

256B.441 VALUE-BASED NURSING FACILITY REIMBURSEMENT SYSTEM.

Subdivision 1. **Rebasing of nursing facility operating payment rates.** (a) The commissioner shall rebase nursing facility operating payment rates to align payments to facilities with the cost of providing care. The rebased operating payment rates shall be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year.

(b) The new operating payment rates based on this section shall take effect beginning with the rate year beginning October 1, 2008, and shall be phased in over eight rate years through October 1, 2015. For each year of the phase-in, the operating payment rates shall be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year.

(c) Operating payment rates shall be rebased on October 1, 2016, and every two years after that date.

(d) Each cost reporting year shall begin on October 1 and end on the following September 30. Beginning in 2006, a statistical and cost report shall be filed by each nursing facility by January 15. Notice of rates shall be distributed by August 15 and the rates shall go into effect on October 1 for one year.

(e) Effective October 1, 2014, property rates shall be rebased in accordance with section 256B.431 and Minnesota Rules, chapter 9549. The commissioner shall determine what the property payment rate for a nursing facility would be had the facility not had its property rate determined under section 256B.434. The commissioner shall allow nursing facilities to provide information affecting this rate determination that would have been filed annually under Minnesota Rules, chapter 9549, and nursing facilities shall report information necessary to determine allowable debt. The commissioner shall use this information to determine the property payment rate.

Subd. 2. **Definitions.** For purposes of this section, the terms in subdivisions 3 to 42a have the meanings given unless otherwise provided for in this section.

Subd. 3. **Active beds.** "Active beds" means licensed beds that are not currently in layaway status.

Subd. 4. **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. 5. **Administrative costs.** "Administrative costs" means the direct 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 11, voice and data communication or transmission, office supplies, 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 director's fees, working capital interest expense, and bad debts and bad debt collection fees.

Subd. 6. **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 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 section and generally accepted accounting principles. All references to costs in this section shall be assumed to refer to allowed costs.

Subd. 7. **Center for Medicare and Medicaid services.** "Center 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. 8. **Commissioner.** "Commissioner" means the commissioner of human services unless specified otherwise.

Subd. 9. **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. 10. **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. 11. **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. 12. [Repealed, 2007 c 147 art 7 s 76]

Subd. 13. **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; long-term care consultation fees under section 256B.0911, subdivision 6; family advisory council fee under section 144A.33; scholarships under section 256B.431, subdivision 36; planned closure rate adjustments under section 256B.437; or single bed room incentives under section 256B.431, subdivision 42; property taxes and property insurance; and PERA.

Subd. 14. **Facility average case mix index.** "Facility average case mix index" or "CMI" means a numerical value score that describes the relative resource use for all residents within the groups under the resource utilization group (RUG-III) 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 total days for all residents in the facility. The RUG's weights used in this section shall be as follows for each RUG's class: SE3 1.605; SE2

1.247; SE1 1.081; RAD 1.509; RAC 1.259; RAB 1.109; RAA 0.957; SSC 1.453; SSB 1.224; SSA 1.047; CC2 1.292; CC1 1.200; CB2 1.086; CB1 1.017; CA2 0.908; CA1 0.834; IB2 0.877; IB1 0.817; IA2 0.720; IA1 0.676; BB2 0.956; BB1 0.885; BA2 0.716; BA1 0.673; PE2 1.199; PE1 1.104; PD2 1.023; PD1 0.948; PC2 0.926; PC1 0.860; PB2 0.786; PB1 0.734; PA2 0.691; PA1 0.651; BC1 0.651; and DDF 1.000.

Subd. 14a. **Facility type groups.** Facilities shall be classified into two groups, called "facility type groups," which shall consist of:

(1) C&NC/R80: facilities that are hospital-attached, or are licensed under Minnesota Rules, parts 9570.2000 to 9570.3400; and

(2) freestanding: all other facilities.

Subd. 15. **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. 16. [Repealed, 2007 c 147 art 7 s 76]

Subd. 17. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life, health, dental, workers' compensation, and other employee insurances and pension, profit sharing, and retirement plans for which the employer pays all or a portion of the costs.

Subd. 18. **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. 19. **Hospital-attached nursing facility status.** (a) For the purpose of setting rates under this section, for rate years beginning after September 30, 2006, "hospital-attached nursing facility" means a nursing facility which meets the requirements of clauses (1) and (2); or (3); or (4), or had hospital-attached status prior to January 1, 1995, and has been recognized as having hospital-attached status by CMS continuously since that date:

(1) the nursing facility is recognized by the federal Medicare program to be a hospital-based nursing facility;

(2) the hospital and nursing facility are physically attached or connected by a corridor;

(3) a nursing facility and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year, shall be considered a hospital-attached nursing facility for purposes of setting payment rates under this section. The nursing facility must file its cost report for that reporting year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital-based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the definition requirements in clauses (1) and (2). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility according to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility;

(4) if a nonprofit or community-operated hospital and attached nursing facility suspend operation of the hospital, the remaining nursing facility must be allowed to continue its status as hospital-attached for rate calculations in the three rate years subsequent to the one in which the hospital ceased operations.

(b) The nursing facility's cost report filed as hospital-attached facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program. Direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

Subd. 20. **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. 21. [Repealed, 2007 c 147 art 7 s 76]

Subd. 22. **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. 23. **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. 24. **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 direct 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. 25. **Normalized direct care costs per day.** "Normalized direct care costs per day" means direct care costs divided by standardized days. It is the costs per day for direct care services associated with a RUG's index of 1.00.

Subd. 26. [Repealed, 2007 c 147 art 7 s 76]

Subd. 27. **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. 28. [Repealed, 2007 c 147 art 7 s 76]

Subd. 28a. **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. 29. **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. 30. **Peer groups.** Facilities shall be classified into three groups by county. The groups shall consist of:

(1) group one: facilities in Anoka, Benton, Carlton, Carver, Chisago, Dakota, Dodge, Goodhue, Hennepin, Isanti, Mille Lacs, Morrison, Olmsted, Ramsey, Rice, Scott, Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright County;

(2) group two: facilities in Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay, Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard, Itasca, Kanabec, Koochiching, Lake,

Lake of the Woods, Le Sueur, Martin, McLeod, Meeker, Mower, Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan, or Wilkin County; and

(3) group three: facilities in all other counties.

Subd. 31. **Prior system operating cost payment rate.** "Prior system operating cost payment rate" means the operating cost payment rate in effect on September 30, 2008, under Minnesota Rules and Minnesota Statutes, not including planned closure rate adjustments under section 256B.437 or single bed room incentives under section 256B.431, subdivision 42.

Subd. 32. **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. 33. **Rate year.** "Rate year" means the 12-month period beginning on October 1 following the second most recent reporting year.

Subd. 33a. **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. 34. **Related organization.** "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 (a) to (d) apply.

(a) "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.

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

(c) "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.

(d) "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. 35. **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.

Subd. 36. **Resident day or actual resident day.** "Resident day" or "actual 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. 37. **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. 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. 38. **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. 39. **Stakeholders.** "Stakeholders" means individuals and representatives of organizations interested in long-term care, including nursing homes, consumers, and labor unions.

Subd. 40. **Standardized days.** "Standardized days" means the sum of resident days by case mix category multiplied by the RUG index for each category.

Subd. 41. **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. 42. [Repealed, 2007 c 147 art 7 s 76]

Subd. 42a. **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. 43. **Reporting of statistical and cost information.** (a) Beginning in 2006, all nursing facilities shall provide information annually to the commissioner on a form and in a manner determined by the commissioner. 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 section 256B.432. The commissioner may grant to facilities one extension of up to 15 days for the filing of this report if the extension is requested by December 15 and the commissioner determines that the extension will not prevent the commissioner from establishing rates in a timely manner required by law. 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 section. 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 subdivision 47. 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.

(b) 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. The commissioner shall make retroactive adjustments to the total payment rate of a nursing facility if an amendment is accepted. Where a retroactive adjustment is to be 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 item does not include a nursing facility's determination that an election between permissible alternatives was not advantageous and should be changed.

(c) 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.

Subd. 44. 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. These methods shall be exempt from the rulemaking requirements under chapter 14.

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

(c) For the initial rate year under the new payment system, the quality measures shall include:

- (1) staff turnover;
- (2) staff retention;
- (3) use of pool staff;
- (4) quality indicators from the minimum data set; and
- (5) survey deficiencies.

(d) For rate years beginning after October 1, 2006, when making revisions to the quality measures or method for calculating scores, the commissioner shall publish the methodology in the State Register at least 15 months prior to the start of the rate year for which the revised methodology is to be used for rate-setting purposes. The quality score used to determine payment rates shall be established for a rate year using data submitted in the statistical and cost report from the associated reporting year, and using data from other sources related to a period beginning no more than six months prior to the associated reporting year.

Subd. 45. [Repealed, 2007 c 147 art 7 s 76]

Subd. 46. Calculation of quality add-on. The payment rate for the quality add-on shall be a variable amount based on each facility's quality score.

(a) For the rate year beginning October 1, 2006, the maximum quality add-on percent shall be 2.4 percent and this add-on shall not be subject to a phase-in. The determination of the quality

score to be used in calculating the quality add-on for October 1, 2006, shall be based on a report which must be filed with the commissioner, according to the requirements in subdivision 43, for a six-month period ending January 31, 2006. This report shall be filed with the commissioner by February 28, 2006. The commissioner shall prorate the six months of data to a full year. When new quality measures are incorporated into the quality score methodology and when existing quality measures are updated or improved, the commissioner may increase the maximum quality add-on percent.

(b) For each facility, determine the operating payment rate.

(c) For each facility determine a ratio of the quality score of the facility determined in subdivision 44, less 40 and then divided by 60. If this value is less than zero, use the value zero.

(d) For each facility, the quality add-on shall be the value determined in paragraph (b) times the value determined in paragraph (c) times the maximum quality add-on percent.

Subd. 46a. Calculation of quality add-on for the rate year beginning October 1, 2007. (a) The payment rate for the rate year beginning October 1, 2007, for the quality add-on, is a variable amount based on each facility's quality score. For the rate year, the maximum quality add-on is .3 percent of the operating payment rate in effect on September 30, 2007. The commissioner shall determine the quality add-on for each facility according to paragraphs (b) to (d).

(b) For each facility, the commissioner shall determine the operating payment rate in effect on September 30, 2007.

(c) For each facility, the commissioner shall determine a ratio of the quality score of the facility determined in subdivision 44, subtract 40, and then divide by 60. If this value is less than zero, the commissioner shall use the value zero.

(d) For each facility, the quality add-on is the value determined in paragraph (b), multiplied by the value determined in paragraph (c), multiplied by .3 percent.

Subd. 47. Audit authority. (a) The commissioner may subject reports and supporting documentation to desk and field audits to determine compliance with this section. 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. 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 years 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.

(d) The commissioner shall extend the period for retention of records under subdivision 43 for purposes of performing field audits as necessary to enforce section 256B.48 with written notice to the facility postmarked no later than 90 days prior to the expiration of the record retention requirement.

Subd. 48. Calculation of operating per diems. The direct care per diem for each facility shall be the facility's direct care costs divided by its standardized days. The other care-related per diem shall be the sum of the facility's activities costs, other direct care costs, raw food costs, therapy costs, and social services costs, divided by the facility's resident days. The other operating per diem shall be the sum of the facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by the facility's resident days.

Subd. 49. Determination of total care-related per diem. The total care-related per diem for each facility shall be the sum of the direct care per diem and the other care-related per diem.

Subd. 50. Determination of total care-related limit. (a) The limit on the total care-related per diem shall be determined for each peer group and facility type group combination. A facility's total care-related per diems shall be limited to 120 percent of the median for the facility's peer and facility type group. The facility-specific direct care costs used in making this comparison and in the calculation of the median shall be based on a RUG's weight of 1.00. A facility that is above that limit shall have its total care-related per diem reduced to the limit. If a reduction of the total care-related per diem is necessary because of this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem.

(b) Beginning with rates determined for October 1, 2016, the total care-related limit shall be a variable amount based on each facility's quality score, as determined under section 256B.441, subdivision 44, in accordance with clauses (1) to (4):

(1) for each facility, the commissioner shall determine the quality score, subtract 40, divide by 40, and convert to a percentage;

(2) if the value determined in clause (1) is less than zero, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group;

(3) if the value determined in clause (1) is greater than 100 percent, the total care-related limit shall be 125 percent of the median for the facility's peer and facility type group; and

(4) if the value determined in clause (1) is greater than zero and less than 100 percent, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group plus one-fifth of the percentage determined in clause (1).

Subd. 50a. Determination of proximity adjustments. (a) For a nursing facility located in close proximity to another nursing facility of the same facility group type but in a different peer group and that has higher limits for care-related or other operating costs, the commissioner shall adjust the limits in accordance with clauses (1) to (4):

(1) determine the difference between the limits;

(2) determine the distance between the two facilities, by the shortest driving route. If the distance exceeds 20 miles, no adjustment shall be made;

(3) subtract the value in clause (2) from 20 miles, divide by 20, and convert to a percentage; and

(4) increase the limits for the nursing facility with the lower limits by the value determined in clause (1) multiplied by the value determined in clause (3).

(b) Effective October 1, 2011, nursing facilities located no more than one-quarter mile from a peer group with higher limits under either subdivision 50 or 51, may receive an operating rate adjustment. The operating payment rates of a lower-limit peer group facility must be adjusted to be equal to those of the nearest facility in a higher-limit peer group if that facility's RUG rate with a weight of 1.00 is higher than the lower-limit peer group facility. Peer groups are those defined in subdivision 30. The nearest facility must be determined by the most direct driving route.

Subd. 51. Determination of other operating limit. The limit on the other operating per diem shall be determined for each peer group. A facility's other operating per diem shall be limited to 105 percent of the median for its peer group. A facility that is above that limit shall have its other operating per diem reduced to the limit.

Subd. 51a. Exception allowing contracting for specialized care. (a) For rate years beginning on or after October 1, 2016, the commissioner may negotiate increases to the care-related limit for nursing facilities that provide specialized care, at a cost to the general fund not to exceed \$600,000 per year. The commissioner shall publish a request for proposals annually, and may negotiate increases to the limits that shall apply for either one or two years before the increase shall be subject to a new proposal and negotiation. The care-related limit may be increased by up to 50 percent.

(b) In selecting facilities with which to negotiate, the commissioner shall consider:

(1) the diagnoses or other circumstances of residents in the specialized program that require care that costs substantially more than the RUG's rates associated with those residents;

(2) the nature of the specialized program or programs offered to meet the needs of these individuals; and

(3) outcomes achieved by the specialized program.

Subd. 52. Determination of efficiency incentive. Each facility shall be eligible for an efficiency incentive based on its other operating per diem. A facility with an other operating per diem that exceeds the limit in subdivision 51 shall receive no efficiency incentive. All other facilities shall receive an incentive calculated as 50 percent times the difference between the facility's other operating per diem and its other operating per diem limit, up to a maximum incentive of \$3.

Subd. 53. Calculation of payment rate for external fixed costs. The commissioner shall calculate a payment rate for external fixed costs.

(a) For a facility licensed as a nursing home, the portion related to section 256.9657 shall be equal to \$8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to \$8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

(c) The portion related to scholarships shall be determined under section 256B.431, subdivision 36.

(d) The portion related to long-term care consultation shall be determined according to section 256B.0911, subdivision 6.

(e) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be \$5 divided by 365.

(f) The portion related to planned closure rate adjustments shall be as determined under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436. Planned closure rate adjustments that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Planned closure rate adjustments that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(g) The portions related to property insurance, real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

(h) The portion related to the Public Employees Retirement Association shall be actual costs divided by resident days.

(i) The single bed room incentives shall be as determined under section 256B.431, subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(j) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to (i).

Subd. 54. Determination of total payment rates. In rate years when rates are rebased, the total payment rate for a RUG's weight of 1.00 shall be the sum of the total care-related payment rate, other operating payment rate, efficiency incentive, external fixed cost rate, and the property rate determined under section 256B.434. To determine a total payment rate for each RUG's level, the total care-related payment rate shall be divided into the direct care payment rate and the other care-related payment rate, and the direct care payment rate multiplied by the RUG's weight for each RUG's level using the weights in subdivision 14.

Subd. 55. Phase-in of rebased operating payment rates. (a) For the rate years beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined under section 256B.434. For purposes of this subdivision, the rate to be used that is determined under section 256B.434 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 256B.434. For the rate period from October 1, 2009, to September 30, 2013, no rate adjustments shall be implemented under this section, but shall be determined under

section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

(b) For the rate year beginning October 1, 2008, the commissioner shall apply limits to the operating payment rate increases under paragraph (a) by creating a minimum percentage increase and a maximum percentage increase.

(1) Each nursing facility that receives a blended October 1, 2008, operating payment rate increase under paragraph (a) of less than one percent, when compared to its operating payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00, shall receive a rate adjustment of one percent.

(2) The commissioner shall determine a maximum percentage increase that will result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the maximum percentage increase.

(3) Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than one percent and less than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the blended October 1, 2008, operating payment rate increase determined under paragraph (a).

(4) The October 1, 2009, through October 1, 2015, operating payment rate for facilities receiving the maximum percentage increase determined in clause (2) shall be the amount determined under paragraph (a) less the difference between the amount determined under paragraph (a) for October 1, 2008, and the amount allowed under clause (2). This rate restriction does not apply to rate increases provided in any other section.

(c) A portion of the funds received under this subdivision that are in excess of operating payment rates that a facility would have received under section 256B.434, as determined in accordance with clauses (1) to (3), shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h).

(1) Determine the amount of additional funding available to a facility, which shall be equal to total medical assistance resident days from the most recent reporting year times the difference between the blended rate determined in paragraph (a) for the rate year being computed and the blended rate for the prior year.

(2) Determine the portion of all operating costs, for the most recent reporting year, that are compensation related. If this value exceeds 75 percent, use 75 percent.

(3) Subtract the amount determined in clause (2) from 75 percent.

(4) The portion of the fund received under this subdivision that shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal the amount determined in clause (1) times the amount determined in clause (3).

Subd. 55a. Alternative to phase-in for publicly owned nursing facilities. (a) For operating payment rates implemented between October 1, 2011, and the day before the phase-in under subdivision 55 is complete, 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 shall be eligible to select an operating payment rate, with a weight of 1.00, up to the rate calculated in subdivision 54, without application of the phase-in under subdivision 55. The rates for the other RUGs shall be computed as provided under subdivision 54.

(b) For operating payment rates implemented beginning the day when the phase-in under subdivision 55 is complete, 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 weight of 1.00, up to an amount determined by the commissioner to be allowable under the Medicare upper payment limit test. The rates for the other RUGs shall be computed under subdivision 54. The rate increase allowed in this paragraph shall take effect only upon federal approval.

(c) Rates determined under this subdivision shall take effect beginning October 1, 2011, based on cost reports for the reporting year ending September 30, 2010, and in future rate years, rates determined for nursing facilities participating under this subdivision shall take effect on October 1 of each year, based on the most recent available cost report.

(d) Eligible nursing facilities that wish to participate under this subdivision shall make an application to the commissioner by August 31, 2011, or by June 30 of any subsequent year.

(e) 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 paragraph (a) or (b), and the rates that the nursing facility would otherwise be paid without application of this subdivision under subdivision 54 or 55 as determined by the commissioner.

(f) The commissioner may, at any time, reduce the payments under this subdivision 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 subdivision 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.

Subd. 56. Hold harmless. For the rate years beginning October 1, 2008, to October 1, 2016, no nursing facility shall receive an operating cost payment rate less than its operating cost payment rate under section 256B.434. For rate years beginning between October 1, 2009, and

October 1, 2015, no nursing facility shall receive an operating payment rate less than its operating payment rate in effect on September 30, 2009. The comparison of operating payment rates under this section shall be made for a RUG's rate with a weight of 1.00.

Subd. 57. **Appeals.** Nursing facilities may appeal, as described under section 256B.50, the determination of a payment rate established under this chapter.

Subd. 58. **Implementation delay.** Within six months prior to the effective date of (1) rebasing of property payment rates under subdivision 1; (2) quality-based rate limits under subdivision 50; and (3) the removal of planned closure rate adjustments and single bed room incentives from external fixed costs under subdivision 53, the commissioner shall compare the average operating cost for all facilities combined from the most recent cost reports to the average medical assistance operating payment rates for all facilities combined from the same time period. Each provision shall not go into effect until the average medical assistance operating payment rate is at least 92 percent of the average operating cost. The rebasing of property payment rates under subdivision 1, and the removal of planned closure rate adjustments and single-bed room incentives from external fixed costs under subdivision 53 shall not go into effect until 82 percent of the operating payment rate from this section is phased in as described in subdivision 55.

Subd. 59. **Single-bed payments for medical assistance recipients.** Effective October 1, 2009, the amount paid for a private room under Minnesota Rules, part 9549.0070, subpart 3, is reduced from 115 percent to 111.5 percent.

Subd. 60. **Method for determining budget-neutral nursing facility rates for relocated beds.** (a) 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 subdivision. All payment rates are based on a 1.0 case mix level, with other case mix 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.

(b) 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 RUGS weight 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 score 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).

(c) 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 RUGS weight of 1.0 by the medical assistance days on the most recent cost report; and

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

(d) The commissioner shall determine the medical assistance costs prior to the bed relocation which must be the sum of the amounts determined in paragraphs (b) and (c).

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

(3) multiply the amount determined in clause (1) by the amount determined in clause (2) by the total payment rate for a RUGS weight 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.

(f) If the amount determined in paragraph (e) is less than or equal to the amount determined in paragraph (d), the commissioner shall allow a total payment rate equal to the amount used in paragraph (e), clause (3).

(g) If the amount determined in paragraph (e) is greater than the amount determined in paragraph (d), the commissioner shall allow a rate with a RUGS weight of 1.0 that when used in paragraph (e), clause (3), results in the amount determined in paragraph (e) being equal to the amount determined in paragraph (d).

(h) If the commissioner relies upon provider estimates in paragraph (e), clause (1) or (2), then annually, for three years after the rates determined in this subdivision take effect, the commissioner shall determine the accuracy of the alternative factors of medical assistance case load and RUGS weight used in this subdivision and shall reduce the total payment rate for a RUGS weight of 1.0 if the factors used result in medical assistance costs exceeding the amount in paragraph (d). 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 paragraph (e) 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.

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

Subd. 61. Rate increase for low-rate facilities. Effective October 1, 2011, operating payment rates of all nursing facilities that are reimbursed under this section or section 256B.434 shall be increased for a resource utilization group rate with a weight of 1.00 by up to 2.45 percent, but not to exceed for the same resource utilization group weight the rate of the facility at the 18th percentile of all nursing facilities in the state. The percentage of the operating payment rate for each facility to be case-mix adjusted shall be equal to the percentage that is case-mix adjusted in that facility's operating payment rate on the preceding September 30.

Subd. 62. **Repeal of rebased operating payment rates.** Notwithstanding subdivision 54 or 55, no further steps toward phase-in of rebased operating payment rates shall be taken.

Subd. 63. **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.

(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 operating payment rates being the sum of 60 percent of the operating payment rate determined in accordance with subdivision 54 and 40 percent of the operating payment rate that would have been allowed had the facility not been designated;

(2) enhanced payments for leave days. Notwithstanding section 256B.431, subdivision 2r, 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 will consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivisions 3f, paragraph (a), and 17e, shall be 40 percent of the amount that would otherwise apply; and

(5) notwithstanding subdivision 58, beginning October 1, 2014, the quality-based rate limits under subdivision 50 shall apply to designated critical access nursing facilities.

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

History: *1Sp2005 c 4 art 7 s 43; 2006 c 212 art 3 s 21; 2007 c 147 art 7 s 25-57; 2008 c 363 art 15 s 10-12; 2009 c 79 art 8 s 61-63; 2009 c 159 s 98,99; 2009 c 173 art 1 s 29; 2010 c 396 s 5; 1Sp2010 c 1 art 15 s 8; art 17 s 12; 2011 c 22 art 1 s 7; 2011 c 76 art 1 s 80; 1Sp2011 c 9 art 7 s 34-37; 2012 c 216 art 9 s 26-28; 2012 c 247 art 4 s 32*