to implement the

necessary changes. Additional staff does not include administrative personnel or other staff not working directly with the client or their services plans. This definition of "additional staff" is consistent with current department policy relating to OTRAs.

The term "program" also is deleted in item F, subitems (2) and (3), and item G of this subpart, for the same reasons.

Item A. It is necessary to delete reference to "program" and insert "allowable historical general" operating cost payment rate because the revised rule does not differentiate program costs from other types of costs. The allowable historical general operating costs are representative of the costs under consideration during the OTRA process, so it is reasonable to refer to those costs here.

Revised item A includes updated citations. It is reasonable to provide the most recent citations to better enable cross-referencing to the cited material.

Item B, subitem (1) substitutes the term economical facility incentive for efficiency incentive. This change is necessary because it is consistent with the revised terms used in this rule revision. This change also occurs in item D, subitem (3).

Subitem (2). Minnesota Statutes, section 256B.501, subdivision 8, contains language which supplements the special needs rate exception rule (rule parts 9510.1020 to 9510.1140) Therefore, it is necessary to reference this statute.

Item C, subitem 1. This subitem is amended to reference the statute governing the special needs rate exception. The statute supplements the special needs rate exception rule (rule parts 9510.1020 to 9510.1140). Therefore, it is necessary to reference this statute.

Item C, subitem (3). It is necessary to delete this language because under the revised rule, the department needs to review the most current information about staff positions. This rule revision adds new rule language under item D, subitem (1) unit (a) for analyzing that information.

Item C, subitem (5) is a technical change which substitutes the term individual program plan for individual habilitation plan. This change is needed and reasonable because the individual program plan is the name of the document generated by facilities, as required under the Code of Federal Regulations, 42 CFR 483.440 (c)(1).

Item C, subitem (6). This subitem requires facilities to submit the client assessment scores of all clients for the rate year covering the deficiency order or need determination. The department collects and maintains client assessment information but does not always have the most recent client assessment scores. Because the commissioner will use this information when

evaluating a facility's request for a one-time rate adjustment, it is necessary to have the most recent and pertinent information when granting a rate adjustment. Therefore, it is reasonable to require the facility requesting a one-time rate adjustment to submit this information.

It is also reasonable for a facility to submit assessments completed according to item D, subitem (7), because this provides the commissioner with information about the anticipated service characteristics of clients who are planning to reside in the facility. Item D, subitem (7), explains how to complete these assessments.

Item D. This item is revised to allow the commissioner to consider the information submitted by the provider and any other information available to the commissioner, using the criteria in items A and B. This language was added so that the commissioner could, when appropriate, consider client assessment information from previous years. This information could, for example, indicate increasing client service needs over a period of several years. The commissioner already has several years of client data available on computer at the department. Under this revision, the commissioner can consider the information stored in the computer rather than require providers to resubmit the information.

The commissioner also may have and may want to consider, client classifications for clients recommended for residence in the facility. This information can indicate the level of services these clients need and receive in their present ICF/MR, and provide some indication of the level of services the clients will need in the facility requesting the OTRA.

Subitem (1), unit (a). This item was added to reflect a procedure which has been the practice of the department when reviewing one time rate adjustment (OTRA) applications. When reviewing requests for OTRAs, DHS audits staff historically have adjusted the staff hours requested by the amount of any decrease in staff from prior reporting years. If a provider had the resources in its rate to maintain a certain level of staff but did not maintain that level and subsequently asked for a rate adjustment, it is reasonable that the provider be held accountable for that portion of staff hours that was previously in its rate. It is necessary to include this language so all providers will understand how the department evaluates this information. This unit specifies that, if the facility's occupancy has declined during this period, the review of direct service staff hours must be on the basis of hours per client day. This requirement is reasonable because it accounts for and prevents penalizing a provider that reduced staff because of a decrease in occupancy.

This unit also prevents providers from using the OTRA inappropriately to fund employee raises. Without this provision, providers could reduce total staff hours, give raises to existing staff, then request an OTRA to replace the reduced hours. The OTRA provision exists to adjust the rates of facilities that have undergone substantial changes in program and that require additional staff to implement those changes. It is not intended to fund salary increases. The salary ranges, raise schedules and criteria for granting pay increases is a facility management

decision. The rule already reimburses historic costs and provides inflation increases that facilities can use to grant raises, based on their internal management policy. Industry-wide increases in staff wages at rates beyond inflation must be legislatively appropriated.

The department received comments stating that this provision should not be incorporated into the rule because it adds unnecessary length and detail. Commenters said that the department should continue its current practice when reviewing OTRA requests without incorporating this practice into the rule. The department, however, chose to incorporate this policy into the rule so that providers will be informed in advance of the department's practice and will have this information available to them when making facility management decisions.

The changes in unit (b) are necessary to delete the term "program" and to substitute language clarifying the kind of "supplies" mentioned in this unit. For purposes of this unit, program supplies means supplies required to correct the deficiency or implement determination of need.

Unit (c). It is necessary to substitute "services" for "the program" because the term "program", as used in this unit, is intended to mean "services".

The changes in unit (d) are necessary to substitute language clarifying the meaning of "program consultants" as used in this unit.
Subitem (6) This subitem is necessary to incorporate use of client assessment information when evaluating a facility's request for a one time rate adjustment. This subitem provides the commissioner with a more refined tool for evaluating a facility requesting a one-time rate adjustment. In calculating a rate adjustment, it is reasonable to consider client assessment information because it provides information on the needs and services of clients residing in the facility. By using the same groups and arrays defined as in subpart 2, item A, subitem (4), a facility can be fairly compared with similar facilities.

The following example is for illustrative purposes only. This example demonstrates the use of groups and arrays in the evaluation.

XYZ Home (a fictitious facility), a class A metro/ small facility, applies for a one time rate adjustment. The facility's most recent average case mix score is 1.49 and the actual operating cost per client day (allowable general operating cost per diem) is $75.00. The provider is requesting a one time rate adjustment of $30.00 per client day. For this example, we will assume that the provider has submitted all required documentation, is eligible, and qualifies for an OTRA under items A and B.

The facility's requested operating cost per client day, with the requested OTRA amount, is $105.00. This amount is "standardized" by dividing the requested general operating cost per diem by the facility's service unit score (1.49), producing a standardized operating cost per client day of $70.47.

Next, we find the four facilities in the group with service unit scores most similar to the service unit score of XYZ Home (two facilities at or directly above XYZ's score and two facilities at or directly below XYZ). Below is a group of real facilities with fictitious names, and their actual service unit scores and costs:

	Facility	Service unit score	Standard cost
1.	Blue Home	1.50	$70.50
2.	*Red Home	1.63	$67.55
3.	*Green Home	1.63	$89.71
4.	Yellow Home	1.48	$49.01
5.	Orange Home	1.47	$92.07

* Because these facilities had the same service unit score, which was directly above XYZ Home's score, both were included in the calculation.

To compare the facility requesting the OTRA to these similar facilities, calculate the average standardized operating cost (average cost per service unit) for these five facilities. In this case, the average cost per service unit for these five facilities is $73.77. This amount is higher than the cost per service unit XYZ Home is requesting ($70.47), indicating that the amount requested is within the parameters of rates received by similar facilities (similar in size, geographic location, class, and similar in client service characteristics.)

Requiring additional documentation from facilities with a requested cost per unit higher than the standard cost of four similar facilities is a reasonable method of assuring that rate adjustments are not unnecessarily inflated. This additional requirement will help the department to evaluate requests for rate adjustments consistently and fully, using all tools available to the commissioner.

It is also reasonable that the commissioner use this information as one factor for evaluation, but not categorically deny a request based solely on the information. There may be valid reasons why a facility requesting an OTRA would request an amount higher than the average for facilities used for comparison in the grouping array. For example, the facility may be serving a person with unique service intensive needs that are not typical to the clients of the ICFs/MR.

Subitem (7) is necessary to provide guidance when the provider requests an OTRA because it is planning to serve higher-need clients for whom the facility has not conducted an assessment. Because the client's service needs are not represented in the facility's most recent service unit score, it is reasonable to consider existing client classifications for these clients (such as the client classification established at RTC for a client residing at an RTC), or for the facility QMRP to provide the anticipated client classification of the proposed clients. This information will indicate the anticipated service needs of the clients and will be useful in determining a reasonable OTRA amount.

This information shall be used according to the method in subitem (6) to compare the costs and client characteristics of the facility requesting the OTRA to similar facilities.

The advisory committee recommended the method in subitem 6 (See part I of Recommendations to the Commissioner [exhibit 4]). The committee's recommendation further supports the reasonableness of this subitem.

PART 9553.0060 Determination of Property Related Payment Rate

Subpart 1. Depreciation.

Item B. It is necessary to revise this item in order to delete a reference to part 9553.0030, subpart 4, item E, because this subpart no longer exists.

Item C, subitem (1). It is necessary to revise this subitem to include limits for the maximum investment per bed. Each year the investment-per-bed limits are increased to account for inflation. The department disseminates this information to the industry through written bulletins. At the suggestion of an advisory committee member, the limits to date are incorporated into the rule for convenient reference. The 1990 legislature set up different limits for newly constructed or newly established providers entering the medical assistance program after May 1, 1990. These limits also are incorporated into the rule for reference.

Item C, subitem (5). This subitem has clarifying language related to cost allocation. It specifies that central, affiliated, or corporate office property-related costs of capital assets used directly by a facility to provide ICF/MR services must be classified to the property-related cost category of the facility that uses the capital asset. This provision is necessary because this item otherwise specifically excludes those costs from the general operating cost category.

It is also necessary to correct the internal cite for the new general operating cost category.

Item E, subitem (8). It is necessary and reasonable to use the acronym MHFA instead of Minnesota Housing Finance Agency because this agency is more commonly referred to using this acronym.

Subitem (9). This subitem is necessary to give the same treatment to financing sources which are similar to MHFA when the amount to be deposited as funded depreciation is not less than what is required under subitem (1) (calculation of funded depreciation.) The new language also requires the name and terms of the mortgagee. These requirements are necessary for establishing an audit trail by which the department may validate the financing information.

Subpart 3 Allowable interest expense.

Item F. This item is necessary to put into rule a current practice of the department. A provider can take four different actions regarding the 20 percent down payment of the asset on which the rule does not allow financing costs.

- The provider can pay 20 percent of the purchase price of the new asset in cash;
- A facility asset can be exchanged (traded in) and the money received from the trade-in can be applied toward the purchase;
- The provider can finance 100 percent of the purchase price, but only claim 80 percent for reimbursement; or
- The provider can finance 100 percent of the purchase price, claim 100 percent for reimbursement, and have the department adjust the capital debt to 80 percent during a desk or field audit.

This item is reasonable because it adds flexibility for providers by permitting the trade-in of an asset to be counted toward the 20 percent down requirement. In particular, it permits the 80 percent debt limitation to be applied to the original purchase price of a vehicle, not the price less trade-in. The trade-in value will be counted toward the 20 percent down payment requirement. The advisory committee supports this provision. This provision was included in the part I recommendations to the commissioner (See exhibit 4.)

Subpart 6. Energy conservation incentive. It is necessary to delete the phrase "and must be classified in the plant operation and maintenance cost category" because this rule revision eliminates these categories and creates one general operating cost category. The change in the citation referring to certification of the auditor is for the sake of greater accuracy.

9553.0070 Determination of Total Payment Rate

Subpart 1. Total payment rate. The word "general" has been added to the phrase "total operating cost payment rate" to distinguish it from the special operating cost payment rate.

Subpart 3. Temporary Care Payment Rate

The change of the term "respite care" to "temporary care" requires amendment of present subpart 3 and a reference to rules appropriate for temporary care clients. It is necessary to inform providers that the department is changing the terminology in the rule. See the definition of temporary care in part 9553.0020, subpart 44, and the accompanying SNR section.

Subpart 4. Adjustment to total payment rate. This subpart is being deleted because it relates to a phase-in that was done only in 1985. Therefore, this subpart is no longer necessary.

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 deletions and addition of references to other parts of the rule are necessary to revise rule citations to be consistent with amended rules and proposed revisions in other parts.

It is reasonable that a new facility or a facility undergoing a class A to B conversion not be subject to part 9553.0050, subpart 2, item A [except subitem (8)]during the interim period because the interim period is the period of time in which the historical operating costs are established. The facility does not have the historic rate information necessary to implement these provisions. Therefore, it is reasonable to exempt these facilities (a newly established facility or one with an A to B conversion) during the interim rate period. However, because a facility will be subject to the high cost limit, it is appropriate to subject these facilities to that limit during the interim rate period. To not do so would give a conflicting message to the provider.

It is reasonable that a facility with an interim rate should not be eligible for the economical facility incentive (part 9553.0050, subpart 2, item B) because facilities on an interim rate are establishing new rates that reflect their costs. These facilities do not have the historic cost information needed to determine an economic facility incentive. After settle-up, facilities will be eligible to earn economical facility incentives and may receive an incentive payment based on their future economical performance as compared with other facilities. This provision is consistent with the present rule, which excludes facilities on interim rates from being eligible for an efficiency incentive.

It is reasonable that part 9553.0050, subpart 3 (OTRA) should not apply to facilities with interim rates because these facilities are already having a rate adjustment. Therefore, an OTRA would be redundant and unnecessary.

Subpart 2. Interim Payment Rate Settle up. It is reasonable that part 9553.0050, subpart 2, item A(6) [the spend-up limit], item B [the economical facility incentive], subpart 3 [OTRA]; and part 9553.0060 subpart 6 [energy conservation provision] should not apply to facilities with a settle up to the interim payment rate for the same reasons stated under subpart 1, above.

9553.0080 APPEAL PROCEDURES

Subparts 1 to 4. These amendments are necessary because they incorporate changes in the appeals process specified under Minnesota Statutes, section 256B.50.

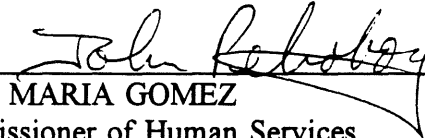
Expert Witnesses

In the event of a hearing, the department does not intend to present expert witnesses from outside the department.

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

Impact on Agricultural Lands Minnesota Statutes, section 14.11, subdivision 2, requires agencies proposing rules that have a direct and substantial adverse impact on agricultural land in this state to comply with additional statutory requirements. The amendments of the rule governing payment for intermediate care facilities for persons with mental retardation or related conditions do not have a direct substantial adverse impact on agricultural land, and therefore the additional statutory provisions do not apply.

Date: 10/30/95



MARIA GOMEZ
Commissioner of Human Services