CHAPTER 75-02-06
RATESETTING FOR NURSING HOME CARE

SECTION 1: Section 75-02-06-01 is amended as follows:

75-02-06-01. Definitions.

In this chapter, unless the context or subject matter requires otherwise:

1. "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of expenses in the period when incurred, regardless of when they are paid.

2. "Actual rate" means the facility rate for each cost category calculated using allowable historical operating costs and adjustment factors.

3. "Adjustment factor" means the inflation rate for nursing home services used to develop the legislative appropriation for the department for the applicable rate year.

4. "Admission" means any time a resident is admitted to the facility from an outside location, including readmission resulting from a discharge.

5. "Allowable cost" means the facility's actual cost after appropriate adjustments as required by medical assistance regulations.

6. "Bona fide sale" means the purchase of a facility's capital assets with cash or debt in an arm's-length transaction. It does not include:

    a. A purchase of shares in a corporation that owns, operates, or controls a facility except as provided under subsection 3 of section 75-02-06-07;

    b. A sale and leaseback to the same licensee;

    c. A transfer of an interest to a trust;

    d. Gifts or other transfers for nominal or no consideration;

    e. A merger of two or more related organizations;

    f. A change in the legal form of doing business;

    g. The addition or deletion of a partner, owner, or shareholder; or

    h. A sale, merger, reorganization, or any other transfer of interest between related organizations.

7. "Building" means the physical plant, including building components and building services equipment, licensed as a facility, and used directly for resident care, and auxiliary buildings including sheds, garages, and storage buildings located on the site used directly for resident care.

8. "Capital asset" means a facility's buildings, land improvements, fixed equipment, movable equipment, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

9. "Certified nurse aide" means:

   a. An individual who has satisfactorily completed a nurse aide training and competency evaluation program approved by the state as meeting the requirements of 42 CFR 483.151 through 483.154 and is registered on a state-established registry of nurse aides as required by 42 CFR 483.156; or who has been deemed or determined competent as provided in 42 CFR 483.151(a) and (b) and is registered on a state-established registry of nurse aides as required by 42 CFR 483.156; or

   b. An individual who has worked less than four months as a nurse aide and is enrolled in a training and evaluation program approved by the state as meeting the requirements of 42 CFR 483.151 through 483.154.

10. "Chain organization" means a group of two or more health care facilities owned, leased, or, through any other device, controlled by one business entity. This includes not only proprietary chains, but also chains operated by various religious and other charitable organizations. A chain organization may also include business organizations engaged in other activities not directly related to health care.

11. "Close relative" means an individual whose relationship by blood, marriage, or adoption to an individual who is directly or indirectly affiliated with, controls, or is controlled by a facility is within the third degree of kinship.

12. "Community contribution" means a contribution to a civic organization or sponsorship of community activities. It does not include a donation to a charity.

13. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, the determination of cost limitations, and determination of rates.

14. "Cost center" means a division, department, or subdivision thereof, group of services or employees or both, or any unit or type of activity into which functions of a facility are divided for purposes of cost assignment and allocations.

15. "Cost report" means the department approved form for reporting costs, statistical data, and other relevant information of the facility.

16. "Department" means the department of human services.

17. "Depreciable asset" means a capital asset for which the cost must be capitalized for ratesetting purposes.

18. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.

19. "Depreciation guidelines" means the American hospital association's guidelines as published by American hospital publishing, inc., in "Estimated Useful Lives of Depreciable Hospital Assets", revised ~~2013~~2018 edition.

20. "Desk audit rate" means the rate established by the department based upon a review of the cost report submission prior to an audit of the cost report.

21. "Direct care costs" means the cost category for allowable nursing and therapy costs.

22. "Direct costing" means identification of actual costs directly to a facility or cost category without use of any means of allocation.

23. "Discharge" means the voluntary or involuntary release of a bed by a resident when the resident vacates the nursing facility premises.

24. "Employment benefits" means fringe benefits, other employee benefits including vision insurance, disability insurance, long-term care insurance, employee assistance programs, employee child care benefits, and payroll taxes.

25. "Established rate" means the rate paid for services.

26. "Facility" means a nursing facility not owned or administered by state government or a nursing facility, owned or administered by state government, which agrees to accept a rate established under this chapter. It does not mean an intermediate care facility for individuals with intellectual disabilities.

27. "Fair market value" means value at which an asset could be sold in the open market in a transaction between informed, unrelated parties.

28. "Final decision rate" means the amount, if any, determined on a per day basis, by which a rate otherwise set under this chapter is increased as a result of a request for reconsideration, a request for an administrative appeal, or a request for judicial appeal taken from a decision on an administrative appeal.

29. "Final rate" means the rate established after any adjustments by the department, including adjustments resulting from cost report reviews and audits.

30. "Fixed equipment" means equipment used directly for resident care affixed to a building, not easily movable, and identified as such in the depreciation guidelines.

31. "Freestanding facility" means a nursing facility which does not share basic services with a hospital-based provider.

32. "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, uniform allowances, and medical services furnished at nursing facility expense.

33. "Highest market-driven compensation" means the highest compensation given to an employee of a freestanding facility who is not an owner of the facility or is not a member of the governing board of the facility.

34. "Historical operating costs" means the allowable operating costs incurred by the facility during the report year immediately preceding the rate year for which the established rate becomes effective.

35. "Hospice general inpatient care" means short-term inpatient care necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. It does not mean care provided to an individual residing in a nursing facility.

36. "Hospice inpatient respite care" means short-term inpatient care provided to an individual when necessary to relieve family members or other persons caring for the individual at home. Care may be provided for no more than five consecutive days. For purposes of the definition, home does not include nursing facility.

37. "Hospital leave day" means any day that a resident is not in the facility, but is in an acute care setting as an inpatient or has been identified in a resident assessment instrument as "discharged anticipated to return".

38. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy, and dietary, exclusive of food costs.

39. "In-house resident day" for nursing facilities means a day that a resident was actually residing in the facility and was not on therapeutic leave or in the hospital. "In-house resident day" for hospitals means an inpatient day.

40. "Institutional leave day" means any day that a resident is not in the facility, but is in another nursing facility, swing-bed facility, transitional care unit, subacute care unit, or intermediate care facility for individuals with intellectual disabilities.

41. "Land improvements" means any improvement to the land surrounding the facility used directly for resident care and identified as such in the depreciation guidelines.

42. "Limit rate" means the rate established as the maximum allowable rate for a cost category.

43. "Lobbyist" means any person who in any manner, directly or indirectly, attempts to secure the passage, amendment, defeat, approval, or veto of any legislation, attempts to influence decisions made by the legislative council, and is required to register as a lobbyist.

44. "Managed care organization" means a Medicaid managed care organization as that term is defined in section 1903(m) of the Social Security Act [42 U.S.C. 1396b(m)].

45. "Medical assistance program" means the program which pays the cost of health care provided to eligible recipients pursuant to North Dakota Century Code chapter 50-24.1.

46. "Medical records costs" means costs associated with the determination that medical record standards are met and with the maintenance of records for individuals who have been discharged from the facility. It does not include maintenance of medical records for in-house residents.

47. "Movable equipment" means movable care and support services equipment generally used in a facility, including equipment identified as major movable equipment in the depreciation guidelines.

48. "Noncovered day" means a resident day that is not payable by medical assistance but is counted as a resident day.

49. "Other direct care costs" means the cost category for allowable activities, social services, laundry, and food costs.

50. "Payroll taxes" means the employer's share of Federal Insurance Contributions Act (FICA) taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.

51. "Pending decision rate" means the amount, determined on a per day basis, by which a rate otherwise set under this chapter would increase if a facility prevails on a request for reconsideration, on a request for an administrative appeal, or on a request for a judicial appeal taken from a decision on an administrative appeal; however, the amount may not cause any component of the rate to exceed rate limits established under this chapter.

52. "Private-pay resident" means a nursing facility resident on whose behalf the facility is not receiving medical assistance payments and whose payment rate is not established by any governmental entity with ratesetting authority, including veterans' administration or Medicare, or whose payment rate is not negotiated by any managed care organization contracting with a facility to provide services to the resident.

53. "Private room" means a room equipped for use by only one resident.

54. "Property costs" means the cost category for allowable real property costs and other costs which are passed through.

55. "Provider" means the organization or individual who has executed a provider agreement with the department.

56. "Rate adjustment percentage" means the percentage used to determine the minimum adjustment threshold to the rate weight of one.

57. "Rate year" means the calendar year from January first through December thirty-first.

~~57.~~58. "Reasonable resident-related cost" means the cost that must be incurred by an efficiently and economically operated facility to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards. Reasonable resident-related cost takes into account that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or services.

~~58.~~59. "Related organization" means a close relative or person or an organization which a provider is, to a significant extent, associated with, affiliated with,

able to control, or controlled by, and which furnishes services, facilities, or supplies to the provider. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the policies of an organization or provider.

~~59.~~60. "Report year" means the fiscal year from July first through June thirtieth of the year immediately preceding the rate year.

~~60.~~61. "Resident" means a person who has been admitted to the facility, but not discharged.

~~61.~~62. "Resident day" in a nursing facility means all days for which service is provided or for which payment is ordinarily sought, including hospital leave days and therapeutic leave days. The day of admission and the day of death are resident days. The day of discharge is not a resident day. "Resident day" in a hospital means all inpatient days for which payment is ordinarily sought.

~~62.~~63. "Respite care" means short-term care provided to an individual when necessary to relieve family members or other persons caring for the individual at home.

~~63.~~64. "Routine hair care" means hair hygiene which includes grooming, shampooing, cutting, and setting.

~~64.~~65. "Significant capacity increase" means an increase of fifty percent or more in the number of licensed beds or an increase of twenty beds, whichever is greater; but does not mean an increase by a facility which reduces the number of its licensed beds and thereafter relicenses those beds, and does not mean an increase in a nursing facility's licensed capacity resulting from converting beds formerly licensed as basic care beds.

~~65.~~66. "Standardized resident day" means a resident day times the classification weight for the resident.

~~66.~~67. "Therapeutic leave day" means any day that a resident is not in the facility, another nursing facility, swing-bed facility, transitional care unit, subacute unit, an intermediate care facility for individuals with intellectual disabilities, or an acute care setting, or, if not in an institutional setting, is not receiving home- and community-based waivered services.

~~67.~~68. "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators, and any other person performing functions ordinarily performed by such personnel.

~~68.~~69. "Working capital debt" means debt incurred to finance nursing facility operating costs, but does not include debt incurred to acquire or refinance a capital asset or to refund or refinance debt associated with acquiring a capital asset.

History: Effective September 1, 1980; amended effective December 1, 1983; June 1, 1985; September 1, 1987; January 1, 1990; January 1, 1992; November 22, 1993; January 1, 1996; July 1, 1996; January 1, 1998; January 1, 1999; January 1, 2000; July 2, 2002; July 2, 2003; December 1, 2005; October 1, 2010; July 1, 2012; January 1, 2014; July 1, 2016; January 1, 2020.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 2: Section 75-02-06-02.2 is amended as follows:

75-02-06-02.2. Direct care costs.

Direct care costs include only those costs identified in this section.

1. **Therapies.**

   a. Salary and employment benefits for speech, occupational, and physical therapists, or for personnel, who are not reported in subsection 2, performing therapy under the direction of a licensed therapist.

   b. The cost of noncapitalized therapy equipment or supplies used to directly provide therapy.

   c. Training required to maintain licensure, certification, or professional standards, and the related travel costs.

2. **Nursing.**

   a. Salary and employment benefits for the director of nursing, nursing supervisors, inservice trainers for nursing staff, registered nurses, licensed practical nurses, quality assurance personnel, certified nurse aides, individuals providing assistance with activities of daily living identified in subdivision a of subsection 5 of section 75-02-06-17, individuals with a cognitive impairment who provide care-related services and who require the direction or supervision of a registered nurse in order to perform those services, and ward clerks.

   b. ~~Routine~~Allowable routine nursing ~~care~~ supplies ~~including items furnished routinely and relatively uniformly to all residents; items stocked at nursing stations or on the floor in gross supply and~~

~~distributed or used individually in small quantities; and items used by individual residents that are reusable, vary by the needs of an individual, and are expected to be available in the facility~~, personal hygiene supplies, medical supplies, and noncapitalized equipment necessary to provide for the care of residents routinely used in the provision of daily care of residents based on the resident needs.

c. Training required to maintain licensure, certification, or professional standards requirements, and the related travel costs.

d. Routine hair care.

e. The cost of noncapitalized wheelchairs.

History: Effective January 1, 1990; amended effective January 1, 1992; November 22, 1993; January 1, 1996; January 1, 2000; July 2, 2002; November 19, 2003; January 1, 2020.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 3: Subsection 1 of section 75-02-06-02.4 is amended as follows:

1. **Administration.** Direct costs for administering the overall activities of the facility include:

   a. Salary and employment benefits for administrators, except in a facility of sixty or fewer beds, part of an administrator's salary may be allocated to other cost categories provided adequate records identifying the hours and services provided are maintained by the facility.

   b. Salary and employment benefits for assistant administrators, top management personnel, accounting personnel, clerical personnel, secretaries and receptionists, data processing personnel, purchasing, receiving, and store personnel, medical director, security personnel, and of all personnel not designated in other cost categories.

   c. Board of directors' fees and related travel expenses.

   d. Security personnel or services.

   e. Supplies except as specifically provided for in the direct care, other direct care, and other cost centers of the indirect care cost category.

   f. Insurance, except insurance included as a fringe benefit and insurance included as part of related party lease costs.

g. Telephone and telegraph.

h. Postage and freight.

i. Membership dues and subscriptions.

j. Professional fees for services such as legal, accounting, and data processing.

k. Central or home office costs including property costs except as provided for in section 75-02-06-06.1.

l. Advertising and personnel recruitment costs.

m. Management consultants and fees.

n. Bad debts and collection fees as provided for in section 75-02-06-10.

o. Business meetings, conventions, association meetings, and seminars.

p. Travel, except as necessary for training programs for personnel required to maintain licensure, certification, or professional standards requirements.

q. Training, except for training for personnel required to maintain licensure, certification, or professional standards requirements.

r. Business office functions.

s. ~~Computer software costs, except costs that must be capitalized, and computer maintenance contracts.~~

~~t.~~ Working capital interest.

~~u.~~t. Any costs that cannot be specifically classified to other cost categories.

History: Effective January 1, 1990; amended effective November 1, 1992; November 22, 1993; January 1, 1996; January 1, 2000; January 1, 2020.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 4: Section 75-02-06-02.5 is amended as follows:

75-02-06-02.5. Property costs and other passthrough costs.

Property-related costs and other passthrough costs include only those costs identified in this section:

1. Depreciation.

2. Interest expense on capital debt.

3. Property taxes including special assessments as provided for in section 75-02-06-09.

4. Lease and rental costs.

5. Startup costs.

6. Reasonable legal and related expenses:

   a. Incurred or as a result of a successful challenge to a decision by a governmental agency, made on or after January 1, 1990, regarding a rate year beginning on or after January 1, 1990;

   b. Related to legal services furnished on or after January 1, 1990; and

   c. In the case of a partially successful challenge, not in excess of an amount determined by developing a ratio of total amounts claimed successfully to total amounts claimed in the partially successful challenge and applying that ratio to the total legal expenses paid.

7. Allowable bad debt expense under section 75-02-06-10 in the report year in which bad debt is determined to be uncollectible with no likelihood of future recovery.

8. Education expense allowed under section 75-02-06-12.1 in the report year in which it is expended.

9. Computer software and related technology costs, including cloud-based costs.

History: Effective January 1, 1990; amended effective November 22, 1993; January 1, 1996; January 1, 2010; January 1, 2020.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 5: Subsection 7 of section 75-02-06-03 is amended as follows:

7. A per bed cost limitation based on single and double occupancy must be used to determine the total allowable cost basis of buildings and fixed equipment for a facility with construction, renovation, or remodeling.

   a. Effective July 1, ~~2015~~2019, the per bed limitation basis for double occupancy is ~~$156,783~~168,864 and for a single occupancy is ~~$235,176~~253,297.

   b. The per bed limitation basis for single occupancy must be calculated using the limitation determined in subdivision a, multiplied by 1.5.

   c. The double and single occupancy per bed limitation must be adjusted annually on July first, using the increase, if any, in the consumer price index for all urban consumers, United States city average, all items, for the twelve-month period ending the preceding May thirty-first.

   d. The per bed limitation in effect at the time a construction, renovation, or remodeling project is put in service must be multiplied times the number of beds in double and single occupancy rooms to establish the maximum allowable cost basis of buildings and fixed equipment.

   e. The cost basis of a facility's buildings and fixed equipment must be limited to the lower of the recorded cost of total facility buildings and fixed equipment or the per bed limitation.

   f. The per bed limitation is not applicable to projects started or approved by the state health council before July 1, 1994.

   g. For rate years beginning after December 31, 2007, the limitations of subdivision a do not apply to the valuation basis of assets acquired as a result of a natural disaster before December 31, 2006. The provisions of this subsection may not be applied retroactively to any rate year before January 1, 2008.

History: Effective September 1, 1980; amended effective December 1, 1983; October 1, 1984; September 1, 1987; January 1, 1990; January 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998; July 2, 2003; September 7, 2007; July 1, 2009; January 1, 2014; July 1, 2016; January 1, 2020.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 6: Subsection 1 of section 75-02-06-05 is amended as follows:

1. Compensation on an annual basis for top management personnel must be limited, prior to allocation, if any, to the highest market-driven compensation of an administrator employed by a freestanding facility, with licensed capacity, during the previous report year, at least equal to the licensed capacity of the smallest facility within the top quartile of all facilities ranked by licensed capacity, increased by the adjustment factor. Compensation for top management personnel employed for less than a year must be limited to an amount equal to the limitation divided by three hundred sixty-five times the number of calendar days the individual was employed.

History: Effective September 1, 1980; amended effective July 1, 1981; December 1, 1983; September 1, 1987; January 1, 1990; November 22, 1993; January 1, 1996; January 1, 1999; January 1, 2020.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 7: Subsection 7 of section 75-02-06-14 is amended as follows:

7. Residents admitted to the facility through a hospice program or electing hospice benefits while in a facility must be identified as hospice residents for ~~census and~~ billing purposes.

History: Effective September 1, 1980; amended effective December 1, 1983; September 1, 1987; January 1, 1990; November 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998; January 1, 1999; July 2, 2002; January 1, 2019.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 8: Subsections 2, 5, and 9 of section 75-02-06-16 are amended as follows:

2. a. For a facility with an actual rate below the limit rate for indirect care costs, an incentive amount equal to seventy percent times the difference between the actual rate, exclusive of the adjustment factor, and the limit rate in effect at the end of the year immediately preceding the rate year, up to a maximum of two dollars and sixty cents or the difference between the actual rate, inclusive of the adjustment factor and the limit rate for indirect care costs, whichever is less, must be included as part of the indirect care cost rate.

b. A facility shall receive an operating margin of ~~three~~four and four-tenths percent, effective January 1, 2020 through June 30, 2021, and three percent effective July 1, 2021 based on the lesser of the actual direct care and other direct care rates, exclusive of the adjustment factor, or the limit rate in effect at the end of the year immediately preceding the rate year. The ~~three percent~~ operating

margin must be added to the rate for the direct care and other direct care cost categories.

5. Rate adjustments.

a. Desk audit rate.

(1) The cost report must be reviewed taking into consideration the prior year's adjustments. The facility must be notified by ~~facsimile transmission or~~ electronic mail of any adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why the desk adjustment should not be made. The department shall review the information and make appropriate adjustments.

(2) The desk audit rate must be effective January first of each rate year unless the department specifically identifies an alternative effective date and must continue in effect until a final rate is established.

(3) Until a final rate is effective, pursuant to paragraph 3 of subdivision b, private-pay rates may not exceed the desk audit rate except as provided for in section 75-02-06-22 or subdivision c.

(4) The facility may request a reconsideration of the desk rate for purposes of establishing a pending decision rate. The request for reconsideration must be filed with the department's medical services division within thirty days of the date of the rate notification and must contain the information required in subsection 1 of section 75-02-06-26. No decision on the request for reconsideration of the desk rate may be made by the department unless, after the facility has been notified that the desk rate is the final rate, the facility requests, in writing within thirty days of the rate notification, the department to issue a decision on that request for reconsideration.

(5) The desk rate may be adjusted for special rates or one-time adjustments provided for in this section.

(6) The desk rate may be adjusted to reflect errors, adjustments, or omissions for the report year that result in a change of at least ~~ten cents~~the rate adjustment percentage per day ~~for the rate weight of one~~.

b. Final rate.

(1) The cost report may be field audited to establish a final rate. If no field audit is performed, the desk audit rate must become the final rate upon notification from the department. The final rate is effective January first of each rate year unless the department specifically identifies an alternative effective date.

(2) The final rate must include any adjustments for nonallowable costs, errors, or omissions that result in a change from the desk audit rate of at least ~~ten cents~~the rate adjustment percentage per day ~~for the rate weight of one~~ that are found during a field audit or are reported by the facility within twelve months of the rate yearend.

(3) The private-pay rate must be adjusted to the final rate no later than the first day of the second month following receipt of notification by the department of the final rate and is not retroactive except as provided for in subdivision c.

(4) The final rate may be revised at any time for special rates or one-time adjustments provided for in this section.

(5) If adjustments, errors, or omissions are found after a final rate has been established, the following procedures must be used:

(a) Adjustments, errors, or omissions found within twelve months of establishment of the final rate, not including subsequent revisions, resulting in a change of at least ~~ten cents~~the rate adjustment percentage per day ~~for the rate weight of one~~ must result in a change to the final rate. The change must be applied retroactively as provided for in this section.

(b) Adjustments, errors, or omissions found later than twelve months after the establishment of the final rate, not including subsequent revisions, that would have resulted in a change of at least ~~ten cents~~the rate adjustment percentage per day ~~for the rate weight of one~~ had they been included, must be included as an adjustment in the report year that the adjustment, error, or omission was found.

(c) ~~Adjustments resulting from an audit of home office costs, that result in a change of at least ten cents per day for the rate weight of one, must be included as an adjustment in the report year in which the costs were incurred.~~

~~(d)~~ The two report years immediately preceding the report year to which the adjustments, errors, or omissions apply may also be reviewed for similar adjustments, errors, or omissions.

c. Pending decision rates for private-pay residents.

(1) If a facility has made a request for reconsideration, taken an administrative appeal, or taken a judicial appeal from a decision on an administrative appeal, and has provided information sufficient to allow the department to accurately calculate, on a per day basis, the effect of each of the disputed issues on the facility's rate, the department shall determine and issue a pending decision rate within thirty days of receipt of the request for reconsideration, administrative appeal, or judicial appeal. If the information furnished is insufficient to determine a pending decision rate, the department, within thirty days of receipt of the request for reconsideration, shall inform the facility of the insufficiency and may identify information that would correct the insufficiency.

(2) The department shall add the pending decision rate to the rate that would otherwise be set under this chapter, and, notwithstanding North Dakota Century Code section 50-24.4-19, the total must be the rate chargeable to private-pay residents until a final decision on the request for reconsideration or appeal is made and is no longer subject to further appeal. The pending decision rate is subject to any rate limitation that may apply.

(3) The facility shall establish and maintain records that reflect the amount of any pending decision rate paid by each private-pay resident from the date the facility charges a private-pay resident the pending decision rate.

(4) If the pending decision rate paid by a private-pay resident exceeds the final decision rate, the facility shall refund the difference, plus interest accrued at the legal rate from the date of notification of the pending decision rate, within sixty

days after the final decision is no longer subject to appeal. If a facility fails to provide a timely refund to a living resident or former resident, the facility shall pay interest at three times the legal rate for the period after the refund is due. If a former resident is deceased, the facility shall pay the refund to a person lawfully administering the estate of the deceased former resident or lawfully acting as successor to the deceased former resident. If no person is lawfully administering the estate or lawfully acting as a successor, the facility may make any disposition of the refund permitted by law. Interest paid under this subsection is not an allowable cost.

d. The final rate as established must be retroactive to the effective date of the desk rate, except with respect to rates paid by private-pay residents. A rate paid by a private-pay resident must be retroactively adjusted and the difference refunded to the resident, if the rate paid by the private-pay resident exceeds the final rate by at least one dollar per day, except that a pending decision rate is not subject to adjustment or refund until a decision on the disputed amount is made.

9. Under no circumstances, including an appeal or judicial decision to the effect a rate was erroneously established, may a rate adjustment be made to any rate established under this chapter, unless the cumulative impact of all adjustments not already included in the established rate equals or exceeds ~~ten cents~~the rate adjustment percentage per day ~~for the rate weight of one~~.

History: Effective September 1, 1980; amended effective July 1, 1981; December 1, 1983; July 1, 1984; September 1, 1987; January 1, 1990; April 1, 1991; January 1, 1992; November 1, 1992; November 22, 1993; January 1, 1996; January 1, 1998; January 1, 1999; January 1, 2000; January 1, 2002; July 2, 2003; December 1, 2005; January 1, 2010; July 1, 2010; January 1, 2012; January 1, 2014; July 1, 2016; April 1, 2018; January 1, 2020.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 9: Subsections 3 and 6 of section 75-02-06-17 are amended as follows:

3. Resident assessments must be completed as follows:

a. The facility shall assess the resident within the first fourteen days after any admission or return from an acute hospital stay. The assessment reference date must be between day seven and day fourteen.

b. The facility shall assess the resident quarterly after any admission or return from an acute hospital stay. The quarterly assessment reference period ends on the day of the third subsequent month corresponding to the day of admission or return from an acute hospital stay, except if that month does not have a corresponding date, the quarterly assessment reference period ends on the first day of the next month. The assessment reference period begins seven days prior to the ending date of a quarterly assessment period. The assessment reference date used for the resident assessment instrument must be within the assessment reference period.

c. An assessment must be submitted upon initiation of rehabilitation therapy if initiation of rehabilitation therapy occurs outside of the quarterly assessment reference period established in subdivision b.

d. An assessment must be submitted upon discontinuation of rehabilitation therapy if discontinuation of rehabilitation therapy occurs outside of the quarterly assessment reference period established in subdivision b.

6. The major categories in hierarchical order are:

a. Rehabilitation category. To qualify for the rehabilitation category, a resident must receive rehabilitation therapy. A resident who qualifies for the rehabilitation category is assigned a subcategory based on the resident's activities of daily living score. The rehabilitation category may be assigned within a classification period based on initiation or discontinuation dates if therapies are begun or discontinued on any date not within an assessment reference period.

b. Extensive services category. To qualify for the extensive services category, a resident must have an activities of daily living score of at least two and within the fourteen days preceding the assessment, received tracheostomy care or required a ventilator, or respirator~~, or infection isolation~~ while a resident.

c. Special care high category.

(1) To qualify for the special care high category, a resident must have at least one of the following conditions or treatments with an activities of daily living score of at least two:

(a) Comatose and completely dependent for activities of daily living;

(b) Septicemia;

(c) Diabetes with:

[1] Insulin injections seven days a week; and

[2] Insulin order changes on two or more days;

(d) Quadriplegia with an activities of daily living score of at least five;

(e) Chronic obstructive pulmonary disease and shortness of breath when lying flat;

(f) A fever in combination with:

[1] Pneumonia;

[2] Vomiting;

[3] Weight loss; or

[4] Tube feedings while a resident that comprise at least:

[a] Twenty-six percent of daily caloric requirements and at least five hundred and one milliliters of fluid through the tube per day; or

[b] Fifty-one percent of daily caloric requirements;

(g) Parenteral or intravenous feedings provided in and administered in and by the nursing facility; or

(h) Respiratory therapy seven days a week.

(2) A resident who qualifies for the special care category is assigned a subcategory based on the resident's activities of daily living score and whether the resident has signs of depression.

d. Special care low category.

(1) To qualify for the special care low category, a resident must have at least one of the following conditions or treatments with an activities of daily living score of at least two:

(a) Multiple sclerosis, cerebral palsy, or Parkinson's disease with an activities of daily living score of at least five;

(b) Respiratory failure and oxygen therapy while a resident administered continuously for at least two hours or intermittently with at least two applications of at least thirty minutes each within the facility in the fourteen days preceding the assessment;

(c) Tube feedings while a resident that comprise at least:

[1] Twenty-six percent of daily caloric requirements and at least five hundred and one milliliters of fluid through the tube per day; or

[2] Fifty-one percent of daily caloric requirements.

(d) Two or more stage two pressure ulcers with two or more skin treatments;

(e) Stage three or four pressure ulcer with two or more skin treatments;

(f) Two or more venous or arterial ulcers with two or more skin treatments;

(g) One stage two pressure ulcer and one venous or arterial ulcer with two or more skin treatments;

(h) Foot infection, diabetic foot ulcer, or other open lesion of foot with application of dressings to the foot;

(i) Radiation treatment while a resident; or

(j) Dialysis treatment while a resident.

(2) A resident who qualifies for the special care low category is assigned a subcategory based on the resident's activities of daily living score and whether the resident has signs of depression.

e. Clinically complex category.

(1) To qualify for the clinically complex category, a resident must have one or more of the conditions for the extensive services or special care categories with an activities of daily living score of zero or one or have at least one of the following conditions, treatments, or circumstances:

(a) Pneumonia;

(b) Hemiplegia or hemiparesis with an activities of daily living score of at least five;

(c) Surgical wounds or open lesions with at least one skin treatment;

(d) Burns;

(e) Chemotherapy while a resident;

(f) Oxygen therapy while a resident administered continuously for at least two hours or intermittently with at least two applications of at least thirty minutes each within the facility in the fourteen days preceding the assessment;

(g) Intravenous medication provided, instilled, and administered by staff within the facility while a resident; or

(h) Transfusions while a resident.

(2) A resident who qualifies for the clinically complex category is assigned a subcategory based on the resident's activities of daily living score and whether the resident has signs of depression.

f. Behavioral symptoms and cognitive performance category. To qualify for the behavioral symptoms and cognitive performance category, a resident must have an activities of daily living score of less than six.

(1) To qualify for the behavioral symptoms and cognitive performance category, a resident must either:

(a) Be cognitively impaired based on one of the following:

[1] A brief interview of mental status score of less than ten;

[2] Coma and completely dependent for activities of daily living;

[3] Severely impaired cognitive skills; or

[4] Have a severe problem being understood or severe cognitive skills problem and two or more of the following:

[a] Problem being understood;

[b] Short-term memory problem; or

[c] Cognitive skills problem.

(b) Exhibit behavioral symptoms with one or more of the following symptoms:

[1] Hallucinations;

[2] Delusions;

[3] Physical or verbal behavior symptoms directed toward others on at least four days in the seven days preceding the assessment;

[4] Other behavioral symptoms not directed toward others on at least four days in the seven days preceding the assessment;

[5] Rejection of care on at least four days in the seven days preceding the assessment; or

[6] Wandering on at least four days in the seven days preceding the assessment.

(2) A resident who qualifies for the behavioral symptoms and cognitive performance category is assigned a subcategory based on the resident's activities of daily living score and the resident's need for nursing rehabilitation services.

g. Reduced physical functioning category. To qualify for the reduced physical functioning category, a resident may not qualify for any other group. A resident who qualifies for the reduced physical functioning category is assigned a subcategory based on the resident's activities of daily living score and the resident's need for nursing rehabilitation services.

History: Effective September 1, 1987; amended effective January 1, 1990; November 22, 1993; January 1, 1996; January 1, 1998; January 1, 1999; January 1, 2000; July 2, 2002; October 1, 2010; January 1, 2012; January 1, 2014; January 1, 2020.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 10: Subsection 2 of section 75-02-06-25 is amended as follows:

2. The facility shall provide to all private-pay residents a thirty-day written notification of any increase in the rates for each classification. An increase in rates is not effective unless the facility has notified private-pay residents that the rate increase is effective by the first day of the second month following the date of notification by the department. If the facility does not notify private-pay residents by the first day of the first month following notification by the department, the established rate in effect at the time of notification by the department must remain in effect until the date the rate is payable by private-pay residents. No retroactive adjustment may be made to an established rate that remains in effect because the facility did not promptly notify private-pay residents unless the adjustment would result in a decrease of at least ~~ten cents~~the rate adjustment percentage per day ~~for the rate weight of one~~. A facility may make a rate change without giving a thirty-day written notice when the purpose of the rate change is to reflect a necessary change in the case-mix classification of a resident.

History: Effective January 1, 1996; amended effective January 1, 2000.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)