BEFORE THE
ADMINISTRATIVE RULES COMMITTEE
OF THE
NORTH DAKOTA LEGISLATIVE COUNCIL

N.D. Admin. Code Chapter 75-02-06, Ratesetting for Nursing Home Care (Pages 140-155)	))))	**REPORT OF THE DEPT. OF HUMAN SERVICES September 14, 2010**

For its report, the North Dakota Department of Human Services states:

1. The proposed amendments to N.D. Admin. Code chapter 75-02-06 are not related to statutory changes made by the Legislative Assembly.
2. These rules are not related to changes in a federal statute or regulation.
3. The Department of Human Services uses direct and electronic mail as the preferred ways of notifying interested persons of proposed rulemaking. The Department uses a basic mailing list for each rulemaking project that includes the county social service boards, the regional human service centers, Legal Services offices in North Dakota, all persons who have asked to be on the basic list, and internal circulation within the Department. Additionally, the Department constructs relevant mailing lists for specific rulemaking. The Department also places public announcements in all county newspapers advising generally of the content of the rulemaking, of over 50 locations throughout the state where the proposed rulemaking documents may be reviewed, and stating the location, date, and time of the public hearing.

   The Department conducts public hearings on all substantive rule-making. Oral comments are recorded. Oral comments, as well as

any written comments that have been received, are summarized and presented to the Department's executive director, together with any response to the comments that may seem appropriate and a re-drafted rule incorporating any changes occasioned by the comments.

4. A public hearing on the proposed rules was held in Bismarck on June 8, 2010. The record was held open until 5:00 p.m. on June 18, 2010, to allow written comments to be submitted. A summary of the comments received is attached to this report.

5. The cost of giving public notice, holding a hearing, and the cost (not including staff time) of developing and adopting the rules was $2,016.12.

6. The proposed rule amends chapter 75-02-06. The following specific changes were made:

   Section 75-02-06-01. Section 75-02-06-01 is amended to update definitions including institutional leave day and therapeutic leave day and to define non-covered day.

   Section 75-02-06-17. Section 75-02-06-17 is amended to clarify when resident assessments must be completed and to redefine the criteria for resident classifications as they related to IV, oxygen, and therapy services provided in the facility.

7. No written requests for regulatory analysis have been filed by the Governor or by any agency. The proposed amendments are not expected to have an impact on the regulated community in excess of $50,000. A regulatory analysis was prepared and is attached to this report.

8. A small entity regulatory analysis and small entity economic impact statement were prepared and are attached to this report.

9. A constitutional takings assessment was prepared and is attached to this report.

10. These rules were not adopted as emergency (interim final) rules.

Prepared by:

Jonathan Alm
Legal Advisory Unit
North Dakota Department of Human Services
September 14, 2010

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John Hoeven, Governor
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SUMMARY OF COMMENTS RECEIVED REGARDING PROPOSED AMENDMENTS TO N.D. ADMIN. CODE CHAPTER 75-02-06 RATESETTING FOR NURSING HOME CARE

The North Dakota Department of Human Services held a public hearing on June 8, 2010, in Bismarck, ND, concerning the proposed amendments to N.D. Administrative Code chapter 75-02-06, ratesetting for nursing home care.

Written comments on these proposed amendments could be offered through 5:00 p.m. on Friday, June 18, 2010.

No one attended or provided comments at the public hearing. Seven sets of written comments were received within the comment period. The commentors were:

1. Shelly Peterson, President, North Dakota Long Term Care Association, 1900 N 11th St, Bismarck, ND 58501
2. Kirk Greff, Administrator, Medcenter One St. Vincent's Care Center, 1021 N 26th St, Bismarck, ND 58501
3. Wade Peterson, Administrator, Medcenter One Mandan Living Center, 1011 Boundary St NW, Mandan, ND 58554
4. Jim Hawkins, Administrator, Medcenter One Mandan Care Center Off Collins, 201 14th St NW, Mandan, ND 58554
5. Kevin Greff, President/CEO, Benedictine Living Communities, 1839 E Capitol Ave, Bismarck, ND 58501
6. Randal Albrecht, Administrator, Medcenter One Living Centers, 1000 18th St NW, Ste 1, Mandan, ND 58554
7. Kim Jensrud, Administrator, Medcenter One Prairieview, 83 Lincoln Ave, Underwood, ND 58576
8. (postmarked June 18, 2010) Kirsten Reile, Director of Nursing, Elim Care, Inc., 3534 University Dr S, Fargo, ND 58104
9. (postmarked June 18, 2010) Rick Wittmeier, Administrator, Trinity Homes, 305 8th Ave NE, Minot, ND 58702

SUMMARY OF COMMENTS

Comment: 75-02-06, The proposed rule change will have an impact of much greater than $50,000. The rehabilitation category alone will change the payment of individuals dramatically when therapy begins or ends. We are not arguing the virtue of this change, but wish to simply make the point that the financial impact will be greater than $50,000 annually.

Response: No response necessary.

Comment: 75-02-06, To best reflect the changes in resident condition we believe it might be better to change the rate when a significant change in resident condition occurs. This way when a resident's condition improves they would fall into a lower rate classification, as well as, when their condition deteriorates and needs more care, the rate would increase. CMS already defines what constitutes significant change, thus objective criteria exists to implement this change. We believe this issue should be evaluated and considered. After further study, if this is a better approach for accurately and fairly classifying residents in a rate category when their conditions change, the rules should be amended.

Response: Allowing significant change assessments to affect a resident's classification has been studied in the past. The Centers for Medicare & Medicaid Services (CMS) determines what is a significant change based on clinical needs. This may or may not affect the rate classification. To accept significant change assessments there would need to be a process for the client to request a rate change based upon what would constitute a significant change. No change to the proposed rules is necessary based on this comment.

Comment: 75-02-06-17(3)(c)(d), recommend at beginning or end of therapy when the assessment is completed, the rate should be re-calculated based upon this assessment. This would better allow you to capture the clinical and medical condition of the resident at that specific point.

Response: To maintain the integrity of a prospective payment system there must be fixed review points. The inclusion of a specific rate period for therapies within the existing three month rate period allows for the recognition of increased costs for therapies and does not impact the recognition of the other data elements impacting a classification. Therefore, the classification that is applicable to nontherapy resources must be maintained for the entire three-month period. The initiation or discontinuation of therapy does not require a comprehensive assessment so not all of the data elements needed for classification may be present on the assessment. Based on our review no change will be made to the proposed rules.

Comment: Significant changes can adjust acuity up or down, meaning that in some instances the resident's daily rate will increase and other significant changes will reduce the daily rate. What is important is that at all times the rate being charged and paid accurately reflects the care being provided to the resident at that time. Hospitals will soon be penalized by CMS for re-hospitalizations. With that in mind they will be looking at ways to properly treat the patient/resident in the nursing home. That will mean that nursing homes will begin costly treatments and therapies (traditionally carried out in the hospitals) that could carry on for some time and the nursing facility will continue to be paid at a lower rate. Most of these episodes will require significant change MDS's. The rule change as written only works to the benefit of the payor or resident and the provider will be treated unfairly. Rates need to

accurately reflect the impact the additional costs or savings triggered by a significant change MDS.

Response: To maintain the integrity of a prospective payment system there must be fixed review points. Allowing significant change assessments to affect a resident's classification has been studied in the past. The Centers for Medicare & Medicaid Services (CMS) determines what is a significant change based on clinical needs. This may or may not affect the rate classification. To accept significant change assessments there would need to be a process for the client to request a rate change based upon what would constitute a significant change. No change to the proposed rules is necessary based on this comment.

Comment: 75-02-06-17(3)(c)(d), This change will create an imbalance in the ups and downs of care needs between assessments during a resident's stay with us. If this change is made, additional changes are needed so that all significant changes are immediately recognized by change in classification. Rates would need to accurately reflect the additional costs triggered by all significant change MDS's and not isolated only to a change in therapy.

Response: To maintain the integrity of a prospective payment system there must be fixed review points. Allowing significant change assessments to affect a resident's classification has been studied in the past. The Centers for Medicare & Medicaid Services (CMS) determines what is a significant change based on clinical needs. This may or may not affect the rate classification. To accept significant change assessments there would need to be a process for the client to request a rate change based upon what would constitute a significant change. The inclusion of a specific rate period for therapies within the existing three-month rate period allows for the recognition of increased costs for therapies and does not impact the recognition of the other data elements affecting a classification. Based on our review no change will be made to the proposed rules.

Comment: Agree with the proposed changes, it should be noted that the current payment system using the resident assessment tool, the MDS, is using the law of averages. Rates are set for a three-month period and without a hospital stay, the rate doesn't change.

Response: No response necessary.

Comment: Please consider a rate change with the significant change MDS. This would reflect a rate based upon the residents current condition and this would be fair to all.

Response: Allowing significant change assessments to affect a resident's classification has been studied in the past. The Centers for Medicare & Medicaid Services (CMS) determines what is a significant change based on clinical needs. This may or may not affect the rate

classification. To accept significant change assessments there would need to be a process for the client to request a rate change based upon what would constitute a significant change. No change to the proposed rules is necessary based on this comment.

Comment: 75-02-06-01, supportive of the clarification of the definitions in this section but would like "physicians" definition be added to the definition section. Recommended that the definition used in MDS 3.0 be utilized. It states, "Includes medical doctors, doctors of osteopathy, podiatrist, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician." Throughout the years the role and use of the physician has been expanded to include additional professionals and we recommend the rules be changed to reflect this current practice.

Response: "Physician" is defined as stated above in the Resident Assessment Instrument (RAI) Manual . The Centers for Medicare and Medicaid (CMS) issues the RAI Manual which contains detailed coding instructions for the resident assessment. It is not necessary to reiterate the same definition in administrative rules. Based on our review no change will be made to the proposed rules.

Comment: 75-02-06-17(6)(d), agree that the oxygen must be provided within the facility during the assessment reference period but disagree with the time limits set forth in the rules. Each time oxygen is utilized by a resident, clinical skills of a professional nurse are required to assess the resident to assure adequate oxygenation. Therefore there should be no minimum regarding frequency and duration of oxygen use in the establishment of the rate. Professional nursing knowledge and assessment skills are continually used to monitor the resident to assure they attain a therapeutic oxygen saturation level. Thus when oxygen is used during the assessment period, regardless of frequency, it should be used to determine payment. Oxygen therapy is very expensive in terms of supplies, oxygen, and nursing time. When it is provided in the facility, it should be captured in the payment system.

Response: The RAI Manual states that oxygen therapy should be coded if "continuous or intermittent oxygen administered via mask, cannula, etc." While the RAI manual does not provide a definition of continuous or intermittent oxygen administration to accurately code the resident assessment, the criteria identified within the rule is the same as the state-specific criteria approved for North Dakota by CMS for coding oxygen administration. Adding this to the rules ensures consistent coding on the assessment. No change to the proposed rules is made based on the comment.

Comment: The rule change proposes the completion of an MDS at the end of a course of Therapy. This additional MDS will reflect actual cares provided and adjust the resident's rate in a timely manner. MDS 3.0 will ignore care provided in the hospital, which should also reduce the rates charged to a nursing facility resident. In both instances the charges will

reflect timely and accurate costs related to the services being provided to the resident. The proposed rules do not reflect the costs that have to be absorbed by a facility when a resident's condition worsens due to a medical condition such as IVs for an infection or diseases such as COPD. The resident and the state are the only parties fairly treated by these proposed rules.

Response: To maintain the integrity of a prospective payment system there must be fixed review points.The proposed rule changes also require the completion of a resident assessment at the initiation of therapy. The initiation of therapy may or may not coincide with the quarterly assessment. The nursing facility resident will receive an appropriate classification based on the initiation of therapy as well as the discontinuation of therapy. The inclusion of a specific rate period for therapies within the existing three-month rate period allows for the recognition of increased costs for therapies and does not impact the recognition of the other data elements affecting a classification. Therefore the classification that is applicable to nontherapy resources must be maintained for the entire three month period. The initiation or discontinuation of therapy does not require a comprehensive assessment so not all of the data elements needed for classification may be present. Based on our review no change will be made to the proposed rules.

Prepared by:

Julie Leer

Julie Leer, Director
Legal Advisory Unit
N.D. Dept. of Human Services

In Consultation with: LeeAnn Thiel, Medical Services

July 7, 2010

Cc: LeeAnn Thiel, Medical Services

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MEMO

TO: Julie Leer, Director, Legal Advisory Unit

FROM: LeeAnn Thiel, Administrator LT
Medicaid Payment and Reimbursement Services, Medical Services

RE: Regulatory Analysis of Proposed North Dakota Administrative Code chapter 75-02-06

DATE: April 27, 2010

The purpose of this regulatory analysis is to fulfill the requirements of N.D.C.C. § 28-32-08. This analysis pertains to proposed amendments to North Dakota Administrative Code Article 75-02-06. These amendments are not anticipated to have a fiscal impact on the regulated community in excess of $50,000.

Purpose

The amendments update the definitions used in this chapter and redefine the criteria for resident classification as they relate to IV, oxygen and therapy services provided in the facility.

Classes of Persons Who Will be Affected

Nursing facility operators and nursing facility residents will be affected by the proposed rule changes since some of the changes affect the classifications of residents which are used for payment.

Probable Impact

The estimated impact of the changes to the definitions is zero.

The estimated impact of the changes to the resident assessment categories cannot be determined.

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Probable Cost of Implementation

The amendments become part of existing rules on ratesetting and there are no additional costs associated with implementing the rule changes. It is estimated there will be no effect on state revenues.

Consideration of Alternative Methods

The Department did not consider whether there are any less intrusive or less costly alternative methods of achieving the purpose of the proposed rules. The amendments to update the resident assessment categories coincide with the implementation of a new resident assessment classification system.

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MEMORANDUM

TO: Julie Leer, Director, Legal Advisory Unit

FROM: LeeAnn Thiel, Administrator
Medicaid Payment and Reimbursement Services, Medical Services

DATE: April 27, 2010

SUBJECT: Small Entity Regulatory Analysis Regarding Proposed Amendments to N.D. Admin. Code chapter 75-02-06

The purpose of this small entity regulatory analysis is to fulfill the requirements of N.D.C.C. § 28-32-08.1. This regulatory analysis pertains to proposed amendments to N.D. Admin. Code chapter 75-02-06. The proposed rules are not mandated by federal law.

Consistent with public health, safety, and welfare, the Department has considered using regulatory methods that will accomplish the objectives of applicable statutes while minimizing adverse impact on small entities. For this analysis, the Department has considered the following methods for reducing the rules' impact on small entities:

1. Establishment of Less Stringent Compliance or Reporting Requirements

The only small entities affected by the proposed amendments are licensed nursing facilities that have gross revenues of less than $2.5 million annually. The proposed amendments affect components of the ratesetting processes for nursing facilities that are applied to costs reported by the entities. Because all costs must be considered when establishing limits used in the rate setting process, facilities, including facilities that are considered to be small entities, must file a uniform annual cost report. 42 CFR 447.253(f) requires that the Medicaid agency provide for the filing of uniform cost reports by each participating provider. The proposed amendments do not alter the uniform cost reporting requirements necessary to establish the rates for all nursing facilities in the state that choose to participate in Medicaid and therefore establishment of less stringent compliance or reporting requirements for these small entities was not considered.

2. Establishment of Less Stringent Schedules or Deadlines for Compliance or Reporting Requirements for Small Entities

The proposed amendments will not alter any required schedules or deadlines for the uniform cost reporting requirements and therefore establishment of less stringent schedules or deadlines for compliance or reporting requirements for these small entities was not considered.

3. Consolidation or Simplification of Compliance or Reporting Requirements for Small Entities

The proposed amendments will not alter any uniform cost reporting requirements, therefore, consolidation or simplification of compliance or reporting requirements for these small entities was not considered.

4. Establishment of Performance Standards for Small Entities to Replace Design or Operational Standards Required in the Proposed Rules

The proposed amendments do not affect any design or operational standards in existence for these small entities, therefore, establishment of new performance standards were not considered.

5. Exemption of Small Entities From All or Any Part of the Requirements Contained in the Proposed Rules

The requirements of the proposed amendments are applicable to all nursing facilities that choose to participate in Medicaid and have a rate established for payment of services. Entities choosing not to participate in Medicaid would not be impacted by the proposed amendments.

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MEMORANDUM

TO: Julie Leer, Director, Legal Advisory Unit

FROM: LeeAnn Thiel, Administrator
Medicaid Payment and Reimbursement Services, Medical Services

DATE: April 27, 2010

SUBJECT: Small Entity Economic Impact Statement Regarding Proposed Amendments to N.D. Admin. Code chapter 75-02-06

The purpose of this small entity economic impact statement is to fulfill the requirements of N.D.C.C. § 28-32-08.1. This impact statement pertains to proposed amendments to N.D. Admin. Code chapter 75-02-06. The proposed rules are not mandated by federal law. The proposed rules are not anticipated to have an adverse economic impact on small entities.

1. Small Entities Subject to the Proposed Rules

The small entities that are subject to the proposed amended rules are nursing facilities participating in the Medicaid program that have gross annual revenue less than $2.5 million.

There are no other small entities subject to the proposed amendments.

2. Costs For Compliance

Administrative and other costs required of nursing facilities for compliance with the proposed amendments are expected to be zero. The proposed amendments affect only the assignment of the classification based on resident characteristics used to establish a resident's payment rate.

3. Costs and Benefits

The probable cost on an aggregate basis to private persons and consumers who are affected by the proposed rules is expected to be budget neutral as some consumers may experience a decreased payment rate due to a classification change while others may experience an increased payment rate.

The probable benefit on an aggregate basis to private persons and consumers who are affected by the proposed rules is that their classification and payment rate may decrease with the discontinuation of therapy.

4. Probable Effect on State Revenue

The probable effect of the proposed rules on state revenues is expected to be none as the proposed amendments affect state expenditures.

5. Alternative Methods

The Department did not consider whether there are any less intrusive or less costly alternative methods of achieving the purpose of the proposed rules. The amendments to update the resident assessment categories coincide with the implementation of a new resident assessment classification system.

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TAKINGS ASSESSMENT

concerning proposed amendment to N.D. Admin. Code chapter 75-02-06.

This document constitutes the written assessment of the constitutional takings implications of this proposed rulemaking as required by N.D.C.C. § 28-32-09.

1. This proposed rulemaking does not appear to cause a taking of private real property by government action which requires compensation to the owner of that property by the Fifth or Fourteenth Amendment to the Constitution of the United States or N.D. Const. art. I, § 16. This proposed rulemaking does not appear to reduce the value of any real property by more than fifty percent and is thus not a "regulatory taking" as that term is used in N.D.C.C. § 28-32-09. The likelihood that the proposed rules may result in a taking or regulatory taking is nil.

2. The purpose of this proposed rule is clearly and specifically identified in the public notice of proposed rulemaking which is by reference incorporated in this assessment.

3. The reasons this proposed rule is necessary to substantially advance that purpose are described in the regulatory analysis which is by reference incorporated in this assessment.

4. The potential cost to the government if a court determines that this proposed rulemaking constitutes a taking or regulatory taking cannot be reliably estimated to be greater than $0. The agency is unable to identify any application of the proposed rulemaking that could conceivably constitute a taking or a regulatory taking. Until an adversely impacted landowner identifies the land allegedly impacted, no basis exists for an estimate of potential compensation costs greater than $0.

5. There is no fund identified in the agency's current appropriation as a source of payment for any compensation that may be ordered.

6. I certify that the benefits of the proposed rulemaking exceed the estimated compensation costs.

Dated this 5th day of May, 2010.

by: Julie Lee
N.D. Dept. of Human Services