CHAPTER 75-02-06
RATESETTING FOR NURSING HOME CARE

Section

SECTION 1. Subsections 19 and 26 of section 75-02-06-01 are amended as follows:

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 ~~2008~~ 2013 edition.

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 ~~developmental~~ intellectual disabilities.

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.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 2. 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, ~~2009~~2013, the per bed limitation basis for double occupancy is ~~$112,732~~122,846 and for a single occupancy is ~~$169,098~~184,271.
   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.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 3. Two new subsections to section 75-02-06-12.1 are created as follows:

75-02-06-12.1. Nonallowable costs. Costs not related to resident care are costs not appropriate or necessary and proper in developing and maintaining the operation of resident care facilities and activities. These costs are not allowed in computing the rates. Nonallowable costs include:

45. Supplemental payments not offset to costs.
46. Alcohol and tobacco products.

History: Effective January 1, 1990; amended effective January 1, 1992; November 1, 1992; November 22, 1993; January 1, 1996; July 1, 1996; January 1, 1998; January 1, 1999; January 1, 2010; January 1, 2012; January 1, 2014.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 4. Subsection 3 and subdivision a of subsection 5 of section 75-02-06-16 are amended as follows:

3. Limitations.
   a. The department shall accumulate and analyze statistics on costs incurred by facilities. Statistics may be used to establish reasonable ceiling limitations and incentives for efficiency and economy based on reasonable determination of standards of operations necessary for efficient delivery of needed services. Limitations and incentives may be established on the basis of cost of comparable facilities and services and may be applied as ceilings on the overall costs of providing services or on specific areas of operations. The department may implement ceilings at any time based upon information available.
   b. The department shall review, on an ongoing basis, aggregate payments to facilities to determine that payments do not exceed an amount that can reasonably be estimated would have been paid for those services under medicare payment principles. If aggregate

payments to facilities exceed estimated payments under medicare, the department may make adjustments to rates to establish the upper limitations so that aggregate payments do not exceed an amount that can be estimated would have been paid under medicare payment principles.

c. All facilities except those nongeriatric facilities for individuals with physical disabilities or units within a nursing facility providing geropsychiatric services described in North Dakota Century Code section 50-24.4-13 must be used to establish a limit rate for the direct care, other direct care, and indirect care cost categories. The base year is the report year ended June 30, ~~2006~~2010. Base year costs may not be adjusted in any manner or for any reason not provided for in this subsection.

d. The limit rate for each of the cost categories must be established as follows:
   (1) Historical costs for the report year ended June 30, ~~2006~~2010, as adjusted, must be used to establish rates for all facilities in the direct care, other direct care, and indirect care cost categories. The rates as established must be ranked from low to high for each cost category.
   (2) For the rate year beginning January 1, ~~2012~~2013, the limit rate for each cost category is:
      (a) For the direct care cost category, one hundred ~~thirty-one~~ fifty-one dollars and ~~fifty-nine~~ nineteen cents;
      (b) For the other direct care cost category, ~~twenty-four~~ twenty-five dollars and ~~sixty-seven~~ forty-six cents; and
      (c) For the indirect care cost category, ~~sixty-two~~ sixty-five dollars and ~~forty-two~~ thirteen cents.

e. A facility with an actual rate that exceeds the limit rate for a cost category shall receive the limit rate.

f. The actual rate for indirect care costs and property costs must be the lesser of the rate established using:
   (1) Actual census for the report year; or
   (2) Ninety percent of licensed bed capacity available for occupancy as of June thirtieth of the report year:
      (a) Multiplied times three hundred sixty-five; and
      (b) Reduced by the number of affected beds, for each day any bed is not in service during the report year, due to a remodeling, renovation, or construction project.

g. The department may waive or reduce the application of subdivision f if the facility demonstrates that occupancy below ninety percent of licensed capacity results from the use of alternative home and community services by individuals who would otherwise be eligible for admission to the facility and:
   (1) The facility has reduced licensed capacity; or

(2) The facility's governing board has approved a capacity decrease to occur no later than the end of the rate year which would be affected by subdivision f.

h. The department may waive the application of paragraph 2 of subdivision f for nongeriatric facilities for individuals with disabilities or geropsychiatric facilities or units if occupancy below ninety percent is due to lack of department-approved referrals or admissions.

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 ~~telephone~~ 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 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.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

SECTION 5. Subdivisions c and d of subsection 6 and subdivisions q and r of subsection 7 of section 75-02-06-17 are amended as follows:

6. The major categories in hierarchical order are:

   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 <u>while a resident</u> 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.

7. Except as provided in subsection 2, each resident must be classified into a case-mix class with the corresponding group label, activities of daily living score, other criteria, and case-mix weight as follows:

q. Special care low with depression and an activities of daily living score of fifteen or sixteen~~, inclusive~~ (group LE2); case-mix weight: 1.61.

r. Special care low with an activities of daily living score of fifteen or sixteen~~, inclusive~~ (group LE1); case-mix weight: 1.26.

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.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)