SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

S.F. No. 1286

(SENATE AUTHORS: HANN)

DATE	D-PG	OFFICIAL STATUS
04/26/2011	1407	Introduction and first reading Referred to Health and Human Services
04/28/2011	1482	Comm report: To pass
	1539	Second reading
05/20/2011	3024	Special Order
	3024	Third reading Passed
05/23/2011	3435	Returned from House with amendment
	3435	Senate concurred and repassed bill
	3435	Third reading

A bill for an act

relating to health; changing provisions to resident case mix classification; amending Minnesota Statutes 2010, section 144.0724, subdivisions 2, 3, 4, 5, 6, 9, by adding a subdivision.

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

Section 1. Minnesota Statutes 2010, section 144.0724, subdivision 2, is amended to read:

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

(a) "Assessment reference date" 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.

(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" means the assessment instrument 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 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 TBI waiver services under section 256B.49; and

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

Sec. 2. Minnesota Statutes 2010, section 144.0724, subdivision 3, is amended to read:

Subd. 3. **Resident reimbursement classifications prior to January 1, 2012.** (a) Resident reimbursement classifications shall be based on the minimum data set, version ~~2.0~~ 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. ~~The facility manual for case mix classification shall be drafted by the Minnesota Department of Health and presented to the chairs of health and human services legislative committees by December 31, 2001.~~

(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.

Sec. 3. Minnesota Statutes 2010, section 144.0724, is amended by adding a subdivision to read:

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 according to the 48 group, resource utilization groups. Resident classes 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 as defined in the Facility Manual for Case Mix Classification issued by the Minnesota Department of Health.

Sec. 4. Minnesota Statutes 2010, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health case mix 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 ~~2.0~~ 3.0, ~~October 1995,~~ and subsequent ~~clarifications made in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0, August 1996~~ 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 ~~be completed~~ have an assessment reference date (ARD) within 366 days of the ARD of the last comprehensive assessment;

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

(4) ~~the second~~ all quarterly ~~assessment following either a new admission assessment, an annual assessment, or a significant change assessment, and all quarterly assessments beginning October 1, 2006. Each quarterly assessment~~ assessments must ~~be completed~~

have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment.

(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.

Sec. 5. Minnesota Statutes 2010, section 144.0724, subdivision 5, is amended to read:

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.

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

(c) ~~After implementation of the revised case mix system,~~ 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).

Sec. 6. Minnesota Statutes 2010, section 144.0724, subdivision 6, is amended to read:

Subd. 6. **Penalties for late or nonsubmission.** A facility that fails to complete or submit an assessment for a RUG-III or RUG-IV classification within seven days of the time requirements in subdivisions 4 and 5 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 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 of the resident's assessment.

Sec. 7. Minnesota Statutes 2010, section 144.0724, subdivision 9, is amended to read:

Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident assessments performed under section 256B.438 through desk audits, on-site review of residents and their records, and interviews with staff and 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 Resident Assessment Instrument 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 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 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 ~~RUGS-III~~ RUG-III or RUG-IV classifications after the audit

are changed, 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 35 percent, the commissioner may expand the audit to all of the remaining assessments.

(3) 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) 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.

(f) Within 15 working days of completing the audit process, the commissioner shall ~~mail the written~~ make available electronically the results of the audit to the facility~~;~~ ~~along with a written notice for each resident affected to be forwarded by 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.