CHAPTER 99--S.F.No. 2539

An act relating to human services; recodifying nursing facility payment language; making conforming changes; repealing obsolete provisions; amending Minnesota Statutes 2014, sections 144A.071, subdivision 2; 256B.0625, by adding a subdivision; 256B.19, subdivision 1e; 256B.431, subdivision 22; 256B.434, subdivision 10; 256B.48, subdivisions 2, 3a; 256B.50, subdivision 1a; Minnesota Statutes 2015 Supplement, sections 144A.15, subdivision 6; 256I.05, subdivision 2; proposing coding for new law as Minnesota Statutes, chapter 256R; repealing Minnesota Statutes 2014, sections 256B.0911, subdivision 7; 256B.25, subdivision 4; 256B.27, subdivision 2a; 256B.41, subdivisions 1, 2, 3; 256B.411, subdivisions 1, 2; 256B.421, subdivisions 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15; 256B.431, subdivisions 1, 2d, 2e, 2n, 2r, 2s, 2t, 3e, 32, 35, 42, 44; 256B.432, subdivisions 1, 2, 3, 4, 4a, 5, 6, 6a, 7, 8; 256B.433, subdivisions 1, 2, 3, 3a; 256B.434, subdivisions 2, 9, 11, 12, 14, 15, 16, 18, 19a, 20, 21; 256B.437, subdivisions 1, 3, 4, 5, 6, 7, 9, 10; 256B.438, subdivisions 1, 2, 3, 4, 5, 6, 7, 8; 256B.441, subdivisions 2, 3, 4, 7, 8, 9, 10, 11, 15, 18, 20, 22, 23, 24, 25, 27, 28a, 29, 32, 33a, 34, 36, 37, 38, 39, 41, 42a, 43, 46b, 47, 49, 57, 59, 60, 61, 64; 256B.47, subdivisions 1, 2, 3, 4; 256B.48, subdivisions 1, 1a, 1b, 1c, 3, 4, 5, 6a, 7, 8; Minnesota Statutes 2015 Supplement, sections 256B.431, subdivisions 2b, 36; 256B.441, subdivisions 1, 5, 6, 11a, 13, 14, 17, 30, 31, 33, 35, 40, 44, 46c, 46d, 48, 50, 51, 51a, 51b, 53, 54, 55a, 56, 63, 65, 66, 67; 256B.495, subdivisions 1, 5; Minnesota Rules, parts 9549.0035, subparts 1, 3, 7, 8; 9549.0041, subpart 6; 9549.0055, subparts 1, 2, 3; 9549.0070, subparts 2, 3.

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

ARTICLE 1

NURSING FACILITY RECODIFICATION

GENERAL

Section 1. **[256R.01] GENERAL.**

Subdivision 1. **Payment rates.** Payment rates paid to any nursing facility receiving medical assistance payments must be those rates established pursuant to this chapter and rules adopted under it.

Subd. 2. **Authority of commissioner.** The commissioner shall establish, by rule, procedures for determining rates for care of residents of nursing facilities which qualify as vendors of medical assistance, and for implementing the provisions of this chapter and section 256B.50. The procedures shall specify the costs that are allowable for establishing payment rates through medical assistance.

Subd. 3. **Compliance with federal requirements.** If any provision of this chapter and section 256B.50 is determined by the United States government to be in conflict with existing or future requirements of the United States government with respect to federal participation in medical assistance, the federal requirements shall prevail.

EFFECTIVE DATE. The grant of rulemaking authority to the commissioner of human services in this section is a continuation of authority previously granted in Minnesota Statutes, section 256B.41, subdivision 1.

Sec. 2. **[256R.02] DEFINITIONS.**

Subdivision 1. **Application.** For purposes of this chapter, the terms in this section have the meanings given unless otherwise provided for in this chapter.

Subd. 2. **Active beds.** "Active beds" means licensed beds that are not currently in layaway status.

Subd. 3. **Activities costs.** "Activities costs" means the costs for the salaries and wages of the supervisor and other activities workers, associated fringe benefits and payroll taxes, supplies, services, and consultants.

Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, and permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in subdivision 17, voice and data communication or transmission, office supplies, property and liability insurance and other forms of insurance not designated to other areas, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, Web site, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, advertising, board of directors fees, working capital interest expense, and bad debts and bad debt collection fees.

Subd. 5. **Allowed costs.** "Allowed costs" means the amounts reported by the facility which are necessary for the operation of the facility and the care of residents and which are reviewed by the Department of Human Services for accuracy; reasonableness, in accordance with the requirements set forth in title XVIII of the federal Social Security Act and the interpretations in the provider reimbursement manual; and compliance with this chapter and generally accepted accounting principles. All references to costs in this chapter shall be assumed to refer to allowed costs, unless otherwise specified.

Subd. 6. **Applicable credit.** "Applicable credit" means a receipt or expense reduction as a result of a purchase discount, rebate, refund, allowance, public grant, beauty shop income, guest meals income, adjustment for overcharges, insurance claims settlement, recovered bad debts, or any other adjustment or income reducing the costs claimed by a nursing facility.

Subd. 7. **Assessment reference date.** "Assessment reference date" has the meaning given in section 144.0724, subdivision 2, paragraph (a).

Subd. 8. **Capital assets.** "Capital assets" means a nursing facility's buildings, attached fixtures, land improvements, leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

Subd. 9. **Case mix classification.** "Case mix classification" refers to resident reimbursement case mix classifications described in section 144.0724.

Subd. 10. **Case mix index.** "Case mix index" has the meaning given in section 144.0724, subdivision 2, paragraph (b).

Subd. 11. **Centers for Medicare and Medicaid services.** "Centers for Medicare and Medicaid services" means the federal agency, in the United States Department of Health and Human Services that administers Medicaid, also referred to as "CMS."

Subd. 12. **Commissioner.** "Commissioner" means the commissioner of human services unless specified otherwise.

Subd. 13. **Consulting agreement.** "Consulting agreement" means any agreement the purpose of which is for a central, affiliated, or corporate office to advise, counsel, recommend, or suggest to the owner or operator of the nonrelated nursing facility measures and methods for improving the operations of the nursing facility.

Subd. 14. **Cost to limit ratio.** "Cost to limit ratio" means a facility's total care-related cost per day divided by its total care-related payment rate limit.

Subd. 15. **Desk audit.** "Desk audit" means the establishment of the payment rate based on the commissioner's review and analysis of required reports, supporting documentation, and work sheets submitted by the nursing facility.

Subd. 16. **Dietary costs.** "Dietary costs" means the costs for the salaries and wages of the dietary supervisor, dietitians, chefs, cooks, dishwashers, and other employees assigned to the kitchen and dining room, and associated fringe benefits and payroll taxes. Dietary costs also includes the salaries or fees of dietary consultants, dietary supplies, and food preparation and serving.

Subd. 17. **Direct care costs.** "Direct care costs" means costs for the wages of nursing administration, direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, employees conducting training in resident care topics and associated fringe benefits and payroll taxes; services from a supplemental nursing services agency; supplies that are stocked at nursing stations or on the floor and distributed or used individually, including, but not limited to: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, clinical reagents or similar diagnostic agents, drugs that are not paid on a separate fee schedule by the medical assistance program or any other payer, and technology related to the provision of nursing care to residents, such as electronic charting systems; costs of materials used for resident care training, and training courses outside of the facility attended by direct care staff on resident care topics.

Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means premium expenses for group coverage and reinsurance, actual expenses incurred for self-insured plans, and employer contributions to employee health reimbursement and health savings accounts. Premium and expense costs and contributions are allowable for (1) all employees and (2) the spouse and dependents of employees who meet the definition of full-time employees under the federal Affordable Care Act, Public Law 111-148.

Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; family advisory council fee under section 144A.33; scholarships under section 256R.37; planned closure rate adjustments under section 256R.40; single-bed room incentives under section 256R.41; property

taxes, assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under section 256R.39; performance-based incentive payments under section 256R.38; special dietary needs under section 256R.51; and Public Employees Retirement Association.

Subd. 20. **Facility average case mix index.** "Facility average case mix index" or "CMI" means a numerical score that describes the relative resource use for all residents within the case mix classifications under the resource utilization group (RUG) classification system prescribed by the commissioner based on an assessment of each resident. The facility average CMI shall be computed as the standardized days divided by the sum of the facility's resident days. The case mix indices used shall be based on the system prescribed in section 256R.17.

Subd. 21. **Field audit.** "Field audit" means the examination, verification, and review of the financial records, statistical records, and related supporting documentation on the nursing home and any related organization.

Subd. 22. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life, dental, workers' compensation, and other employee insurances and pension, except for the Public Employees Retirement Association and employer health insurance costs; profit sharing; and retirement plans for which the employer pays all or a portion of the costs.

Subd. 23. **Generally accepted accounting principles.** "Generally accepted accounting principles" means the body of pronouncements adopted by the American Institute of Certified Public Accountants regarding proper accounting procedures, guidelines, and rules.

Subd. 24. **Housekeeping costs.** "Housekeeping costs" means the costs for the salaries and wages of the housekeeping supervisor, housekeepers, and other cleaning employees and associated fringe benefits and payroll taxes. It also includes the cost of housekeeping supplies, including, but not limited to, cleaning and lavatory supplies and contract services.

Subd. 25. **Identifiable cost.** "Identifiable cost" means a cost that can be directly identified with a specific nursing facility or can be directly identified with an activity or function.

Subd. 26. **Laundry costs.** "Laundry costs" means the costs for the salaries and wages of the laundry supervisor and other laundry employees, associated fringe benefits, and payroll taxes. It also includes the costs of linen and bedding, the laundering of resident clothing, laundry supplies, and contract services.

Subd. 27. **Leave day.** "Leave day" means any calendar day during which the recipient leaves the facility and is absent overnight, and all subsequent, consecutive calendar days. An overnight absence from the facility of less than 23 hours does not constitute a leave day. Nevertheless, if the recipient is absent from the facility to participate in active programming of the facility under the personal direction and observation of facility staff, the day shall not be considered a leave day regardless of the number of hours of the recipient's absence. For purposes of this subdivision, "calendar day" means the 24-hour period ending at midnight.

Subd. 28. **Licensee.** "Licensee" means the individual or organization listed on the form issued by the Minnesota Department of Health under chapter 144A or sections 144.50 to 144.56.

Subd. 29. **Maintenance and plant operations costs.** "Maintenance and plant operations costs" means the costs for the salaries and wages of the maintenance supervisor, engineers, heating-plant employees, and other maintenance employees and associated fringe benefits and payroll taxes. It

also includes identifiable costs for maintenance and operation of the building and grounds, including, but not limited to, fuel, electricity, medical waste and garbage removal, water, sewer, supplies, tools, and repairs.

Subd. 30. **Management agreement.** "Management agreement" means an agreement in which one or more of the following criteria exist:

(1) the central, affiliated, or corporate office has or is authorized to assume day-to-day operational control of the nursing facility for any six-month period within a 24-month period. "Day-to-day operational control" means that the central, affiliated, or corporate office has the authority to require, mandate, direct, or compel the employees of the nursing facility to perform or refrain from performing certain acts, or to supplant or take the place of the top management of the nursing facility. "Day-to-day operational control" includes the authority to hire or terminate employees or to provide an employee of the central, affiliated, or corporate office to serve as administrator of the nursing facility;

(2) the central, affiliated, or corporate office performs or is authorized to perform two or more of the following: the execution of contracts; authorization of purchase orders; signature authority for checks, notes, or other financial instruments; requiring the nursing facility to use the group or volume purchasing services of the central, affiliated, or corporate office; or the authority to make annual capital expenditures for the nursing facility exceeding $50,000, or $500 per licensed bed, whichever is less, without first securing the approval of the nursing facility board of directors;

(3) the central, affiliated, or corporate office becomes or is required to become the licensee under applicable state law;

(4) the agreement provides that the compensation for services provided under the agreement is directly related to any profits made by the nursing facility; or

(5) the nursing facility entering into the agreement is governed by a governing body that meets fewer than four times per year, that does not publish notice of its meetings, or that does not keep formal records of its proceedings.

Subd. 31. **Medical assistance program.** "Medical assistance program" means the program which reimburses the cost of health care provided to eligible recipients pursuant to chapters 256B and 256R, and United States Code, title 42, section 1396, et seq.

Subd. 32. **Minimum data set.** "Minimum data set" has the meaning given in section 144.0724, subdivision 2, paragraph (d).

Subd. 33. **Nursing facility.** "Nursing facility" means a facility with a medical assistance provider agreement that is licensed as a nursing home under chapter 144A or as a boarding care home under sections 144.50 to 144.56.

Subd. 34. **Other care-related costs.** "Other care-related costs" means the sum of activities costs, other direct care costs, raw food costs, therapy costs, and social services costs.

Subd. 35. **Other direct care costs.** "Other direct care costs" means the costs for the salaries and wages and associated fringe benefits and payroll taxes of mental health workers, religious personnel, and other direct care employees not specified in the definition of direct care costs.

Subd. 36. **Other operating costs.** "Other operating costs" means the sum of administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operation costs.

Subd. 37. **Payroll taxes.** "Payroll taxes" means the costs for the employer's share of the FICA and Medicare withholding tax, and state and federal unemployment compensation taxes.

Subd. 38. **Prior system operating cost payment rate.** "Prior system operating cost payment rate" means the operating cost payment rate in effect on December 31, 2015, under Minnesota Rules and Minnesota Statutes, inclusive of health insurance, plus property insurance costs from external fixed costs, minus any rate increases allowed under Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 55a.

Subd. 39. **Private paying resident.** "Private paying resident" means a nursing facility resident who is not a medical assistance recipient and whose payment rate is not established by another third party, including the veterans administration or Medicare.

Subd. 40. **Public accountant.** "Public accountant" means a certified public accountant or certified public accounting firm licensed in accordance with chapter 326A.

Subd. 41. **Rate year.** "Rate year" means the 12-month period beginning on January 1.

Subd. 42. **Raw food costs.** "Raw food costs" means the cost of food provided to nursing facility residents. Also included are special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet.

Subd. 43. **Related organization.** (a) "Related organization" means a person that furnishes goods or services to a nursing facility and that is a close relative of a nursing facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility, or an affiliate of a close relative of an affiliate of a nursing facility. As used in this subdivision, paragraphs (b) to (e) apply.

(b) "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with another person.

(c) "Person" means an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

(d) "Close relative of an affiliate of a nursing facility" means an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a nursing facility is no more remote than first cousin.

(e) "Control" including the terms "controlling," "controlled by," and "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management, operations, or policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

Subd. 44. **Reporting period.** "Reporting period" means the one-year period beginning on October 1 and ending on the following September 30 during which incurred costs are accumulated and then reported on the statistical and cost report. If a facility is reporting for an interim or settle-up period, the reporting period beginning date may be a date other than October 1. An interim or settle-up report must cover at least five months, but no more than 17 months, and must always end on September 30.

Subd. 45. **Resident day.** "Resident day" means a day for which nursing services are rendered and billable, or a day for which a bed is held and billed. The day of admission is considered a resident day, regardless of the time of admission. The day of discharge is not considered a resident day, regardless of the time of discharge.

Subd. 46. **Resource utilization group.** "Resource utilization groups" or "RUG" has the meaning given in section 144.0724, subdivision 2, paragraph (f).

Subd. 47. **Salaries and wages.** "Salaries and wages" means amounts earned by and paid to employees or on behalf of employees to compensate for necessary services provided. Salaries and wages include accrued vested vacation and accrued vested sick leave pay.

Subd. 48. **Social services costs.** "Social services costs" means the costs for the salaries and wages of the supervisor and other social work employees, associated fringe benefits and payroll taxes, supplies, services, and consultants. This category includes the cost of those employees who manage and process admission to the nursing facility.

Subd. 49. **Stakeholders.** "Stakeholders" means individuals and representatives of organizations interested in long-term care, including nursing homes, consumers, and labor unions.

Subd. 50. **Standardized days.** "Standardized days" means the sum of resident days by case mix classification multiplied by the case mix index for each classification. When a facility has resident days at a penalty classification, these days shall be reported as resident days at the case mix classification established immediately after the penalty period, if available, and otherwise, at the case mix classification in effect before the penalty began.

Subd. 51. **Statistical and cost report.** "Statistical and cost report" means the forms supplied by the commissioner for annual reporting of nursing facility expenses and statistics, including instructions and definitions of items in the report.

Subd. 52. **Therapy costs.** "Therapy costs" means any costs related to medical assistance therapy services provided to residents that are not billed separately from the daily operating rate.

Subd. 53. **Working capital debt.** "Working capital debt" means debt incurred to finance nursing facility operating costs. Working capital debt does not include debt incurred to acquire or refinance a capital asset.

Subd. 54. **Working capital interest expense.** "Working capital interest expense" means the interest expense incurred on working capital debt during the reporting period.

CONDITIONS FOR PARTICIPATION

Sec. 3. **[256R.03] CONDITIONS FOR FUNDING.**

Subdivision 1. **Requirements for funding.** (a) No medical assistance payments shall be made to any nursing facility unless the nursing facility is certified to participate in the medical assistance program under title XIX of the federal Social Security Act and has in effect a provider agreement with the commissioner meeting the requirements of state and federal statutes and rules.

(b) No medical assistance payments shall be made to any nursing facility unless the nursing facility complies with all requirements of Minnesota Statutes including, but not limited to, this chapter and chapter 256B and rules adopted under them that govern participation in the program.

(c) Subject to exceptions in section 256B.25, subdivision 3, no nursing facility may receive any state or local payment for providing care to a person eligible for medical assistance, except under the medical assistance program.

Subd. 2. **Payment during suspended admissions.** A nursing home or boarding care home that has received a notice to suspend admissions under section 144A.105 shall be ineligible to receive payment for admissions that occur during the effective dates of the suspension. Upon termination of the suspension by the commissioner of health, payments may be made for eligible persons, beginning with the day after the suspension ends.

Subd. 3. **Payments to facilities withdrawing from medical assistance.** This section applies whether the nursing facility participates fully in the medical assistance program or is withdrawing from the medical assistance program. No medical assistance payments may be made to any nursing facility which has withdrawn or is withdrawing from the medical assistance program except as provided in subdivision 4, or federal law.

Subd. 4. **Termination.** If a nursing facility terminates its participation in the medical assistance program, whether voluntarily or involuntarily, the commissioner may authorize the nursing facility to receive continued medical assistance reimbursement until medical assistance residents can be relocated to nursing facilities participating in the medical assistance program.

Sec. 4. **[256R.04] PROHIBITED PRACTICES.**

Subdivision 1. **Financial exploitation.** A nursing facility is not eligible to receive medical assistance payments unless it refrains from all of the following:

(1) charging, soliciting, accepting, or receiving from an applicant for admission to the facility, or from anyone acting on behalf of the applicant, as a condition of admission, expediting the admission, or as a requirement for the individual's continued stay, any fee, deposit, gift, money, donation, or other consideration not otherwise required as payment under the Medicaid state plan;

(2) requiring an individual, or anyone acting on behalf of the individual, to loan any money to the nursing facility;

(3) requiring an individual, or anyone acting on behalf of the individual, to promise to leave all or part of the individual's estate to the facility; or

(4) requiring a third-party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

Nothing in this subdivision prohibits discharge for nonpayment of services in accordance with state and federal regulations.

Subd. 2. **Restricting resident choice of vendors of medical services.** (a) A nursing facility is not eligible to receive medical assistance payments unless it refrains from requiring any resident of the nursing facility to utilize a vendor of health care services chosen by the nursing facility.

(b) A nursing facility may require a resident to use pharmacies that utilize unit dose packing systems approved by the Minnesota Board of Pharmacy, and may require a resident to use pharmacies that are able to meet the federal regulations for safe and timely administration of medications such as systems with specific number of doses, prompt delivery of medications, or access to medications on a 24-hour basis. Notwithstanding the provisions of this subdivision, nursing facilities shall not restrict a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit dose drug packing.

Subd. 3. **Differential treatment.** A nursing facility is not eligible to receive medical assistance payments unless it refrains from providing differential treatment on the basis of status with regard to public assistance.

Subd. 4. **Discrimination.** A nursing facility is not eligible to receive medical assistance payments unless it refrains from discriminating in admissions, services offered, or room assignment on the basis of status with regard to public assistance or refusal to purchase special services. Admissions discrimination shall include, but is not limited to:

(1) basing admissions decisions upon assurance by the applicant to the nursing facility, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek public assistance for payment of nursing facility care costs; and

(2) engaging in preferential selection from waiting lists based on an applicant's ability to pay privately or an applicant's refusal to pay for a special service.

The collection and use by a nursing facility of financial information of any applicant pursuant to a preadmission screening program established by law shall not raise an inference that the nursing facility is utilizing that information for any purpose prohibited by this subdivision.

Subd. 5. **Kickbacks.** A nursing facility is not eligible to receive medical assistance payments unless it refrains from requiring any vendor of medical care as defined by section 256B.02, subdivision 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any amount based on utilization or service levels or any portion of the vendor's fee to the nursing facility except as payment for renting or leasing space or equipment or purchasing support services from the nursing facility as limited by section 256R.54. All agreements must be disclosed to the commissioner upon request of the commissioner. Nursing facilities and vendors of ancillary services that are found to be in violation of this subdivision shall each be subject to an action by the state of Minnesota or any of its subdivisions or agencies for treble civil damages on the portion of the fee in excess of that allowed by this subdivision and section 256R.54. Damages awarded must include three times the excess payments together with costs and disbursements including reasonable attorney fees or their equivalent.

Subd. 6. **Refusing readmissions.** A nursing facility is not eligible to receive medical assistance payments unless it refrains from refusing, for more than 24 hours, to accept a resident returning to the same bed or a bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.

Subd. 7. **Violations and penalties.** For a period not to exceed 180 days, the commissioner may continue to make medical assistance payments to a nursing facility or boarding care home which is in violation of this section if extreme hardship to the residents would result. In these cases the commissioner shall issue an order requiring the nursing facility to correct the violation. The nursing facility shall have 20 days from its receipt of the order to correct the violation. If the violation is not corrected within the 20-day period the commissioner may reduce the payment rate to the nursing facility by up to 20 percent. The amount of the payment rate reduction shall be related to the severity of the violation and shall remain in effect until the violation is corrected. The nursing facility or boarding care home may appeal the commissioner's action pursuant to the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of notice of the commissioner's proposed action.

Subd. 8. **Temporary reimbursement to facilities in violation of this section.** In the event that the commissioner determines that, due to a violation of this section, a nursing facility is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing facility to receive reimbursement on a temporary basis until the resident can be relocated to a participating nursing facility.

Sec. 5. **[256R.05] REQUIRED PRACTICES.**

Subdivision 1. **Preadmission screening.** (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the county has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement in section 144.0724, subdivision 11, or, if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of 1987, unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with developmental disability is approved by the state developmental disability authority.

(b) The nursing facility must not bill a person who is not a medical assistance recipient for resident days that preceded the date of completion of screening activities as required under section 256.975, subdivisions 7a to 7c. The nursing facility must include unreimbursed resident days in the nursing facility resident day totals reported to the commissioner.

Subd. 2. **Referrals to Medicare providers.** (a) Notwithstanding sections 256R.04 and 256R.06, subdivisions 2 and 4, nursing facility providers that do not participate in or accept Medicare assignment must refer and document the referral of dual eligible recipients for whom placement is requested and for whom the resident would be qualified for a Medicare-covered stay to Medicare providers. The commissioner shall audit nursing facilities that do not accept Medicare and determine if dual eligible individuals with Medicare qualifying stays have been admitted. If such a determination is made, the commissioner shall deny Medicaid payment for the first 20 days of that resident's stay.

(b) A nursing facility that violates this subdivision is subject to section 256R.04, subdivisions 7 and 8.

Sec. 6. **[256R.06] PRIVATE PAY RESIDENTS; REQUIRED PRACTICES.**

Subdivision 1. **Medical assistance rates not to exceed private pay residents' rates.** (a) The total payment rate must not exceed the rate paid by private paying residents for similar services for the same period.

(b) The medical assistance rate limitation in paragraph (a) shall not apply to retroactive adjustments to the total payment rate established under this chapter unless the facility was in violation of paragraph (a) prior to the retroactive rate adjustment.

Subd. 2. **Private pay rates not to exceed medical assistance residents' rates.** (a) A nursing facility is not eligible to receive medical assistance payments unless it refrains from charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate. The nursing facility may (1) charge private paying residents a higher rate for a private room, and (2) charge for special services which are not included in the daily rate if medical assistance residents

are charged separately at the same rate for the same services in addition to the daily rate paid by the commissioner.

(b) Services covered by the payment rate must be the same regardless of payment source.

(c) Special services, if offered, must:

(1) be available to all residents in all areas of the nursing facility;

(2) be charged separately at the same rate; and

(3) not include services which must be provided by the nursing facility in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing facility. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting period.

(d) Residents must be free to select or decline special services.

Subd. 3. **Violations and penalties.** A nursing facility that violates subdivision 2, 6, or 7 is subject to section 256R.04, subdivisions 7 and 8.

Subd. 4. **Civil penalties and procedures.** A nursing facility that charges a private paying resident a rate in violation of subdivision 2 is subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing facility that charges the resident rates in violation of subdivision 2. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorney fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing facility may request a hearing to determine the allowed rate or rates at issue in the cause of action. Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of an administrative law judge under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The administrative law judge shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in subdivision 2 shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance.

Subd. 5. **Notice to residents.** (a) No increase in nursing facility rates for private paying residents shall be effective unless the nursing facility notifies the resident or person responsible for payment of the increase in writing 30 days before the increase takes effect.

A nursing facility may adjust its rates without giving the notice required by this subdivision when the purpose of the rate adjustment is to reflect a change in the case mix classification of the resident.

If the state fails to set rates as required by section 256R.09, subdivision 1, the time required for giving notice is decreased by the number of days by which the state was late in setting the rates.

(b) If the state does not set rates by the date required in section 256R.09, subdivision 1, nursing facilities shall meet the requirement for advance notice by informing the resident or person responsible for payments, on or before the effective date of the increase, that a rate increase will be effective on that date.

If the exact amount has not yet been determined, the nursing facility may raise the rates by the amount anticipated to be allowed. Any amounts collected from private pay residents in excess of the allowable rate must be repaid to private pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the rate increase is effective.

Subd. 6. **Refund of excess charges.** Any nursing facility which has charged a resident a rate for a case mix classification upon admission which is in excess of the rate for the case mix classification established by the commissioner of health and effective on the date of admission, must refund the amount charged in excess of that rate. Refunds must be credited to the next monthly billing or refunded within 15 days of receipt of the case mix classification notice from the Department of Health. Failure to refund the excess charge is a violation of this section.

Subd. 7. **Notification to a spouse or health care agent.** (a) When a private pay resident who has not yet been screened by the preadmission screening team is admitted to a nursing facility or boarding care facility, the nursing facility or boarding care facility must notify the resident and the resident's spouse or health care agent of the following:

(1) their right to retain certain resources under sections 256B.0575, 256B.058, 256B.059, 256B.0595, and 256B.14, subdivision 2; and

(2) that the federal Medicare hospital insurance benefits program covers posthospital extended care services in a qualified skilled nursing facility for up to 100 days and that there are several limitations on this benefit. The resident and the resident's family or health care agent must be informed about all mechanisms to appeal limitations imposed under this federal benefit program.

(b) This notice may be included in the nursing facility's or boarding care facility's admission agreement and must clearly explain what resources the resident and spouse may retain if the resident applies for medical assistance. The Department of Human Services must notify nursing facilities and boarding care facilities of changes in the determination of medical assistance eligibility that relate to resources retained by a resident and the resident's spouse.

(c) The preadmission screening team has primary responsibility for informing all private pay applicants to a nursing facility or boarding care facility of the resources the resident and spouse may retain.

DATA COLLECTION AND REPORTING

Sec. 7. **[256R.07] ADEQUATE DOCUMENTATION.**

Subdivision 1. **Criteria.** A nursing facility shall keep adequate documentation. In order to be adequate, documentation must:

(1) be maintained in orderly, well-organized files;

(2) not include documentation of more than one nursing facility in one set of files unless transactions may be traced by the commissioner to the nursing facility's annual cost report;

(3) include a paid invoice or copy of a paid invoice with date of purchase, vendor name and address, purchaser name and delivery destination address, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any

allocation of costs between accounts or nursing facilities. If any of the information is not available, the nursing facility shall document its good faith attempt to obtain the information;

(4) include contracts, agreements, amortization schedules, mortgages, other debt instruments, and all other documents necessary to explain the nursing facility's costs or revenues; and

(5) be retained by the nursing facility to support the five most recent annual cost reports. The commissioner may extend the period of retention if the field audit was postponed because of inadequate record keeping or accounting practices as in section 256R.13, subdivisions 2 and 4, the records are necessary to resolve a pending appeal, or the records are required for the enforcement of sections 256R.04; 256R.05, subdivision 2; 256R.06, subdivisions 2, 6, and 7; 256R.08, subdivisions 1 to 3; and 256R.09, subdivisions 3 and 4.

Subd. 2. **Documentation of compensation.** Compensation for personal services, regardless of whether treated as identifiable costs or costs that are not identifiable, must be documented on payroll records. Payrolls must be supported by time and attendance or equivalent records for individual employees. Salaries and wages of employees which are allocated to more than one cost category must be supported by time distribution records. The method used must produce a proportional distribution of actual time spent, or an accurate estimate of time spent performing assigned duties. The nursing facility that chooses to estimate time spent must use a statistically valid method. The compensation must reflect an amount proportionate to a full-time basis if the services are rendered on less than a full-time basis.

Subd. 3. **Adequate documentation supporting nursing facility payrolls.** Payroll records supporting compensation costs claimed by nursing facilities must be supported by affirmative time and attendance records prepared by each individual at intervals of not more than one month. The requirements of this subdivision are met when documentation is provided under either clause (1) or (2) as follows:

(1) the affirmative time and attendance record must identify the individual's name; the days worked during each pay period; the number of hours worked each day; and the number of hours taken each day by the individual for vacation, sick, and other leave. The affirmative time and attendance record must include a signed verification by the individual and the individual's supervisor, if any, that the entries reported on the record are correct; or

(2) if the affirmative time and attendance records identifying the individual's name, the days worked each pay period, the number of hours worked each day, and the number of hours taken each day by the individual for vacation, sick, and other leave are placed on microfilm, equipment must be made available for viewing and printing them, or if the records are stored as automated data, summary data must be available for viewing and printing.

Subd. 4. **Documentation of mileage.** Except for vehicles used exclusively for nursing facility business, the nursing facility or related organization must maintain a motor vehicle log that shows nursing facility mileage for the reporting period. Mileage paid for the use of a personal vehicle must be documented.

Subd. 5. **Records for cost allocations.** Complete and orderly records must be maintained for cost allocations made to cost categories.

Sec. 8. **[256R.08] REPORTING OF FINANCIAL STATEMENTS.**

Subdivision 1. **Reporting of financial statements.** (a) No later than February 1 of each year, a nursing facility shall:

(1) provide the state agency with a copy of its audited financial statements or its working trial balance;

(2) provide the state agency with a statement of ownership for the facility;

(3) provide the state agency with separate, audited financial statements or working trial balances for every other facility owned in whole or in part by an individual or entity that has an ownership interest in the facility;

(4) upon request, provide the state agency with separate, audited financial statements or working trial balances for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

(5) provide the state agency with copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility; and

(6) upon request, provide the state agency with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs.

(b) Audited financial statements submitted under paragraph (a) must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statement of cash flows, notes to the financial statements, audited applicable supplemental information, and the public accountant's report. Public accountants must conduct audits in accordance with chapter 326A. The cost of an audit shall not be an allowable cost unless the nursing facility submits its audited financial statements in the manner otherwise specified in this subdivision. A nursing facility must permit access by the state agency to the public accountant's audit work papers that support the audited financial statements submitted under paragraph (a).

(c) Documents or information provided to the state agency pursuant to this subdivision shall be public.

(d) If the requirements of paragraphs (a) and (b) are not met, the reimbursement rate may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting period and the reduction shall continue until the requirements are met.

Subd. 2. **Extensions.** The commissioner may grant up to a 15-day extension of the reporting deadline to a nursing facility for good cause. To receive such an extension, a nursing facility shall submit a written request by January 1. The commissioner shall notify the nursing facility of the decision by January 15. Between January 1 and February 1, the nursing facility may request a reporting extension for good cause by telephone and followed by a written request.

Subd. 3. **False reports.** If a nursing facility knowingly supplies inaccurate or false information in a required report that results in an overpayment, the commissioner shall:

(1) immediately adjust the nursing facility's payment rate to recover the entire overpayment within the rate year;

(2) terminate the commissioner's agreement with the nursing facility;

(3) prosecute under applicable state or federal law; or

(4) use any combination of the foregoing actions.

Subd. 4. **Violations and penalties.** A nursing facility that violates this section is subject to section 256R.04, subdivisions 7 and 8.

Sec. 9. **[256R.09] REPORTING OF STATISTICAL AND COST REPORTS.**

Subdivision 1. **Reporting timeline.** Each nursing facility shall file a statistical and cost report for the prior reporting period by February 1 in a form and manner specified by the commissioner. Notice of rates shall be distributed by November 15.

Subd. 2. **Reporting of statistical and cost information.** All nursing facilities shall provide information annually to the commissioner on a form and in a manner determined by the commissioner. The commissioner may separately require facilities to submit in a manner specified by the commissioner documentation of statistical and cost information included in the report to ensure accuracy in establishing payment rates and to perform audit and appeal review functions under this chapter. The commissioner may also require nursing facilities to provide statistical and cost information for a subset of the items in the annual report on a semiannual basis. Nursing facilities shall report only costs directly related to the operation of the nursing facility. The facility shall not include costs which are separately reimbursed by residents, medical assistance, or other payors. Allocations of costs from central, affiliated, or corporate office and related organization transactions shall be reported according to sections 256R.07, subdivision 3, and 256R.12, subdivisions 1 to 7. The commissioner shall not grant facilities extensions to the filing deadline.

Subd. 3. **Record retention.** Facilities shall retain all records necessary to document statistical and cost information on the report for a period of no less than seven years. The commissioner may amend information in the report according to section 256R.13, subdivision 2. For computerized accounting systems, the records must include copies of electronically generated media and technology to enable access to the records.

Subd. 4. **Incomplete or inaccurate reports; reports not submitted in a timely manner.** The commissioner may reject a report filed by a nursing facility under this section if the commissioner determines that the report has been filed in a form that is incomplete or inaccurate and the information is insufficient to establish accurate payment rates. In the event that a complete report is not submitted in a timely manner, the commissioner shall reduce the reimbursement payments to a nursing facility to 85 percent of amounts due until the information is filed. The release of withheld payments shall be retroactive for no more than 90 days. A nursing facility that does not submit a report or whose report is filed in a timely manner but determined to be incomplete shall be given written notice that a payment reduction is to be implemented and allowed ten days to complete the report prior to any payment reduction. The commissioner may delay the payment withhold under exceptional circumstances to be determined at the sole discretion of the commissioner.

Subd. 5. **Method of accounting.** The accrual method of accounting in accordance with generally accepted accounting principles is the only method acceptable for purposes of satisfying the reporting requirements of this chapter. If a governmentally owned nursing facility demonstrates that the accrual method of accounting is not applicable to its accounts and that a cash or modified accrual method of accounting more accurately reports the nursing facility's financial operations, the

commissioner shall permit the governmentally owned nursing facility to use a cash or modified accrual method of accounting.

Subd. 6. **Amending statistical and cost information.** (a) Nursing facilities may, within 12 months of the due date of a statistical and cost report, file an amendment when errors or omissions in the annual statistical and cost report are discovered and an amendment would result in a rate increase of at least 0.15 percent of the statewide weighted average operating payment rate and shall, at any time, file an amendment which would result in a rate reduction of at least 0.15 percent of the statewide weighted average operating payment rate.

(b) The commissioner must calculate the statewide average operating payment rate as follows:

(1) for each nursing facility reimbursed under this chapter, multiply the number of resident days in each case mix classification the facility has billed to the commissioner under this chapter during the previous reporting year by the facility's corresponding case mix adjusted total payment rates;

(2) sum the results of clause (1) for all facilities reimbursed under this chapter;

(3) calculate the total number of resident days billed by all nursing facilities reimbursed under this chapter during the previous reporting year; and

(4) divide the result of clause (2) by the result of clause (3).

(c) The commissioner shall make retroactive adjustments to the total payment rate of a nursing facility if an amendment is accepted. When a retroactive adjustment is made as a result of an amended report, audit findings, or other determination of an incorrect payment rate, the commissioner may settle the payment error through a negotiated agreement with the facility and a gross adjustment of the payments to the facility. Retroactive adjustments shall not be applied to private pay residents. An error or omission for purposes of this subdivision does not include a nursing facility's determination that an election between permissible alternatives was not advantageous and should be changed.

Subd. 7. **Reporting of false statistical and cost information.** If the commissioner determines that a nursing facility knowingly supplied inaccurate or false information or failed to file an amendment to a statistical and cost report that resulted in or would result in an overpayment, the commissioner shall immediately adjust the nursing facility's payment rate and recover the entire overpayment. The commissioner may also terminate the commissioner's agreement with the nursing facility and prosecute under applicable state or federal law.

Sec. 10. **[256R.10] ALLOWED COSTS.**

Subdivision 1. **General cost principles.** Only costs determined to be allowable shall be used to compute the total payment rate for nursing facilities participating in the medical assistance program. To be considered an allowable cost for rate-setting purposes, a cost must satisfy the following criteria:

(1) the cost is ordinary, necessary, and related to resident care;

(2) the cost is what a prudent and cost-conscious business person would pay for the specific good or service in the open market in an arm's-length transaction;

(3) the cost is for goods or services actually provided in the nursing facility;

(4) the cost effects of transactions that have the effect of circumventing this chapter are not allowable under the principle that the substance of the transaction shall prevail over form; and

(5) costs that are incurred due to management inefficiency, unnecessary care or facilities, agreements not to compete, or activities not commonly accepted in the nursing facility care field are not allowable.

Subd. 2. **Employees represented by a collective bargaining agent.** (a) For facilities where employees are represented by collective bargaining agents, costs related to the salaries and wages, payroll taxes, and employer's share of fringe benefit costs, except employer health insurance costs, for facility employees who are members of the bargaining unit are allowed costs only if:

(1) these costs are incurred pursuant to a collective bargaining agreement. The commissioner shall allow a collective bargaining agent until March 1 following the date on which the cost report was required to be submitted to notify the commissioner if a collective bargaining agreement, effective on the last day of the reporting period, was not in effect; or

(2) the collective bargaining agent notifies the commissioner by October 1 following the date on which the cost report was required to be submitted that these costs are incurred pursuant to an agreement or understanding between the facility and the collective bargaining agent.

(b) In any year when a portion of a facility's reported costs are not allowed costs under paragraph (a), when calculating the operating payment rate for the facility, the commissioner shall use the facility's allowed costs from the facility's second most recent cost report in place of the nonallowed costs. For the purpose of setting the other operating payment rate under section 256R.24, subdivision 3, the commissioner shall reduce the other operating payment rate by the difference between the nonallowed costs and the allowed costs from the facility's second most recent cost report.

Subd. 3. **Employer sponsored retirement plans.** In addition to the approved pension or profit-sharing plans allowed by Minnesota Rules, parts 9549.0010 to 9549.0080, the commissioner shall allow those plans specified in Internal Revenue Code, sections 403(b) and 408(k).

Subd. 4. **Workers' compensation insurance costs.** The commissioner shall allow as workers' compensation insurance costs under section 256R.02, subdivision 22, the costs of workers' compensation coverage obtained under the following conditions:

(1) a plan approved by the commissioner of commerce as a Minnesota group or individual self-insurance plan as provided in section 79A.03;

(2) a plan in which:

(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) a related organization to the nursing facility reinsures the workers' compensation coverage purchased, directly or indirectly, by the nursing facility; and

(iii) all of the conditions in clause (4) are met;

(3) a plan in which:

(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) the insurance premium is calculated retrospectively, including a maximum premium limit, and paid using the paid loss retro method; and

(iii) all of the conditions in clause (4) are met;

(4) additional conditions are:

(i) the costs of the plan are allowable under the federal Medicare program;

(ii) the reserves for the plan are maintained in an account controlled and administered by a person which is not a related organization to the nursing facility;

(iii) the reserves for the plan cannot be used, directly or indirectly, as collateral for debts incurred or other obligations of the nursing facility or related organizations to the nursing facility;

(iv) if the plan provides workers' compensation coverage for non-Minnesota nursing facilities, the plan's cost methodology must be consistent among all nursing facilities covered by the plan, and if reasonable, is allowed notwithstanding any reimbursement laws regarding cost allocation to the contrary;

(v) central, affiliated, corporate, or nursing facility costs related to their administration of the plan are costs which must remain in the nursing facility's administrative cost category and must not be allocated to other cost categories;

(vi) required security deposits, whether in the form of cash, investments, securities, assets, letters of credit, or in any other form are not allowable costs for purposes of establishing the facility's payment rate; and

(vii) a group of nursing facilities related by common ownership that self-insures workers' compensation may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are reimbursed under this chapter. The method of cost allocation shall be based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly allocated within each nursing facility's operating cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate method of allocation of self-insurance costs must be received by the commissioner no later than May 1, 1998, to take effect July 1, 1998, or such costs shall continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its workers' compensation self-insurance costs, it shall remain in effect until such time as the group no longer self-insures these costs;

(5) any costs allowed pursuant to clauses (1) to (3) are subject to the following requirements:

(i) if the nursing facility is sold or otherwise ceases operations, the plan's reserves must be subject to an actuarially based settle up after 36 months from the date of sale or the date on which operations ceased. The facility's medical assistance portion of the total excess plan reserves must be paid to the state within 30 days following the date on which excess plan reserves are determined;

(ii) any distribution of excess plan reserves made to or withdrawals made by the nursing facility or a related organization are applicable credits and must be used to reduce the nursing facility's workers' compensation insurance costs in the reporting period in which a distribution or withdrawal is received;

(iii) if reimbursement for the plan is sought under the federal Medicare program, and is audited pursuant to the Medicare program, the nursing facility must provide a copy of Medicare's final audit report, including attachments and exhibits, to the commissioner within 30 days of receipt by the nursing facility or any related organization. The commissioner shall implement the audit findings associated with the plan upon receipt of Medicare's final audit report. The department's authority to implement the audit findings is independent of its authority to conduct a field audit.

Subd. 5. **Salaries and wages.** Salaries and wages must be paid within 30 days of the end of the reporting period in order to be allowable costs of the reporting period.

Subd. 6. **Applicable credits.** Applicable credits must be used to offset or reduce the expenses of the nursing facility to the extent that the cost to which the credits apply was claimed as a nursing facility cost. Interest income, dividend income, and other investment income of the nursing facility or related organization are not applicable credits except to the extent that the interest expense on working capital debt is incurred and claimed as a reimbursable expense by the nursing facility or related organization.

Sec. 11. **[256R.11] NONALLOWED COSTS.**

Subdivision 1. **Generally.** (a) The following costs shall not be recognized as allowable:

(1) political contributions;

(2) salaries or expenses of a lobbyist, as defined in section 10A.01, subdivision 21, for lobbying activities;

(3) advertising designed to encourage potential residents to select a particular nursing facility;

(4) assessments levied by the commissioner of health for uncorrected violations;

(5) legal and related expenses for unsuccessful challenges to decisions by governmental agencies;

(6) memberships in sports, health or similar social clubs or organizations;

(7) costs incurred for activities directly related to influencing employees with respect to unionization; and

(8) costs of providing services which are billed separately from the nursing facility's payment rate or pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475.

(b) The commissioner shall by rule exclude the costs of any other items not directly related to the provision of resident care.

Subd. 2. **Collective bargaining.** Costs incurred for any activities which are directed at or are intended to influence or dissuade employees in the exercise of their legal rights to freely engage in the process of selecting an exclusive representative for the purpose of collective bargaining with their employer shall not be allowable for purposes of setting payment rates.

EFFECTIVE DATE. The grant of rulemaking authority to the commissioner of human services in this section is a continuation of authority previously granted in Minnesota Statutes, section 256B.47, subdivision 1.

Sec. 12. **[256R.12] COST ALLOCATION.**

Subdivision 1. **Allocation; direct identification of costs; management agreement.** All costs that can be directly identified with a specific nursing facility that is a related organization to the central, affiliated, or corporate office, or that is controlled by the central, affiliated, or corporate office under a management agreement, must be allocated to that nursing facility.

Subd. 2. **Allocation; direct identification of costs to other activities.** All costs that can be directly identified with any other activity or function not described in subdivision 1 must be allocated to that activity or function.

Subd. 3. **Cost allocation on a functional basis.** (a) Costs that have not been directly identified must be allocated to nursing facilities on a basis designed to equitably allocate the costs to the nursing facilities or activities receiving the benefits of the costs. This allocation must be made in a manner reasonably related to the services received by the nursing facilities. Where practical and the amounts are material, these costs must be allocated on a functional basis. The functions, or cost centers used to allocate central office costs, and the unit bases used to allocate the costs, including those central office costs allocated according to subdivision 4, must be used consistently from one central office accounting period to another.

(b) If the central office wishes to change its allocation bases and believes the change will result in more appropriate and more accurate allocations, the central office must make a written request, with its justification, to the commissioner for approval of the change no later than 120 days after the beginning of the central office accounting period to which the change is to apply. The commissioner's approval of a central office request must be furnished to the central office in writing. Where the commissioner approves the central office request, the change must be applied to the accounting period for which the request was made, and to all subsequent central office accounting periods unless the commissioner approves a subsequent request for change by the central office. The effective date of the change will be the beginning of the accounting period for which the request was made.

Subd. 4. **Allocation of remaining costs; allocation ratio.** (a) After the costs that can be directly identified according to subdivisions 1 and 2 have been allocated, the remaining central, affiliated, or corporate office costs must be allocated between the nursing facility operations and the other activities or facilities unrelated to the nursing facility operations based on the ratio of total operating costs. However, in the event that these remaining costs are partially attributable to the start-up of home and community-based services intended to fill a gap identified by the local agency, the facility may assign these remaining costs to the appropriate cost category of the facility for a period not to exceed two years.

(b) For purposes of allocating these remaining central, affiliated, or corporate office costs, the numerator for the allocation ratio is determined as follows:

(1) for nursing facilities that are related organizations or are controlled by a central, affiliated, or corporate office under a management agreement, the numerator of the allocation ratio is equal to the sum of the total operating costs incurred by each related organization or controlled nursing facility;

(2) for a central, affiliated, or corporate office providing goods or services to related organizations that are not nursing facilities, the numerator of the allocation ratio is equal to the sum of the total operating costs incurred by the nonnursing facility related organizations;

(3) for a central, affiliated, or corporate office providing goods or services to unrelated nursing facilities under a consulting agreement, the numerator of the allocation ratio is equal to the greater of directly identified central, affiliated, or corporate costs or the contracted amount; or

(4) for business activities that involve the providing of goods or services to unrelated parties which are not nursing facilities, the numerator of the allocation ratio is equal to the greater of directly identified costs or revenues generated by the activity or function.

(c) The denominator for the allocation ratio is the sum of the numerators in paragraph (b), clauses (1) to (4).

Subd. 5. **Cost allocation between nursing facilities.** (a) Nursing operations that have nursing facilities in Minnesota and comparable facilities outside of Minnesota must allocate the nursing operation's central, affiliated, or corporate office costs identified in subdivision 4 to Minnesota, based on the ratio of the sum of the nursing operation's resident days in Minnesota nursing facilities to the sum of the nursing operation's resident days in all its facilities.

(b) The Minnesota nursing operation's central, affiliated, or corporate office costs identified in paragraph (a) must be allocated to each Minnesota nursing facility on the basis of resident days.

Subd. 6. **Related organization costs.** (a) Costs applicable to services, capital assets, and supplies directly or indirectly furnished to the nursing facility by any related organization are includable in the allowable cost of the nursing facility at the purchase price paid by the related organization for capital assets or supplies and at the cost incurred by the related organization for the provision of services to the nursing facility if these prices or costs do not exceed the price of comparable services, capital assets, or supplies that could be purchased elsewhere. For this purpose, the related organization's costs must not include an amount for markup or profit.

(b) If the related organization in the normal course of business sells services, capital assets, or supplies to nonrelated organizations, the cost to the nursing facility is the nonrelated organization's price provided that sales to nonrelated organizations constitute at least 50 percent of total annual sales of similar services, capital assets, or supplies.

(c) The cost of ownership of a capital asset used by the nursing facility must be included in the allowable cost of the nursing facility even though it is owned by a related organization.

Subd. 7. **Receiverships.** This section does not apply to payment rates determined under sections 245A.12, 245A.13, and 256R.52, except that any additional directly identified costs associated with the Department of Human Services' or the Department of Health's managing agent under a receivership agreement must be allocated to the facility under receivership, and are nonallowable costs to the managing agent on the facility's cost reports.

Subd. 8. **Allocation of costs for therapy services; non-hospital-attached facilities.** (a) To ensure the avoidance of double payments as required by section 256R.54, the direct and indirect reporting period costs of providing residents of nursing facilities that are not hospital attached with therapy services that are billed separately from the nursing facility payment rate or according to Minnesota Rules, parts 9505.0170 to 9505.0475, must be determined and deducted from the appropriate cost categories of the annual cost report according to paragraphs (b) to (g).

(b) The costs of wages and salaries for employees providing or participating in providing and consultants providing services shall be allocated to the therapy service based on direct identification.

(c) The costs of fringe benefits and payroll taxes relating to the costs in paragraph (b) must be allocated to the therapy service based on direct identification or the ratio of total costs in paragraph (b) to the sum of total allowable salaries and the costs in paragraph (b).

(d) The costs of housekeeping, plant operations and maintenance, real estate taxes, special assessments, and insurance, other than the amounts classified as a fringe benefit, must be allocated to the therapy service based on the ratio of service area square footage to total facility square footage.

(e) The costs of bookkeeping and medical records must be allocated to the therapy service either by the method in paragraph (f) or based on direct identification. Direct identification may be used if adequate documentation is provided to, and accepted by, the commissioner.

(f) The costs of administrators, bookkeeping, and medical records salaries, except as provided in paragraph (e), must be allocated to the therapy service based on the ratio of the total costs in paragraphs (b) to (e) to the sum of total allowable nursing facility costs and the costs in paragraphs (b) to (e).

(g) The cost of property must be allocated to the therapy service and removed from the nursing facility's property-related payment rate, based on the ratio of service area square footage to total facility square footage multiplied by the property-related payment rate.

Subd. 9. **Allocation of costs for therapy services; hospital-attached facilities.** To ensure the avoidance of double payments as required by section 256R.54, the direct and indirect reporting period costs of providing therapy services to residents of a hospital-attached nursing facility, when the services are billed separately from the nursing facility's payment rate or according to Minnesota Rules, parts 9505.0170 to 9505.0475, must be determined and deducted from the appropriate cost categories of the annual cost report based on the Medicare step-down as prepared in accordance with instructions provided by the commissioner.

Subd. 10. **Allocation of self-insurance costs.** For the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures group health, dental, or life insurance may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are reimbursed under this chapter. The method of cost allocation shall be based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly allocated within each nursing facility's operating cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate method of allocation of self-insurance costs must be received by the commissioner no later than May 1, 1998, to take effect July 1, 1998, or those self-insurance costs shall continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its group health, dental, or life insurance self-insurance costs, it shall remain in effect until such time as the group no longer self-insures these costs.

Sec. 13. **[256R.13] AUDITING REQUIREMENTS.**

Subdivision 1. **Audit authority.** (a) The commissioner shall provide for an audit of the cost and statistical data of nursing facilities participating as vendors of medical assistance. The commissioner shall select for audit at least 15 percent of the nursing facilities' data reported at random or using factors including, but not limited to: data reported to the public as criteria for rating

nursing facilities; data used to set limits for other medical assistance programs or vendors of services to nursing facilities; change in ownership; frequent changes in administration in excess of normal turnover rates; complaints to the commissioner of health about care, safety, or rights; where previous inspections or reinspections under section 144A.10 have resulted in correction orders related to care, safety, or rights; or where persons involved in ownership or administration of the facility have been indicted for alleged criminal activity.

(b) The commissioner shall meet the 15 percent requirement by either conducting an audit focused on an individual nursing facility, a group of facilities, or targeting specific data categories in multiple nursing facilities. These audits may be conducted on site at the nursing facility, at office space used by a nursing facility or a nursing facility's parent organization, or at the commissioner's office. Data being audited may be collected electronically, in person, or by any other means the commissioner finds acceptable.

Subd. 2. **Desk and field audits of statistical and cost reports.** (a) The commissioner may subject reports and supporting documentation to desk and field audits to determine compliance with this chapter. Retroactive adjustments shall be made as a result of desk or field audit findings if the cumulative impact of the finding would result in a rate adjustment of at least 0.15 percent of the statewide weighted average operating payment rate as determined in section 256R.09, subdivision 6. If a field audit reveals inadequacies in a nursing facility's record keeping or accounting practices, the commissioner may require the nursing facility to engage competent professional assistance to correct those inadequacies within 90 days so that the field audit may proceed.

(b) Field audits may cover the four most recent annual statistical and cost reports for which desk audits have been completed and payment rates have been established. The field audit must be an independent review of the nursing facility's statistical and cost report. All transactions, invoices, or other documentation that support or relate to the statistics and costs claimed on the annual statistical and cost reports are subject to review by the field auditor. If the provider fails to provide the field auditor access to supporting documentation related to the information reported on the statistical and cost report within the time period specified by the commissioner, the commissioner shall calculate the total payment rate by disallowing the cost of the items for which access to the supporting documentation is not provided.

(c) Changes in the total payment rate which result from desk or field audit adjustments to statistical and cost reports for reporting periods earlier than the four most recent annual cost reports must be made to the four most recent annual statistical and cost reports, the current statistical and cost report, and future statistical and cost reports to the extent that those adjustments affect the total payment rate established by those reporting years.

Subd. 3. **Audit adjustments.** If the commissioner requests supporting documentation during an audit for an item of cost reported by a nursing facility, and the nursing facility's response does not adequately document the item of cost, the commissioner may make reasoned assumptions considered appropriate in the absence of the requested documentation to reasonably establish a payment rate rather than disallow the entire item of cost. This subdivision shall not diminish the nursing facility's appeal rights.

Subd. 4. **Extended record retention requirements.** The commissioner shall extend the period for retention of records under section 256R.09, subdivision 3, for purposes of performing field audits as necessary to enforce sections 256R.04; 256R.05, subdivision 2; 256R.06, subdivisions 2, 6, and 7; 256R.08, subdivisions 1 to 3; and 256R.09, subdivisions 3 and 4, with written notice to

the facility postmarked no later than 90 days prior to the expiration of the record retention requirement.

Sec. 14. **[256R.16] QUALITY OF CARE.**

Subdivision 1. **Calculation of a quality score.** (a) The commissioner shall determine a quality score for each nursing facility using quality measures established in section 256B.439, according to methods determined by the commissioner in consultation with stakeholders and experts, and using the most recently available data as provided in the Minnesota Nursing Home Report Card. These methods shall be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score shall be determined with the number of points assigned as determined by the commissioner using the methodology established according to this subdivision. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

(c) The quality score shall include up to 50 points related to the Minnesota quality indicators score derived from the minimum data set, up to 40 points related to the resident quality of life score derived from the consumer survey conducted under section 256B.439, subdivision 3, and up to ten points related to the state inspection results score.

(d) The commissioner, in cooperation with the commissioner of health, may adjust the formula in paragraph (c), or the methodology for computing the total quality score, effective July 1 of any year, with five months advance public notice. In changing the formula, the commissioner shall consider quality measure priorities registered by report card users, advice of stakeholders, and available research.

Subd. 2. **Monitoring quality of care.** If an annual cost report or field audit indicates that expenditures for direct resident care have been reduced in amounts large enough to indicate a possible detrimental effect on the quality of care, the commissioner shall notify the commissioner of health.

EFFECTIVE DATE. Subdivision 1, paragraph (d), is effective February 1, 2017.

Sec. 15. **[256R.17] CASE MIX.**

Subdivision 1. **Case mix classifications.** The case mix classifications shall be those established under section 144.0724.

Subd. 2. **Case mix indices.** (a) The commissioner shall assign a case mix index to each case mix classification based on the Centers for Medicare and Medicaid Services staff time measurement study.

(b) An index maximization approach shall be used to classify residents. "Index maximization" has the meaning given in section 144.0724, subdivision 2, paragraph (c).

Subd. 3. **Resident assessment schedule.** (a) Nursing facilities shall conduct and submit case mix classification assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

(b) The case mix classifications established under section 144.0724, subdivision 3a, shall be effective the day of admission for new admission assessments. The effective date for significant

change assessments shall be the assessment reference date. The effective date for annual and quarterly assessments shall be the first day of the month following assessment reference date.

Subd. 4. **Notice of resident reimbursement case mix classification.** Nursing facilities shall provide notice to a resident of the resident's case mix classification according to procedures established by the commissioner of health under section 144.0724, subdivision 7.

Subd. 5. **Reconsideration of resident case mix classification.** Any request for reconsideration of a resident case mix classification must be made under section 144.0724, subdivision 8.

RATE STRUCTURE/RATE CALCULATION

Sec. 16. **[256R.21] TOTAL PAYMENT RATE.**

Subdivision 1. **Total payment rates.** For each facility, the commissioner shall calculate a total payment rate using the statistical and cost report filed by each nursing facility for the reporting period ending 15 months prior to the rate year.

The total payment rates are the total payment rates in effect on the first day of the rate year, unless another date is specified.

Subd. 2. **Determination of total care-related payment rates.** A facility's total care-related payment rate is the sum of:

(1) its direct care payment rate as determined in section 256R.23, subdivision 7; and

(2) its other care-related payment rate as determined in section 256R.23, subdivision 8.

A facility's total care-related payment rate is its total care-related payment rate associated with a case mix index of 1.00.

Subd. 3. **Determination of operating payment rates.** A facility's operating payment rate is the sum of:

(1) its total care-related payment rate as determined in subdivision 2; and

(2) its other operating payment rate as determined in section 256R.24.

A facility's operating payment rate is its operating payment rate associated with a case mix index of 1.00.

Subd. 4. **Determination of total payment rates.** A facility's total payment rate is the sum of:

(1) its operating payment rate as determined in subdivision 3;

(2) its external fixed costs payment rate as determined in section 256R.25; and

(3) its property payment rate as determined in section 256R.26.

A facility's total payment rate is its total payment rate associated with a case mix index of 1.00.

Sec. 17. **[256R.22] CASE MIX ADJUSTED TOTAL PAYMENT RATE.**

Subdivision 1. **Case mix adjusted payment rates generally.** For each facility, the commissioner shall calculate case mix adjusted payment rates for each case mix classification.

Subd. 2. **Determination of case mix adjusted total care-related payment rates.** A facility's case mix adjusted total care-related payment rate for each case mix classification is the sum of:

(1) its direct care payment rate as determined in section 256R.23, subdivision 7, multiplied by the case mix index; and

(2) its other care-related payment rate as determined in section 256R.23, subdivision 8.

Subd. 3. **Determination of case mix adjusted operating payment rates.** A facility's case mix adjusted operating payment rate for each case mix classification is the sum of:

(1) its case mix adjusted total care-related payment rate as determined in subdivision 2; and

(2) its other operating payment rate as determined in section 256R.24.

Subd. 4. **Determination of case mix adjusted total payment rates.** A facility's case mix adjusted total payment rate for each case mix classification is the sum of:

(1) its case mix adjusted operating payment rate as determined in subdivision 3;

(2) its external fixed costs payment rate as determined in section 256R.25; and

(3) its property payment rate as determined in section 256R.26.

Sec. 18. **[256R.23] TOTAL CARE-RELATED PAYMENT RATES.**

Subdivision 1. **Determination of total care-related cost per day.** Each facility's total care-related cost per day is the sum of its direct care cost per standardized day and its other care-related cost per resident day.

Subd. 2. **Calculation of direct care cost per standardized day.** Each facility's direct care cost per standardized day is the facility's direct care costs divided by the sum of the facility's standardized days. A facility's direct care cost per standardized day is the facility's cost per day for direct care services associated with a case mix index of 1.00.

Subd. 3. **Calculation of other care-related cost per resident day.** Each facility's other care-related cost per resident day is its other care-related costs, divided by the sum of the facility's resident days.

Subd. 4. **Determination of the median total care-related cost per day.** The commissioner must determine the median total care-related cost per day using the cost reports from nursing facilities in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

Subd. 5. **Determination of total care-related payment rate limits.** The commissioner must determine each facility's total care-related payment rate limit by:

(1) multiplying the facility's quality score, as determined under section 256R.16, subdivision 1, by 0.5625;

(2) adding 89.375 to the amount determined in clause (1), and dividing the total by 100; and

(3) multiplying the amount determined in clause (2) by the median total care-related cost per day.

Subd. 6. **Payment rate limit reduction.** No facility shall be subject in any rate year to a care-related payment rate limit reduction greater than five percent of the median determined in subdivision 4.

Subd. 7. **Determination of direct care payment rates.** A facility's direct care payment rate equals the lesser of (1) the facility's direct care costs per standardized day, or (2) the facility's direct care costs per standardized day divided by its cost to limit ratio.

Subd. 8. **Determination of other care-related payment rates.** A facility's other care-related payment rate equals the lesser of (1) the facility's other care-related cost per resident day, or (2) the facility's other care-related cost per resident day divided by its cost to limit ratio.

Subd. 9. **Determination of total care-related payment rates.** A facility's total care-related payment rate is the sum of its direct care payment rate as determined in subdivision 7 and its other care-related payment rate as determined in subdivision 8.

Sec. 19. **[256R.24] OTHER OPERATING PAYMENT RATE.**

Subdivision 1. **Determination of other operating cost per day.** Each facility's other operating cost per day is its other operating costs divided by the sum of the facility's resident days.

Subd. 2. **Determination of the median other operating cost per day.** The commissioner must determine the median other operating cost per day using the cost reports from nursing facilities in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

Subd. 3. **Determination of the other operating payment rate.** A facility's other operating payment rate equals 105 percent of the median other operating cost per day.

Sec. 20. **[256R.25] EXTERNAL FIXED COSTS PAYMENT RATE.**

(a) The payment rate for external fixed costs is the sum of the amounts in paragraphs (b) to (m).

(b) For a facility licensed as a nursing home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day. For a facility licensed as both a nursing home and a boarding care home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(c) The portion related to the licensure fee under section 144.122, paragraph (d), is the amount of the fee divided by the sum of the facility's resident days.

(d) The portion related to development and education of resident and family advisory councils under section 144A.33 is $5 per resident day divided by 365.

(e) The portion related to scholarships is determined under section 256R.37.

(f) The portion related to planned closure rate adjustments is as determined under section 256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.

(g) The portion related to single-bed room incentives is as determined under section 256R.41.

(h) The portions related to real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility are the actual amounts divided

by the sum of the facility's resident days. Allowable costs under this paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes.

(i) The portion related to employer health insurance costs is the allowable costs divided by the sum of the facility's resident days.

(j) The portion related to the Public Employees Retirement Association is actual costs divided by the sum of the facility's resident days.

(k) The portion related to quality improvement incentive payment rate adjustments is the amount determined under section 256R.39.

(l) The portion related to performance-based incentive payments is the amount determined under section 256R.38.

(m) The portion related to special dietary needs is the amount determined under section 256R.51.

Sec. 21. **[256R.26] PROPERTY PAYMENT RATE.**

The property payment rate for a nursing facility is the property rate established for the facility under sections 256B.431 and 256B.434.

Sec. 22. **[256R.32] APPEALS.**

Nursing facilities may appeal, as described under section 256B.50, the determination of a payment rate established under this chapter.

ADJUSTMENTS AND ADD-ONS TO THE TOTAL PAYMENT RATE

Sec. 23. **[256R.36] HOLD HARMLESS.**

No nursing facility's operating payment rate, plus its employer health insurance costs portion of the external fixed costs payment rate, will be less than its prior system operating cost payment rate.

Sec. 24. **[256R.37] SCHOLARSHIPS.**

(a) For the 27-month period beginning October 1, 2015, through December 31, 2017, the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing facility with no scholarship per diem that is requesting a scholarship per diem to be added to the external fixed payment rate to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least ten hours per week at the facility except the administrator, and to reimburse student loan expenses for newly hired and recently graduated registered nurses and licensed practical nurses, and training expenses

for nursing assistants as defined in section 144A.611, subdivision 2, who are newly hired and have graduated within the last 12 months; and

(ii) the course of study is expected to lead to career advancement with the facility or in long-term care, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) All facilities may annually request a rate adjustment under this section by submitting information to the commissioner on a schedule and in a form supplied by the commissioner. The commissioner shall allow a scholarship payment rate equal to the reported and allowable costs divided by resident days.

(c) In calculating the per diem under paragraph (b), the commissioner shall allow costs related to tuition, direct educational expenses, and reasonable costs as defined by the commissioner for child care costs and transportation expenses related to direct educational expenses.

(d) The rate increase under this section is an optional rate add-on that the facility must request from the commissioner in a manner prescribed by the commissioner. The rate increase must be used for scholarships as specified in this section.

(e) For instances in which a rate adjustment will be 15 cents or greater, nursing facilities that close beds during a rate year may request to have their scholarship adjustment under paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect the reduction in resident days compared to the cost report year.

Sec. 25. **[256R.38] PERFORMANCE-BASED INCENTIVE PAYMENTS.**

The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit proposals and select those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this section to operate the incentive payments within funds appropriated for this purpose. The commissioner shall approve proposals through a memorandum of understanding which shall specify various levels of payment for various levels of performance. Incentive payments to facilities under this section shall be in the form of time-limited rate adjustments which shall be included in the external fixed payment rate under section 256R.25. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Minnesota Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Sec. 26. **[256R.39] QUALITY IMPROVEMENT INCENTIVE PROGRAM.**

The commissioner shall develop a quality improvement incentive program in consultation with stakeholders. The annual funding pool available for quality improvement incentive payments shall be equal to 0.8 percent of all operating payments, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under section 256R.48, critical access nursing facility program participation under section 256R.47, or performance-based incentive payment program participation under section 256R.38. For the period from October 1, 2015, to December 31, 2016, rate adjustments provided under this section shall be effective for 15 months. Beginning January 1, 2017, annual rate adjustments provided under this section shall be effective for one rate year.

Sec. 27. **[256R.40] NURSING FACILITY VOLUNTARY CLOSURE; ALTERNATIVES.**

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Closure" means the cessation of operations of a nursing facility and delicensure and decertification of all beds within the facility.

(c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of the resulting savings to provide planned closure rate adjustments at other facilities.

(d) "Commencement of closure" means the date on which residents and designated representatives are notified of a planned closure as provided in section 144A.161, subdivision 5a, as part of an approved closure plan.

(e) "Completion of closure" means the date on which the final resident of the nursing facility designated for closure in an approved closure plan is discharged from the facility.

(f) "Partial closure" means the delicensure and decertification of a portion of the beds within the facility.

(g) "Planned closure rate adjustment" means an increase in a nursing facility's operating rates resulting from a planned closure or a planned partial closure of another facility.

Subd. 2. **Applications for planned closure rate.** (a) To be considered for approval of a planned closure, an application must include:

(1) a description of the proposed closure plan, which must include identification of the facility or facilities to receive a planned closure rate adjustment;

(2) the proposed timetable for any proposed closure, including the proposed dates for announcement to residents, commencement of closure, and completion of closure;

(3) if available, the proposed relocation plan for current residents of any facility designated for closure. If a relocation plan is not available, the application must include a statement agreeing to develop a relocation plan designed to comply with section 144A.161;

(4) a description of the relationship between the nursing facility that is proposed for closure and the nursing facility or facilities proposed to receive the planned closure rate adjustment. If these facilities are not under common ownership, copies of any contracts, purchase agreements, or other documents establishing a relationship or proposed relationship must be provided; and

(5) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a planned closure rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan.

(b) The application must also address the criteria listed in subdivision 3.

Subd. 3. **Criteria for review of application.** In reviewing and approving closure proposals, the commissioner shall consider, but not be limited to, the following criteria:

(1) improved quality of care and quality of life for consumers;

(2) closure of a nursing facility that has a poor physical plant;

(3) the existence of excess nursing facility beds, measured in terms of beds per thousand persons aged 85 or older. The excess must be measured in reference to:

(i) the county in which the facility is located. A facility in a county that is in the lowest quartile of counties with reference to beds per thousand persons aged 85 or older is not in an area of excess capacity;

(ii) the county and all contiguous counties;

(iii) the region in which the facility is located; or

(iv) the facility's service area. The facility shall indicate in its application the service area it believes is appropriate for this measurement;

(4) low-occupancy rates, provided that the unoccupied beds are not the result of a personnel shortage. In analyzing occupancy rates, the commissioner shall examine waiting lists in the applicant facility and at facilities in the surrounding area, as determined under clause (3);

(5) evidence of coordination between the community planning process and the facility application. If the planning group does not support a level of nursing facility closures that the commissioner considers to be reasonable, the commissioner may approve a planned closure proposal without its support;

(6) proposed usage of funds available from a planned closure rate adjustment for care-related purposes;

(7) innovative use planned for the closed facility's physical plant;

(8) evidence that the proposal serves the interests of the state; and

(9) evidence of other factors that affect the viability of the facility, including excessive nursing pool costs.

Subd. 4. **Review and approval of applications.** (a) The commissioner, in consultation with the commissioner of health, shall approve or deny an application within 30 days after receiving it. The commissioner may appoint an advisory review panel composed of representatives of counties, consumers, and providers to review proposals and provide comments and recommendations to the committee. The commissioners of human services and health shall provide staff and technical assistance to the committee for the review and analysis of proposals.

(b) Approval of a planned closure expires 18 months after approval by the commissioner unless commencement of closure has begun.

(c) The commissioner may change any provision of the application to which the applicant, the regional planning group, and the commissioner agree.

Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the amount of the planned closure rate adjustment available under subdivision 6 according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's external fixed payment rate.

(c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to paragraph (a).

(e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased.

Subd. 6. **Assignment of closure rate to another facility.** A facility or facilities reimbursed under this chapter with a closure plan approved by the commissioner under subdivision 4 may assign a planned closure rate adjustment to another facility or facilities that are not closing or in the case of a partial closure, to the facility undertaking the partial closure. A facility may also elect to have a planned closure rate adjustment shared equally by the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that is closing is located. The planned closure rate adjustment must be calculated under subdivision 5. Facilities that delicense beds without a closure plan, or whose closure plan is not approved by the commissioner, are not eligible to assign a planned closure rate adjustment under subdivision 5, unless they: (1) are delicensing five or fewer beds, or less than six percent of their total licensed bed capacity, whichever is greater; (2) are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older; and (3) have not delicensed beds in the prior three months. Facilities meeting these criteria are eligible to assign the amount calculated under subdivision 5 to themselves. If a facility is delicensing the greater of six or more beds, or six percent or more of its total licensed bed capacity, and does not have an approved closure plan or is not eligible for the adjustment under subdivision 5, the commissioner shall calculate the amount

the facility would have been eligible to assign under subdivision 5, and shall use this amount to provide equal rate adjustments to the five nursing facilities with the lowest total operating payment rates in the state development region designated under section 462.385, in which the facility that delicensed beds is located.

Subd. 7. **Other rate adjustments.** Facilities receiving planned closure rate adjustments remain eligible for any applicable rate adjustments provided under this chapter.

Sec. 28. **[256R.41] SINGLE-BED ROOM INCENTIVE.**

(a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this chapter shall be increased by 20 percent multiplied by the ratio of the number of new single-bed rooms created divided by the number of active beds on July 1, 2005, for each bed closure that results in the creation of a single-bed room after July 1, 2005. The commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each year. For eligible bed closures for which the commissioner receives a notice from a facility during a calendar quarter that a bed has been delicensed and a new single-bed room has been established, the rate adjustment in this paragraph shall be effective on the first day of the second month following that calendar quarter.

(b) A nursing facility is prohibited from discharging residents for purposes of establishing single-bed rooms. A nursing facility must submit documentation to the commissioner in a form prescribed by the commissioner, certifying the occupancy status of beds closed to create single-bed rooms. In the event that the commissioner determines that a facility has discharged a resident for purposes of establishing a single-bed room, the commissioner shall not provide a rate adjustment under paragraph (a).

Sec. 29. **[256R.42] RATE ADJUSTMENT FOR THE FIRST 30 DAYS.**

(a) During the first 30 calendar days after admission, the total payment rate for a case mix classification must be increased by 20 percent. Beginning with the 31st calendar day after admission, the total payment rate is the rate otherwise determined under this chapter.

(b) The enhanced rates under this section shall not be allowed if a resident has resided during the previous 30 calendar days in:

(1) the same nursing facility;

(2) a nursing facility owned or operated by a related party; or

(3) a nursing facility or part of a facility that closed or was in the process of closing.

Sec. 30. **[256R.43] BED HOLDS.**

The commissioner shall limit payment for leave days in a nursing facility to 30 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 96 percent, notwithstanding Minnesota Rules, part 9505.0415.

Sec. 31. **[256R.44] RATE ADJUSTMENT FOR PRIVATE ROOMS FOR MEDICAL NECESSITY.**

The amount paid for a private room is 111.5 percent of the established total payment rate for a resident if the resident is a medical assistance recipient and the private room is considered a medical necessity for the resident or others who are affected by the resident's condition, except as provided in Minnesota Rules, part 9549.0060, subpart 11, item C. Conditions requiring a private room must be determined by the resident's attending physician and submitted to the commissioner for approval or denial by the commissioner on the basis of medical necessity.

Sec. 32. **[256R.45] RATE ADJUSTMENT FOR VENTILATOR-DEPENDENT PERSONS.**

The commissioner may negotiate with a nursing facility eligible to receive medical assistance payments to provide services to a ventilator-dependent person identified by the commissioner according to criteria developed by the commissioner, including:

(1) nursing facility care has been recommended for the person by a preadmission screening team;

(2) the person has been hospitalized and no longer requires inpatient acute care hospital services; and

(3) the commissioner has determined that necessary services for the person cannot be provided under existing nursing facility rates.

The commissioner may negotiate an adjustment to the operating payment rate for a nursing facility with a resident who is ventilator-dependent, for that resident. The negotiated adjustment must reflect only the actual additional cost of meeting the specialized care needs of a ventilator-dependent person identified by the commissioner for whom necessary services cannot be provided under existing nursing facility rates and which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or 9505.0170 to 9505.0475. The negotiated payment rate must not exceed 300 percent of the case mix adjusted operating payment rate for the highest case mix classification. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256R.06, subdivision 2.

Sec. 33. **[256R.46] SPECIALIZED CARE FACILITIES.**

(a) The total care-related payment rate limit for specialized care facilities shall be increased by 50 percent.

(b) "Specialized care facilities" are defined as a facility having a program licensed under chapter 245A and Minnesota Rules, chapter 9570, or a facility with 96 beds on January 1, 2015, located in Robbinsdale that specializes in the treatment of Huntington's Disease.

Sec. 34. **[256R.47] RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING FACILITIES.**

(a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. To the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;

(2) enhanced payments for leave days. Notwithstanding section 256R.43, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health shall consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and

(5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to designated critical access nursing facilities.

(d) Designation of a critical access nursing facility is for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

(e) This section is suspended and no state or federal funding shall be appropriated or allocated for the purposes of this section from January 1, 2016, to December 31, 2017.

Sec. 35. **[256R.48] PUBLICLY OWNED FACILITIES.**

(a) The commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local governmental entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply are eligible to select an operating payment rate with a case mix index of 1.00, up to an amount determined by the commissioner to be allowable under the Medicare upper payment limit test. The case mix adjusted rates shall be computed under section 256R.22. The rate increase allowed in this paragraph shall take effect only upon federal approval.

(b) Rates determined under this section shall take effect in accordance with the rate year in section 256R.02, subdivision 41, based on the most recent available cost report.

(c) Eligible nursing facilities that wish to participate under this section shall make an application to the commissioner by September 30 to be allowed participation on the following January 1.

(d) For each participating nursing facility, the public entity that owns the physical plant or is the license holder of the nursing facility shall pay to the state the entire nonfederal share of medical assistance payments received as a result of the difference between the nursing facility's payment rate under this section, and the rates that the nursing facility would otherwise be paid without application of this section under section 256R.21 as determined by the commissioner.

(e) The commissioner may, at any time, reduce the payments under this section based on the commissioner's determination that the payments shall cause nursing facility rates to exceed the state's Medicare upper payment limit or any other federal limitation. If the commissioner determines a reduction is necessary, the commissioner shall reduce all payment rates for participating nursing facilities by a percentage applied to the amount of increase they would otherwise receive under this section and shall notify participating facilities of the reductions. If payments to a nursing facility are reduced, payments under section 256B.19, subdivision 1e, shall be reduced accordingly.

Sec. 36. **[256R.49] RATE ADJUSTMENTS FOR COMPENSATION-RELATED COSTS FOR MINIMUM WAGE CHANGES.**

Subdivision 1. **Rate adjustments for compensation-related costs.** (a) Operating payment rates of all nursing facilities that are reimbursed under this chapter shall be increased effective for rate years beginning on and after October 1, 2014, to address changes in compensation costs for nursing facility employees paid less than $14 per hour in accordance with this section.

(b) Nursing facilities that receive approval of the applications in subdivision 2 must receive rate adjustments according to subdivision 4. The rate adjustments must be used to pay compensation costs for nursing facility employees paid less than $14 per hour.

Subd. 2. **Application process.** To receive a rate adjustment, nursing facilities must submit applications to the commissioner in a form and manner determined by the commissioner. The applications for the rate adjustments shall include specified data, and spending plans that describe how the funds from the rate adjustments will be allocated for compensation to employees paid less than $14 per hour. The applications must be submitted within three months of the effective date of any operating payment rate adjustment under this section. The commissioner may request any additional information needed to determine the rate adjustment within three weeks of receiving a complete application. The nursing facility must provide any additional information requested by the commissioner within six months of the effective date of any operating payment rate adjustment under this section. The commissioner may waive the deadlines in this section under extraordinary circumstances.

Subd. 3. **Additional application requirements for facilities with employees represented by an exclusive bargaining representative.** For nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the applications submitted under subdivision 2 only upon receipt of a letter or letters of acceptance of the spending plans in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after

May 31, 2014. Upon receipt of the letter or letters of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

Subd. 4. **Determination of the rate adjustments for compensation-related costs.** Based on the application in subdivision 2, the commissioner shall calculate the allowable annualized compensation costs by adding the totals of clauses (1), (2), and (3). The result must be divided by the standardized or resident days from the most recently available cost report to determine per day amounts, which must be included in the operating portion of the total payment rate and allocated to direct care or other operating as determined by the commissioner:

(1) the sum of the difference between $9.50 and any hourly wage rate less than $9.50 for October 1, 2016; and between the indexed value of the minimum wage, as defined in section 177.24, subdivision 1, paragraph (f), and any hourly wage less than that indexed value for rate years beginning on and after October 1, 2017; multiplied by the number of compensated hours at that wage rate;

(2) using wages and hours in effect during the first three months of calendar year 2014, beginning with the first pay period beginning on or after January 1, 2014; 22.2 percent of the sum of items (i) to (viii) for October 1, 2016;

(i) for all compensated hours from $8 to $8.49 per hour, the number of compensated hours is multiplied by $0.13;

(ii) for all compensated hours from $8.50 to $8.99 per hour, the number of compensated hours is multiplied by $0.25;

(iii) for all compensated hours from $9 to $9.49 per hour, the number of compensated hours is multiplied by $0.38;

(iv) for all compensated hours from $9.50 to $10.49 per hour, the number of compensated hours is multiplied by $0.50;

(v) for all compensated hours from $10.50 to $10.99 per hour, the number of compensated hours is multiplied by $0.40;

(vi) for all compensated hours from $11 to $11.49 per hour, the number of compensated hours is multiplied by $0.30;

(vii) for all compensated hours from $11.50 to $11.99 per hour, the number of compensated hours is multiplied by $0.20; and

(viii) for all compensated hours from $12 to $13 per hour, the number of compensated hours is multiplied by $0.10; and

(3) the sum of the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, pensions, and contributions to employee retirement accounts attributable to the amounts in clauses (1) and (2).

Sec. 37. **[256R.50] BED RELOCATIONS.**

Subdivision 1. **Method for determining budget-neutral nursing facility rates for relocated beds.** Nursing facility rates for bed relocations must be calculated by comparing the estimated medical assistance costs prior to and after the proposed bed relocation using the calculations in this

section. All payment rates are based on a case mix index of 1.0, with other case mix adjusted rates determined accordingly. Nursing facility beds on layaway status that are being moved must be included in the calculation for both the originating and receiving facility and treated as though they were in active status with the occupancy characteristics of the active beds of the originating facility.

Subd. 2. **Determination of costs in originating facility.** Medical assistance costs of the beds in the originating nursing facilities must be calculated as follows:

(1) multiply each originating facility's total payment rate for a case mix index of 1.0 by the facility's percentage of medical assistance days on its most recent available cost report;

(2) take the products in clause (1) and multiply by each facility's average case mix index for medical assistance residents on its most recent available cost report;

(3) take the products in clause (2) and multiply by the number of beds being relocated, times 365; and

(4) calculate the sum of the amounts determined in clause (3).

Subd. 3. **Determination of costs in receiving facility.** Medical assistance costs in the receiving facility, prior to the bed relocation, must be calculated as follows:

(1) multiply the facility's total payment rate for a case mix index of 1.0 by the medical assistance days on the most recent cost report; and

(2) multiply the product in clause (1) by the facility average case mix index of medical assistance residents on the most recent cost report.

Subd. 4. **Determination of costs prior to relocation.** The commissioner shall determine the medical assistance costs prior to the bed relocation which must be the sum of the amounts determined in subdivisions 2 and 3.

Subd. 5. **Estimation of costs after bed relocation.** The commissioner shall estimate the medical assistance costs after the bed relocation as follows:

(1) estimate the medical assistance days in the receiving facility after the bed relocation. The commissioner may use the current medical assistance portion, or if data does not exist, may use the statewide average, or may use the provider's estimate of the medical assistance utilization of the relocated beds;

(2) estimate the receiving facility's average case mix index of medical assistance residents after the bed relocation. The commissioner may use current facility average case mix index or, if data does not exist, may use the statewide average case mix index, or may use the provider's estimate of the facility average case mix index; and

(3) multiply the amount determined in clause (1) by the amount determined in clause (2) by the total payment rate for a case mix index of 1.0 that is the highest rate of the facilities from which the relocated beds either originate or to which they are being relocated so long as that rate is associated with ten percent or more of the total number of beds to be in the receiving facility after the bed relocation.

Subd. 6. **Determination of rate adjustment.** (a) If the amount determined in subdivision 5 is less than or equal to the amount determined in subdivision 4, the commissioner shall allow a total payment rate equal to the amount used in subdivision 5, clause (3).

(b) If the amount determined in subdivision 5 is greater than the amount determined in subdivision 4, the commissioner shall allow a rate with a case mix index of 1.0 that when used in subdivision 5, clause (3), results in the amount determined in subdivision 5 being equal to the amount determined in subdivision 4.

(c) If the commissioner relies upon provider estimates in subdivision 5, clause (1) or (2), then annually, for three years after the rates determined in this section take effect, the commissioner shall determine the accuracy of the alternative factors of medical assistance case load and the facility average case mix index used in this section and shall reduce the total payment rate if the factors used result in medical assistance costs exceeding the amount in subdivision 4. If the actual medical assistance costs exceed the estimates by more than five percent, the commissioner shall also recover the difference between the estimated costs in subdivision 5 and the actual costs according to section 256B.0641. The commissioner may require submission of data from the receiving facility needed to implement this paragraph.

(d) When beds approved for relocation are put into active service at the destination facility, rates determined in this section must be adjusted by any adjustment amounts that were implemented after the date of the letter of approval.

Sec. 38. **[256R.51] ADJUSTMENT FOR SPECIAL DIETARY NEEDS.**

(a) The commissioner shall adjust the rates of a nursing facility that meets the criteria for the special dietary needs of its residents and the requirements in section 31.651 or 31.658. The adjustment for raw food cost shall be the difference between the nursing facility's most recently reported allowable raw food cost per resident day and 115 percent of the median allowable raw food cost per resident day. This amount shall be removed from other care-related costs per resident day as determined in section 256R.23, subdivision 3, and included in the external fixed costs payment rate under section 256R.25.

(b) In calculating a nursing facility's other care-related costs per day for the purposes of comparing to an array, a median, or other statistical measure of nursing facility payment rates used to determine future rate adjustments under this chapter, the commissioner shall exclude adjustments for raw food costs under this section.

Sec. 39. **[256R.52] NURSING FACILITY RECEIVERSHIP FEES.**

Subdivision 1. **Payment of receivership fees.** (a) When the commissioner of health notifies the commissioner of human services that a nursing facility is subject to the receivership provisions under section 144A.15 and provides a recommendation in accordance with section 144A.154, the commissioner in consultation with the commissioner of health may establish a receivership fee that is added to a nursing facility payment. The commissioner shall reduce the requested amount by any amounts the commissioner determines are included in the nursing facility's payment rate and that are not specifically required to be paid for expenditures of the nursing facility.

A receivership fee shall be set according to paragraphs (b) and (c) and payment shall be according to paragraphs (d) to (f).

(b) The receivership fee per day shall be determined and revised as necessary by dividing the estimated amount of needed additional funding or actual additional costs of the receivership by the estimated resident days for the projected duration of the receivership.

(c) The receivership fee per day shall be added to the nursing facility's payment rate.

(d) Notification of the payment rate increase must meet the requirements of section 256R.06, subdivisions 5.

(e) The payment rate in paragraph (c) for a nursing facility is effective the first day of the receivership.

(f) The commissioner may elect to make a lump-sum payment of a portion of the receivership fee to the receiver or managing agent. In this case, the commissioner and the receiver or managing agent shall agree to a repayment plan. Regardless of whether the commissioner makes a lump-sum payment under this paragraph, the provisions of paragraphs (b) to (e) apply.

Subd. 2. **Sale or transfer of a nursing facility in receivership after closure.** (a) Upon the subsequent sale or transfer of a nursing facility in receivership, the commissioner shall seek to recover from the prior licensee any amounts paid through payment rate adjustments under subdivision 1. The prior licensee shall repay this amount to the commissioner within 60 days after the commissioner notifies the prior licensee of the obligation to repay.

(b) The commissioner may recover amounts paid through the receivership fee by means of withholding from the prior licensee payments related to any other medical assistance provider of the prior licensee in Minnesota. The prior licensee must also repay private-pay residents the amount the private-pay resident paid for the receivership fee.

(c) If a nursing facility with payment rates determined under subdivision 1 is later sold while the nursing facility is in receivership, the payment rates in effect prior to the receivership shall be the new owner's payment rates. The commissioner shall apply to these rates any rate adjustment provided to other nursing facilities for which the facility is qualified.

(d) The commissioner may adjust, reclassify, or disallow costs reported for a facility that was in receivership for periods of a reporting period during which the receivership was in effect and for the prior year.

Sec. 40. **[256R.53] FACILITY SPECIFIC EXEMPTIONS.**

Subdivision 1. **Nursing facility in Golden Valley.** The operating payment rate for a facility located in the city of Golden Valley at 3915 Golden Valley Road with 44 licensed rehabilitation beds as of January 7, 2015, is the sum of its direct care costs per standardized day, its other care-related costs per resident day, and its other operating costs per day.

Subd. 2. **Nursing facility in Breckenridge.** The operating payment rate of a nonprofit nursing facility that exists on January 1, 2015, is located within the boundaries of the city of Breckenridge, and is reimbursed under this chapter, is equal to the greater of:

(1) the operating payment rate determined under section 256R.21, subdivision 3; or

(2) the median case mix adjusted rates, including comparable rate components as determined by the median case mix adjusted rates, including comparable rate components as determined by the commissioner, for the equivalent case mix indices of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities contiguous to the adjacent city. The Minnesota facility's operating payment rate with a case mix index of 1.0 is computed by dividing the adjacent city's nursing facility or facilities' median operating payment rate with an index of 1.02 by 1.02.

PAYMENTS FOR SERVICES BILLED SEPARATELY

Sec. 41. **[256R.54] ANCILLARY SERVICES.**

Subdivision 1. **Setting payment; monitoring use of therapy services.** (a) The commissioner shall adopt rules under the Administrative Procedure Act to set the amount and method of payment for ancillary materials and services provided to recipients residing in nursing facilities. Payment for materials and services may be made to either the vendor of ancillary services pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475, or to a nursing facility pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475.

(b) Payment for the same or similar service to a recipient shall not be made to both the nursing facility and the vendor. The commissioner shall ensure: (1) the avoidance of double payments through audits and adjustments to the nursing facility's annual cost report as required by section 256R.12, subdivisions 8 and 9; and (2) that charges and arrangements for ancillary materials and services are cost-effective and as would be incurred by a prudent and cost-conscious buyer.

(c) Therapy services provided to a recipient must be medically necessary and appropriate to the medical condition of the recipient. If the vendor, nursing facility, or ordering physician cannot provide adequate medical necessity justification, as determined by the commissioner, the commissioner may recover or disallow the payment for the services and may require prior authorization for therapy services as a condition of payment or may impose administrative sanctions to limit the vendor, nursing facility, or ordering physician's participation in the medical assistance program. If the provider number of a nursing facility is used to bill services provided by a vendor of therapy services that is not related to the nursing facility by ownership, control, affiliation, or employment status, no withholding of payment shall be imposed against the nursing facility for services not medically necessary except for funds due the unrelated vendor of therapy services as provided in subdivision 5. For the purpose of this subdivision, no monetary recovery may be imposed against the nursing facility for funds paid to the unrelated vendor of therapy services as provided in subdivision 5, for services not medically necessary.

(d) For purposes of this section and section 256R.12, subdivisions 8 and 9, therapy includes physical therapy, occupational therapy, speech therapy, audiology, and mental health services that are covered services according to Minnesota Rules, parts 9505.0170 to 9505.0475.

(e) For purposes of this subdivision, "ancillary services" includes transportation defined as a covered service in section 256B.0625, subdivision 17.

Subd. 2. **Certification that treatment is appropriate.** The physical therapist, occupational therapist, speech therapist, mental health professional, or audiologist who provides or supervises the provision of therapy services, other than an initial evaluation, to a medical assistance recipient must certify in writing that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient every 30 days. The therapist's statement of certification must be maintained in the recipient's medical record together with the specific orders by the physician and the treatment plan. If the recipient's medical record does not include these documents, the commissioner may recover or disallow the payment for such services. If the therapist determines that the therapy's nature, scope, duration, or intensity is not appropriate to the medical condition of the recipient, the therapist must provide a statement to that effect in writing to the nursing facility for inclusion in the recipient's medical record. The commissioner shall make recommendations regarding the medical necessity of services provided.

Subd. 3. **Separate billings for therapy services; nursing facility provider number.** Payment for therapy services provided to nursing facility residents that are billed separate from nursing facility's payment rate or according to Minnesota Rules, parts 9505.0170 to 9505.0475, shall be subject to the requirements in this subdivision and subdivisions 4 to 8.

The practitioner invoice must include, in a format specified by the commissioner, the provider number of the nursing facility where the medical assistance recipient resides regardless of the service setting.

Subd. 4. **Separate billings for therapy services; related vendors.** Nursing facilities that are related by ownership, control, affiliation, or employment status to the vendor of therapy services shall report, in a format specified by the commissioner, the revenues received during the reporting period for therapy services provided to residents of the nursing facility. The commissioner shall offset the revenues received during the reporting period for therapy services provided to residents of the nursing facility to the total payment rate of the nursing facility by dividing the amount of offset by the sum of the nursing facility's resident days. Except as specified in subdivisions 6 and 8, the amount of offset shall be the revenue in excess of 108 percent of the cost removed from the cost report resulting from the requirement of the commissioner to ensure the avoidance of double payments as determined by section 256R.12, subdivisions 8 and 9.

Subd. 5. **Separate billings for therapy services; unrelated vendors.** Nursing facilities shall limit charges in total to vendors of therapy services for renting space, equipment, or obtaining other services during the rate year to 108 percent of the annualized cost removed from the reporting period cost report resulting from the requirement of the commissioner to ensure the avoidance of double payments as determined by section 256R.12, subdivisions 8 and 9. If the arrangement for therapy services is changed so that a nursing facility is subject to this subdivision instead of subdivision 4, the cost that is used to determine rent must be adjusted to exclude the annualized costs for therapy services that are not provided in the rate year. The maximum charges to the vendors shall be based on the commissioner's determination of annualized cost and may be subsequently adjusted upon resolution of appeals.

Subd. 6. **Separate billings for therapy services; cost to revenue ratio.** The commissioner shall require reporting of all revenues relating to the provision of therapy services and shall establish a therapy cost, as determined by section 256R.12, subdivisions 8 and 9, to revenue ratio for the reporting period ending in 1986. For subsequent reporting periods the ratio may increase five percentage points in total until a new base year is established under subdivision 7. Increases in excess of five percentage points may be allowed if adequate justification is provided to and accepted by the commissioner. Unless an exception is allowed by the commissioner, the amount of offset in subdivision 4 is the greater of the amount determined in subdivision 4 or the amount of offset that is imputed based on one minus the lesser of (1) the actual reporting period ratio or (2) the base reporting period ratio increased by five percentage points, multiplied by the revenues.

Subd. 7. **Separate billings for therapy services; base year.** The commissioner may establish a new base reporting period for determining the cost to revenue ratio.

Subd. 8. **Separate billings for therapy services; transition from unrelated to related vendor.** If the arrangement for therapy services is changed so that a nursing facility is subject to the provisions of subdivision 4 instead of subdivision 5, an average cost to revenue ratio based on the ratios of nursing facilities that are subject to the provisions of subdivision 4 shall be imputed for subdivision 6.

Subd. 9. **Separate billings for therapy services; prohibited practices.** This section does not allow unrelated nursing facilities to reorganize related organization therapy services and provide services among themselves to avoid offsetting revenues. Nursing facilities that are found to be in violation of this provision are subject to the penalty requirements of section 256R.04, subdivision 5.

EFFECTIVE DATE. The grant of rulemaking authority to the commissioner of human services in this section is a continuation of authority previously granted in Minnesota Statutes, section 256B.433, subdivision 1.

Sec. 42. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall make necessary cross-reference changes and remove statutory cross-references in Minnesota Statutes and Minnesota Rules to conform with the recodification and repealer in this act. The revisor may make technical and other necessary changes to sentence structure to preserve the meaning of the text. The revisor may alter the statutory coding in this act to incorporate statutory changes made by other law in the 2016 regular legislative session. If a provision repealed in this act is also amended in the 2016 regular legislative session by other law, the revisor shall merge the amendment into the recodification, notwithstanding Minnesota Statutes, section 645.30.

Sec. 43. **REPEALER.**

(a) Minnesota Statutes 2014, sections 256B.0911, subdivision 7; 256B.25, subdivision 4; 256B.27, subdivision 2a; 256B.41, subdivisions 1, 2, and 3; 256B.411, subdivisions 1 and 2; 256B.421, subdivisions 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15; 256B.431, subdivisions 1, 2d, 2e, 2n, 2r, 2s, 2t, 3e, 32, 35, 42, and 44; 256B.432, subdivisions 1, 2, 3, 4, 4a, 5, 6, 6a, 7, and 8; 256B.433, subdivisions 1, 2, 3, and 3a; 256B.434, subdivisions 2, 9, 11, 12, 14, 15, 16, 18, 19a, 20, and 21; 256B.437, subdivisions 1, 3, 4, 5, 6, 7, 9, and 10; 256B.438, subdivisions 1, 2, 3, 4, 5, 6, 7, and 8; 256B.441, subdivisions 2, 3, 4, 7, 8, 9, 10, 11, 15, 18, 20, 22, 23, 24, 25, 27, 28a, 29, 32, 33a, 34, 36, 37, 38, 39, 41, 42a, 43, 46b, 47, 49, 57, 59, 60, 61, and 64; 256B.47, subdivisions 1, 2, 3, and 4; and 256B.48, subdivisions 1, 1a, 1b, 1c, 3, 4, 5, 6a, 7, and 8, are repealed.

(b) Minnesota Statutes 2015 Supplement, sections 256B.431, subdivisions 2b and 36; 256B.441, subdivisions 1, 5, 6, 11a, 13, 14, 17, 30, 31, 33, 35, 40, 44, 46c, 46d, 48, 50, 51, 51a, 51b, 53, 54, 55a, 56, 63, 65, 66, and 67; and 256B.495, subdivisions 1 and 5, are repealed.

(c) Minnesota Rules, parts 9549.0035, subparts 1, 3, 7, and 8; 9549.0041, subpart 6; 9549.0055, subparts 1, 2, and 3; and 9549.0070, subparts 2 and 3, are repealed.

ARTICLE 2

CONFORMING CHANGES

Section 1. Minnesota Statutes 2014, section 144A.071, subdivision 2, is amended to read:

Subd. 2. **Moratorium.** The commissioner of health, in coordination with the commissioner of human services, shall deny each request for new licensed or certified nursing home or certified boarding care beds except as provided in subdivision 3 or 4a, or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the

purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq. Certified beds in facilities which do not allow medical assistance intake shall be deemed to be decertified for purposes of this section only.

The commissioner of human services, in coordination with the commissioner of health, shall deny any request to issue a license under section 252.28 and chapter 245A to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

In addition, the commissioner of health must not approve any construction project whose cost exceeds $1,000,000, unless:

(a) any construction costs exceeding $1,000,000 are not added to the facility's appraised value and are not included in the facility's payment rate for reimbursement under the medical assistance program; or

(b) the project:

(1) has been approved through the process described in section 144A.073;

(2) meets an exception in subdivision 3 or 4a;

(3) is necessary to correct violations of state or federal law issued by the commissioner of health;

(4) is necessary to repair or replace a portion of the facility that was damaged by fire, lightning, ground shifts, or other such hazards, including environmental hazards, provided that the provisions of subdivision 4a, clause (a), are met;

(5) as of May 1, 1992, the facility has submitted to the commissioner of health written documentation evidencing that the facility meets the "commenced construction" definition as specified in subdivision 1a, clause (d), or that substantial steps have been taken prior to April 1, 1992, relating to the construction project. "Substantial steps" require that the facility has made arrangements with outside parties relating to the construction project and include the hiring of an architect or construction firm, submission of preliminary plans to the Department of Health or documentation from a financial institution that financing arrangements for the construction project have been made; or

(6) is being proposed by a licensed nursing facility that is not certified to participate in the medical assistance program and will not result in new licensed or certified beds.

Prior to the final plan approval of any construction project, the commissioner of health shall be provided with an itemized cost estimate for the project construction costs. If a construction project is anticipated to be completed in phases, the total estimated cost of all phases of the project shall be submitted to the commissioner and shall be considered as one construction project. Once the construction project is completed and prior to the final clearance by the commissioner, the total project construction costs for the construction project shall be submitted to the commissioner. If the final project construction cost exceeds the dollar threshold in this subdivision, the commissioner of human services shall not recognize any of the project construction costs or the related financing costs in excess of this threshold in establishing the facility's property-related payment rate.

The dollar thresholds for construction projects are as follows: for construction projects other than those authorized in clauses (1) to (6), the dollar threshold is $1,000,000. For projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost estimate submitted with a proposal

for an exception under section 144A.073, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project construction costs submitted to the commissioner of health at the time of final plan approval, plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

The commissioner of health shall adopt rules to implement this section or to amend the emergency rules for granting exceptions to the moratorium on nursing homes under section 144A.073.

Sec. 2. Minnesota Statutes 2015 Supplement, section 144A.15, subdivision 6, is amended to read:

Subd. 6. **Postreceivership period; facility remaining open.** ~~(a)~~ If a facility remains open after the receivership is concluded, a new operator is only legally responsible under state law for its actions after the receivership has concluded.

~~(b) The commissioner of human services may adjust, reclassify, or disallow costs reported for a facility that was in receivership for periods of a reporting year during which the receivership was in effect and for the prior year.~~

Sec. 3. Minnesota Statutes 2014, section 256B.0625, is amended by adding a subdivision to read:

Subd. 57a. **Payment limitation for Medicare-covered skilled nursing facility stays.** For services rendered on or after July 1, 2003, for facilities reimbursed under this chapter or chapter 256R, the Medicaid program shall only pay a co-payment during a Medicare-covered skilled nursing facility stay if the Medicare rate less the resident's co-payment responsibility is less than the case mix adjusted total payment rate under chapter 256R. The amount that shall be paid by the Medicaid program is equal to the amount by which the case mix adjusted total payment rate exceeds the Medicare rate less the co-payment responsibility. Health plans paying for nursing home services under section 256B.69, subdivision 6a, may limit payments as allowed under this subdivision.

Sec. 4. Minnesota Statutes 2014, section 256B.19, subdivision 1e, is amended to read:

Subd. 1e. **Additional local share of certain nursing facility costs.** ~~Beginning October 1, 2011,~~ Participating local governmental entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section ~~256B.441, subdivision 55a~~ 256R.48, shall be responsible for paying the portion of nonfederal costs calculated under section ~~256B.441, subdivision 55a, paragraph (c)~~ 256R.48, paragraph (d). Payments of the nonfederal share shall be submitted to the commissioner by the 15th day of the month prior to payment to the nursing facility for that month's services. If any participating governmental entity obligated to pay an amount under this subdivision does not make timely payment of the monthly installment, the commissioner shall revoke participation under this subdivision and end payments determined under section ~~256B.441, subdivision 55a~~ 256R.48, to the participating nursing facility effective on the first day of the month for which timely payment was not received. In the event of revocation, the nursing facility may not bill, collect, or retain the amount allowed in section ~~256B.441, subdivision 55a~~ 256R.48, from private-pay residents for days of service on or after the first day of the month following the month in which the revocation occurred.

Sec. 5. Minnesota Statutes 2014, section 256B.431, subdivision 22, is amended to read:

Subd. 22. **Changes to nursing facility reimbursement.** ~~The nursing facility reimbursement changes in paragraphs (a) to (d) apply to Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, and are effective for rate years beginning on or after July 1, 1993, unless otherwise indicated.~~

~~(a) In addition to the approved pension or profit-sharing plans allowed by the reimbursement rule, the commissioner shall allow those plans specified in Internal Revenue Code, sections 403(b) and 408(k).~~

~~(b) The commissioner shall allow as workers' compensation insurance costs under section 256B.421, subdivision 14, the costs of workers' compensation coverage obtained under the following conditions:~~

~~(1) a plan approved by the commissioner of commerce as a Minnesota group or individual self-insurance plan as provided in section 79A.03;~~

~~(2) a plan in which:~~

~~(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;~~

~~(ii) a related organization to the nursing facility reinsures the workers' compensation coverage purchased, directly or indirectly, by the nursing facility; and~~

~~(iii) all of the conditions in clause (4) are met;~~

~~(3) a plan in which:~~

~~(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;~~

~~(ii) the insurance premium is calculated retrospectively, including a maximum premium limit, and paid using the paid loss retro method; and~~

~~(iii) all of the conditions in clause (4) are met;~~

~~(4) additional conditions are:~~

~~(i) the costs of the plan are allowable under the federal Medicare program;~~

~~(ii) the reserves for the plan are maintained in an account controlled and administered by a person which is not a related organization to the nursing facility;~~

~~(iii) the reserves for the plan cannot be used, directly or indirectly, as collateral for debts incurred or other obligations of the nursing facility or related organizations to the nursing facility;~~

~~(iv) if the plan provides workers' compensation coverage for non-Minnesota nursing facilities, the plan's cost methodology must be consistent among all nursing facilities covered by the plan, and if reasonable, is allowed notwithstanding any reimbursement laws regarding cost allocation to the contrary;~~

~~(v) central, affiliated, corporate, or nursing facility costs related to their administration of the plan are costs which must remain in the nursing facility's administrative cost category and must not be allocated to other cost categories;~~

~~(vi) required security deposits, whether in the form of cash, investments, securities, assets, letters of credit, or in any other form are not allowable costs for purposes of establishing the facilities payment rate; and~~

~~(vii) for the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures workers' compensation may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are reimbursed under this section or section 256B.434. The method of cost allocation shall be based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly allocated within each nursing facility's operating cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate method of allocation of self-insurance costs must be received by the commissioner no later than May 1, 1998, to take effect July 1, 1998, or such costs shall continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its workers' compensation self-insurance costs, it shall remain in effect until such time as the group no longer self-insures these costs;~~

~~(5) any costs allowed pursuant to clauses (1) to (3) are subject to the following requirements:~~

~~(i) if the nursing facility is sold or otherwise ceases operations, the plan's reserves must be subject to an actuarially based settle up after 36 months from the date of sale or the date on which operations ceased. The facility's medical assistance portion of the total excess plan reserves must be paid to the state within 30 days following the date on which excess plan reserves are determined;~~

~~(ii) any distribution of excess plan reserves made to or withdrawals made by the nursing facility or a related organization are applicable credits and must be used to reduce the nursing facility's workers' compensation insurance costs in the reporting period in which a distribution or withdrawal is received;~~

~~(iii) if reimbursement for the plan is sought under the federal Medicare program, and is audited pursuant to the Medicare program, the nursing facility must provide a copy of Medicare's final audit report, including attachments and exhibits, to the commissioner within 30 days of receipt by the nursing facility or any related organization. The commissioner shall implement the audit findings associated with the plan upon receipt of Medicare's final audit report. The department's authority to implement the audit findings is independent of its authority to conduct a field audit.~~

~~(e)~~ In the determination of incremental increases in the nursing facility's rental rate as required in subdivisions 14 to 21, except for a refinancing permitted under subdivision 19, the commissioner must adjust the nursing facility's property-related payment rate for both incremental increases and decreases in recomputations of its rental rate~~;~~.

~~(d) A nursing facility's administrative cost limitation must be modified as follows:~~

~~(1) if the nursing facility's licensed beds exceed 195 licensed beds, the general and administrative cost category limitation shall be 13 percent;~~

~~(2) if the nursing facility's licensed beds are more than 150 licensed beds, but less than 196 licensed beds, the general and administrative cost category limitation shall be 14 percent; or~~

~~(3) if the nursing facility's licensed beds is less than 151 licensed beds, the general and administrative cost category limitation shall remain at 15 percent.~~

~~(c) For the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures group health, dental, or life insurance may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are reimbursed under this section or section 256B.434. The method of cost allocation shall be based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly allocated within each nursing facility's operating cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate method of allocation of self-insurance costs must be received by the commissioner no later than May 1, 1998, to take effect July 1, 1998, or those self-insurance costs shall continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its group health, dental, or life insurance self-insurance costs, it shall remain in effect until such time as the group no longer self-insures these costs.~~

Sec. 6. Minnesota Statutes 2014, section 256B.434, subdivision 10, is amended to read:

Subd. 10. **Exemptions.** ~~(a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.~~

~~(b)~~ A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this ~~paragraph~~ subdivision. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this ~~paragraph~~ subdivision that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost of the project. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project from seeking legislative approval of an exception to the moratorium under section 144A.071, and, if enacted, the facility's rates shall be adjusted to reflect the cost of the project.

~~(c) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the Centers for Medicare and Medicaid Services otherwise~~

~~requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.~~

~~(d) A facility that is under contract with the commissioner under this section shall be allowed to change therapy arrangements from an unrelated vendor to a related vendor during the term of the contract. The commissioner may develop reasonable requirements designed to prevent an increase in therapy utilization for residents enrolled in the medical assistance program.~~

~~(e) Nursing facilities participating in the alternative payment system demonstration project must either participate in the alternative payment system quality improvement program established by the commissioner or submit information on their own quality improvement process to the commissioner for approval. Nursing facilities that have had their own quality improvement process approved by the commissioner must report results for at least one key area of quality improvement annually to the commissioner.~~

Sec. 7. Minnesota Statutes 2014, section 256B.48, subdivision 2, is amended to read:

Subd. 2. **Reporting requirements.** (a) No later than December 31 of each year, ~~a skilled nursing facility or~~ an intermediate care facility, including boarding care facilities, which receives medical assistance payments or other reimbursements from the state agency shall:

(1) provide the state agency with a copy of its audited financial statements~~. The audited financial statements must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statement of cash flows, notes to the financial statements, audited applicable supplemental information, and the certified public accountant's or licensed public accountant's opinion. The examination by the certified public accountant or licensed public accountant shall be conducted in accordance with generally accepted auditing standards as promulgated and adopted by the American Institute of Certified Public Accountants. Beginning with the reporting year which begins October 1, 1992, a nursing facility is no longer required to have a certified audit of its financial statements. The cost of a certified audit shall not be an allowable cost in that reporting year, nor in subsequent reporting years unless the nursing facility submits its certified audited financial statements in the manner otherwise specified in this subdivision. A nursing facility which does not submit a certified audit must submit its working trial balance~~;

(2) provide the state agency with a statement of ownership for the facility;

(3) provide the state agency with separate, audited financial statements ~~as specified in clause (1)~~ for every other facility owned in whole or part by an individual or entity which has an ownership interest in the facility;

(4) upon request, provide the state agency with separate, audited financial statements ~~as specified in clause (1)~~ for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

(5) provide the state agency with copies of leases, purchase agreements, and other documents related to the lease or purchase of the ~~nursing~~ facility; and

(6) upon request, provide the state agency with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs~~; and~~.

~~(7) permit access by the state agency to the certified public accountant's and licensed public accountant's audit work papers which support the audited financial statements required in clauses (1), (3), and (4).~~

(b) Audited financial statements submitted under paragraph (a) must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statement of cash flows, notes to the financial statements, audited applicable supplemental information, and the certified public accountant's report. Certified public accountants must conduct audits in accordance with chapter 326A. The cost of an audit shall not be an allowable cost unless the intermediate care facility submits its audited financial statements in the manner otherwise specified in this subdivision. An intermediate care facility must permit access by the state agency to the certified public accountant's work papers that support the audited financial statements submitted under paragraph (a).

(c) Documents or information provided to the state agency pursuant to this subdivision shall be public.

(d) If the requirements of ~~clauses (1) to (7)~~ paragraphs (a) and (b) are not met, the reimbursement rate may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting ~~year,~~ period and the reduction shall continue until the requirements are met.

(e) ~~Both nursing facilities and~~ Intermediate care facilities for the developmentally disabled must maintain statistical and accounting records in sufficient detail to support information contained in the facility's cost report for at least six years, including the year following the submission of the cost report. For computerized accounting systems, the records must include copies of electronically generated media such as magnetic discs and tapes.

Sec. 8. Minnesota Statutes 2014, section 256B.48, subdivision 3a, is amended to read:

Subd. 3a. **Audit adjustments.** If the commissioner requests supporting documentation during an audit for an item of cost reported by ~~a long-term care~~ an intermediate care facility, and the ~~long-term care~~ facility's response does not adequately document the item of cost, the commissioner may make reasoned assumptions considered appropriate in the absence of the requested documentation to reasonably establish a payment rate rather than disallow the entire item of cost. This provision shall not diminish the ~~long-term care~~ facility's appeal rights.

Sec. 9. Minnesota Statutes 2014, section 256B.50, subdivision 1a, is amended to read:

Subd. 1a. **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

~~(a)~~ (b) "Determination of a payment rate" means the process by which the commissioner establishes the payment rate paid to a provider pursuant to this chapter, including determinations made in desk audit, field audit, or pursuant to an amendment filed by the provider.

~~(b)~~ (c) "Provider" means a nursing facility as defined in section ~~256B.421, subdivision 7~~ 256R.02, subdivision 33, or a facility as defined in section 256B.501, subdivision 1.

~~(c) "Reimbursement rules" means Minnesota Rules, parts 9510.0010 to 9510.0480, 9510.0500 to 9510.0890, and rules adopted by the commissioner pursuant to sections 256B.41 and 256B.501, subdivision 3.~~

(d) The definitions in section 256R.02 apply to this section.

Sec. 10. Minnesota Statutes 2015 Supplement, section 256I.05, subdivision 2, is amended to read:

Subd. 2. **Monthly rates; exemptions.** This subdivision applies to a residence that on August 1, 1984, was licensed by the commissioner of health only as a boarding care home, certified by the commissioner of health as an intermediate care facility, and licensed by the commissioner of human services under Minnesota Rules, parts 9520.0500 to 9520.0690. Notwithstanding the provisions of subdivision 1c, the rate paid to a facility reimbursed under this subdivision shall be determined under ~~section 256B.431, 256B.434, or 256B.441~~ chapter 256R, if the facility is accepted by the commissioner for participation in the alternative payment demonstration project. The rate paid to this facility shall also include adjustments to the group residential housing rate according to subdivision 1, and any adjustments applicable to supplemental service rates statewide.

Presented to the governor May 9, 2016

Signed by the governor May 12, 2016, 1:22 p.m.