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 ~~2003~~ 2008 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 the mentally retarded.
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, sub-acute care unit, intermediate care facility for the mentally retarded, or basic care facility.
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. "Non-covered 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.
~~49.~~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.
~~50.~~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.

~~51.~~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.

~~52.~~53. "Private room" means a room equipped for use by only one resident.

~~53.~~54. "Property costs" means the cost category for allowable real property costs and other costs which are passed through.

~~54.~~55. "Provider" means the organization or individual who has executed a provider agreement with the department.

~~55.~~56. "Rate year" means the calendar year from January first through December thirty-first.

~~56.~~57. "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.

~~57.~~58. "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.

~~58.~~59. "Report year" means the fiscal year from July first through June thirtieth of the year immediately preceding the rate year.

~~59.~~60. "Resident" means a person who has been admitted to the facility, but not discharged.

~~60.~~61. "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.

~~61.~~62. "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.

~~62.~~63. "Routine hair care" means hair hygiene which includes grooming, shampooing, cutting, and setting.

~~63.~~64. "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.

~~64.~~65. "Standardized resident day" means a resident day times the classification weight for the resident.

~~65.~~66. "Therapeutic leave day" means any day that a resident is not in the facility, another nursing facility, swing bed facility, transitional care unit, sub-acute unit, an intermediate care facility for the mentally retarded, a basic care facility, or an acute care setting, or, if not in an institutional setting, is not receiving home and community-based waivered services.

~~66.~~67. "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.

~~67.~~68 "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.
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 75-02-06-17 is amended as follows:

75-02-06-17. Classifications.

1. A facility shall complete a resident assessment for any resident occupying a licensed facility bed, except a respite care, hospice inpatient respite care, or hospice general care resident.
2. A resident must be classified in one of thirty-four classifications based on the resident assessment. If a resident assessment is not performed in accordance with subsection 3, except for a respite care, hospice inpatient respite care, or hospice general inpatient care resident, the resident must be included in group BC1, not classified, until the next required resident assessment is performed in accordance with subsection 3. For purposes of determining standardized resident days, any resident day classified as group BC1 must be assigned the relative weight of one. A resident, except for a respite care, hospice inpatient respite care, or hospice general inpatient care resident, who has not been classified, must be billed at the group BC1 established rate. The case-mix weight for establishing the rate for group BC1 is .62. Days for a respite care, hospice inpatient respite care, or hospice general inpatient care resident who is not classified must be given a weight of one when determining standardized resident days. Therapeutic, hospital, or institutional leave days that are resident days

must be given a weight of .62 when determining standardized resident days.

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.
   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 of this subsection.
   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 of this subsection.
4. The resident classification is based on resident characteristics and health status recorded on the resident assessment instrument, including the ability to perform activities of daily living, diagnoses, and treatment received. The resident is first classified in one of seven major categories. The resident is then classified into subdivisions of each major category based on the resident's activities of daily living score and whether nursing rehabilitation services are needed or the resident has signs of depression.
5. For purposes of this section:
   a. A resident's activities of daily living score used in determining the resident's classification is based on the amount of assistance, as described in the resident assessment instrument, the resident needs to complete the activities of bed mobility, transferring, toileting, and eating;
   b. A resident has a need for nursing rehabilitation services if the resident receives two or more of the following for at least fifteen minutes per day for at least six of the seven days preceding the assessment:
      (1) Passive or active range of motion;
      (2) Amputation or prosthesis care;
      (3) Splint or brace assistance;
      (4) Dressing or grooming training;
      (5) Eating or swallowing training;

(6) Bed mobility or walking training;
(7) Transfer training;
(8) Communication training; or
(9) Any scheduled toileting or bladder retraining program; and

c. A resident has signs of depression if the resident exhibits at least three of the following:
(1) Negative statements;
(2) Repetitive questions;
(3) Repetitive verbalization;
(4) Persistent anger with self and others;
(5) Self deprecation;
(6) Expressions of unrealistic fears;
(7) Recurrent statements that something terrible is to happen;
(8) Repetitive health complaints;
(9) Repetitive anxious complaints or concerns of nonhealth-related issues;
(10) Unpleasant mood in morning;
(11) Insomnia or changes in usual sleep patterns;
(12) Sad, pained, or worried facial expression;
(13) Crying or tearfulness;
(14) Repetitive physical movements;
(15) Withdrawal from activities of interest; or
(16) Reduced social interaction.

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.
(1) To qualify for the extensive services category, a resident must have an activities of daily living score of at least seven and have:
(a) Within the fourteen days preceding the assessment, received tracheostomy care or required a ventilator, respirator, or suctioning; or
(b) Within the seven days preceding the assessment, received intravenous medications or intravenous feeding provided and administered by staff within the facility; and
(2) A resident who qualifies for the extensive services category must have assigned a qualifier score of zero to five based on:

(a) The presence of a clinical criteria that qualifies the resident for the special care category, clinically complex category, or impaired cognition category;
(b) Whether the resident received intravenous medications or intravenous feeding provided and administered by staff within the facility;
(c) Whether the resident received tracheostomy care and suctioning; or
(d) Whether the resident required a ventilator or respirator.

c. Special care category.
(1) To qualify for the special care category, a resident must have one or more of the conditions for the extensive care category with an activities of daily living score of less than seven or have at least one of the following conditions or treatments with an activities of daily living score of at least seven:
(a) Multiple sclerosis, cerebral palsy, or quadriplegia with an activities of daily living score of at least ten;
(b) Respiratory therapy seven days a week;
(c) Treatment for pressure or stasis ulcers on two or more body sites;
(d) Surgical wound or open lesion with treatment;
(e) Tube feedings that comprise at least twenty-six percent of daily caloric requirements and at least five hundred and one milliliters of fluid through the tube per day, and be aphasic;
(f) Radiation therapy; or
(g) A fever in combination with dehydration, pneumonia, vomiting, weight loss, or tube feeding.
(2) A resident who qualifies for the special care category is assigned a subcategory based on the resident's activities of daily living score.

d. Clinically complex category.
(1) To qualify for the clinically complex category, a resident must have one or more of the conditions for the special care category with an activities of daily living score of less than seven or have at least one of the following conditions, treatments, or circumstances:
(a) Comatose;
(b) Burns;
(c) Septicemia;
(d) Pneumonia;
(e) Internal bleeding;
(f) Dehydration;
(g) Dialysis;

(h) Hemiplegia with an activities of daily living score of at least ten;
(i) Chemotherapy;
(j) Tube feedings that comprise at least twenty-six percent of daily caloric requirements and at least five hundred and one milliliters of fluid through the tube per day;
(k) Transfusions;
(l) Foot wound with treatment;
(m) Diabetes mellitus, with injections seven days per week and two or more physician order changes in the fourteen days preceding the assessment;
(n) Oxygen therapy 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; or
(o) Within the fourteen days preceding the assessment, at least one physician visit with at least four order changes or at least two physician visits with at least two order changes.

(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.

e. Impaired cognition category. To qualify for the impaired cognition category, a resident must have a cognition performance scale score of three, four, or five and an activities of daily living score of less than eleven. A resident who qualifies for the impaired cognition category is assigned a subcategory based on the resident's activities of daily living score and the resident's need for nursing rehabilitation services.

f. Behavior only category.

(1) To qualify for the behavior only category, a resident must have exhibited, in four of the seven days preceding the assessment, one or more of the following behaviors:
(a) Resisting care;
(b) Combativeness;
(c) Physical abuse;
(d) Verbal abuse;
(e) Wandering; or
(f) Hallucinating or having delusions.

(2) A resident who qualifies for the behavior only 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.

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:
   a. Rehabilitation with an activities of daily living score of seventeen or eighteen (group RAD); case-mix weight: 1.79.
   b. Rehabilitation with an activities of daily living score between fourteen and sixteen, inclusive (group RAC); case-mix weight: 1.54.
   c. Rehabilitation with an activities of daily living score between nine and thirteen, inclusive (group RAB); case-mix weight: 1.26.
   d. Rehabilitation with an activities of daily living score between four and eight, inclusive (group RAA); case-mix weight: 1.07.
   e. Extensive services with an activities of daily living score of at least seven and a qualifier score of four or five (group SE3); case-mix weight: 2.62.
   f. Extensive services with an activities of daily living score of at least seven and a qualifier score of two or three (group SE2); case-mix weight: 1.72.
   g. Extensive services with an activities of daily living score of at least seven and a qualifier score of zero or one (group SE1); case-mix weight: 1.56.
   h. Special care with an activities of daily living score of seventeen or eighteen (group SSC); case-mix weight: 1.50.
   i. Special care with an activities of daily living score of fifteen or sixteen (group SSB); case-mix weight: 1.39.
   j. Special care with an activities of daily living score between seven and fourteen, inclusive, or extensive services with an activities of daily living score of less than seven (group SSA); case-mix weight: 1.33.
   k. Clinically complex with depression and an activities of daily living score of seventeen or eighteen (group CC2); case-mix weight: 1.46.
   l. Clinically complex with an activities of daily living score of seventeen or eighteen (group CC1); case-mix weight: 1.27.
   m. Clinically complex with depression and an activities of daily living score between twelve and sixteen, inclusive (group CB2); case-mix weight: 1.18.
   n. Clinically complex with an activities of daily living score between twelve and sixteen, inclusive (group CB1); case-mix weight: 1.17.

o. Clinically complex with depression and an activities of daily living score between four and eleven, inclusive (group CA2); case-mix weight: 1.08.
p. Clinically complex with an activities of daily living score between four and eleven, inclusive, or special care with an activities of daily living score of less than seven (group CA1); case-mix weight: 1.02.
q. Impaired cognition with nursing rehabilitation and an activities of daily living score between six and ten, inclusive (group IB2); case-mix weight: .98.
r. Impaired cognition with an activities of daily living score between six and ten, inclusive (group IB1); case-mix weight: .88.
s. Impaired cognition with nursing rehabilitation and an activities of daily living score of four or five (group IA2); case-mix weight: .80.
t. Impaired cognition with an activities of daily living score of four or five (group IA1); case-mix weight: .67.
u. Behavior only with nursing rehabilitation and an activities of daily living score between six and ten, inclusive (group BB2); case-mix weight: .97.
v. Behavior only with an activities of daily living score between six and ten, inclusive (group BB1); case-mix weight: .85.
w. Behavior only with nursing rehabilitation and an activities of daily living score of four or five (group BA2); case-mix weight: .69.
x. Behavior only with an activities of daily living score of four or five (group BA1); case-mix weight: .63.
y. Reduced physical functioning with nursing rehabilitation and an activities of daily living score between sixteen and eighteen, inclusive (group PE2); case-mix weight: 1.04.
z. Reduced physical functioning with an activities of daily living score between sixteen and eighteen, inclusive (group PE1); case-mix weight: .96.
aa. Reduced physical functioning with nursing rehabilitation and an activities of daily living score between eleven and fifteen, inclusive (group PD2); case-mix weight: .95.
bb. Reduced physical functioning with an activities of daily living score between eleven and fifteen, inclusive (group PD1); case-mix weight: .87.
cc. Reduced physical functioning with nursing rehabilitation and an activities of daily living score of nine or ten (group PC2); case-mix weight: .86.
dd. Reduced physical functioning with an activities of daily living score of nine or ten (group PC1); case-mix weight: .84.
ee. Reduced physical functioning with nursing rehabilitation and an activities of daily living score between six and eight, inclusive (group PB2); case-mix weight: .75.
ff. Reduced physical functioning with an activities of daily living score between six and eight, inclusive (group PB1); case-mix weight: .68.

gg. Reduced physical functioning with nursing rehabilitation and an activities of daily living score of four or five (group PA2); case-mix weight: .66.

hh. Reduced physical functioning with an activities of daily living score of four or five (group PA1); case-mix weight: .62.

8. The classification is effective the date the resident assessment must be completed in all cases except an admission or for a return from an acute hospital stay. The classification for an admission or for a return is effective the date of the admission or return.

9. A facility complying with any provision of this section that requires a resident assessment must use the minimum data set in a resident assessment instrument that conforms to standards for a resident classification system described in 42 CFR 413.333.

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.

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