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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. **2851**

03/10/2016 Authored by Schomacker

The bill was read for the first time and referred to the Committee on Aging and Long-Term Care Policy

1.1 A bill for an act

1.2 relating to human services; recodifying nursing facility payment language;

1.3 making conforming changes; repealing obsolete provisions; amending

1.4 Minnesota Statutes 2014, sections 144A.071, subdivision 2; 256B.0625, by

1.5 adding a subdivision; 256B.19, subdivision 1e; 256B.431, subdivision 22;

1.6 256B.434, subdivision 10; 256B.48, subdivisions 2, 3a; 256B.50, subdivision 1a;

1.7 Minnesota Statutes 2015 Supplement, sections 144A.15, subdivision 6; 256I.05,

1.8 subdivision 2; proposing coding for new law as Minnesota Statutes, chapter

1.9 256R; repealing Minnesota Statutes 2014, sections 256B.0911, subdivision 7;

1.10 256B.25, subdivision 4; 256B.27, subdivision 2a; 256B.41, subdivisions 1, 2, 3;

1.11 256B.411, subdivisions 1, 2; 256B.421, subdivisions 2, 3, 4, 5, 6, 7, 8, 9, 10, 11,

1.12 12, 13, 14, 15; 256B.431, subdivisions 1, 2d, 2e, 2n, 2r, 2s, 2t, 3e, 32, 35, 42, 44;

1.13 256B.432, subdivisions 1, 2, 3, 4, 4a, 5, 6, 6a, 7, 8; 256B.433, subdivisions 1, 2,

1.14 3, 3a; 256B.434, subdivisions 2, 9, 11, 12, 14, 15, 16, 18, 19a, 20, 21; 256B.437,

1.15 subdivisions 1, 3, 4, 5, 6, 7, 9, 10; 256B.438, subdivisions 1, 2, 3, 4, 5, 6, 7, 8;

1.16 256B.441, subdivisions 2, 3, 4, 7, 8, 9, 10, 11, 15, 18, 20, 22, 23, 24, 25, 27,

1.17 28a, 29, 32, 33a, 34, 36, 37, 38, 39, 41, 42a, 43, 46b, 47, 49, 57, 59, 60, 61, 64;

1.18 256B.47, subdivisions 1, 2, 3, 4; 256B.48, subdivisions 1, 1a, 1b, 1c, 3, 4, 5, 6a,

1.19 7, 8; Minnesota Statutes 2015 Supplement, sections 256B.431, subdivisions 2b,

1.20 36; 256B.441, subdivisions 1, 5, 6, 11a, 13, 14, 17, 30, 31, 33, 35, 40, 44, 46c,

1.21 46d, 48, 50, 51, 51a, 51b, 53, 54, 55a, 56, 63, 65, 66, 67; 256B.495, subdivisions

1.22 1, 5; Minnesota Rules, parts 9549.0035, subparts 1, 3, 7, 8; 9549.0041, subpart 6;

1.23 9549.0055, subparts 1, 2, 3; 9549.0070, subparts 2, 3.

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

1.25 **ARTICLE 1**

1.26 **NURSING FACILITY RECODIFICATION**

1.27 **GENERAL**

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

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

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

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

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

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

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

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

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

2.24 Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable
2.25 costs for administering the overall activities of the nursing home. These costs include
2.26 salaries and wages of the administrator, assistant administrator, business office employees,
2.27 security guards, and associated fringe benefits and payroll taxes, fees, contracts, or
2.28 purchases related to business office functions, licenses, and permits except as provided
2.29 in the external fixed costs category, employee recognition, travel including meals and
2.30 lodging, all training except as specified in subdivision 17, voice and data communication
2.31 or transmission, office supplies, property and liability insurance and other forms of
2.32 insurance not designated to other areas, personnel recruitment, legal services, accounting
2.33 services, management or business consultants, data processing, information technology,
2.34 Web site, central or home office costs, business meetings and seminars, postage, fees for

3.1 professional organizations, subscriptions, security services, advertising, board of directors
3.2 fees, working capital interest expense, and bad debts and bad debt collection fees.

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

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

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

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

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

3.22 Subd. 10. **Case mix index.** "Case mix index" has the meaning given in section
3.23 144.0724, subdivision 2, paragraph (b).

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

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

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

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

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

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

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

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

4.29 Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the
4.30 nursing home surcharge under section 256.9657, subdivision 1; licensure fees under
4.31 section 144.122; family advisory council fee under section 144A.33; scholarships under
4.32 section 256R.37; planned closure rate adjustments under section 256R.40; single-bed
4.33 room incentives under section 256R.41; property taxes, assessments, and payments in
4.34 lieu of taxes; employer health insurance costs; quality improvement incentive payment
4.35 rate adjustments under section 256R.39; performance-based incentive payments under

5.1 section 256R.38; special dietary needs under section 256R.51; and Public Employees
5.2 Retirement Association.

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

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

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

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

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

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

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

5.33 Subd. 27. **Leave day.** "Leave day" means any calendar day during which the
5.34 recipient leaves the facility and is absent overnight, and all subsequent, consecutive
5.35 calendar days. An overnight absence from the facility of less than 23 hours does
5.36 not constitute a leave day. Nevertheless, if the recipient is absent from the facility

6.1 to participate in active programming of the facility under the personal direction and
6.2 observation of facility staff, the day shall not be considered a leave day regardless of the
6.3 number of hours of the recipient's absence. For purposes of this subdivision, "calendar
6.4 day" means the 24-hour period ending at midnight.

6.5 Subd. 28. **Licensee.** "Licensee" means the individual or organization listed on the
6.6 form issued by the Minnesota Department of Health under chapter 144A or sections
6.7 144.50 to 144.56.

6.8 Subd. 29. **Maintenance and plant operations costs.** "Maintenance and plant
6.9 operations costs" means the costs for the salaries and wages of the maintenance supervisor,
6.10 engineers, heating-plant employees, and other maintenance employees and associated
6.11 fringe benefits and payroll taxes. It also includes identifiable costs for maintenance and
6.12 operation of the building and grounds, including, but not limited to, fuel, electricity,
6.13 medical waste and garbage removal, water, sewer, supplies, tools, and repairs.

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

6.16 (1) the central, affiliated, or corporate office has or is authorized to assume
6.17 day-to-day operational control of the nursing facility for any six-month period within a
6.18 24-month period. "Day-to-day operational control" means that the central, affiliated, or
6.19 corporate office has the authority to require, mandate, direct, or compel the employees
6.20 of the nursing facility to perform or refrain from performing certain acts, or to supplant
6.21 or take the place of the top management of the nursing facility. "Day-to-day operational
6.22 control" includes the authority to hire or terminate employees or to provide an employee
6.23 of the central, affiliated, or corporate office to serve as administrator of the nursing facility;

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

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

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

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

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

7.7 Subd. 32. **Minimum data set.** "Minimum data set" has the meaning given in section
7.8 144.0724, subdivision 2, paragraph (d).

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

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

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

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

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

7.25 Subd. 38. **Prior system operating cost payment rate.** "Prior system operating
7.26 cost payment rate" means the operating cost payment rate in effect on December 31,
7.27 2015, under Minnesota Rules and Minnesota Statutes, inclusive of health insurance, plus
7.28 property insurance costs from external fixed costs, minus any rate increases allowed under
7.29 Minnesota Statutes 2015 Supplement, section 256B.441, subdivision 55a.

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

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

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

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

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

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

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

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

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

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

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

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

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

8.35 Subd. 48. **Social services costs.** "Social services costs" means the costs for the
8.36 salaries and wages of the supervisor and other social work employees, associated fringe

9.1 benefits and payroll taxes, supplies, services, and consultants. This category includes the
 9.2 cost of those employees who manage and process admission to the nursing facility.

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

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

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

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

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

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

9.22 **CONDITIONS FOR PARTICIPATION**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.24 Subd. 5. **Kickbacks.** A nursing facility is not eligible to receive medical assistance
11.25 payments unless it refrains from requiring any vendor of medical care as defined by
11.26 section 256B.02, subdivision 7, who is reimbursed by medical assistance under a separate
11.27 fee schedule, to pay any amount based on utilization or service levels or any portion of
11.28 the vendor's fee to the nursing facility except as payment for renting or leasing space or
11.29 equipment or purchasing support services from the nursing facility as limited by section
11.30 256R.54. All agreements must be disclosed to the commissioner upon request of the
11.31 commissioner. Nursing facilities and vendors of ancillary services that are found to be in
11.32 violation of this subdivision shall each be subject to an action by the state of Minnesota or
11.33 any of its subdivisions or agencies for treble civil damages on the portion of the fee in
11.34 excess of that allowed by this subdivision and section 256R.54. Damages awarded must
11.35 include three times the excess payments together with costs and disbursements including
11.36 reasonable attorney fees or their equivalent.

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

12.5 Subd. 7. Violations and penalties. For a period not to exceed 180 days, the
12.6 commissioner may continue to make medical assistance payments to a nursing facility
12.7 or boarding care home which is in violation of this section if extreme hardship to the
12.8 residents would result. In these cases the commissioner shall issue an order requiring the
12.9 nursing facility to correct the violation. The nursing facility shall have 20 days from its
12.10 receipt of the order to correct the violation. If the violation is not corrected within the
12.11 20-day period the commissioner may reduce the payment rate to the nursing facility
12.12 by up to 20 percent. The amount of the payment rate reduction shall be related to the
12.13 severity of the violation and shall remain in effect until the violation is corrected. The
12.14 nursing facility or boarding care home may appeal the commissioner's action pursuant to
12.15 the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered
12.16 timely if written notice of appeal is received by the commissioner within 20 days of
12.17 notice of the commissioner's proposed action.

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

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

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

12.34 (b) The nursing facility must not bill a person who is not a medical assistance
12.35 recipient for resident days that preceded the date of completion of screening activities

13.1 as required under section 256.975, subdivisions 7a to 7c. The nursing facility must
 13.2 include unreimbursed resident days in the nursing facility resident day totals reported to
 13.3 the commissioner.

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

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

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

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

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

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

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

13.31 (c) Special services, if offered, must:

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

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

13.34 (3) not include services which must be provided by the nursing facility in order to
 13.35 comply with licensure or certification standards and that if not provided would result in a

14.1 deficiency or violation by the nursing facility. Services beyond those required to comply
14.2 with licensure or certification standards must not be charged separately as a special service
14.3 if they were included in the payment rate for the previous reporting period.

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

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

14.7 Subd. 4. **Civil penalties and procedures.** A nursing facility that charges a private
14.8 paying resident a rate in violation of subdivision 2 is subject to an action by the state of
14.9 Minnesota or any of its subdivisions or agencies for civil damages. A private paying
14.10 resident or the resident's legal representative has a cause of action for civil damages against
14.11 a nursing facility that charges the resident rates in violation of subdivision 2. The damages
14.12 awarded shall include three times the payments that result from the violation, together with
14.13 costs and disbursements, including reasonable attorney fees or their equivalent. A private
14.14 paying resident or the resident's legal representative, the state, subdivision or agency, or a
14.15 nursing facility may request a hearing to determine the allowed rate or rates at issue in
14.16 the cause of action. Within 15 calendar days after receiving a request for such a hearing,
14.17 the commissioner shall request assignment of an administrative law judge under sections
14.18 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by
14.19 the parties. The administrative law judge shall issue a report within 15 calendar days
14.20 following the close of the hearing. The prohibition set forth in subdivision 2 shall not
14.21 apply to facilities licensed as boarding care facilities which are not certified as skilled or
14.22 intermediate care facilities level I or II for reimbursement through medical assistance.

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

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

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

14.32 (b) If the state does not set rates by the date required in section 256R.09, subdivision
14.33 1, nursing facilities shall meet the requirement for advance notice by informing the
14.34 resident or person responsible for payments, on or before the effective date of the increase,
14.35 that a rate increase will be effective on that date.

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

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

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

15.17 (1) their right to retain certain resources under sections 256B.0575, 256B.058,
 15.18 256B.059, 256B.0595, and 256B.14, subdivision 2; and

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

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

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

15.33 **DATA COLLECTION AND REPORTING**

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

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

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

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

16.7 (3) include a paid invoice or copy of a paid invoice with date of purchase, vendor
16.8 name and address, purchaser name and delivery destination address, listing of items or
16.9 services purchased, cost of items purchased, account number to which the cost is posted,
16.10 and a breakdown of any allocation of costs between accounts or nursing facilities. If any
16.11 of the information is not available, the nursing facility shall document its good faith
16.12 attempt to obtain the information;

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

16.16 (5) be retained by the nursing facility to support the five most recent annual cost
16.17 reports. The commissioner may extend the period of retention if the field audit was
16.18 postponed because of inadequate record keeping or accounting practices as in section
16.19 256R.13, subdivisions 2 and 4, the records are necessary to resolve a pending appeal, or
16.20 the records are required for the enforcement of sections 256R.04; 256R.05, subdivision
16.21 2; 256R.06, subdivisions 2, 6, and 7; 256R.08, subdivisions 1 to 3; and 256R.09,
16.22 subdivisions 3 and 4.

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

16.33 Subd. 3. **Adequate documentation supporting nursing facility payrolls.** Payroll
16.34 records supporting compensation costs claimed by nursing facilities must be supported by
16.35 affirmative time and attendance records prepared by each individual at intervals of not

17.1 more than one month. The requirements of this subdivision are met when documentation
 17.2 is provided under either clause (1) or (2) as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18.31 (4) use any combination of the foregoing actions.

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

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

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

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

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

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

19.34 Subd. 5. **Method of accounting.** The accrual method of accounting in accordance
19.35 with generally accepted accounting principles is the only method acceptable for purposes
19.36 of satisfying the reporting requirements of this chapter. If a governmentally owned nursing

20.1 facility demonstrates that the accrual method of accounting is not applicable to its accounts
20.2 and that a cash or modified accrual method of accounting more accurately reports the
20.3 nursing facility's financial operations, the commissioner shall permit the governmentally
20.4 owned nursing facility to use a cash or modified accrual method of accounting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22.1 Subd. 3. **Employer sponsored retirement plans.** In addition to the approved
22.2 pension or profit-sharing plans allowed by Minnesota Rules, parts 9549.0010 to
22.3 9549.0080, the commissioner shall allow those plans specified in Internal Revenue Code,
22.4 sections 403(b) and 408(k).

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

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

22.10 (2) a plan in which:

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

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

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

22.17 (3) a plan in which:

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

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

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

22.24 (4) additional conditions are:

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

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

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

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

- 23.1 (v) central, affiliated, corporate, or nursing facility costs related to their
23.2 administration of the plan are costs which must remain in the nursing facility's
23.3 administrative cost category and must not be allocated to other cost categories;
- 23.4 (vi) required security deposits, whether in the form of cash, investments, securities,
23.5 assets, letters of credit, or in any other form are not allowable costs for purposes of
23.6 establishing the facility's payment rate; and
- 23.7 (vii) a group of nursing facilities related by common ownership that self-insures
23.8 workers' compensation may allocate its directly identified costs of self-insuring its
23.9 Minnesota nursing facility workers among those nursing facilities in the group that are
23.10 reimbursed under this chapter. The method of cost allocation shall be based on the ratio
23.11 of each nursing facility's total allowable salaries and wages to that of the nursing facility
23.12 group's total allowable salaries and wages, then similarly allocated within each nursing
23.13 facility's operating cost categories. The costs associated with the administration of the
23.14 group's self-insurance plan must remain classified in the nursing facility's administrative
23.15 cost category. A written request of the nursing facility group's election to use this alternate
23.16 method of allocation of self-insurance costs must be received by the commissioner no
23.17 later than May 1, 1998, to take effect July 1, 1998, or such costs shall continue to be
23.18 allocated under the existing cost allocation methods. Once a nursing facility group elects
23.19 this method of cost allocation for its workers' compensation self-insurance costs, it shall
23.20 remain in effect until such time as the group no longer self-insures these costs;
- 23.21 (5) any costs allowed pursuant to clauses (1) to (3) are subject to the following
23.22 requirements:
- 23.23 (i) if the nursing facility is sold or otherwise ceases operations, the plan's reserves
23.24 must be subject to an actuarially based settle up after 36 months from the date of sale or
23.25 the date on which operations ceased. The facility's medical assistance portion of the
23.26 total excess plan reserves must be paid to the state within 30 days following the date on
23.27 which excess plan reserves are determined;
- 23.28 (ii) any distribution of excess plan reserves made to or withdrawals made by the
23.29 nursing facility or a related organization are applicable credits and must be used to reduce
23.30 the nursing facility's workers' compensation insurance costs in the reporting period in
23.31 which a distribution or withdrawal is received;
- 23.32 (iii) if reimbursement for the plan is sought under the federal Medicare program,
23.33 and is audited pursuant to the Medicare program, the nursing facility must provide a copy
23.34 of Medicare's final audit report, including attachments and exhibits, to the commissioner
23.35 within 30 days of receipt by the nursing facility or any related organization. The
23.36 commissioner shall implement the audit findings associated with the plan upon receipt of

24.1 Medicare's final audit report. The department's authority to implement the audit findings is
 24.2 independent of its authority to conduct a field audit.

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

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

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

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

24.14 (1) political contributions;

24.15 (2) salaries or expenses of a lobbyist, as defined in section 10A.01, subdivision
 24.16 21, for lobbying activities;

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

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

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

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

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

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

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

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

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

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

25.5 Subdivision 1. **Allocation; direct identification of costs; management agreement.**

25.6 All costs that can be directly identified with a specific nursing facility that is a related
 25.7 organization to the central, affiliated, or corporate office, or that is controlled by the
 25.8 central, affiliated, or corporate office under a management agreement, must be allocated to
 25.9 that nursing facility.

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

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

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

25.32 Subd. 4. **Allocation of remaining costs; allocation ratio.** (a) After the costs that can
 25.33 be directly identified according to subdivisions 1 and 2 have been allocated, the remaining
 25.34 central, affiliated, or corporate office costs must be allocated between the nursing facility
 25.35 operations and the other activities or facilities unrelated to the nursing facility operations

26.1 based on the ratio of total operating costs. However, in the event that these remaining
26.2 costs are partially attributable to the start-up of home and community-based services
26.3 intended to fill a gap identified by the local agency, the facility may assign these remaining
26.4 costs to the appropriate cost category of the facility for a period not to exceed two years.

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

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

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

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

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

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

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

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

26.32 Subd. 6. **Related organization costs.** (a) Costs applicable to services, capital
26.33 assets, and supplies directly or indirectly furnished to the nursing facility by any related
26.34 organization are includable in the allowable cost of the nursing facility at the purchase
26.35 price paid by the related organization for capital assets or supplies and at the cost incurred
26.36 by the related organization for the provision of services to the nursing facility if these

27.1 prices or costs do not exceed the price of comparable services, capital assets, or supplies
27.2 that could be purchased elsewhere. For this purpose, the related organization's costs must
27.3 not include an amount for markup or profit.

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

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

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

27.17 Subd. 8. **Allocation of costs for therapy services; non-hospital-attached**
27.18 **facilities.** (a) To ensure the avoidance of double payments as required by section 256R.54,
27.19 the direct and indirect reporting period costs of providing residents of nursing facilities
27.20 that are not hospital attached with therapy services that are billed separately from the
27.21 nursing facility payment rate or according to Minnesota Rules, parts 9505.0170 to
27.22 9505.0475, must be determined and deducted from the appropriate cost categories of the
27.23 annual cost report according to paragraphs (b) to (g).

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

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

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

27.34 (e) The costs of bookkeeping and medical records must be allocated to the therapy
27.35 service either by the method in paragraph (f) or based on direct identification. Direct

28.1 identification may be used if adequate documentation is provided to, and accepted by,
28.2 the commissioner.

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

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

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

28.18 Subd. 10. **Allocation of self-insurance costs.** For the rate year beginning on July 1,
28.19 1998, a group of nursing facilities related by common ownership that self-insures group
28.20 health, dental, or life insurance may allocate its directly identified costs of self-insuring its
28.21 Minnesota nursing facility workers among those nursing facilities in the group that are
28.22 reimbursed under this chapter. The method of cost allocation shall be based on the ratio
28.23 of each nursing facility's total allowable salaries and wages to that of the nursing facility
28.24 group's total allowable salaries and wages, then similarly allocated within each nursing
28.25 facility's operating cost categories. The costs associated with the administration of the
28.26 group's self-insurance plan must remain classified in the nursing facility's administrative
28.27 cost category. A written request of the nursing facility group's election to use this alternate
28.28 method of allocation of self-insurance costs must be received by the commissioner no later
28.29 than May 1, 1998, to take effect July 1, 1998, or those self-insurance costs shall continue to
28.30 be allocated under the existing cost allocation methods. Once a nursing facility group elects
28.31 this method of cost allocation for its group health, dental, or life insurance self-insurance
28.32 costs, it shall remain in effect until such time as the group no longer self-insures these costs.

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

28.34 Subdivision 1. **Audit authority.** (a) The commissioner shall provide for an audit
28.35 of the cost and statistical data of nursing facilities participating as vendors of medical

29.1 assistance. The commissioner shall select for audit at least 15 percent of the nursing
29.2 facilities' data reported at random or using factors including, but not limited to: data
29.3 reported to the public as criteria for rating nursing facilities; data used to set limits for
29.4 other medical assistance programs or vendors of services to nursing facilities; change
29.5 in ownership; frequent changes in administration in excess of normal turnover rates;
29.6 complaints to the commissioner of health about care, safety, or rights; where previous
29.7 inspections or reinspections under section 144A.10 have resulted in correction orders
29.8 related to care, safety, or rights; or where persons involved in ownership or administration
29.9 of the facility have been indicted for alleged criminal activity.

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

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

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

29.35 (c) Changes in the total payment rate which result from desk or field audit adjustments
29.36 to statistical and cost reports for reporting periods earlier than the four most recent annual

30.1 cost reports must be made to the four most recent annual statistical and cost reports, the
30.2 current statistical and cost report, and future statistical and cost reports to the extent that
30.3 those adjustments affect the total payment rate established by those reporting years.

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

30.10 Subd. 4. **Extended record retention requirements.** The commissioner shall extend
30.11 the period for retention of records under section 256R.09, subdivision 3, for purposes of
30.12 performing field audits as necessary to enforce sections 256R.04; 256R.05, subdivision
30.13 2; 256R.06, subdivisions 2, 6, and 7; 256R.08, subdivisions 1 to 3; and 256R.09,
30.14 subdivisions 3 and 4, with written notice to the facility postmarked no later than 90 days
30.15 prior to the expiration of the record retention requirement.

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

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

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

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

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

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

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

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

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

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

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

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

31.17 (b) The case mix classifications established under section 144.0724, subdivision 3a,
 31.18 shall be effective the day of admission for new admission assessments. The effective date
 31.19 for significant change assessments shall be the assessment reference date. The effective
 31.20 date for annual and quarterly assessments shall be the first day of the month following
 31.21 assessment reference date.

31.22 Subd. 4. **Notice of resident reimbursement case mix classification.** Nursing
 31.23 facilities shall provide notice to a resident of the resident's case mix classification
 31.24 according to procedures established by the commissioner of health under section
 31.25 144.0724, subdivision 7.

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

31.29 **RATE STRUCTURE/RATE CALCULATION**

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

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

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

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

- 32.5 (1) its direct care payment rate as determined in section 256R.23, subdivision 7; and
 32.6 (2) its other care-related payment rate as determined in section 256R.23, subdivision
 32.7 8.

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

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

- 32.12 (1) its total care-related payment rate as determined in subdivision 2; and
 32.13 (2) its other operating payment rate as determined in section 256R.24.

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

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

- 32.18 (1) its operating payment rate as determined in subdivision 3;
 32.19 (2) its external fixed costs payment rate as determined in section 256R.25; and
 32.20 (3) its property payment rate as determined in section 256R.26.

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

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

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

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

- 32.30 (1) its direct care payment rate as determined in section 256R.23, subdivision 7,
 32.31 multiplied by the case mix index; and
 32.32 (2) its other care-related payment rate as determined in section 256R.23, subdivision
 32.33 8.

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

33.4 (1) its case mix adjusted total care-related payment rate as determined in subdivision
 33.5 2; and

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

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

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

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

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

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

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

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

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

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

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

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

33.31 (2) adding 89.375 to the amount determined in clause (1), and dividing the total by
 33.32 100; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35.6 (g) The portion related to single-bed room incentives is as determined under section
 35.7 256R.41.

35.8 (h) The portions related to real estate taxes, special assessments, and payments made
 35.9 in lieu of real estate taxes directly identified or allocated to the nursing facility are the
 35.10 actual amounts divided by the sum of the facility's resident days. Allowable costs under
 35.11 this paragraph for payments made by a nonprofit nursing facility that are in lieu of real
 35.12 estate taxes shall not exceed the amount which the nursing facility would have paid to
 35.13 a city or township and county for fire, police, sanitation services, and road maintenance
 35.14 costs had real estate taxes been levied on that property for those purposes.

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

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

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

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

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

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

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

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

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

35.31 **ADJUSTMENTS AND ADD-ONS TO THE TOTAL PAYMENT RATE**

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

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

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

36.5 (a) For the 27-month period beginning October 1, 2015, through December 31,
36.6 2017, the commissioner shall allow a scholarship per diem of up to 25 cents for each
36.7 nursing facility with no scholarship per diem that is requesting a scholarship per diem to
36.8 be added to the external fixed payment rate to be used:

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

36.10 (i) scholarships are available to all employees who work an average of at least ten
36.11 hours per week at the facility except the administrator, and to reimburse student loan
36.12 expenses for newly hired and recently graduated registered nurses and licensed practical
36.13 nurses, and training expenses for nursing assistants as defined in section 144A.611,
36.14 subdivision 2, who are newly hired and have graduated within the last 12 months; and

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

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

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

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

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

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

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

37.1 The commissioner shall develop additional incentive-based payments of up to
 37.2 five percent above a facility's operating payment rate for achieving outcomes specified
 37.3 in a contract. The commissioner may solicit proposals and select those which, on a
 37.4 competitive basis, best meet the state's policy objectives. The commissioner shall limit
 37.5 the amount of any incentive payment and the number of contract amendments under this
 37.6 section to operate the incentive payments within funds appropriated for this purpose.
 37.7 The commissioner shall approve proposals through a memorandum of understanding
 37.8 which shall specify various levels of payment for various levels of performance. Incentive
 37.9 payments to facilities under this section shall be in the form of time-limited rate
 37.10 adjustments which shall be included in the external fixed payment rate under section
 37.11 256R.25. In establishing the specified outcomes and related criteria, the commissioner
 37.12 shall consider the following state policy objectives:

- 37.13 (1) successful diversion or discharge of residents to the residents' prior home or other
 37.14 community-based alternatives;
 37.15 (2) adoption of new technology to improve quality or efficiency;
 37.16 (3) improved quality as measured in the Minnesota Nursing Home Report Card;
 37.17 (4) reduced acute care costs; and
 37.18 (5) any additional outcomes proposed by a nursing facility that the commissioner
 37.19 finds desirable.

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

37.21 The commissioner shall develop a quality improvement incentive program in
 37.22 consultation with stakeholders. The annual funding pool available for quality improvement
 37.23 incentive payments shall be equal to 0.8 percent of all operating payments, not including
 37.24 any rate components resulting from equitable cost-sharing for publicly owned nursing
 37.25 facility program participation under section 256R.48, critical access nursing facility
 37.26 program participation under section 256R.47, or performance-based incentive payment
 37.27 program participation under section 256R.38. For the period from October 1, 2015, to
 37.28 December 31, 2016, rate adjustments provided under this section shall be effective for
 37.29 15 months. Beginning January 1, 2017, annual rate adjustments provided under this
 37.30 section shall be effective for one rate year.

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

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

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

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

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

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

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

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

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

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

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

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

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

38.29 (5) documentation, in a format approved by the commissioner, that all the nursing
 38.30 facilities receiving a planned closure rate adjustment under the plan have accepted joint
 38.31 and several liability for recovery of overpayments under section 256B.0641, subdivision
 38.32 2, for the facilities designated for closure under the plan.

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

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

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

- 39.1 (2) closure of a nursing facility that has a poor physical plant;
 39.2 (3) the existence of excess nursing facility beds, measured in terms of beds per
 39.3 thousand persons aged 85 or older. The excess must be measured in reference to:
 39.4 (i) the county in which the facility is located. A facility in a county that is in the
 39.5 lowest quartile of counties with reference to beds per thousand persons aged 85 or older is
 39.6 not in an area of excess capacity;
 39.7 (ii) the county and all contiguous counties;
 39.8 (iii) the region in which the facility is located; or
 39.9 (iv) the facility's service area. The facility shall indicate in its application the service
 39.10 area it believes is appropriate for this measurement;
 39.11 (4) low-occupancy rates, provided that the unoccupied beds are not the result of
 39.12 a personnel shortage. In analyzing occupancy rates, the commissioner shall examine
 39.13 waiting lists in the applicant facility and at facilities in the surrounding area, as determined
 39.14 under clause (3);
 39.15 (5) evidence of coordination between the community planning process and the
 39.16 facility application. If the planning group does not support a level of nursing facility
 39.17 closures that the commissioner considers to be reasonable, the commissioner may approve
 39.18 a planned closure proposal without its support;
 39.19 (6) proposed usage of funds available from a planned closure rate adjustment for
 39.20 care-related purposes;
 39.21 (7) innovative use planned for the closed facility's physical plant;
 39.22 (8) evidence that the proposal serves the interests of the state; and
 39.23 (9) evidence of other factors that affect the viability of the facility, including
 39.24 excessive nursing pool costs.
 39.25 **Subd. 4. Review and approval of applications.** (a) The commissioner, in
 39.26 consultation with the commissioner of health, shall approve or deny an application within
 39.27 30 days after receiving it. The commissioner may appoint an advisory review panel
 39.28 composed of representatives of counties, consumers, and providers to review proposals
 39.29 and provide comments and recommendations to the committee. The commissioners of
 39.30 human services and health shall provide staff and technical assistance to the committee
 39.31 for the review and analysis of proposals.
 39.32 (b) Approval of a planned closure expires 18 months after approval by the
 39.33 commissioner unless commencement of closure has begun.
 39.34 (c) The commissioner may change any provision of the application to which the
 39.35 applicant, the regional planning group, and the commissioner agree.

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

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

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

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

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

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

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

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

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

40.25 Subd. 6. **Assignment of closure rate to another facility.** A facility or facilities
40.26 reimbursed under this chapter with a closure plan approved by the commissioner under
40.27 subdivision 4 may assign a planned closure rate adjustment to another facility or facilities
40.28 that are not closing or in the case of a partial closure, to the facility undertaking the partial
40.29 closure. A facility may also elect to have a planned closure rate adjustment shared equally
40.30 by the five nursing facilities with the lowest total operating payment rates in the state
40.31 development region designated under section 462.385, in which the facility that is closing
40.32 is located. The planned closure rate adjustment must be calculated under subdivision 5.
40.33 Facilities that delicense beds without a closure plan, or whose closure plan is not approved
40.34 by the commissioner, are not eligible to assign a planned closure rate adjustment under
40.35 subdivision 5, unless they: (1) are delicensing five or fewer beds, or less than six percent
40.36 of their total licensed bed capacity, whichever is greater; (2) are located in a county in

41.1 the top three quartiles of beds per 1,000 persons aged 65 or older; and (3) have not
41.2 delicensed beds in the prior three months. Facilities meeting these criteria are eligible to
41.3 assign the amount calculated under subdivision 5 to themselves. If a facility is delicensing
41.4 the greater of six or more beds, or six percent or more of its total licensed bed capacity,
41.5 and does not have an approved closure plan or is not eligible for the adjustment under
41.6 subdivision 5, the commissioner shall calculate the amount the facility would have been
41.7 eligible to assign under subdivision 5, and shall use this amount to provide equal rate
41.8 adjustments to the five nursing facilities with the lowest total operating payment rates in
41.9 the state development region designated under section 462.385, in which the facility
41.10 that delicensed beds is located.

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

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

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

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

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

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

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

- 42.1 (1) the same nursing facility;
 42.2 (2) a nursing facility owned or operated by a related party; or
 42.3 (3) a nursing facility or part of a facility that closed or was in the process of closing.

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

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

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

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

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

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

- 42.23 (1) nursing facility care has been recommended for the person by a preadmission
 42.24 screening team;
 42.25 (2) the person has been hospitalized and no longer requires inpatient acute care
 42.26 hospital services; and
 42.27 (3) the commissioner has determined that necessary services for the person cannot
 42.28 be provided under existing nursing facility rates.

42.29 The commissioner may negotiate an adjustment to the operating payment rate
 42.30 for a nursing facility with a resident who is ventilator-dependent, for that resident.
 42.31 The negotiated adjustment must reflect only the actual additional cost of meeting the
 42.32 specialized care needs of a ventilator-dependent person identified by the commissioner
 42.33 for whom necessary services cannot be provided under existing nursing facility rates and

43.1 which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or
 43.2 9505.0170 to 9505.0475. The negotiated payment rate must not exceed 300 percent of
 43.3 the case mix adjusted operating payment rate for the highest case mix classification. The
 43.4 negotiated adjustment shall not affect the payment rate charged to private paying residents
 43.5 under the provisions of section 256R.06, subdivision 2.

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

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

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

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

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

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

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

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

43.33 (2) enhanced payments for leave days. Notwithstanding section 256R.43, upon
 43.34 designation as a critical access nursing facility, the commissioner shall limit payment for

44.1 leave days to 60 percent of that nursing facility's total payment rate for the involved
44.2 resident, and shall allow this payment only when the occupancy of the nursing facility,
44.3 inclusive of bed hold days, is equal to or greater than 90 percent;

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

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

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

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

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

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

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

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

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

44.32 (d) For each participating nursing facility, the public entity that owns the physical
44.33 plant or is the license holder of the nursing facility shall pay to the state the entire
44.34 nonfederal share of medical assistance payments received as a result of the difference
44.35 between the nursing facility's payment rate under this section, and the rates that the

45.1 nursing facility would otherwise be paid without application of this section under section
 45.2 256R.21 as determined by the commissioner.

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

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

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

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

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

45.33 Subd. 3. **Additional application requirements for facilities with employees**
 45.34 **represented by an exclusive bargaining representative.** For nursing facilities in which
 45.35 employees are represented by an exclusive bargaining representative, the commissioner

46.1 shall approve the applications submitted under subdivision 2 only upon receipt of a letter
46.2 or letters of acceptance of the spending plans in regard to members of the bargaining unit,
46.3 signed by the exclusive bargaining agent and dated after May 31, 2014. Upon receipt of
46.4 the letter or letters of acceptance, the commissioner shall deem all requirements of this
46.5 section as having been met in regard to the members of the bargaining unit.

46.6 **Subd. 4. Determination of the rate adjustments for compensation-related costs.**

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

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

46.18 (2) using wages and hours in effect during the first three months of calendar year
46.19 2014, beginning with the first pay period beginning on or after January 1, 2014; 22.2
46.20 percent of the sum of items (i) to (viii) for October 1, 2016;

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

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

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

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

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

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

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

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

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

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

47.5 **Subdivision 1. Method for determining budget-neutral nursing facility rates for**
 47.6 **relocated beds.** Nursing facility rates for bed relocations must be calculated by comparing
 47.7 the estimated medical assistance costs prior to and after the proposed bed relocation
 47.8 using the calculations in this section. All payment rates are based on a case mix index
 47.9 of 1.0, with other case mix adjusted rates determined accordingly. Nursing facility beds
 47.10 on layaway status that are being moved must be included in the calculation for both the
 47.11 originating and receiving facility and treated as though they were in active status with the
 47.12 occupancy characteristics of the active beds of the originating facility.

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

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

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

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

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

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

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

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

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

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

47.33 (1) estimate the medical assistance days in the receiving facility after the bed
 47.34 relocation. The commissioner may use the current medical assistance portion, or if data

48.1 does not exist, may use the statewide average, or may use the provider's estimate of the
48.2 medical assistance utilization of the relocated beds;

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

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

48.12 Subd. 6. **Determination of rate adjustment.** (a) If the amount determined in
48.13 subdivision 5 is less than or equal to the amount determined in subdivision 4, the
48.14 commissioner shall allow a total payment rate equal to the amount used in subdivision
48.15 5, clause (3).

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

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

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

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

48.34 (a) The commissioner shall adjust the rates of a nursing facility that meets the
48.35 criteria for the special dietary needs of its residents and the requirements in section

49.1 31.651 or 31.658. The adjustment for raw food cost shall be the difference between the
49.2 nursing facility's most recently reported allowable raw food cost per resident day and 115
49.3 percent of the median allowable raw food cost per resident day. This amount shall be
49.4 removed from other care-related costs per resident day as determined in section 256R.23,
49.5 subdivision 3, and included in the external fixed costs payment rate under section 256R.25.

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

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

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

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

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

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

49.25 (d) Notification of the payment rate increase must meet the requirements of section
49.26 256R.06, subdivisions 5.

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

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

49.34 Subd. 2. **Sale or transfer of a nursing facility in receivership after closure.** (a)
49.35 Upon the subsequent sale or transfer of a nursing facility in receivership, the commissioner

50.1 shall seek to recover from the prior licensee any amounts paid through payment rate
 50.2 adjustments under subdivision 1. The prior licensee shall repay this amount to the
 50.3 commissioner within 60 days after the commissioner notifies the prior licensee of the
 50.4 obligation to repay.

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

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

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

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

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

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

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

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

50.33 **PAYMENTS FOR SERVICES BILLED SEPARATELY**

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

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

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

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

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

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

51.33 Subd. 2. **Certification that treatment is appropriate.** The physical therapist,
51.34 occupational therapist, speech therapist, mental health professional, or audiologist who
51.35 provides or supervises the provision of therapy services, other than an initial evaluation,
51.36 to a medical assistance recipient must certify in writing that the therapy's nature, scope,

52.1 duration, and intensity are appropriate to the medical condition of the recipient every
 52.2 30 days. The therapist's statement of certification must be maintained in the recipient's
 52.3 medical record together with the specific orders by the physician and the treatment plan. If
 52.4 the recipient's medical record does not include these documents, the commissioner may
 52.5 recover or disallow the payment for such services. If the therapist determines that the
 52.6 therapy's nature, scope, duration, or intensity is not appropriate to the medical condition of
 52.7 the recipient, the therapist must provide a statement to that effect in writing to the nursing
 52.8 facility for inclusion in the recipient's medical record. The commissioner shall make
 52.9 recommendations regarding the medical necessity of services provided.

52.10 **Subd. 3. Separate billings for therapy services; nursing facility provider number.**
 52.11 Payment for therapy services provided to nursing facility residents that are billed separate
 52.12 from nursing facility's payment rate or according to Minnesota Rules, parts 9505.0170 to
 52.13 9505.0475, shall be subject to the requirements in this subdivision and subdivisions 4 to 8.

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

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

52.28 **Subd. 5. Separate billings for therapy services; unrelated vendors.** Nursing
 52.29 facilities shall limit charges in total to vendors of therapy services for renting space,
 52.30 equipment, or obtaining other services during the rate year to 108 percent of the annualized
 52.31 cost removed from the reporting period cost report resulting from the requirement of the
 52.32 commissioner to ensure the avoidance of double payments as determined by section
 52.33 256R.12, subdivisions 8 and 9. If the arrangement for therapy services is changed so that a
 52.34 nursing facility is subject to this subdivision instead of subdivision 4, the cost that is used
 52.35 to determine rent must be adjusted to exclude the annualized costs for therapy services
 52.36 that are not provided in the rate year. The maximum charges to the vendors shall be

53.1 based on the commissioner's determination of annualized cost and may be subsequently
 53.2 adjusted upon resolution of appeals.

53.3 Subd. 6. **Separate billings for therapy services; cost to revenue ratio.** The
 53.4 commissioner shall require reporting of all revenues relating to the provision of therapy
 53.5 services and shall establish a therapy cost, as determined by section 256R.12, subdivisions
 53.6 8 and 9, to revenue ratio for the reporting period ending in 1986. For subsequent reporting
 53.7 periods the ratio may increase five percentage points in total until a new base year is
 53.8 established under subdivision 7. Increases in excess of five percentage points may be
 53.9 allowed if adequate justification is provided to and accepted by the commissioner. Unless
 53.10 an exception is allowed by the commissioner, the amount of offset in subdivision 4 is
 53.11 the greater of the amount determined in subdivision 4 or the amount of offset that is
 53.12 imputed based on one minus the lesser of (1) the actual reporting period ratio or (2) the
 53.13 base reporting period ratio increased by five percentage points, multiplied by the revenues.

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

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

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

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

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

53.30 The revisor of statutes shall make necessary cross-reference changes and remove
 53.31 statutory cross-references in Minnesota Statutes and Minnesota Rules to conform with the
 53.32 recodification and repealer in this act. The revisor may make technical and other necessary
 53.33 changes to sentence structure to preserve the meaning of the text. The revisor may alter
 53.34 the statutory coding in this act to incorporate statutory changes made by other law in the
 53.35 2016 regular legislative session. If a provision repealed in this act is also amended in the

54.1 2016 regular legislative session by other law, the revisor shall merge the amendment into
 54.2 the recodification, notwithstanding Minnesota Statutes, section 645.30.

54.3 Sec. 43. **REPEALER.**

54.4 (a) Minnesota Statutes 2014, sections 256B.0911, subdivision 7; 256B.25,
 54.5 subdivision 4; 256B.27, subdivision 2a; 256B.41, subdivisions 1, 2, and 3; 256B.411,
 54.6 subdivisions 1 and 2; 256B.421, subdivisions 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and
 54.7 15; 256B.431, subdivisions 1, 2d, 2e, 2n, 2r, 2s, 2t, 3e, 32, 35, 42, and 44; 256B.432,
 54.8 subdivisions 1, 2, 3, 4, 4a, 5, 6, 6a, 7, and 8; 256B.433, subdivisions 1, 2, 3, and 3a;
 54.9 256B.434, subdivisions 2, 9, 11, 12, 14, 15, 16, 18, 19a, 20, and 21; 256B.437, subdivisions
 54.10 1, 3, 4, 5, 6, 7, 9, and 10; 256B.438, subdivisions 1, 2, 3, 4, 5, 6, 7, and 8; 256B.441,
 54.11 subdivisions 2, 3, 4, 7, 8, 9, 10, 11, 15, 18, 20, 22, 23, 24, 25, 27, 28a, 29, 32, 33a, 34, 36,
 54.12 37, 38, 39, 41, 42a, 43, 46b, 47, 49, 57, 59, 60, 61, and 64; 256B.47, subdivisions 1, 2, 3,
 54.13 and 4; and 256B.48, subdivisions 1, 1a, 1b, 1c, 3, 4, 5, 6a, 7, and 8, are repealed.

54.14 (b) Minnesota Statutes 2015 Supplement, sections 256B.431, subdivisions 2b and
 54.15 36; 256B.441, subdivisions 1, 5, 6, 11a, 13, 14, 17, 30, 31, 33, 35, 40, 44, 46c, 46d,
 54.16 48, 50, 51, 51a, 51b, 53, 54, 55a, 56, 63, 65, 66, and 67; and 256B.495, subdivisions 1
 54.17 and 5, are repealed.

54.18 (c) Minnesota Rules, parts 9549.0035, subparts 1, 3, 7, and 8; 9549.0041, subpart 6;
 54.19 9549.0055, subparts 1, 2, and 3; and 9549.0070, subparts 2 and 3, are repealed.

54.20 **ARTICLE 2**

54.21 **CONFORMING CHANGES**

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

54.24 Subd. 2. **Moratorium.** The commissioner of health, in coordination with the
 54.25 commissioner of human services, shall deny each request for new licensed or certified
 54.26 nursing home or certified boarding care beds except as provided in subdivision 3 or 4a,
 54.27 or section 144A.073. "Certified bed" means a nursing home bed or a boarding care bed
 54.28 certified by the commissioner of health for the purposes of the medical assistance program,
 54.29 under United States Code, title 42, sections 1396 et seq. Certified beds in facilities which
 54.30 do not allow medical assistance intake shall be deemed to be decertified for purposes
 54.31 of this section only. [256B.48, subd. 1, third unlettered paragraph after paragraph (g),
 54.32 with an old date removed]

54.33 The commissioner of human services, in coordination with the commissioner of
 54.34 health, shall deny any request to issue a license under section 252.28 and chapter 245A to

55.1 a nursing home or boarding care home, if that license would result in an increase in the
55.2 medical assistance reimbursement amount.

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

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

55.8 (b) the project:

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

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

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

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

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

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

55.26 Prior to the final plan approval of any construction project, the commissioner of
55.27 health shall be provided with an itemized cost estimate for the project construction costs.

55.28 If a construction project is anticipated to be completed in phases, the total estimated cost of
55.29 all phases of the project shall be submitted to the commissioner and shall be considered as
55.30 one construction project. Once the construction project is completed and prior to the final
55.31 clearance by the commissioner, the total project construction costs for the construction
55.32 project shall be submitted to the commissioner. If the final project construction cost
55.33 exceeds the dollar threshold in this subdivision, the commissioner of human services shall
55.34 not recognize any of the project construction costs or the related financing costs in excess
55.35 of this threshold in establishing the facility's property-related payment rate.

56.1 The dollar thresholds for construction projects are as follows: for construction
 56.2 projects other than those authorized in clauses (1) to (6), the dollar threshold is \$1,000,000.
 56.3 For projects authorized after July 1, 1993, under clause (1), the dollar threshold is the cost
 56.4 estimate submitted with a proposal for an exception under section 144A.073, plus inflation
 56.5 as calculated according to section 256B.431, subdivision 3f, paragraph (a). For projects
 56.6 authorized under clauses (2) to (4), the dollar threshold is the itemized estimate project
 56.7 construction costs submitted to the commissioner of health at the time of final plan approval,
 56.8 plus inflation as calculated according to section 256B.431, subdivision 3f, paragraph (a).

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

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

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

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

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

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

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

56.32 Subd. 1e. **Additional local share of certain nursing facility costs.** Beginning
 56.33 October 1, 2011, Participating local governmental entities that own the physical plant or are

57.1 the license holders of nursing facilities receiving rate adjustments under section ~~256B.441,~~
 57.2 ~~subdivision 55a 256R.48,~~ shall be responsible for paying the portion of nonfederal costs
 57.3 calculated under section ~~256B.441,~~ ~~subdivision 55a,~~ ~~paragraph (e) 256R.48,~~ ~~paragraph~~
 57.4 ~~(d).~~ Payments of the nonfederal share shall be submitted to the commissioner by the 15th
 57.5 day of the month prior to payment to the nursing facility for that month's services. If any
 57.6 participating governmental entity obligated to pay an amount under this subdivision does
 57.7 not make timely payment of the monthly installment, the commissioner shall revoke
 57.8 participation under this subdivision and end payments determined under section ~~256B.441,~~
 57.9 ~~subdivision 55a 256R.48,~~ to the participating nursing facility effective on the first day of
 57.10 the month for which timely payment was not received. In the event of revocation, the
 57.11 nursing facility may not bill, collect, or retain the amount allowed in section ~~256B.441,~~
 57.12 ~~subdivision 55a 256R.48,~~ from private-pay residents for days of service on or after the
 57.13 first day of the month following the month in which the revocation occurred.

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

57.15 Subd. 22. **Changes to nursing facility reimbursement.** ~~The nursing facility~~
 57.16 ~~reimbursement changes in paragraphs (a) to (d) apply to Minnesota Rules, parts 9549.0010~~
 57.17 ~~to 9549.0080, and this section, and are effective for rate years beginning on or after July 1,~~
 57.18 ~~1993, unless otherwise indicated.~~

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

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

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

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

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

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

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

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

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

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

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

58.7 ~~(4) additional conditions are:~~

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

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

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

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

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

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

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

59.1 ~~its workers' compensation self-insurance costs, it shall remain in effect until such time as~~
 59.2 ~~the group no longer self-insures these costs;~~

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

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

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

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

59.21 ~~(e) In the determination of incremental increases in the nursing facility's rental rate~~
 59.22 ~~as required in subdivisions 14 to 21, except for a refinancing permitted under subdivision~~
 59.23 ~~19, the commissioner must adjust the nursing facility's property-related payment rate for~~
 59.24 ~~both incremental increases and decreases in recomputations of its rental rate;~~

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

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

59.28 ~~(2) if the nursing facility's licensed beds are more than 150 licensed beds, but less~~
 59.29 ~~than 196 licensed beds, the general and administrative cost category limitation shall be~~
 59.30 ~~14 percent; or~~

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

59.33 ~~(e) For the rate year beginning on July 1, 1998, a group of nursing facilities related by~~
 59.34 ~~common ownership that self-insures group health, dental, or life insurance may allocate its~~
 59.35 ~~directly identified costs of self-insuring its Minnesota nursing facility workers among those~~
 59.36 ~~nursing facilities in the group that are reimbursed under this section or section 256B.434.~~

60.1 ~~The method of cost allocation shall be based on the ratio of each nursing facility's total~~
 60.2 ~~allowable salaries and wages to that of the nursing facility group's total allowable salaries~~
 60.3 ~~and wages, then similarly allocated within each nursing facility's operating cost categories.~~
 60.4 ~~The costs associated with the administration of the group's self-insurance plan must remain~~
 60.5 ~~classified in the nursing facility's administrative cost category. A written request of the~~
 60.6 ~~nursing facility group's election to use this alternate method of allocation of self-insurance~~
 60.7 ~~costs must be received by the commissioner no later than May 1, 1998, to take effect July~~
 60.8 ~~1, 1998, or those self-insurance costs shall continue to be allocated under the existing cost~~
 60.9 ~~allocation methods. Once a nursing facility group elects this method of cost allocation for~~
 60.10 ~~its group health, dental, or life insurance self-insurance costs, it shall remain in effect until~~
 60.11 ~~such time as the group no longer self-insures these costs.~~

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

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

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

61.1 the alternative payment demonstration project from seeking legislative approval of an
 61.2 exception to the moratorium under section 144A.071, and, if enacted, the facility's rates
 61.3 shall be adjusted to reflect the cost of the project.

61.4 ~~(e) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing~~
 61.5 ~~administration has not approved a required waiver, or the Centers for Medicare and~~
 61.6 ~~Medicaid Services otherwise requires cost reports to be filed prior to the waiver's approval,~~
 61.7 ~~the commissioner shall require a cost report for the rate year.~~

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

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

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

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

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

62.1 ~~specified in this subdivision. A nursing facility which does not submit a certified audit~~
 62.2 ~~must submit its working trial balance;~~

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

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

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

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

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

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

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

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

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

62.35 (e) ~~Both nursing facilities and~~ Intermediate care facilities for the developmentally
 62.36 disabled must maintain statistical and accounting records in sufficient detail to support

63.1 information contained in the facility's cost report for at least six years, including the year
 63.2 following the submission of the cost report. For computerized accounting systems, the
 63.3 records must include copies of electronically generated media such as magnetic discs
 63.4 and tapes.

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

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

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

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

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

63.20 ~~(b)~~ (c) "Provider" means a nursing facility as defined in section ~~256B.421, subdivision~~
 63.21 7 256R.02, subdivision 33, or a facility as defined in section 256B.501, subdivision 1.

63.22 ~~(e)~~ "Reimbursement rules" means ~~Minnesota Rules, parts 9510.0010 to 9510.0480,~~
 63.23 ~~9510.0500 to 9510.0890, and rules adopted by the commissioner pursuant to sections~~
 63.24 ~~256B.41 and 256B.501, subdivision 3.~~

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

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

63.28 Subd. 2. **Monthly rates; exemptions.** This subdivision applies to a residence
 63.29 that on August 1, 1984, was licensed by the commissioner of health only as a boarding
 63.30 care home, certified by the commissioner of health as an intermediate care facility, and
 63.31 licensed by the commissioner of human services under Minnesota Rules, parts 9520.0500
 63.32 to 9520.0690. Notwithstanding the provisions of subdivision 1c, the rate paid to a facility
 63.33 reimbursed under this subdivision shall be determined under ~~section 256B.431, 256B.434,~~

64.1 ~~or 256B.441~~ chapter 256R, if the facility is accepted by the commissioner for participation
64.2 in the alternative payment demonstration project. The rate paid to this facility shall also
64.3 include adjustments to the group residential housing rate according to subdivision 1, and
64.4 any adjustments applicable to supplemental service rates statewide.

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256B.0911 LONG-TERM CARE CONSULTATION SERVICES.

Subd. 7. **Reimbursement for certified nursing facilities.** (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 completed 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.

256B.25 PAYMENTS TO CERTIFIED FACILITIES.

Subd. 4. **Payment during suspended admissions.** A nursing home or boarding care home that has received a notice to suspend admissions under section 144A.10, subdivision 4a, 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.

256B.27 MEDICAL ASSISTANCE; COST REPORTS.

Subd. 2a. **Cost and statistical data audits.** 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.

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.

256B.41 INTENT.

Subdivision 1. **Authority.** 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 section and sections 256B.421, 256B.431, 256B.432, 256B.433, 256B.47, 256B.48, 256B.50, and 256B.502. The procedures shall specify the costs that are allowable for establishing payment rates through medical assistance.

Subd. 2. **Federal requirements.** If any provision of this section and sections 256B.421, 256B.431, 256B.432, 256B.433, 256B.47, 256B.48, 256B.50, and 256B.502, 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.

Subd. 3. **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.

256B.411 COMPLIANCE WITH STATE STATUTES.

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Subdivision 1. **Funding.** 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. **Requirements.** 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. 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 rules adopted under it that govern participation in the program. This section applies whether the nursing facility participates fully in the medical assistance program or is withdrawing from the medical assistance program. No future payments may be made to any nursing facility which has withdrawn or is withdrawing from the medical assistance program except as provided in section 256B.48, subdivision 1a, or federal law. Payments may also be made under a court order entered on or before June 7, 1985, unless the court order is reversed on appeal.

256B.421 DEFINITIONS.

Subd. 2. **Actual allowable historical operating cost per diem.** "Actual allowable historical operating cost per diem" means the per diem operating costs allowed by the commissioner for the most recent reporting year.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 4. **Final rate.** "Final rate" means the rate established after any adjustment by the commissioner, including but not limited to adjustments resulting from cost report reviews and field audits.

Subd. 5. **General and administrative costs.** "General and administrative costs" means all allowable costs for administering the facility, including but not limited to: salaries of administrators, assistant administrators, accounting personnel, data processing personnel, and all clerical personnel; board of directors fees; business office functions and supplies; travel, except as necessary for training programs for nursing personnel and dietitians required to maintain licensure, certification, or professional standards requirements; telephone and telegraph; advertising; membership dues and subscriptions; postage; insurance, except as included as a fringe benefit under subdivision 14; professional services such as legal, accounting and data processing services; central or home office costs; management fees; management consultants; employee training, for any top management personnel and for other than direct resident care related personnel; and business meetings and seminars.

Subd. 6. **Historical operating costs.** "Historical operating costs" means the allowable operating costs incurred by the facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective, after the commissioner has reviewed those costs and determined them to be allowable costs under the medical assistance program, and after the commissioner has applied appropriate limitations such as the limit on administrative costs.

Subd. 7. **Nursing facility.** "Nursing facility" means a facility licensed under chapter 144A or a boarding care facility licensed under sections 144.50 to 144.56.

Subd. 8. **Operating costs.** "Operating costs" means the day-to-day costs of operating the facility in compliance with licensure and certification standards. Operating cost categories are: nursing, including nurses and nursing assistants training; dietary; laundry and linen; housekeeping; plant operation and maintenance; other care-related services; medical directors; licenses, other than license fees required by the Minnesota Department of Health; permits; general and administration; payroll taxes; real estate taxes, license fees required by the Minnesota Department of Health, and actual special assessments paid; and fringe benefits, including clerical training; and travel necessary for training programs for nursing personnel and dietitians required to maintain licensure, certification, or professional standards requirements.

Subd. 9. **Payment rate.** "Payment rate" means the rate determined under section 256B.431.

Subd. 10. **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. 11. **Rate year.** "Rate year" means the fiscal year for which a payment rate determined under section 256B.431 is effective, from July 1 to the next June 30.

Subd. 12. **Reporting year.** "Reporting year" means the period from October 1 to September 30, immediately preceding the rate year, for which the nursing facility submits reports required under section 256B.48, subdivision 2.

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Subd. 13. **Actual resident day.** "Actual resident day" means a billable, countable day as defined by the commissioner.

Subd. 14. **Fringe benefits.** "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, except for Public Employee Retirement Act contributions, and uniform allowances.

Subd. 15. **Payroll taxes.** "Payroll taxes" means the employer's share of FICA taxes, governmentally required retirement contributions, and state and federal unemployment insurance taxes.

256B.431 RATE DETERMINATION.

Subdivision 1. **In general.** The commissioner shall determine prospective payment rates for resident care costs. For rates established on or after July 1, 1985, the commissioner shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs, geographic location, and other factors as determined by the commissioner. The commissioner shall consider whether the fact that a facility is attached to a hospital or has an average length of stay of 180 days or less should be taken into account in determining rates. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. The commissioner shall provide notice to each nursing facility on or before August 15 of the rates effective for the following rate year except that if legislation is pending on August 15 that may affect rates for nursing facilities, the commissioner shall set the rates after the legislation is enacted and provide notice to each facility as soon as possible.

Compensation for top management personnel shall continue to be categorized as a general and administrative cost and is subject to any limits imposed on that cost category.

Subd. 2b. **Operating costs after July 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner shall establish procedures for determining per diem reimbursement for operating costs.

(b) The commissioner shall contract with an econometric firm with recognized expertise in and access to national economic change indices that can be applied to the appropriate cost categories when determining the operating cost payment rate.

(c) The commissioner shall analyze and evaluate each nursing facility's cost report of allowable operating costs incurred by the nursing facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective.

(d) The commissioner shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs for the reporting year that begins October 1, 1983, taking into consideration relevant factors including resident needs, geographic location, and size of the nursing facility. In developing the geographic groups for purposes of reimbursement under this section, the commissioner shall ensure that nursing facilities in any county contiguous to the Minneapolis-St. Paul seven-county metropolitan area are included in the same geographic group. The limits established by the commissioner shall not be less, in the aggregate, than the 60th percentile of total actual allowable historical operating cost per diems for each group of nursing facilities established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year. For rate years beginning on or after July 1, 1989, facilities located in geographic group I as described in Minnesota Rules, part 9549.0052, on January 1, 1989, may choose to have the commissioner apply either the care related limits or the other operating cost limits calculated for facilities located in geographic group II, or both, if either of the limits calculated for the group II facilities is higher. The efficiency incentive for geographic group I nursing facilities must be calculated based on geographic group I limits. The phase-in must be established utilizing the chosen limits. For purposes of these exceptions to the geographic grouping requirements, the definitions in Minnesota Rules, parts 9549.0050 to 9549.0059 (Emergency), and 9549.0010 to 9549.0080, apply. The limits established under this paragraph remain in effect until the commissioner establishes a new base period. Until the new base period is established, the commissioner shall adjust the limits annually using the appropriate economic change indices established in paragraph (e). In determining allowable historical operating cost per diems for purposes of setting limits and nursing facility payment rates, the commissioner shall divide the allowable historical operating costs by the actual number of resident days, except that where a nursing facility is occupied at less than 90 percent of licensed capacity days, the commissioner may establish procedures to adjust the computation of the per diem to an imputed occupancy level at or below 90 percent. The commissioner shall establish efficiency incentives as appropriate. The commissioner may establish efficiency incentives for different operating cost categories. The commissioner shall consider establishing efficiency incentives in care related cost categories. The commissioner may combine one or more operating cost categories and may use

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different methods for calculating payment rates for each operating cost category or combination of operating cost categories. For the rate year beginning on July 1, 1985, the commissioner shall:

(1) allow nursing facilities that have an average length of stay of 180 days or less in their skilled nursing level of care, 125 percent of the care related limit and 105 percent of the other operating cost limit established by rule; and

(2) exempt nursing facilities licensed on July 1, 1983, by the commissioner to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3600, from the care related limits and allow 105 percent of the other operating cost limit established by rule.

For the purpose of calculating the other operating cost efficiency incentive for nursing facilities referred to in clause (1) or (2), the commissioner shall use the other operating cost limit established by rule before application of the 105 percent.

(e) The commissioner shall establish a composite index or indices by determining the appropriate economic change indicators to be applied to specific operating cost categories or combination of operating cost categories.

(f) Each nursing facility shall receive an operating cost payment rate equal to the sum of the nursing facility's operating cost payment rates for each operating cost category. The operating cost payment rate for an operating cost category shall be the lesser of the nursing facility's historical operating cost in the category increased by the appropriate index established in paragraph (e) for the operating cost category plus an efficiency incentive established pursuant to paragraph (d) or the limit for the operating cost category increased by the same index. If a nursing facility's actual historic operating costs are greater than the prospective payment rate for that rate year, there shall be no retroactive cost settle up. In establishing payment rates for one or more operating cost categories, the commissioner may establish separate rates for different classes of residents based on their relative care needs.

(g) The commissioner shall include the reported actual real estate tax liability or payments in lieu of real estate tax of each nursing facility as an operating cost of that nursing facility. Allowable costs under this subdivision 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. For rate years beginning on or after July 1, 1987, the reported actual real estate tax liability or payments in lieu of real estate tax of nursing facilities shall be adjusted to include an amount equal to one-half of the dollar change in real estate taxes from the prior year. The commissioner shall include a reported actual special assessment, and reported actual license fees required by the Minnesota Department of Health, for each nursing facility as an operating cost of that nursing facility. For rate years beginning on or after July 1, 1989, the commissioner shall include a nursing facility's reported Public Employee Retirement Act contribution for the reporting year as apportioned to the care-related operating cost categories and other operating cost categories multiplied by the appropriate composite index or indices established pursuant to paragraph (e) as costs under this paragraph. Total adjusted real estate tax liability, payments in lieu of real estate tax, actual special assessments paid, the indexed Public Employee Retirement Act contribution, and license fees paid as required by the Minnesota Department of Health, for each nursing facility (1) shall be divided by actual resident days in order to compute the operating cost payment rate for this operating cost category, (2) shall not be used to compute the care-related operating cost limits or other operating cost limits established by the commissioner, and (3) shall not be increased by the composite index or indices established pursuant to paragraph (e), unless otherwise indicated in this paragraph.

Subd. 2d. **Cost report or audit.** 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 and the interagency long-term care planning committee. If a field audit reveals that unallowable expenditures have been included in the nursing facility's historical operating costs, the commissioner shall disallow the expenditures and recover the entire overpayment. The commissioner shall establish, by rule, procedures for assessing an interest charge at the rate determined for unpaid taxes or penalties under section 270C.40 on any outstanding balance resulting from an overpayment or underpayment.

Subd. 2e. **Contracts for services for ventilator-dependent persons.** (a) 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;

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(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 cost 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. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate under this subdivision negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest multiple bedroom payment rate for the facility, as initially established by the commissioner for the rate year for case mix classification K; or, upon implementation of the RUG's-based case mix system, 200 percent of the highest RUG's rate. For persons initially admitted to a nursing facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the facility's multiple bedroom payment rate for case mix classification K; or, upon implementation of the RUG's-based case mix system, 300 percent of the highest RUG's rate. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256B.48, subdivision 1.

(b) Effective July 1, 2007, or upon opening a unit of at least ten beds dedicated to care of ventilator-dependent persons in partnership with Mayo Health Systems, whichever is later, the operating payment rates for residents determined eligible under paragraph (a) of a nursing facility in Waseca County that on February 1, 2007, was licensed for 70 beds and reimbursed under this section, section 256B.434, or section 256B.441, shall be 300 percent of the facility's highest RUG rate.

Subd. 2n. **Efficiency incentive reductions for substandard care.** For rate years beginning on or after July 1, 1991, the efficiency incentive established under subdivision 2b, paragraph (d), shall be reduced or eliminated for nursing facilities determined by the commissioner of health under section 144A.10, subdivision 4, to have uncorrected or repeated violations which create a risk to resident care, safety, or rights, except for uncorrected or repeated violations relating to a facility's physical plant. Upon being notified by the commissioner of health of uncorrected or repeated violations, the commissioner of human services shall require the nursing facility to use efficiency incentive payments to correct the violations. The commissioner of human services shall require the nursing facility to forfeit efficiency incentive payments for failure to correct the violations. Any forfeiture shall be limited to the amount necessary to correct the violation.

Subd. 2r. **Payment restrictions on leave days.** (a) Effective July 1, 1993, the commissioner shall limit payment for leave days in a nursing facility to 79 percent of that nursing facility's total payment rate for the involved resident.

(b) For services rendered on or after July 1, 2003, for facilities reimbursed under this section or section 256B.434, the commissioner shall limit payment for leave days in a nursing facility to 60 percent of that nursing facility's total payment rate for the involved resident.

(c) For services rendered on or after July 1, 2011, for facilities reimbursed under this chapter, 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.

Subd. 2s. **Nonallowable cost.** 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.

Subd. 2t. **Payment limitation.** For services rendered on or after July 1, 2003, for facilities reimbursed under this chapter, 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 Medicaid RUG-III case-mix payment rate, or, beginning January 1, 2012, the Medicaid RUG-IV case-mix payment rate. The amount that shall be paid by the Medicaid program is equal to the amount by which the Medicaid RUG-III or RUG-IV case-mix 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.

Subd. 3e. **Hospital-attached convalescent and nursing care facilities.** If a nonprofit or community-operated hospital and attached convalescent and nursing care facility suspend

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operation of the hospital, the surviving nursing care facility must be allowed to continue its status as a hospital-attached convalescent and nursing care facility for reimbursement purposes in five subsequent rate years. In the fourth year the facility shall receive 60 percent of the difference between the hospital-attached limit and the freestanding nursing facility limit, and in the fifth year the facility shall receive 30 percent of the difference.

Subd. 32. **Payment during first 30 days.** (a) For rate years beginning on or after July 1, 2011, the total payment rate for a facility reimbursed under this section, section 256B.434, or any other section shall be:

(1) for the first 30 calendar days after admission, the rate shall be 120 percent of the facility's medical assistance rate for each RUG class;

(2) beginning with the 31st calendar day after admission, the payment rate shall be the rate otherwise determined under this section, section 256B.434, or any other section; and

(3) payments under this paragraph apply to admissions occurring on or after July 1, 2011.

(b) The enhanced rates under this subdivision 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.

Subd. 35. **Exclusion of raw food cost adjustment.** For rate years beginning on or after July 1, 2001, in calculating a nursing facility's operating cost per diem for the purposes of comparing to an array, a median, or other statistical measure of nursing facility payment rates to be used to determine future rate adjustments under this section, section 256B.434, or any other section, the commissioner shall exclude adjustments for raw food costs under subdivision 2b, paragraph (h), that are related to providing special diets based on religious beliefs.

Subd. 36. **Employee scholarship costs and training in English as a second language.**

(a) For the period between July 1, 2001, and June 30, 2003, the commissioner shall provide to each nursing facility reimbursed under this section, section 256B.434, or any other section, a scholarship per diem of 25 cents to the total operating payment rate. 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 subdivision 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 subdivision 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 subdivision.

(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.

Subd. 42. **Incentive to establish single-bed rooms.** (a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed under this section, section 256B.434, or 256B.441 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

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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).

(c) If after August 1, 2005, and before December 31, 2007, more than 4,000 nursing home beds are removed from service, a portion of the appropriation for nursing homes shall be transferred to the alternative care program. The amount of this transfer shall equal the number of beds removed from service less 4,000, multiplied by the average monthly per-person cost for alternative care, multiplied by 12, and further multiplied by 0.3.

Subd. 44. **Property rate increases for certain nursing facilities.** (a) Notwithstanding any other law to the contrary, money available for moratorium projects under section 144A.073, subdivision 11, shall be used, effective November 1, 2010, to fund an approved moratorium exception project for a nursing facility in Bloomington licensed for 137 beds as of November 1, 2010, up to a total property rate adjustment of \$19.33.

(b) Effective June 1, 2012, any nursing facility in McLeod County licensed for 110 beds shall have its replacement-cost-new limit under subdivision 17e adjusted to allow \$1,129,463 of a completed construction project to increase the property payment rate. Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increase in the replacement-cost-new limit.

(c) Effective July 1, 2012, any nursing facility in Dakota County licensed for 61 beds shall have their replacement-cost-new limit under subdivision 17e adjusted to allow \$1,407,624 of a completed construction project to increase their property payment rate. Effective September 1, 2013, or later, their replacement-cost-new limit under subdivision 17e shall be adjusted to allow \$1,244,599 of a completed construction project to increase the property payment rate. Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increase in the replacement-cost-new limit.

(d) Effective July 1, 2013, or later, any boarding care facility in Hennepin County licensed for 101 beds shall be allowed to receive a property rate adjustment for a construction project that takes action to come into compliance with Minnesota Department of Labor and Industry elevator upgrade requirements, with costs below the minimum threshold under subdivision 16. Only costs related to the construction project that brings the facility into compliance with the elevator requirements shall be allowed. Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance program.

256B.432 LONG-TERM CARE FACILITIES; OFFICE COSTS.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "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

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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 a year, that does not publish notice of its meetings, or that does not keep formal records of its proceedings.

(b) "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.

(c) "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. 2. **Effective date.** For rate years beginning on or after July 1, 1990, the central, affiliated, or corporate office cost allocations in subdivisions 3 to 6 must be used when determining medical assistance rates under section 256B.431, 256B.434, or 256B.441.

Subd. 3. **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. 4. **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 3 must be allocated to that activity or function.

Subd. 4a. **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 5, 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 will 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. 5. **Allocation of remaining costs; allocation ratio.** (a) After the costs that can be directly identified according to subdivisions 3 and 4 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 shall be 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 shall be 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 shall be equal to the sum of the total operating costs incurred by the nonnursing facility related organizations;

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(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 shall be 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 shall be 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. 6. Cost allocation between nursing facilities. (a) Those nursing operations that have nursing facilities both in Minnesota and comparable facilities outside of Minnesota must allocate the nursing operation's central, affiliated, or corporate office costs identified in subdivision 5 to Minnesota based on the ratio of total resident days in Minnesota nursing facilities to the total resident days in all 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. 6a. 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 shall be 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.

Subd. 7. Receiverships. This section does not apply to payment rates determined under sections 245A.12, 245A.13, and 256B.495, 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. Adequate documentation supporting long-term care facility payrolls. Beginning July 1, 1998, payroll records supporting compensation costs claimed by long-term care 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.

256B.433 ANCILLARY SERVICES.

Subdivision 1. Setting payment; monitoring use of therapy services. 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. 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 the avoidance of double payments through audits and adjustments to the nursing facility's annual cost report as required by section 256B.47, and that charges and arrangements for ancillary materials and services are cost-effective and as would be incurred by a prudent and cost-conscious buyer. 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

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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 3, paragraph (c). 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 3, paragraph (c), for services not medically necessary. For purposes of this section and section 256B.47, 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. 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 utilize a peer review program that meets the requirements of section 256B.064, subdivision 1a, to make recommendations regarding the medical necessity of services provided.

Subd. 3. Separate billings for therapy services. Until new procedures are developed under subdivision 4, 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 following requirements:

(a) 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.

(b) 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 year for therapy services provided to residents of the nursing facility. For rate years beginning on or after July 1, 1988, the commissioner shall offset the revenues received during the reporting year 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 nursing facility's actual resident days. Except as specified in paragraphs (d) and (f), 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 256B.47. Therapy revenues that are specific to mental health services shall be subject to this paragraph for rate years beginning after June 30, 1993. In establishing a new base period for the purpose of setting operating cost payment rate limits and rates, the commissioner shall not include the revenues offset in accordance with this section.

(c) For rate years beginning on or after July 1, 1987, 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 year cost report resulting from the requirement of the commissioner to ensure the avoidance of double payments as determined by section 256B.47. If the arrangement for therapy services is changed so that a nursing facility is subject to this paragraph instead of paragraph (b), 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. Mental health services shall be subject to this paragraph for rate years beginning after June 30, 1993.

(d) 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 256B.47, to revenue

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ratio for the reporting year ending in 1986. For subsequent reporting years, the ratio may increase five percentage points in total until a new base year is established under paragraph (e). 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 paragraph (b) is the greater of the amount determined in paragraph (b) or the amount of offset that is imputed based on one minus the lesser of (1) the actual reporting year ratio or (2) the base reporting year ratio increased by five percentage points, multiplied by the revenues.

(e) The commissioner may establish a new reporting year base for determining the cost to revenue ratio.

(f) If the arrangement for therapy services is changed so that a nursing facility is subject to the provisions of paragraph (b) instead of paragraph (c), an average cost to revenue ratio based on the ratios of nursing facilities that are subject to the provisions of paragraph (b) shall be imputed for paragraph (d).

(g) 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 shall be subject to the penalty requirements of section 256B.48, subdivision 1, paragraph (f).

Subd. 3a. **Exemption from requirement for separate therapy billing.** The provisions of subdivision 3 do not apply to nursing facilities that are reimbursed according to the provisions of section 256B.431. Nursing facilities that are reimbursed according to the provisions of section 256B.434 and are located in a county participating in the prepaid medical assistance program are exempt from the maximum therapy rent revenue provisions of subdivision 3, paragraph (c).

256B.434 ALTERNATIVE PAYMENT DEMONSTRATION PROJECT.

Subd. 2. **Requests for proposals.** (a) At least twice annually the commissioner shall publish in the State Register a request for proposals to provide nursing facility services according to this section. The commissioner must respond to all proposals in a timely manner.

(b) The commissioner may reject any proposal if, in the judgment of the commissioner, a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota. The commissioner may accept up to the number of proposals that can be adequately supported with available state resources, as determined by the commissioner. The commissioner may accept proposals from a single nursing facility or from a group of facilities through a managing entity. The commissioner shall seek to ensure that nursing facilities under contract are located in all geographic areas of the state.

(c) In issuing the request for proposals, the commissioner may develop reasonable requirements which, in the judgment of the commissioner, are necessary to protect residents or ensure that the contractual alternative payment demonstration project furthers the interest of the state of Minnesota. The request for proposals may include, but need not be limited to, the following:

(1) a requirement that a nursing facility make reasonable efforts to maximize Medicare payments on behalf of eligible residents;

(2) requirements designed to prevent inappropriate or illegal discrimination against residents enrolled in the medical assistance program as compared to private paying residents;

(3) requirements designed to ensure that admissions to a nursing facility are appropriate and that reasonable efforts are made to place residents in home and community-based settings when appropriate;

(4) a requirement to agree to participate in a project to develop data collection systems and outcome-based standards. Among other requirements specified by the commissioner, each facility entering into a contract may be required to pay an annual fee. Revenue generated from the fees is appropriated to the commissioner and must be used to contract with a qualified consultant or contractor to develop data collection systems and outcome-based contracting standards;

(5) a requirement that contractors agree to maintain Medicare cost reports and to submit them to the commissioner upon request or at times specified by the commissioner;

(6) a requirement for demonstrated willingness and ability to develop and maintain data collection and retrieval systems to be used in measuring outcomes; and

(7) a requirement to provide all information and assurances required by the terms and conditions of the federal waiver or federal approval.

(d) In addition to the information and assurances contained in the submitted proposals, the commissioner may consider the following in determining whether to accept or deny a proposal:

(1) the facility's history of compliance with federal and state laws and rules, except that a facility deemed to be in substantial compliance with federal and state laws and rules is eligible to

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respond to a request for proposal. A facility's compliance history shall not be the sole determining factor in situations where the facility has been sold and the new owners have submitted a proposal;

(2) whether the facility has a record of excessive licensure fines or sanctions or fraudulent cost reports;

(3) financial history and solvency; and

(4) other factors identified by the commissioner that the commissioner deems relevant to a determination that a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

(e) If the commissioner rejects the proposal of a nursing facility, the commissioner shall provide written notice to the facility of the reason for the rejection, including the factors and evidence upon which the rejection was based.

Subd. 9. **Managed care contracts for other services.** Beginning July 1, 1995, the commissioner may contract with nursing facilities that have entered into alternative payment demonstration project contracts under this section to provide medical assistance services other than nursing facility care to residents of the facility under a prepaid, managed care payment system. Managed care contracts for other services may be entered into at any time during the duration of a nursing facility's alternative payment demonstration project contract, and the terms of the managed care contracts need not coincide with the terms of the alternative payment demonstration project contract.

Subd. 11. **Consumer protection.** As a condition of entering into a contract under this section, a nursing facility must agree to establish resident grievance procedures that are similar to those required under section 256.045, subdivision 3. The commissioner may also require nursing facilities to establish expedited grievance procedures to resolve complaints made by short-stay residents. The facility must notify its resident council of its intent to enter into a contract and must consult with the council regarding any changes in operation expected as a result of the contract.

Subd. 12. **Contracts are voluntary.** Participation of nursing facilities in the alternative payment demonstration project is voluntary. The terms and procedures governing the alternative payment demonstration project are determined under this section and through negotiations between the commissioner and nursing facilities that have submitted a letter of intent to participate in the alternative demonstration project. For purposes of developing requests for proposals and contract requirements, and negotiating the terms, conditions, and requirements of contracts the commissioner is exempt from the rulemaking requirements in chapter 14 until December 31, 2000.

Subd. 14. **Federal requirements.** The commissioner shall implement the contractual alternative payment demonstration project subject to any required federal waivers or approval and in a manner that is consistent with federal requirements. If a provision of this section is inconsistent with a federal requirement the federal requirement supersedes the inconsistent provision. The commissioner shall seek federal approval and request waivers as necessary to implement this section.

Subd. 15. **External review panel.** The commissioner may establish an external review panel consisting of persons appointed by the commissioner for their expertise on issues relating to nursing facility services, quality, payment systems, and other matters, to advise the commissioner on the development and implementation of the contractual alternative payment demonstration project and to assist the commissioner in assessing the quality of care provided and evaluating a facility's compliance with performance standards specified in a contract. The external review panel must include, among other members, representatives of nursing facilities.

Subd. 16. **Alternative contracts.** The commissioner may also contract with nursing facilities in other ways through requests for proposals, including contracts on a risk or nonrisk basis, with nursing facilities or consortia of nursing facilities, to provide comprehensive long-term care coverage on a premium or capitated basis.

Subd. 18. **Facilities without APS contracts as of October 1, 2006.** Effective October 1, 2006, payment rates for property shall no longer be determined under section 256B.431. A facility that does not have a contract with the commissioner under this section shall not be eligible for a rate increase.

Subd. 19a. **Nursing facility rate adjustments beginning September 1, 2013.** A total of a five percent average rate adjustment shall be provided as described under this subdivision and under section 256B.441, subdivision 46b.

(a) Beginning September 1, 2013, the commissioner shall make available to each nursing facility reimbursed under this section a 3.75 percent operating payment rate increase, in accordance with paragraphs (b) to (g).

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except:

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- (1) the administrator;
 - (2) persons employed in the central office of a corporation that has an ownership interest in the nursing facility or exercises control over the nursing facility; and
 - (3) persons paid by the nursing facility under a management contract.
- (c) The commissioner shall allow as compensation-related costs all costs for:
- (1) wage and salary increases effective after May 25, 2013;
 - (2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;
 - (3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and
 - (4) other benefits provided and workforce needs, including the recruiting and training of employees, subject to the approval of the commissioner.
- (d) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements of paragraph (b) shall be provided to nursing facilities effective September 1, 2013. Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraph (b). The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the nursing facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:
- (1) an estimate of the amounts of money that must be used as specified in paragraph (b);
 - (2) a detailed distribution plan specifying the allowable compensation-related increases the nursing facility will implement to use the funds available in clause (1);
 - (3) a description of how the nursing facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and
 - (4) instructions for employees who believe they have not received the compensation-related increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.
- (e) The commissioner shall ensure that cost increases in distribution plans under paragraph (d), clause (2), that may be included in approved applications, comply with the following requirements:
- (1) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct-care employees;
 - (2) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2013, and prior to April 1, 2014; and
 - (3) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent, and dated after May 25, 2013. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this provision as having been met in regard to the members of the bargaining unit.
- (f) The commissioner shall review applications received under paragraph (d) and shall provide the portion of the rate adjustment under paragraph (b) if the requirements of this subdivision have been met. The rate adjustment shall be effective September 1, 2013. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.
- (g) The increase in this subdivision shall be applied as a percentage to operating payment rates in effect on August 31, 2013. For each facility, the commissioner shall determine the operating payment rate, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under section 256B.441, subdivision 55a, critical access nursing facility program participation under section 256B.441, subdivision 63,

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or performance-based incentive payment program participation under subdivision 4, paragraph (d), for a RUG class with a weight of 1.00 in effect on August 31, 2013.

Subd. 20. **Payment of Public Employees Retirement Association costs.** Nursing facilities that participate in the Public Employees Retirement Association (PERA) shall have the component of their payment rate associated with the costs of PERA determined for each rate year. Effective for rate years beginning on and after October 1, 2007, the commissioner shall determine the portion of the payment rate in effect on September 30 each year and shall subtract that amount from the payment rate to be effective on the following October 1. The portion that shall be deemed to be included in the September 30, 2007, rate that is associated with PERA costs shall be the allowed costs in the facility's base for determining rates under this section, divided by the resident days reported for that year. The commissioner shall add to the payment rate to be effective on October 1 each year an amount equal to the reported costs associated with PERA, for the year ending on the most recent September 30 for which data is available, divided by total resident days for that year, as reported by the facility and audited under section 256B.441.

Subd. 21. **Payment of post-PERA pension benefit costs.** Nursing facilities that convert or converted after September 30, 2006, from public to private ownership shall have a portion of their post-PERA pension costs treated as a component of the historic operating rate. Effective for the rate years beginning on or after October 1, 2009, and prior to October 1, 2016, the commissioner shall determine the pension costs to be included in the facility's base for determining rates under this section by using the following formula: post-privatization pension benefit costs as a percentage of salary shall be determined from either the cost report for the first full reporting year after privatization or the most recent report year available, whichever is later. This percentage shall be applied to the salary costs of the alternative payment system base rate year to determine the allowable amount of pension costs. The adjustments provided for in sections 256B.431, 256B.434, and 256B.441, and any other law enacted after the base rate year and prior to the year for which rates are being determined shall be applied to the allowable amount. The adjusted allowable amount shall be added to the operating rate effective the first rate year PERA ceases to remain as a pass-through component of the rate.

256B.437 NURSING FACILITY VOLUNTARY CLOSURE; ALTERNATIVES.

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to subdivisions 2 to 8.

(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. 3. **Applications for planned closure of nursing facilities.** (a) By August 15, 2001, the commissioner of human services shall implement and announce a program for closure or partial closure of nursing facilities. Names and identifying information provided in response to the announcement shall remain private unless approved, according to the timelines established in the plan. The announcement must specify:

(1) the criteria in subdivision 4 that will be used by the commissioner to approve or reject applications;

(2) the information that must accompany an application; and

(3) that applications may combine planned closure rate adjustments with moratorium exception funding, in which case a single application may serve both purposes.

Between August 1, 2001, and June 30, 2003, the commissioner may approve planned closures of up to 5,140 nursing facility beds, less the number of beds delicensed in facilities during the same time period without approved closure plans or that have notified the commissioner of health of their intent to close without an approved closure plan. Beginning July 1, 2004, the commissioner may negotiate a planned closure rate adjustment for nursing facilities providing the proposal, cumulatively, with other proposals that have been approved, has no cost to the state.

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For planned closure rate adjustments negotiated after March 1, 2006, the limit of \$2,080 in subdivision 6, paragraph (a), clause (1), shall not apply. The removal of the limit in subdivision 6, paragraph (a), clause (1), shall not constitute an increase to the amount specified in subdivision 6, paragraph (a), clause (1), for the purposes of subdivision 6, paragraph (f).

(b) A facility or facilities reimbursed under section 256B.431 or 256B.434 with a closure plan approved by the commissioner under subdivision 5 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 6. 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 6, unless they are delicensing five or fewer beds, or less than six percent of their total licensed bed capacity, whichever is greater, are located in a county in the top three quartiles of beds per 1,000 persons aged 65 or older, and have not delicensed beds in the prior three months. Facilities meeting these criteria are eligible to assign the amount calculated under subdivision 6 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 6, the commissioner shall calculate the amount the facility would have been eligible to assign under subdivision 6, 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.

(c) To be considered for approval, 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;

(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; and

(6) an explanation of how the application coordinates with planning efforts under subdivision 2. 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.

(d) The application must address the criteria listed in subdivision 4.

Subd. 4. **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;

(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. 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;

(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

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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. 5. Review and approval of applications. (a) The commissioner of human services, in consultation with the commissioner of health, shall approve or disapprove an application within 30 days after receiving it. The commissioner may appoint an advisory review panel composed of representatives of counties, SAIL projects, 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 of human services, unless commencement of closure has begun.

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

Subd. 6. Planned closure rate adjustment. (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds 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 shall be 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 shall be effective from the date the per bed dollar amount is increased.

(f) For planned closures approved after June 30, 2009, the commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

(g) Between July 16, 2011, and June 30, 2013, the commissioner shall not accept applications for planned closure rate adjustments under subdivision 3.

Subd. 7. Other rate adjustments. Facilities receiving planned closure rate adjustments remain eligible for any applicable rate adjustments provided under section 256B.431, 256B.434, or any other section.

Subd. 9. Transfer of beds. The board of commissioners of St. Louis County may amend their planned closure rate adjustment application to allow up to 50 beds of a 159-licensed bed county-owned nursing facility that is in the process of closing to be transferred to a hospital-attached nursing facility in Aurora and up to 50 beds to a 235-bed nursing facility in Duluth, and may also assign all or a portion of the planned closure rate adjustment that would be received as a result of closure to the Aurora facility or the Duluth facility.

Subd. 10. Big Stone County rate adjustment. Notwithstanding the requirements of this section, the commissioner shall approve a planned closure rate adjustment in Big Stone County

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for an eight-bed facility in Clinton for reassignment to a 50-bed facility in Graceville. The adjustment shall be calculated according to subdivisions 3 and 6.

256B.438 IMPLEMENTATION OF A CASE MIX SYSTEM.

Subdivision 1. **Scope.** This section establishes the method and criteria used to determine resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes whose payment rates are established under section 256B.431, 256B.434, or 256B.441 or any other section. Resident reimbursement classifications shall be established according to the 34 group, resource utilization groups, version III or RUG-III model as described in section 144.0724. Reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003. Reimbursement classifications established under this section shall be implemented no earlier than six weeks after the commissioner mails notices of payment rates to the facilities. Effective January 1, 2012, resident reimbursement classifications shall be established according to the 48 group, resource utilization groups, RUG-IV model under section 144.0724.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given.

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

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

(c) "Index maximization" has the meaning given in section 144.0724, subdivision 2, paragraph (c).

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

(e) "Representative" has the meaning given in section 144.0724, subdivision 2, paragraph (e).

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

Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study and adjusted for Minnesota-specific wage indices. The case mix indices assigned to each resident class shall be published in the Minnesota State Register at least 120 days prior to the implementation of the 34 group, RUG-III resident classification system.

(b) An index maximization approach shall be used to classify residents.

(c) After implementation of the revised case mix system, the commissioner of human services may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the Minnesota State Register adjusted case mix indices at least 45 days prior to the effective date of the adjusted case mix indices.

(d) Upon implementation of the 48-group RUG-IV resident classification system, the commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study. The case mix indices assigned to each resident class shall be published in the State Register at least 120 days prior to the implementation of the RUG-IV resident classification system.

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

(b) The resident reimbursement classifications established under section 144.0724, subdivision 3, 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.

(c) Effective October 1, 2006, the commissioner shall rebase payment rates to account for the change in the resident assessment schedule in section 144.0724, subdivision 4, paragraph (b), clause (4), in a facility specific budget neutral manner, according to subdivision 7, paragraph (b).

(d) Effective January 1, 2012, the commissioner shall determine payment rates to account for the transition to RUG-IV, in a facility-specific, revenue-neutral manner, according to subdivision 8, paragraph (b).

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Subd. 5. **Notice of resident reimbursement 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. 6. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made under section 144.0724, subdivision 8.

Subd. 7. **Rate determination upon transition to RUG-III payment rates.** (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG based payment model in a facility-specific, budget-neutral manner. The case mix indices as defined in subdivision 3 shall be used to allocate the case mix adjusted component of total payment across all case mix groups. To transition from the current calculation methodology to the RUG based methodology, the commissioner of health shall report to the commissioner of human services the resident days classified according to the categories defined in subdivision 3 for the 12-month reporting period ending September 30, 2001, for each nursing facility. The commissioner of human services shall use this data to compute the standardized days for the reporting period under the RUG system.

(b) The commissioner of human services shall determine the case mix adjusted component of the rate as follows:

(1) determine the case mix portion of the 11 case mix rates in effect on June 30, 2002, or the 34 case mix rates in effect on or after June 30, 2003;

(2) multiply each amount in clause (1) by the number of resident days assigned to each group for the reporting period ending September 30, 2001, or the most recent year for which data is available;

(3) compute the sum of the amounts in clause (2);

(4) determine the total RUG standardized days for the reporting period ending September 30, 2001, or the most recent year for which data is available using the new indices calculated under subdivision 3, paragraph (c);

(5) divide the amount in clause (3) by the amount in clause (4) which shall be the average case mix adjusted component of the rate under the RUG method; and

(6) multiply this average rate by the case mix weight in subdivision 3 for each RUG group.

(c) The noncase mix component will be allocated to each RUG group as a constant amount to determine the transition payment rate. Any other rate adjustments that are effective on or after July 1, 2002, shall be applied to the transition rates determined under this section.

Subd. 8. **Rate determination upon transition to RUG-IV payment rates.** (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG-IV-based payment model in a facility-specific, revenue-neutral manner. To transition from the current calculation methodology to the RUG-IV-based methodology, nursing facilities shall report to the commissioner of human services the private pay and Medicaid resident days classified according to the categories defined in subdivision 3, paragraphs (a) and (d), for the six-month reporting period ending June 30, 2011. This report must be submitted to the commissioner, in a form prescribed by the commissioner, by August 15, 2011. The commissioner of human services shall use this data to compute the standardized days for the RUG-III and RUG-IV classification systems.

(b) The commissioner of human services shall determine the case mix adjusted component for the January 1, 2012, rate as follows:

(1) using the September 30, 2010, cost report, determine the case mix portion of the operating cost for each facility;

(2) multiply the 36 operating payment rates in effect on December 31, 2011, by the number of private pay and Medicaid resident days assigned to each group for the reporting period ending June 30, 2011, and compute the total;

(3) compute the product of the amounts in clauses (1) and (2);

(4) determine the private pay and Medicaid RUG standardized days for the reporting period ending June 30, 2011, using the new indices calculated under subdivision 3, paragraph (d);

(5) divide the amount determined in clause (3) by the amount in clause (4), which shall be the default rate (DDF) unadjusted case mix component of the rate under the RUG-IV method; and

(6) determine the case mix adjusted component of each operating rate by multiplying the default rate (DDF) unadjusted case mix component by the case mix weight in subdivision 3, paragraph (d), for each RUG-IV group.

(c) The noncase mix components will be allocated to each RUG group as a constant amount to determine the operating payment rate.

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

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Subdivision 1. **Calculation of nursing facility operating payment rates.** (a) The commissioner shall calculate operating payment rates using the statistical and cost report filed by each nursing facility for the report period ending 15 months prior to the rate year.

(b) The operating payment rates based on this section shall take effect with the rate year beginning January 1, 2016.

(c) Each cost reporting year shall begin on October 1 and end on the following September 30. A statistical and cost report shall be filed by each nursing facility by February 1 in a form and manner specified by the commissioner. Notice of rates shall be distributed by November 15 and the rates shall go into effect on January 1 for one year.

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, 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 director's fees, working capital interest expense, and bad debts and bad debt collection fees.

Subd. 6. **Allowed costs.** (a) "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.

(b) 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 until March 1 following the date on which the cost report was required to be submitted for a collective bargaining agent to notify the commissioner if a collective bargaining agreement, effective on the last day of the cost reporting year, 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.

(c) In any year when a portion of a facility's reported costs are not allowed costs under paragraph (b), 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 price for other operating costs under subdivision 51, the price shall be reduced by the difference between the nonallowed costs and the allowed costs from the facility's second most recent cost report.

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

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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. 11a. **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 employees who meet the definition of full-time employees and their spouse and dependents under the federal Affordable Care Act, Public Law 111-148, and part-time employees.

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; family advisory council fee under section 144A.33; scholarships under section 256B.431, subdivision 36; planned closure rate adjustments under section 256B.437; single bed room incentives under section 256B.431, subdivision 42; property taxes, assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under subdivision 46c; performance-based incentive payments under subdivision 46d; special dietary needs under subdivision 51b; and PERA.

Subd. 14. **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 groups 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 total days for all residents in the facility. The RUG's weights used shall be based on the system prescribed in section 256B.438.

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. 17. **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. 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. 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. 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.

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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. 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. 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. **Median total care-related cost per diem and other operating per diem determined.** (a) The commissioner shall determine the median total care-related per diem to be used in subdivision 50 and the median other operating per diem to be used in subdivision 51 using the cost reports from nursing facilities in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

(b) The median total care-related per diem shall be equal to the median direct care cost for a RUG's weight of 1.00 for facilities located in the counties listed in paragraph (a).

(c) The median other operating per diem shall be equal to the median other operating per diem for facilities located in the counties listed in paragraph (a). The other operating per diem shall be the sum of each facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by each facility's resident days.

Subd. 31. **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, but not including rate increases allowed under subdivision 55a.

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 January 1.

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. 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. 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

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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. When a facility has resident days at a penalty classification, these days shall be reported as resident days at the RUG class established immediately after the penalty period, if available, and otherwise, at the RUG class in effect before the penalty began.

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. 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. Beginning with the September 30, 2013, reporting year, the commissioner shall no longer grant to facilities extensions to the filing deadline. 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.

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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, 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) Beginning January 1, 2016, the quality score shall include up to 50 points related to the Minnesota quality indicators score, up to 40 points related to the resident quality of life score, 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 beginning in 2017, 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. 46b. **Calculation of quality add-on, with an average value of 1.25 percent, effective September 1, 2013.** (a) The commissioner shall determine quality add-ons to the operating payment rates for each facility. The increase in this subdivision shall be applied as a percentage to operating payment rates in effect on August 31, 2013. For each facility, the commissioner shall determine the operating payment rate, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under subdivision 55a, critical access nursing facility program participation under subdivision 63, or performance-based incentive payment program participation under section 256B.434, subdivision 4, paragraph (d), for a RUG class with a weight of 1.00 in effect on August 31, 2013.

(b) For each facility, the commissioner shall compute a quality factor by subtracting 40 from the most recent quality score computed under subdivision 44, and then dividing by 60. If the quality factor is less than zero, the commissioner shall use the value zero.

(c) The quality add-ons shall be the operating payment rates determined in paragraph (a), multiplied by the quality factor determined in paragraph (b), and then multiplied by 3.2 percent. The commissioner shall implement the quality add-ons effective September 1, 2013.

Subd. 46c. **Quality improvement incentive system beginning October 1, 2015.** 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 subdivision 55a, critical access nursing facility program participation under subdivision 63, or performance-based incentive payment program participation under section 256B.434, subdivision 4, paragraph (d). For the period from October 1, 2015, to December 31, 2016, rate adjustments provided under this subdivision shall be effective for 15 months. Beginning January 1, 2017, annual rate adjustments provided under this subdivision shall be effective for one year, starting January 1 and ending the following December 31. The increase in this subdivision shall be included in the external fixed payment rate under subdivisions 13 and 53.

Subd. 46d. **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 subdivision 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 subdivision shall be in the form of time-limited rate adjustments which shall be included in the external fixed payment rate under subdivisions 13 and 53. 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

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

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 care-related 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.

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 median total care-related per diem shall be determined according to subdivision 30.

(b) A facility's total care-related limit shall be a variable amount based on each facility's quality score, as determined under subdivision 44, in accordance with clauses (1) to (3):

(1) the quality score shall be multiplied by 0.5625;

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

(3) multiply the amount determined in clause (2) by the median total care-related per diem determined in subdivision 30, paragraph (b).

(c) A RUG's weight of 1.00 shall be used in the calculation of the median total care-related per diem, and in comparisons of facility-specific direct care costs to the median.

(d) A facility that is above its total care-related limit as determined according to paragraph (b) shall have its total care-related per diem reduced to its limit. If a reduction of the total care-related per diem is necessary due to this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem.

Subd. 51. **Determination of other operating price.** A price for other operating costs shall be determined. The price shall be calculated as 105 percent of the median other operating per diem described in subdivision 30, paragraph (c).

Subd. 51a. **Exception for specialized care facilities.** (a) For rate years beginning on or after January 1, 2016, the care-related 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.

Subd. 51b. **Special dietary needs.** 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 diem and 115 percent of the median allowable raw food cost per diem. For rate years beginning on or after January 1, 2016,

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this amount shall be removed from allowable raw food per diem costs under operating costs and included in the external fixed per diem rate under subdivisions 13 and 53.

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 development and education of resident and family advisory councils under section 144A.33 shall be \$5 divided by 365.

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

(e) 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.

(f) The single bed room incentives shall be as determined under section 256B.431, subdivision 42.

(g) 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 shall be the actual amounts divided by actual resident days.

(h) The portion related to employer health insurance costs shall be the allowable costs divided by resident days.

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

(j) The portion related to quality improvement incentive payment rate adjustments shall be as determined under subdivision 46c.

(k) The portion related to performance-based incentive payments shall be as determined under subdivision 46d.

(l) The portion related to special dietary needs shall be the per diem amount determined under subdivision 51b.

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

Subd. 54. Determination of total payment rates. The total care-related per diem, other operating price, and external fixed per diem for each facility shall be converted to payment rates. 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, 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.

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 operating payment rates are determined under this section, 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 operating payment rates are determined under this section, 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 in accordance with the rate year in subdivision 33, based on the most recent available cost report.

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(d) Eligible nursing facilities that wish to participate under this subdivision shall make an application to the commissioner by August 31, 2011, or by September 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 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.** (a) For the rate years beginning on or after January 1, 2016, no nursing facility shall receive a cost payment rate, including the property insurance portion of operating costs plus the health insurance component of external fixed, less than its prior system cost payment rate, which included operating costs inclusive of health insurance costs plus the property insurance component of external fixed. The comparison of operating payment rates under this section shall be made for a RUG's rate with a weight of 1.00.

(b) For rate years beginning on or after January 1, 2016, no facility shall be subject to a care-related payment rate limit reduction greater than five percent of the median determined in subdivision 30.

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

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;

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(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. 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. Beginning in fiscal year 2015, 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 subdivision 54 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 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

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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 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.

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

Subd. 64. **Rate adjustments for compensation-related costs.** (a) Operating payment rates of all nursing facilities that are reimbursed under this section or section 256B.434 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 subdivision.

(b) Based on the application in paragraph (d), 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 diem 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 \$8 and any hourly wage rate less than \$8 for October 1, 2014; between \$9 and any hourly wage rate less than \$9 for October 1, 2015; 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; 33.3 percent of the sum of items (i) to (viii) for October 1, 2014; 44.4 percent of the sum of items (i) to (viii) for October 1, 2015; and 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).

(c) For the rate years beginning October 1, 2014, and later, nursing facilities that receive approval of the applications in paragraph (d) must receive rate adjustments according to paragraph (b). The rate adjustments must be used to pay compensation costs for nursing facility employees paid less than \$14 per hour.

(d) 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 subdivision. 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

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by the commissioner within six months of the effective date of any operating payment rate adjustment under this subdivision. The commissioner may waive the deadlines in this subdivision under extraordinary circumstances.

(e) For nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the applications submitted under this subdivision 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 subdivision as having been met in regard to the members of the bargaining unit.

Subd. 65. **Nursing facility in Golden Valley.** Effective for the rate year beginning January 1, 2016, and all subsequent rate years, 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, must be calculated without the application of subdivisions 50 and 51.

Subd. 66. **Nursing facilities in border cities.** Effective for the rate year beginning January 1, 2016, and annually thereafter, operating payment rates of a nonprofit nursing facility that exists on January 1, 2015, is located anywhere within the boundaries of the city of Breckenridge, and is reimbursed under this section, section 256B.431, or section 256B.434, shall be adjusted to be equal to the median RUG's rates, including comparable rate components as determined by the commissioner, for the equivalent RUG's weight 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 weight of 1.0 shall be computed by dividing the adjacent city's nursing facilities median operating payment rate with a weight of 1.02 by 1.02. If the adjustments under this subdivision result in a rate that exceeds the limits in subdivisions 50 and 51 in a given rate year, the facility's rate shall not be subject to those limits for that rate year. This subdivision shall apply only if it results in a higher operating payment rate than would otherwise be determined under this section, section 256B.431, or section 256B.434.

Subd. 67. **Nursing facility; contract with insurance provider.** Within the projected cost of nursing facility payment reform under this section, for a facility that did not provide employee health insurance coverage as of May 1, 2015, if the facility has a signed contract with a health insurance provider to begin providing employee health insurance coverage by January 1, 2016, the facility shall be paid for the employer health insurance costs portion of external fixed costs under subdivisions 13 and 53 beginning January 1, 2016.

256B.47 NONALLOWABLE COSTS; NOTICE OF INCREASES.

Subdivision 1. **Nonallowable costs.** 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) direct and indirect costs of providing services which are billed separately from the nursing facility's payment rate or pursuant to Minnesota Rules, parts 9500.0750 to 9500.1080. The commissioner shall by rule exclude the costs of any other items not directly related to the provision of resident care.

Subd. 2. **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 256B.431, 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 256B.431, 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.

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Subd. 3. **Allocation of costs.** To ensure the avoidance of double payments as required by section 256B.433, the direct and indirect reporting year 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 9500.0750 to 9500.1080, must be determined and deducted from the appropriate cost categories of the annual cost report as follows:

(a) 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.

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

(c) 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.

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

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

(f) 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. 4. **Allocation of costs; hospital-attached facilities.** To ensure the avoidance of double payments as required by section 256B.433, the direct and indirect reporting year 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 9500.0750 to 9500.1080, 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.

256B.48 CONDITIONS FOR PARTICIPATION.

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

(a) 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, except under the following circumstances: 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. Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be available to all residents in all areas of the nursing facility and charged separately at the same rate. Residents are free to select or decline special services. Special services must 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 year. A nursing facility that charges a private paying resident a rate in violation of this clause 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 this clause. 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.

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The administrative law judge shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this clause 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.

(b)(1) Charging, soliciting, accepting, or receiving from an applicant for admission to the facility, or from anyone acting in 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 state plan;

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

(3) requiring an individual, or anyone acting in 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 paragraph would prohibit discharge for nonpayment of services in accordance with state and federal regulations.

(c) Requiring any resident of the nursing facility to utilize a vendor of health care services chosen by the nursing facility. 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 paragraph, nursing facilities shall not restrict a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit dose drug packing.

(d) Providing differential treatment on the basis of status with regard to public assistance.

(e) 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 paragraph.

(f) 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 256B.433. 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 provision 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 provision and section 256B.433. Damages awarded must include three times the excess payments together with costs and disbursements including reasonable attorney fees or their equivalent.

(g) 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.

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.

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In the event that the commissioner determines that 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.

Certified beds in facilities which do not allow medical assistance intake on July 1, 1984, or after shall be deemed to be decertified for purposes of section 144A.071 only.

Subd. 1a. **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.

Subd. 1b. **Exception.** Notwithstanding any agreement between a nursing facility and the Department of Human Services or the provisions of this section or section 256B.411, other than subdivision 1a, the commissioner may authorize continued medical assistance payments to a nursing facility which ceased intake of medical assistance recipients prior to July 1, 1983, and which charges private paying residents rates that exceed those permitted by subdivision 1, paragraph (a), for (i) residents who resided in the nursing facility before July 1, 1983, or (ii) residents for whom the commissioner or any predecessors of the commissioner granted a permanent individual waiver prior to October 1, 1983. Nursing facilities seeking continued medical assistance payments under this subdivision shall make the reports required under subdivision 2, except that on or after December 31, 1985, the financial statements required need not be audited by or contain the opinion of a certified public accountant or licensed public accountant, but need only be reviewed by a certified public accountant or licensed public accountant. In the event that the state is determined by the federal government to be no longer eligible for the federal share of medical assistance payments made to a nursing facility under this subdivision, the commissioner may cease medical assistance payments, under this subdivision, to that nursing facility.

Subd. 1c. **Case mix rate for provider with addendum to provider agreement.** A nursing facility with an addendum to its provider agreement effective beginning July 1, 1983, or September 24, 1985, shall have its payment rates established by the commissioner under this subdivision. To save medical assistance resources, for rate years beginning after July 1, 1991, the provider's payment rates shall be the payment rates established by the commissioner July 1, 1990, multiplied by a 12-month inflation factor based on the forecasted inflation between the midpoints of rate years using the inflation index applied by the commissioner to other nursing facilities.

The provider and the Department of Health shall complete case mix assessments under Minnesota Rules, chapter 4656, and parts 9549.0058 and 9549.0059, on only those residents receiving medical assistance. The commissioner of health may audit and verify the limited provider assessments at any time.

Subd. 3. **Incomplete or inaccurate reports.** The commissioner may reject any annual cost report filed by a nursing facility pursuant to this chapter if the commissioner determines that the report or the information required in subdivision 2, clause (1), has been filed in a form that is incomplete or inaccurate. In the event that a report is rejected pursuant to this subdivision, the commissioner shall reduce the reimbursement rate to a nursing facility to 80 percent of its most recently established rate until the information is completely and accurately filed. The reinstatement of the total reimbursement rate is retroactive.

Subd. 4. **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 December 1. The commissioner will notify the nursing facility of the decision by December 15. Between December 1 and December 31, the nursing facility may request a reporting extension for good cause by telephone and followed by a written request.

Subd. 5. **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; or
- (2) terminate the commissioner's agreement with the nursing facility; or
- (3) prosecute under applicable state or federal law; or
- (4) use any combination of the foregoing actions.

Subd. 6a. **Referrals to Medicare providers required.** Notwithstanding subdivision 1, 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

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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.

Subd. 7. **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 of charge in excess of the rate for the case-mix classification established by the commissioner of health and effective on the date of admission. Refunds must be credited to the next monthly billing or refunded within 15 days of receipt of the classification notice from the Department of Health. Failure to refund the excess charge shall be considered to be a violation of this section.

Subd. 8. **Notification to a spouse or health care agent.** 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 150 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.

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.

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.

256B.495 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 diem 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 diem shall be added to the nursing facility's payment rate.

(d) Notification of the payment rate increase must meet the requirements of section 256B.47, subdivision 2.

(e) The payment rate in paragraph (c) for a nursing facility shall be 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. 5. **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.

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(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.

9549.0035 DETERMINATION OF ALLOWABLE COSTS.

Subpart 1. **Allowable costs.** Only costs determined to be allowable under parts 9549.0010 to 9549.0080 shall be used to compute the total payment rate for nursing facilities participating in the medical assistance program.

9549.0035 DETERMINATION OF ALLOWABLE COSTS.

Subp. 3. **Adequate documentation.** A nursing facility shall keep adequate documentation.

A. 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 department 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 Minnesota Statutes, section 256B.441, subdivision 47, the records are necessary to resolve a pending appeal, or are required for the enforcement of Minnesota Statutes, section 256B.48.

B. Compensation for personal services, regardless of whether treated as direct or indirect costs, 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.

C. 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 year. Mileage paid for the use of a personal vehicle must be documented.

D. Complete and orderly records must be maintained for cost allocations made to cost categories.

9549.0035 DETERMINATION OF ALLOWABLE COSTS.

Subp. 7. **Related organization costs.** 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.

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 shall be the nonrelated organization's price provided that sales to nonrelated organizations constitute at least 50 percent of total annual sales of similar services, or capital assets, or supplies.

Subject to parts 9549.0010 to 9549.0080, the cost of ownership of a capital asset which is 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.

9549.0035 DETERMINATION OF ALLOWABLE COSTS.

Subp. 8. **General cost principles.** For rate-setting purposes, a cost must satisfy the following criteria:

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- A. the cost is ordinary, necessary, and related to resident care;
- B. 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;
- C. the cost is for goods or services actually provided in the nursing facility;
- D. the cost effects of transactions that have the effect of circumventing these rules are not allowable under the principle that the substance of the transaction shall prevail over form; and
- E. 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.

9549.0041 GENERAL REPORTING REQUIREMENTS.

Subp. 6. **Method of accounting.** The accrual method of accounting in accordance with generally accepted accounting principles is the only method acceptable for purposes of satisfying reporting requirements. 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.

9549.0055 DETERMINATION OF OPERATING COST ADJUSTMENT FACTORS AND LIMITS.

Subpart 1. **Annual adjustment factors.** The annual adjustment factors must be determined according to items A and B.

A. The annual adjustment factor for the case mix and other care related operating costs must be established according to subitems (1) to (7).

(1) The components and indexes specified in the following table must be used to establish the case mix and other care related operating cost adjustment factor. These indexes are incorporated by reference as specified in subpart 4.

Case Mix and Care Related Components and Indexes		
Component	Weight	Index
Salaries	.7347	Average hourly earnings of employees in nursing and personal care facilities (SIC 805).
Benefits	.1107	Difference between movements in compensation and wages and salary index components of the Employment Cost Index for Service Workers.
Supplies and Drugs	.0363	Consumer Price Index for nonprescription medical equipment and supplies.
Food	.1183	Producer Price Index for consumer foods.
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TOTAL	1.0000	

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

(a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and

(c) summing the results of the calculations in unit (b).

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

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(6) The forecasted composite price index for the rate year must be determined by:

- (a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component;
- (b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and
- (c) summing the results of the calculations in unit (b).

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (c) by the composite price index for the reporting year computed in subitem (4), unit (c).

B. The annual adjustment factor for the other operating costs must be established according to subitems (1) to (7).

(1) The components and indexes specified in the following table must be used to establish the other operating cost adjustment factor. These indexes are incorporated by reference as specified in subpart 4.

Other Operating Costs Components and Indexes		
Component	Weight	Index
Utilities	.1099	Producer Price Index for natural gas (80 percent); and Producer Price Index for commercial power in west north central states (20 percent).
Salaries	.5864	Average hourly earnings of employees in nursing and personal care facilities (SIC 805).
Benefits	.0799	Difference between movements in compensation and wages and salaries index components of the Employment Cost Index for Service Workers.
Additional Professional Services	.1107	Employment Cost Index for wages and salaries of professional and technical workers.
Additional Miscellaneous Service Purchases	.0322	Consumer Price Index for maintenance and repair services.
Miscellaneous Purchases (Commodities)	.0809	Consumer Price Index for maintenance and repair commodities.
TOTAL	1.0000	

(2) The average index value for calendar year 1983 for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(3) The average index value for the reporting year for each component in subitem (1) must be determined by summing the quarterly index values for the component and dividing the results by four.

(4) The composite price index for the reporting year must be determined by:

- (a) dividing the amount in subitem (3) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;
- (b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and
- (c) summing the results of the calculations in unit (b).

(5) The forecasted average index value for the rate year for each component in subitem (1) must be determined by summing the forecasted quarterly index values for that component and dividing the result by four.

(6) The forecasted composite price index for the rate year must be determined by:

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(a) dividing the amount in subitem (5) for each component by the corresponding amount in subitem (2) for that component, except that the utilities component must be 80 percent of the natural gas component plus 20 percent of the commercial power component;

(b) multiplying each amount determined in unit (a) by the corresponding weight for that component in subitem (1); and

(c) summing the results of the calculations in unit (b).

(7) The forecasted adjustment factor is determined by dividing the forecasted composite price index for the rate year computed in subitem (6), unit (c) by the composite price index for the reporting year computed in subitem (4), unit (c).

9549.0055 DETERMINATION OF OPERATING COST ADJUSTMENT FACTORS AND LIMITS.

Subp. 2. **Base year limits.** For each geographic group established in part 9549.0052 the base year operating costs limits must be determined according to items A to E. No redetermination of the base year operating costs limits shall be made due to audit adjustments or appeal settlement.

A. The commissioner shall compute 115 percent of the median of the array of the allowable historical case mix operating cost standardized per diems for the base year.

B. The commissioner shall compute 115 percent of the median of the array of the allowable historical other care related operating cost per diems for the base year. For the purpose of establishing operating cost limits, the commissioner shall compute the allowable historical other care related per diems for the base year by dividing the allowable historical other care related operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period. An exception to this calculation is made for a short length of stay facility. For a short length of stay facility, the allowable historical other care related operating costs must be divided by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

C. The total care related operating cost limit for each resident class must be determined by multiplying the amount determined in item A by the weight for each resident class and adding the amount determined in item B. The total care related operating cost limit for a short length of stay facility must be 125 percent of the total care related operating cost limit. A nursing facility licensed on June 1, 1983, by the commissioner to provide residential services for persons with physical disabilities under parts 9570.2000 to 9570.3600 is exempt from the total care related operating cost limit.

D. The commissioner shall disallow any portion of the general and administrative cost category, exclusive of fringe benefits and payroll taxes, that exceeds 15 percent of the allowable expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administrative. For the purpose of computing the amount of disallowed general and administrative cost, the nursing facility's professional liability and property insurance must be excluded from the general and administrative cost category. For purposes of this item, the term property insurance means general liability coverage for personal injury incurred on the nursing facility property and coverage against loss or damage to the building, building contents, and the property of others on the premises of the nursing facility property insurance does not include any coverage for items such as automobiles, loss of earnings, and extra expenses.

E. The other operating costs limits must be determined in accordance with subitems (1) to (5). For the purpose of establishing operating costs limits, the commissioner shall compute the allowable historical other operating costs per diems for the base year by dividing the allowable historical other operating costs by the greater of resident days or 90 percent of the number of licensed beds multiplied by the number of days in the reporting period. An exception to this calculation is made for a short length of stay facility. For a short length of stay facility, the allowable historical other operating costs must be divided by the greater of resident days or 80 percent of the number of licensed beds multiplied by the number of days in the reporting period.

(1) For each geographic group in part 9549.0052, the commissioner shall group all hospital attached nursing facilities, short length of stay facilities, and nursing facilities licensed on June 1, 1983, by the commissioner to provide residential services for the physically disabled under parts 9570.2000 to 9570.3600.

(2) The other operating cost limit for hospital attached nursing facilities in each geographic group in part 9549.0052 must be 105 percent of the median of the array of the allowable historical other operating cost per diem for each nursing facility in the group established under subitem (1) in the base year.

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(3) The other operating cost limit for all short length of stay facilities and nursing facilities licensed on June 1, 1983, by the commissioner to provide residential services for the physically disabled under parts 9570.2000 to 9570.3600 in each geographic group in part 9549.0052 must be 105 percent of the limit established in subitem (2).

(4) For each geographic group in part 9549.0052, the commissioner shall group all nursing facilities not included in subitem (1).

(5) The other operating cost limit for each group established in subitem (4) must be 105 percent of the median of the array of the allowable historical other operating cost per diems for each nursing facility in the group for the base year.

9549.0055 DETERMINATION OF OPERATING COST ADJUSTMENT FACTORS AND LIMITS.

Subp. 3. **Indexed limits.** For a rate year beginning on or after July 1, 1987, the total care related operating cost limits and the other operating cost limits must be determined under items A and B.

A. The total care related operating cost limits must be determined under subitems (1) and (2).

(1) The composite price index for case mix and other care related operating costs for the current reporting year as determined in subpart 1, item A, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) The limit for each resident class in subpart 2, item C, must be multiplied by the amount determined in subitem (1) to establish the indexed total care related operating cost limits.

B. The total other operating costs limits must be determined under subitems (1) and (2).

(1) The composite price index for other operating costs for the current reporting year as determined in subpart 1, item B, subitem (4), must be divided by the corresponding composite price index for the previous reporting year.

(2) Each limit in subpart 2, item E must be multiplied by the amount determined in subitem (1) to establish the indexed other operating cost limits.

9549.0070 COMPUTATION OF TOTAL PAYMENT RATE.

Subp. 2. **Private payment rate limitation.** The total payment rate must not exceed the rate paid by private paying residents for similar services for the same period. The private payment rate limitation shall not apply to retroactive adjustments to the total payment rate established in parts 9549.0010 to 9549.0080 unless the total payment rate being adjusted was subject to the private payment rate limitation.

9549.0070 COMPUTATION OF TOTAL PAYMENT RATE.

Subp. 3. **Private room payment rate.** A private room payment rate of 115 percent of the established total payment rate for a resident must be allowed if the resident is a medical assistance recipient and the private room is considered as a medical necessity for the resident or others who are affected by the resident's condition except as in 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 department for approval or denial by the commissioner on the basis of medical necessity.