SENATE
STATE OF MINNESOTA
EIGHTY-EIGHTH SESSION

S.F. No. 894

(SENATE AUTHORS: WIKLUND)

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A bill for an act

relating to health; making changes to resident reimbursement classifications; amending Minnesota Statutes 2012, section 144.0724.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2012, section 144.0724, is amended to read:

144.0724 RESIDENT REIMBURSEMENT CLASSIFICATION.

Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section and according to section 256B.438. ~~The reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003.~~

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given.

(a) "Assessment reference date" or "ARD" means the ~~last day of the minimum data set observation period. The date sets the designated endpoint of the common observation period, and all minimum data set items refer back in time from that point.~~ specific end point for look-back periods in the MDS assessment process. This look-back period is also called the observation or assessment period.

(b) "Case mix index" means the weighting factors assigned to the ~~RUG-III or~~ RUG-IV classifications.

(c) "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) "Minimum data set" or "MDS" means ~~the assessment instrument~~ a core set of screening, clinical assessment, and functional status elements, that include common definitions and coding categories specified by the Centers for Medicare and Medicaid Services and designated by the Minnesota Department of Health.

(e) "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the ~~nursing home ombudsman's~~ Office of Ombudsman for Long-Term Care whose assistance has been requested, or any other individual designated by the resident.

(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's minimum data set.

(g) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

(h) "Nursing facility level of care determination" means the assessment process that results in a determination of a resident's or prospective resident's need for nursing facility level of care as established in subdivision 11 for purposes of medical assistance payment of long-term care services for:

(1) nursing facility services under section 256B.434 or 256B.441;

(2) elderly waiver services under section 256B.0915;

(3) CADI and BI waiver services under section 256B.49; and

(4) state payment of alternative care services under section 256B.0913.

~~Subd. 3.~~ **Resident reimbursement classifications prior to January 1, 2012.** ~~(a) Resident reimbursement classifications shall be based on the minimum data set, version 3.0 assessment instrument, or its successor version mandated by the Centers for Medicare and Medicaid Services that nursing facilities are required to complete for all residents. Prior to January 1, 2012, the commissioner of health shall establish resident classes according to the 34 group, resource utilization groups, version III or RUG-III model. Resident classes must be established based on the individual items on the minimum data set and must be completed according to the facility manual for case mix classification issued by the Minnesota Department of Health.~~

~~(b) Each resident must be classified based on the information from the minimum data set according to general domains in clauses (1) to (7):~~

~~(1) extensive services where a resident requires intravenous feeding or medications, suctioning, or tracheostomy care, or is on a ventilator or respirator;~~

~~(2) rehabilitation where a resident requires physical, occupational, or speech therapy;~~

~~(3) special care where a resident has cerebral palsy; quadriplegia; multiple sclerosis; pressure ulcers; ulcers; fever with vomiting, weight loss, pneumonia, or dehydration; surgical wounds with treatment; or tube feeding and aphasia; or is receiving radiation therapy;~~

~~(4) clinically complex status where a resident has tube feeding, burns, coma, septicemia, pneumonia, internal bleeding, chemotherapy, dialysis, oxygen, transfusions, foot infections or lesions with treatment, hemiplegia/hemiparesis, physician visits or order changes, or diabetes with injections and order changes;~~

~~(5) impaired cognition where a resident has poor cognitive performance;~~

~~(6) behavior problems where a resident exhibits wandering or socially inappropriate or disruptive behavior, has hallucinations or delusions, is physically or verbally abusive toward others, or resists care, unless the resident's other condition would place the resident in other categories; and~~

~~(7) reduced physical functioning where a resident has no special clinical conditions.~~

~~(c) The commissioner of health shall establish resident classification according to a 34 group model based on the information on the minimum data set and within the general domains listed in paragraph (b), clauses (1) to (7). Detailed descriptions of each resource utilization group shall be defined in the facility manual for case mix classification issued by the Minnesota Department of Health. The 34 groups are described as follows:~~

~~(1) SE3: requires four or five extensive services;~~

~~(2) SE2: requires two or three extensive services;~~

~~(3) SE1: requires one extensive service;~~

~~(4) RAD: requires rehabilitation services and is dependent in activity of daily living (ADL) at a count of 17 or 18;~~

~~(5) RAC: requires rehabilitation services and ADL count is 14 to 16;~~

~~(6) RAB: requires rehabilitation services and ADL count is ten to 13;~~

~~(7) RAA: requires rehabilitation services and ADL count is four to nine;~~

~~(8) SSC: requires special care and ADL count is 17 or 18;~~

~~(9) SSB: requires special care and ADL count is 15 or 16;~~

~~(10) SSA: requires special care and ADL count is seven to 14;~~

~~(11) CC2: clinically complex with depression and ADL count is 17 or 18;~~

~~(12) CC1: clinically complex with no depression and ADL count is 17 or 18;~~

~~(13) CB2: clinically complex with depression and ADL count is 12 to 16;~~

~~(14) CB1: clinically complex with no depression and ADL count is 12 to 16;~~

~~(15) CA2: clinically complex with depression and ADL count is four to 11;~~

~~(16) CA1: clinically complex with no depression and ADL count is four to 11;~~

~~(17) IB2: impaired cognition with nursing rehabilitation and ADL count is six to ten;~~

~~(18) IB1: impaired cognition with no nursing rehabilitation and ADL count is six to ten;~~

~~(19) IA2: impaired cognition with nursing rehabilitation and ADL count is four or five;~~

~~(20) IA1: impaired cognition with no nursing rehabilitation and ADL count is four or five;~~

~~(21) BB2: behavior problems with nursing rehabilitation and ADL count is six to ten;~~

~~(22) BB1: behavior problems with no nursing rehabilitation and ADL count is six to ten;~~

~~(23) BA2: behavior problems with nursing rehabilitation and ADL count is four to five;~~

~~(24) BA1: behavior problems with no nursing rehabilitation and ADL count is four to five;~~

~~(25) PE2: reduced physical functioning with nursing rehabilitation and ADL count is 16 to 18;~~

~~(26) PE1: reduced physical functioning with no nursing rehabilitation and ADL count is 16 to 18;~~

~~(27) PD2: reduced physical functioning with nursing rehabilitation and ADL count is 11 to 15;~~

~~(28) PD1: reduced physical functioning with no nursing rehabilitation and ADL count is 11 to 15;~~

~~(29) PC2: reduced physical functioning with nursing rehabilitation and ADL count is nine or ten;~~

~~(30) PC1: reduced physical functioning with no nursing rehabilitation and ADL count is nine or ten;~~

~~(31) PB2: reduced physical functioning with nursing rehabilitation and ADL count is six to eight;~~

~~(32) PB1: reduced physical functioning with no nursing rehabilitation and ADL count is six to eight;~~

~~(33) PA2: reduced physical functioning with nursing rehabilitation and ADL count is four or five; and~~

~~(34) PA1: reduced physical functioning with no nursing rehabilitation and ADL count is four or five.~~

Subd. 3a. **Resident reimbursement classifications beginning January 1, 2012.** (a) Beginning January 1, 2012, resident reimbursement classifications shall be based

on the minimum data set, version 3.0 assessment instrument, or its successor version mandated by the Centers for Medicare and Medicaid Services that nursing facilities are required to complete for all residents. The commissioner of health shall establish resident ~~classes~~ classifications according to the RUG-IV, 48 group, resource utilization groups. Resident ~~classes~~ classification must be established based on the individual items on the minimum data set, which must be completed according to the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare and Medicaid Services.

(b) Each resident must be classified based on the information from the minimum data set according to general ~~domains~~ categories as defined in the ~~Facility Manual for~~ Case Mix Classification Manual for Nursing Facilities issued by the Minnesota Department of Health.

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health ~~case mix~~ MDS assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment ~~must be completed by day 14 following admission~~;

(2) an annual assessment which must have an assessment reference date (ARD) within 92 days of the previous assessment and within 366 days of the ARD of the ~~last~~ previous comprehensive assessment;

(3) a significant change in status assessment must be completed within 14 days of the identification of a significant change; ~~and~~

(4) all quarterly assessments must have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment~~.~~;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; and

(6) any significant correction to a prior quarterly assessment, if the assessment being corrected is the current one being used for RUG classification.

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256B.0911, subdivision 4a, by a county, tribe, or managed care organization under contract with the Department of Human Services; and

(2) a face-to-face long-term care consultation assessment completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an ~~initial~~ admission assessment for all residents who stay in the facility ~~less than~~ 14 days or less.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents who stay ~~less than~~ 14 days or less in lieu of submitting an ~~initial~~ admission assessment. Facilities shall make this election annually.

(c) Nursing facilities must elect one of the options described in paragraphs (a) and (b) by reporting to the commissioner of health, as prescribed by the commissioner. The election is effective on July 1 each year.

~~(d) For residents who are admitted or readmitted and leave the facility on a frequent basis and for whom readmission is expected, the resident may be discharged on an extended leave status. This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred since the last assessment. The case mix classification for these residents is determined by the facility election made in paragraphs (a) and (b).~~

Subd. 6. **Penalties for late or nonsubmission.** A facility that fails to complete or submit an assessment according to subdivisions 4 and 5 for a ~~RUG-III or~~ RUG-IV classification within seven days of the time requirements ~~in subdivisions 4 and 5~~ listed in the Long-Term Care Facility Resident Assessment Instrument User's Manual is subject to a reduced rate for that resident. The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments, on the ARD for significant change in status assessments, or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission and acceptance of the resident's assessment.

Subd. 7. **Notice of resident reimbursement classification.** (a) The commissioner of health shall provide to a nursing facility a notice for each resident of the reimbursement classification established under subdivision 1. The notice must inform the resident of the

classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification and the address and telephone number of the Office of Ombudsman for Long-Term Care. The commissioner must transmit the notice of resident classification by electronic means to the nursing facility. A nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the electronic file of notice of case mix classifications from the commissioner of health.

(b) If a facility submits a ~~correction~~ modification to the most recent assessment used to establish a case mix classification conducted under subdivision 3 that results in a change in case mix classification, the facility shall give written notice to the resident or the resident's representative about the item that was ~~corrected~~ modified and the reason for the ~~correction~~ modification. The notice of ~~corrected~~ modified assessment may be provided at the same time that the resident or resident's representative is provided the resident's ~~corrected~~ modified notice of classification.

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, ~~the requested classification changes,~~ and documentation supporting the ~~requested classification~~ request. ~~The documentation accompanying the reconsideration request is limited to documentation which establishes that the needs of the resident at the time of the assessment justify a classification which is different than the classification established by the commissioner of health.~~ The documentation accompanying the reconsideration request is limited to a copy of the MDS that determined the classification and other documents that would support or change the MDS findings.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration

request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information listed in item (iii) with the reconsideration request, the commissioner may request that the facility provide the information within 14 calendar days. The reconsideration request must be denied if the information is then not provided, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the ~~initial~~ assessment that determined the classification and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect ~~the needs or assessment~~ characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after

the decision is made. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing facility level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident assessments performed under section 256B.438 through any of the following: desk audits~~,~~; on-site review of residents and their records~~,~~; and interviews with staff ~~and~~, residents, or residents' families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

~~(1) The commissioner may target facilities that demonstrate an atypical pattern of scoring minimum data set items, nonsubmission of assessments, late submission of assessments, or a previous history of audit changes of greater than 35 percent. The commissioner shall select at least 20 percent, with a minimum of ten assessments, of the most current assessments submitted to the state for audit. Audits of assessments selected in the targeted facilities must focus on the factors leading to the audit. If the number of targeted assessments selected does not meet the threshold of 20 percent of the facility residents, then a stratified sample of the remainder of assessments shall be drawn to meet the quota. If the total change exceeds 35 percent, the commissioner may conduct an expanded audit up to 100 percent of the remaining current assessments.~~

~~(2) Facilities that are not a part of the targeted group shall be placed in a general pool from which facilities will be selected on a random basis for audit. Every~~ (1) Each facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a ~~targeted~~ special audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent, with a minimum of ten assessments, of the most current assessments shall be selected for audit. If more than 20 percent of the ~~RUG-III or~~ RUG-IV classifications ~~after the audit~~ are changed as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a minimum of ten assessments. If the total change between the first and second samples ~~exceed~~ is 35 percent or greater, the commissioner may expand the audit to all of the remaining assessments.

~~(3)~~ (2) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

~~(4)~~ (3) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

(i) frequent changes in the administration or management of the facility;

(ii) an unusually high percentage of residents in a specific case mix classification;

(iii) a high frequency in the number of reconsideration requests received from a facility;

(iv) frequent adjustments of case mix classifications as the result of reconsiderations or audits;

(v) a criminal indictment alleging provider fraud; ~~or~~

(vi) other similar factors that relate to a facility's ability to conduct accurate assessments~~.~~;

(vii) an atypical pattern of scoring minimum data set items;

(viii) nonsubmission of assessments;

(ix) late submission of assessments; or

(x) a previous history of audit changes of 35 percent or greater.

(f) Within 15 working days of completing the audit process, the commissioner shall make available electronically the results of the audit to the facility. If the results of the audit reflect a change in the resident's case mix classification, a case mix classification notice will be made available electronically to the facility, using the procedure in subdivision 7, paragraph (a). The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility

of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the ~~area nursing home ombudsman~~ Office of Ombudsman for Long-Term Care.

Subd. 10. **Transition.** After implementation of this section, reconsiderations requested for classifications made under section 144.0722, subdivision 1, shall be determined under section 144.0722, subdivision 3.

Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment of long-term care services, a recipient must be determined, using assessments defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

(1) the person requires formal clinical monitoring at least once per day;

(2) the person needs the assistance of another person or constant supervision to begin and complete at least four of the following activities of living: bathing, bed mobility, dressing, eating, grooming, toileting, transferring, and walking;

(3) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

(4) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;

(5) the person has had a qualifying nursing facility stay of at least 90 days;

(6) the person meets the nursing facility level of care criteria determined 90 days after admission or on the first quarterly assessment after admission, whichever is later; or

(7) the person is determined to be at risk for nursing facility admission or readmission through a face-to-face long-term care consultation assessment as specified in section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization under contract with the Department of Human Services. The person is considered at risk under this clause if the person currently lives alone or will live alone upon discharge and also meets one of the following criteria:

(i) the person has experienced a fall resulting in a fracture;

(ii) the person has been determined to be at risk of maltreatment or neglect, including self-neglect; or

(iii) the person has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

(b) The assessment used to establish medical assistance payment for nursing facility services must be the most recent assessment performed under subdivision 4, paragraph (b), that occurred no more than 90 calendar days before the effective date of medical assistance eligibility for payment of long-term care services. In no case shall medical

assistance payment for long-term care services occur prior to the date of the determination of nursing facility level of care.

(c) The assessment used to establish medical assistance payment for long-term care services provided under sections 256B.0915 and 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face assessment performed under section 256B.0911, subdivision 3a, 3b, or 4d, that occurred no more than 60 calendar days before the effective date of medical assistance eligibility for payment of long-term care services.

Subd. 12. **Appeal of nursing facility level of care determination.** A resident or prospective resident whose level of care determination results in a denial of long-term care services can appeal the determination as outlined in section 256B.0911, subdivision 3a, paragraph (h), clause (7).