Testimony for the Long-Term Care Committee
May 6, 2010

Good morning Chairman Kreidt and members of the Long-Term Care Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. We appreciate the opportunity to share our position regarding the nursing facility private pay appeals process.

We urge the committee to maintain the current appeal process for nursing facility residents. We believe the Department of Human Services is the best entity to conduct appeals and believe they should retain the responsibility. If the department believes they need more staff to conduct the appeal process we encourage this committee to support that action. We believe the appeal process should stay with the Department of Human Services for the following reasons:

1. In 1987 the North Dakota Legislature passed "Equalization of Rates" and determined at that time the Department of Human Services would control rate setting regardless of "who" is paying the bill. Today, over 20 years later the department, through rule making and statue determined the rate system and payment process for private pay and individuals who are Medicaid qualified. Given the Department's key role in the rate setting process for private pay they too are most appropriate to conduct appeals if there is a dispute in the resident's classification.
2. Attached please find Attachment A which outlines the reconsideration and appeal process and Attachment B which outlines how residents are classified into the 34 classifications of care. (Medicare has 53 classifications and is going to 66 classifications on October 1, 2010).

   As you review the process for classification you quickly see it is based upon medical conditions and diagnosis, the ability to perform activities of daily living, a resident's cognition, a resident's need for rehabilitation, daily treatments received, health status and resident characteristics. If the resident appeals the classification, documentation in their "assessment" and medical record determines the outcome of the appeal.

   Today a Department of Human Services nurse conducts the appeal. Having nursing skills and knowledge is critical to best understand the medical record and documentation.

3. The appeal process with the department works very well for families/residents. They are not intimidated and having a nurse review the classification makes sense to families. They trust the department and families can navigate the appeal process by themselves.
4. Our final reason for keeping the appeal process with the Department of Human Services is money and time. If the Office of Administrative Hearing conducts the appeal, surely the cost will increase. We don't believe the department will save much time, as they still retain the responsibility and authority to determine the final outcome (Attachment C).

   The administrative law judge makes recommended findings and recommended orders. The Department of Human Services may adopt the recommended findings as submitted, or modify, or reject them, or make additional findings as they deem appropriate. This means they must still take time to review the case, the documentation and arrive at a decision. Given the department's significant role and final decision maker, why use the Office of Administrative Hearings? Doesn't it just create another layer of bureaucracy that is not necessary?

The process used for the past 20 years is working, gives residents a voice in their appeals and should be continued. Again, if the department needs more employees to conduct this important function please support that need. We are hopeful we will see a decrease in appeals after October 1, 2010. On October 1, 2010 two issues involving a number of appeals will be changing. On October 1 we anticipate you will no longer count hydration/IV given in the hospital and not continued in the nursing facility, as a trigger to a higher classification. Additionally when therapy stops (physical therapy/occupational therapy), the payment for therapy also stops. Today you remain in the rehab category until your next 90 day review period.

Family/residents will be pleased with these changes and all appeals related to frustration with this part of the classification system should cease after October 1, 2010.

This concludes my testimony, if you have any questions I would be happy to answer them. Thank you.

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

15. "Payment rate" means the rate determined under section 50-24.4-06.

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

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

18. "Rate year" means the fiscal year for which a payment rate determined under this chapter is effective, from January first to the next December thirty-first.

19. "Real estate" means improvements to real property and attached fixtures used directly for resident care.

20. "Reporting year" means the period from July first to June thirtieth, immediately preceding the rate year, for which the nursing home submits reports required under this chapter.

21. "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators, nursing home administrators, and other persons performing functions ordinarily performed by such personnel.

50-24.4-01.1. Nursing home resident payment classifications - Procedures for reconsideration.

1. For purposes of this section, "resident's representative" includes the resident's guardian or conservator, a person authorized or required to pay the nursing home expenses of the resident, or any other person designated by the resident in writing.

2. The department shall establish resident payment classifications for the care of residents of nursing homes.

3. The department shall assign nursing home residents to the appropriate payment classification based upon assessments of the residents.

4. The department shall notify each resident, and the nursing home in which the resident resides, of the payment classification established under subsection 3. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the department, and the opportunity to appeal the classification. The notice of resident classification must be sent by first-class mail. The individual resident notices may be sent to the resident's nursing home for distribution to the resident in which event the nursing home is responsible for the distribution of the notice to the resident and to the resident's representative, if any. This notice must be distributed to the resident and sent first-class mail or hand-delivered to the resident's representative within three working days after the nursing home's receipt of the notice from the department.

5. The resident or the nursing home may appeal the assigned payment classification to the department. The appeal must be submitted in writing to the department within

thirty days of the receipt of the notice of resident classification. For appeals submitted by or on behalf of the resident, the time period for submission of the request begins on the date the classification notice is delivered to the resident, or mailed or delivered to the resident's representative, whichever is latest. The appeal must be accompanied by the name of the resident, the name and address of the nursing home in which the resident resides, the reasons for the appeal, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the appeal is limited to documentation intended to establish that the needs of the resident, at the time of the assessment resulting in the disputed classification, justify a change of classification.

6. Upon written request, the nursing home shall give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the department to support the assessment findings. The nursing home shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's appeal. A copy of any requested material must be provided within three working days of receipt of a written request for the information. Upon request, the nursing home shall assist the resident in preparing an appeal.

7. In addition to the information required in subsection 5, an appeal by a nursing home must be accompanied by the following information: the date the resident payment classification notices were received by the nursing home; the date the classification notices were distributed to the resident or the resident's representative; and a copy of a notice of appeal sent to the resident or to the resident's representative. This notice must tell the resident or the resident's representative that the resident's classification is being appealed, the reason for the appeal, that the resident's rate will change if the appeal is approved by the department and the extent of the change, that copies of the nursing home's appeal and supporting documentation are available for review, and that the resident also has the right to appeal. If the nursing home fails to provide this information with the appeal, the appeal must be denied, and the nursing home may not make further appeals concerning that specific resident payment classification until such time as the resident's payment classification is reestablished by the department.

8. The appeal determination of the department must be made by individuals not involved in reviewing the assessment that established the disputed classification. The appeal determination must be based upon the initial assessment and upon the information provided to the department under subsection 5. If the department determines that it is necessary for the appeal determination, it may conduct onsite reviews. Within fifteen working days of receiving the appeal, the department shall affirm or modify the original resident classification. The original classification must be modified if the department determines that the assessment resulting in the classification did not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing home must be notified within five working days after the decision is made.

9. The appeal determination under subsection 8 is the final administrative decision of the agency. That decision is subject to appeal to the district court, and for that purpose, the decision must be treated as a decision on a petition for rehearing made pursuant to section 28-32-40. Appeal to the district court must be taken in the manner required by section 28-32-42.

50-24.4-02. Authority. The department shall establish, by rule, procedures for determining rates for care of residents of nursing homes which qualify as vendors of medical assistance and for implementing the provisions of this chapter. The procedures must be based on methods and standards which the department finds are adequate to recognize the costs that must be incurred for the care of residents in efficiently and economically operated nursing homes. The department shall identify costs that are recognized for establishing payment rates.

Section 32 - 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 a hospital stay. The day of admission or return is counted as day one. The assessment reference date (A3a) on the MDS must be within the fourteen days.

   b. The facility shall assess the resident quarterly after any admission or return from an acute hospital stay. The quarterly assessment 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 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 (A3a) on the MDS must be within the assessment reference period.

4. A resident's 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 classification is determined using an index maximizing method. Index maximizing identifies all groups for which a resident qualifies and the resident is then classified in the group with the highest case mix index. The resident is first classified in one or more 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. A resident meeting the criteria for more than one classification shall be classified in the group with the highest case-mix weight.

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 prothesis 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.

b. Extensive service 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 intravenous medication in the facility or tracheostomy care or required a ventilator, respirator, or suctioning; or

(b) Within the seven days preceding the assessment, received intravenous feeding; 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 while in 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 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 calorie 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 and an activities of daily living score of less than seven or have at least one of the following conditions, treatment, 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 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, any one 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:

Group	Classification Category	ADL Score	Qualifier Nursing Rehabilitation	Signs of Depression	Relative Weight
RAD	Rehabilitation	17-18			1.79
RAC	Rehabilitation	14-16			1.54
RAB	Rehabilitation	9-13			1.26
RAA	Rehabilitation	4-8			1.07
SE3	Extensive Services	7-18	4-5		2.62
SE2	Extensive Services	7-18	2-3		1.72
SE1	Extensive Services	7-18	0-1		1.56
SSA	Extensive Services	4-6	0-5		1.33
SSC	Special Care	17-18			1.50
SSB	Special Care	15-16			1.39
SSA	Special Care	7-14			1.33
CA1	Special Care	4-6			1.02
CC2	Clinically Complex	17-18		Yes	1.46
CC1	Clinically Complex	17-18		No	1.27
CB2	Clinically Complex	12-16		Yes	1.18
CB1	Clinically Complex	12-16		No	1.17
CA2	Clinically Complex	4-11		Yes	1.08
CA1	Clinically Complex	4-11		No	1.02
IB2	Impaired Cognition	6-10	Yes		0.98
IB1	Impaired Cognition	6-10	No		0.88
IA2	Impaired Cognition	4-5	Yes		0.80
IA1	Impaired Cognition	4-5	No		0.67
BB2	Behavior Only	6-10	Yes		0.97
BB1	Behavior Only	6-10	No		0.85
BA2	Behavior Only	4-5	Yes		0.69
BA1	Behavior Only	4-5	No		0.63
PE2	Reduced Physical Functioning	16-18	Yes		1.04
PE1	Reduced Physical Functioning	16-18	No		0.96
PD2	Reduced Physical Functioning	11-15	Yes		0.95
PD1	Reduced Physical Functioning	11-15	No		0.87
PC2	Reduced Physical Functioning	9-10	Yes		0.86
PC1	Reduced Physical Functioning	9-10	No		0.84
PB2	Reduced Physical Functioning	6-8	Yes		0.75
PB1	Reduced Physical Functioning	6-8	No		0.68
PA2	Reduced Physical Functioning	4-5	Yes		0.66
PA1	Reduced Physical Functioning	4-5	No		0.62

8. The classification is effective the date the resident classification must be completed (the final day of the assessment reference period) 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.

ATTACHMENT C

OFFICE OF ADMINISTRATIVE HEARINGS

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March 10, 2010

Ms. Carol K. Olson
Executive Director
Department of Human Services
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

Re: [redacted]
Medical Assistance Appeal
OAH File No. 20090340

Dear Ms. Olson:

Enclosed for your consideration are the administrative law judge's recommended findings and recommended order, together with a proposed final order for your signature, in the above-titled matter. I am also returning the file that was originally transmitted to us, together with all pleadings, exhibits, and correspondence received while the file has been in our possession.

You may adopt these recommended findings as submitted, or modify, or reject them, or make such additional findings as you deem appropriate. So that we may keep apprised of the ultimate outcome of administrative proceedings involving the Office of Administrative Hearings, please provide us with a copy of your final Order.

Additionally, please send us a copy of any decision or order issued by the district court or the supreme court as a result of an appeal of this matter.

Thank you for your attention to these matters.

Sincerely,

Bonny M. Fetch

Bonny M. Fetch
Administrative Law Judge

fz

Encl.

cc: Melvin L. Webster
Shari Doe, Burleigh CSSs
Jeanne Steiner, AAG