

SENATE
STATE OF MINNESOTA
EIGHTY-NINTH SESSION

S.F. No. 273

(SENATE AUTHORS: LOUREY, Rosen, Eken, Koenen and Stumpf)

DATE	D-PG	OFFICIAL STATUS
01/22/2015	116	Introduction and first reading Referred to Finance
02/19/2015	369	Withdrawn and re-referred to Health, Human Services and Housing
03/16/2015	882a	Comm report: To pass as amended and re-refer to Finance

A bill for an act

1.1 relating to human services; modifying the nursing facility reimbursement
 1.2 system; amending Minnesota Statutes 2014, sections 256B.0915, subdivision
 1.3 3a; 256B.431, subdivision 2b; 256B.441, subdivisions 1, 5, 13, 14, 17, 30, 31,
 1.4 35, 48, 50, 51, 51a, 53, 54, 56, by adding a subdivision; 256I.05, subdivision 2;
 1.5 repealing Minnesota Statutes 2014, section 256B.441, subdivisions 14a, 19,
 1.6 50a, 52, 55, 58, 62.
 1.7

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

1.9 Section 1. Minnesota Statutes 2014, section 256B.0915, subdivision 3a, is amended to
 1.10 read:

1.11 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of
 1.12 waived services to an individual elderly waiver client except for individuals described
 1.13 in paragraphs (b) and (d) shall be the weighted average monthly nursing facility rate of
 1.14 the case mix resident class to which the elderly waiver client would be assigned under
 1.15 Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs
 1.16 allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal
 1.17 year in which the resident assessment system as described in section 256B.438 for nursing
 1.18 home rate determination is implemented. Effective on the first day of the state fiscal year
 1.19 in which the resident assessment system as described in section 256B.438 for nursing
 1.20 home rate determination is implemented and the first day of each subsequent state fiscal
 1.21 year, the monthly limit for the cost of waived services to an individual elderly waiver
 1.22 client shall be the rate of the case mix resident class to which the waiver client would be
 1.23 assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last
 1.24 day of the previous state fiscal year, adjusted by the greater of any legislatively adopted

2.1 home and community-based services percentage rate adjustment or the average statewide
2.2 percentage increase in nursing facility operating payment rates under section 256B.441.

2.3 (b) The monthly limit for the cost of waived services under paragraph (a) to an
2.4 individual elderly waiver client assigned to a case mix classification A ~~under paragraph~~
2.5 ~~(a)~~ with:

2.6 (1) no dependencies in activities of daily living; or

2.7 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating
2.8 when the dependency score in eating is three or greater as determined by an assessment
2.9 performed under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011,
2.10 for all new participants enrolled in the program on or after July 1, 2011. This monthly
2.11 limit shall be applied to all other participants who meet this criteria at reassessment. This
2.12 monthly limit shall be increased annually as described in paragraph (a).

2.13 (c) If extended medical supplies and equipment or environmental modifications are
2.14 or will be purchased for an elderly waiver client, the costs may be prorated for up to
2.15 12 consecutive months beginning with the month of purchase. If the monthly cost of a
2.16 recipient's waived services exceeds the monthly limit established in paragraph (a) or
2.17 (b), the annual cost of all waived services shall be determined. In this event, the annual
2.18 cost of all waived services shall not exceed 12 times the monthly limit of waived
2.19 services as described in paragraph (a) or (b).

2.20 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including
2.21 any necessary home care services described in section 256B.0651, subdivision 2, for
2.22 individuals who meet the criteria as ventilator-dependent given in section 256B.0651,
2.23 subdivision 1, paragraph (g), shall be the average of the monthly medical assistance
2.24 amount established for home care services as described in section 256B.0652, subdivision
2.25 7, and the annual average contracted amount established by the commissioner for nursing
2.26 facility services for ventilator-dependent individuals. This monthly limit shall be increased
2.27 annually as described in paragraph (a).

2.28 Sec. 2. Minnesota Statutes 2014, section 256B.431, subdivision 2b, is amended to read:

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

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

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

3.4 (d) The commissioner shall establish limits on actual allowable historical operating
3.5 cost per diems based on cost reports of allowable operating costs for the reporting year
3.6 that begins October 1, 1983, taking into consideration relevant factors including resident
3.7 needs, geographic location, and size of the nursing facility. In developing the geographic
3.8 groups for purposes of reimbursement under this section, the commissioner shall ensure
3.9 that nursing facilities in any county contiguous to the Minneapolis-St. Paul seven-county
3.10 metropolitan area are included in the same geographic group. The limits established by
3.11 the commissioner shall not be less, in the aggregate, than the 60th percentile of total
3.12 actual allowable historical operating cost per diems for each group of nursing facilities
3.13 established under subdivision 1 based on cost reports of allowable operating costs in the
3.14 previous reporting year. For rate years beginning on or after July 1, 1989, facilities located
3.15 in geographic group I as described in Minnesota Rules, part 9549.0052, on January 1,
3.16 1989, may choose to have the commissioner apply either the care related limits or the
3.17 other operating cost limits calculated for facilities located in geographic group II, or
3.18 both, if either of the limits calculated for the group II facilities is higher. The efficiency
3.19 incentive for geographic group I nursing facilities must be calculated based on geographic
3.20 group I limits. The phase-in must be established utilizing the chosen limits. For purposes
3.21 of these exceptions to the geographic grouping requirements, the definitions in Minnesota
3.22 Rules, parts 9549.0050 to 9549.0059 (Emergency), and 9549.0010 to 9549.0080, apply.
3.23 The limits established under this paragraph remain in effect until the commissioner
3.24 establishes a new base period. Until the new base period is established, the commissioner
3.25 shall adjust the limits annually using the appropriate economic change indices established
3.26 in paragraph (e). In determining allowable historical operating cost per diems for purposes
3.27 of setting limits and nursing facility payment rates, the commissioner shall divide the
3.28 allowable historical operating costs by the actual number of resident days, except that
3.29 where a nursing facility is occupied at less than 90 percent of licensed capacity days, the
3.30 commissioner may establish procedures to adjust the computation of the per diem to
3.31 an imputed occupancy level at or below 90 percent. The commissioner shall establish
3.32 efficiency incentives as appropriate. The commissioner may establish efficiency incentives
3.33 for different operating cost categories. The commissioner shall consider establishing
3.34 efficiency incentives in care related cost categories. The commissioner may combine one
3.35 or more operating cost categories and may use different methods for calculating payment

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

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

4.6 (2) exempt nursing facilities licensed on July 1, 1983, by the commissioner to
4.7 provide residential services for the physically disabled under Minnesota Rules, parts
4.8 9570.2000 to 9570.3600, from the care related limits and allow 105 percent of the other
4.9 operating cost limit established by rule.

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

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

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

4.26 (g) The commissioner shall include the reported actual real estate tax liability or
4.27 payments in lieu of real estate tax of each nursing facility as an operating cost of that
4.28 nursing facility. Allowable costs under this subdivision for payments made by a nonprofit
4.29 nursing facility that are in lieu of real estate taxes shall not exceed the amount which the
4.30 nursing facility would have paid to a city or township and county for fire, police, sanitation
4.31 services, and road maintenance costs had real estate taxes been levied on that property
4.32 for those purposes. For rate years beginning on or after July 1, 1987, the reported actual
4.33 real estate tax liability or payments in lieu of real estate tax of nursing facilities shall be
4.34 adjusted to include an amount equal to one-half of the dollar change in real estate taxes
4.35 from the prior year. The commissioner shall include a reported actual special assessment,
4.36 and reported actual license fees required by the Minnesota Department of Health, for each

5.1 nursing facility as an operating cost of that nursing facility. For rate years beginning
 5.2 on or after July 1, 1989, the commissioner shall include a nursing facility's reported
 5.3 Public Employee Retirement Act contribution for the reporting year as apportioned to the
 5.4 care-related operating cost categories and other operating cost categories multiplied by
 5.5 the appropriate composite index or indices established pursuant to paragraph (e) as costs
 5.6 under this paragraph. Total adjusted real estate tax liability, payments in lieu of real
 5.7 estate tax, actual special assessments paid, the indexed Public Employee Retirement Act
 5.8 contribution, and license fees paid as required by the Minnesota Department of Health,
 5.9 for each nursing facility (1) shall be divided by actual resident days in order to compute
 5.10 the operating cost payment rate for this operating cost category, (2) shall not be used to
 5.11 compute the care-related operating cost limits or other operating cost limits established
 5.12 by the commissioner, and (3) shall not be increased by the composite index or indices
 5.13 established pursuant to paragraph (e), unless otherwise indicated in this paragraph.

5.14 (h) For rate years beginning on or after July 1, 1987, the commissioner shall adjust the
 5.15 rates of a nursing facility reimbursed under section 256B.434 or 256B.441 that meets the
 5.16 criteria for the special dietary needs of its residents and the requirements in section 31.651.
 5.17 The adjustment for raw food cost shall be the difference between the nursing facility's
 5.18 most recently reported, allowable historical raw food cost per diem and 115 percent of the
 5.19 median ~~historical~~ allowable raw food cost per diem of the corresponding geographic peer
 5.20 group. For rate years beginning on or after October 1, 2015, this amount shall be removed
 5.21 from allowable raw food per diem costs under operating costs and included in the external
 5.22 fixed per diem rate under section 256B.441, subdivisions 13 and 53.

5.23 The rate adjustment shall be reduced by the applicable phase-in percentage as
 5.24 provided under subdivision 2h.

5.25 Sec. 3. Minnesota Statutes 2014, section 256B.441, subdivision 1, is amended to read:

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

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

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

6.3 (d) Each cost reporting year shall begin on October 1 and end on the following
6.4 September 30. ~~Beginning in 2014,~~ A statistical and cost report shall be filed by each
6.5 nursing facility by February 1. Notice of rates shall be distributed by August 15 and the
6.6 rates shall go into effect on October 1 for one year.

6.7 (e) ~~(d)~~ Effective October 1, ~~2014~~ 2016, property rates shall be rebased in accordance
6.8 with ~~section 256B.431 and Minnesota Rules, chapter 9549.~~ The commissioner shall
6.9 determine what the property payment rate for a nursing facility would be had the facility
6.10 not had its property rate determined under section 256B.434. The commissioner shall
6.11 allow nursing facilities to provide information affecting this rate determination that would
6.12 have been filed annually under Minnesota Rules, chapter 9549, and nursing facilities shall
6.13 report information necessary to determine allowable debt. The commissioner shall use
6.14 this information to determine the property payment rate recalculated based on a new
6.15 property rate system to be developed by the commissioner in consultation with nursing
6.16 facility providers and other stakeholders. The new property rate system shall be designed
6.17 to provide payment rates that allow providers to efficiently meet consumer needs and
6.18 preferences throughout the state.

6.19 Sec. 4. Minnesota Statutes 2014, section 256B.441, subdivision 5, is amended to read:

6.20 Subd. 5. **Administrative costs.** "Administrative costs" means the direct costs for
6.21 administering the overall activities of the nursing home. These costs include salaries and
6.22 wages of the administrator, assistant administrator, business office employees, security
6.23 guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases
6.24 related to business office functions, licenses, and permits except as provided in the
6.25 external fixed costs category, employee recognition, travel including meals and lodging,
6.26 all training except as specified in subdivision 11, voice and data communication or
6.27 transmission, office supplies, property and liability insurance and other forms of insurance
6.28 not designated to other areas, personnel recruitment, legal services, accounting services,
6.29 management or business consultants, data processing, information technology, Web
6.30 site, central or home office costs, business meetings and seminars, postage, fees for
6.31 professional organizations, subscriptions, security services, advertising, board of director's
6.32 fees, working capital interest expense, and bad debts and bad debt collection fees.

6.33 Sec. 5. Minnesota Statutes 2014, section 256B.441, is amended by adding a
6.34 subdivision to read:

7.1 Subd. 11a. **Employer health insurance costs.** "Employer health insurance costs"
 7.2 means premium expenses for group coverage and reinsurance, actual expenses incurred
 7.3 for self-insured plans, and employer contributions to employee health reimbursement and
 7.4 savings accounts. Premium expenses, costs, and contributions shall only be allowable if
 7.5 they are for employees who meet the definition of full-time employees under the federal
 7.6 Affordable Care Act, Public Law 111-148, or their family members.

7.7 Sec. 6. Minnesota Statutes 2014, section 256B.441, subdivision 13, is amended to read:

7.8 Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the
 7.9 nursing home surcharge under section 256.9657, subdivision 1; licensure fees under
 7.10 section 144.122; ~~until September 30, 2013, long-term care consultation fees under section~~
 7.11 ~~256B.0911, subdivision 6;~~ family advisory council fee under section 144A.33; scholarships
 7.12 under section 256B.431, subdivision 36; planned closure rate adjustments under section
 7.13 256B.437; ~~or~~ single bed room incentives under section 256B.431, subdivision 42; property
 7.14 taxes ~~and property insurance~~, assessments, and payments in lieu of taxes; employer health
 7.15 insurance costs; shared responsibility payments under the Affordable Care Act; special
 7.16 dietary needs under section 256B.431, subdivision 2b, paragraph (h); and PERA.

7.17 Sec. 7. Minnesota Statutes 2014, section 256B.441, subdivision 14, is amended to read:

7.18 Subd. 14. **Facility average case mix index.** "Facility average case mix index"
 7.19 or "CMI" means a numerical value score that describes the relative resource use for
 7.20 all residents within the groups under the resource utilization group (~~RUG-III~~ RUG)
 7.21 classification system prescribed by the commissioner based on an assessment of each
 7.22 resident. The facility average CMI shall be computed as the standardized days divided by
 7.23 total days for all residents in the facility. ~~The RUG's weights used in this section shall be~~
 7.24 ~~as follows for each RUG's class: SE3 1.605; SE2 1.247; SE1 1.081; RAD 1.509; RAC~~
 7.25 ~~1.259; RAB 1.109; RAA 0.957; SSC 1.453; SSB 1.224; SSA 1.047; CC2 1.292; CC1~~
 7.26 ~~1.200; CB2 1.086; CB1 1.017; CA2 0.908; CA1 0.834; IB2 0.877; IB1 0.817; IA2 0.720;~~
 7.27 ~~IA1 0.676; BB2 0.956; BB1 0.885; BA2 0.716; BA1 0.673; PE2 1.199; PE1 1.104; PD2~~
 7.28 ~~1.023; PD1 0.948; PC2 0.926; PC1 0.860; PB2 0.786; PB1 0.734; PA2 0.691; PA1 0.651;~~
 7.29 ~~BC1 0.651; and DDF 1.000~~ shall be based on the system prescribed in section 256B.438.

7.30 Sec. 8. Minnesota Statutes 2014, section 256B.441, subdivision 17, is amended to read:

7.31 Subd. 17. **Fringe benefit costs.** "Fringe benefit costs" means the costs for:
 7.32 (1) group life, health, dental, workers' compensation, and other employee insurances
 7.33 and except health insurance;

- 8.1 ~~pension,~~ (2) pensions, except for the Public Employee Retirement Association;
 8.2 (3) profit sharing; and
 8.3 (4) retirement plans for which the employer pays all or a portion of the costs.

8.4 Sec. 9. Minnesota Statutes 2014, section 256B.441, subdivision 30, is amended to read:

8.5 Subd. 30. **Peer groups.** (a) Facilities shall be classified into ~~three~~ two groups by
 8.6 county. The groups shall consist of:

8.7 (1) group one: facilities in Anoka, Benton, Blue Earth, Carlton, Carver, Chisago,
 8.8 Clay, Cook, Crow Wing, Dakota, Dodge, Goodhue, Hennepin, Isanti, Kanabec, Lake,
 8.9 Le Sueur, McLeod, Meeker, Mille Lacs, Morrison, Nicollet, Olmsted, Pine, Ramsey,
 8.10 Rice, Scott, Sherburne, Sibley, St. Louis, Stearns, Steele, Wabasha, Waseca, Washington,
 8.11 Winona, or Wright County; and

8.12 (2) ~~group two:~~ facilities in ~~Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay,~~
 8.13 ~~Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard, Itasea, Kanabec,~~
 8.14 ~~Koochiching, Lake, Lake of the Woods, Le Sueur, Martin, McLeod, Meeker, Mower,~~
 8.15 ~~Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan, or Wilkin~~
 8.16 ~~County; and~~

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

8.18 (b) The commissioner shall regularly review the appropriations of the peer groups
 8.19 established in paragraph (a). The review shall use the most recent cost report data and look
 8.20 at relative wages for nursing department positions across counties. The commissioner shall
 8.21 provide a report to the chairs and ranking minority members of the legislative committees
 8.22 with jurisdiction over nursing facility payment rates on the review of the wage data every
 8.23 two years beginning on January 15, 2017. The report may include recommendations to
 8.24 change the assignment of counties between the two groups based on the review of the data.

8.25 Sec. 10. Minnesota Statutes 2014, section 256B.441, subdivision 31, is amended to read:

8.26 Subd. 31. **Prior system operating cost payment rate.** "Prior system operating cost
 8.27 payment rate" means the operating cost payment rate in effect on September 30, ~~2008~~
 8.28 2015, under Minnesota Rules and Minnesota Statutes, not including planned closure
 8.29 rate adjustments under section 256B.437 or single bed room incentives under section
 8.30 256B.431, subdivision 42.

8.31 Sec. 11. Minnesota Statutes 2014, section 256B.441, subdivision 35, is amended to read:

8.32 Subd. 35. **Reporting period.** "Reporting period" means the one-year period
 8.33 beginning on October 1 and ending on the following September 30 during which incurred

9.1 costs are accumulated and then reported on the statistical and cost report. If a facility is
 9.2 reporting for an interim or settle-up period, the reporting period beginning date may be a
 9.3 date other than October 1. An interim or settle-up report must cover at least five months,
 9.4 but no more than 17 months, and must always end on September 30.

9.5 Sec. 12. Minnesota Statutes 2014, section 256B.441, subdivision 48, is amended to read:

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

9.13 Sec. 13. Minnesota Statutes 2014, section 256B.441, subdivision 50, is amended to read:

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

9.23 (b) ~~Beginning with rates determined for October 1, 2016, The~~ A facility's total
 9.24 care-related limit shall be a variable amount based on each facility's quality score, as
 9.25 determined under subdivision 44, in accordance with clauses (1) to (4) (3):

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

9.28 (2) ~~if the value determined in clause (1) is less than zero~~ (1) for each facility with a
 9.29 quality score of ten or less, the total care-related limit shall be 105 95 percent of the
 9.30 median for the facility's peer and facility type group;

9.31 (3) ~~if the value determined in clause (1) is greater than 100 percent~~ (2) for each
 9.32 facility with a quality score of 90 or more, the total care-related limit shall be 125 140
 9.33 percent of the median for the facility's peer and facility type group; and

10.1 ~~(4) if the value determined in clause (1) is greater than zero and less than 100~~
 10.2 ~~percent, the total care-related limit shall be 105 percent of the median for the facility's peer~~
 10.3 ~~and facility type group plus one-fifth of the percentage determined in clause (1) (3) for~~
 10.4 ~~each facility with a quality score of more than ten and less than 90, the total care-related~~
 10.5 ~~limit shall be computed by:~~

10.6 (i) computing the difference between the facility's quality score and ten;
 10.7 (ii) dividing the amount in item (i) by 80;
 10.8 (iii) multiplying the amount in item (ii) by 0.45;
 10.9 (iv) adding the amount in item (iii) to 0.95; and
 10.10 (v) multiplying the amount in item (iv) by the median for the facility's peer group.

10.11 (c) A RUG's weight of 1.00 shall be used in the calculation of each peer group's
 10.12 median total care-related per diem, and in comparisons of facility-specific direct care
 10.13 costs to the peer group median.

10.14 (d) A facility that is above its total care-related limit as determined according to
 10.15 paragraph (b) shall have its total care-related per diem reduced to its limit. If a reduction
 10.16 of the total care-related per diem is necessary due to this limit, the reduction shall be made
 10.17 proportionally to both the direct care per diem and the other care-related per diem.

10.18 Sec. 14. Minnesota Statutes 2014, section 256B.441, subdivision 51, is amended to read:

10.19 Subd. 51. **Determination of other operating limit price.** ~~The limit on the A price~~
 10.20 ~~for other operating per diem costs shall be determined for each peer group. A facility's~~
 10.21 ~~other operating per diem shall be limited to~~ The price shall be calculated as 105 percent
 10.22 of the median other operating per diem for its a facility's peer group. A facility that is
 10.23 above that limit shall have its other operating per diem reduced to the limit The other
 10.24 operating per diem shall be the sum of each facility's administrative costs, dietary costs,
 10.25 housekeeping costs, laundry costs, and maintenance and plant operations costs divided
 10.26 by each facility's resident days.

10.27 Sec. 15. Minnesota Statutes 2014, section 256B.441, subdivision 51a, is amended to
 10.28 read:

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

11.1 ~~negotiation. The 2015, the care-related limit may calculated under subdivision 50 for~~
 11.2 ~~specialized care facilities shall be increased by up to 50 percent.~~

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

11.4 ~~Specialized care facilities are defined as having a program license issued under chapter~~
 11.5 ~~245A and Minnesota Rules, chapter 9570, or a facility with 96 beds on January 1, 2015, in~~
 11.6 ~~Robbinsdale that specializes in the treatment of Huntington's Disease.~~

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

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

11.12 ~~(3) outcomes achieved by the specialized program.~~

11.13 Sec. 16. Minnesota Statutes 2014, section 256B.441, subdivision 53, is amended to read:

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

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

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

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

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

11.26 ~~(d) Until September 30, 2013, the portion related to long-term care consultation shall~~
 11.27 ~~be determined according to section 256B.0911, subdivision 6.~~

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

11.30 ~~(f) (e) The portion related to planned closure rate adjustments shall be as determined~~
 11.31 ~~under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436.~~
 11.32 ~~Planned closure rate adjustments that take effect before October 1, 2014, shall no longer~~
 11.33 ~~be included in the payment rate for external fixed costs beginning October 1, 2016.~~

11.34 ~~Planned closure rate adjustments that take effect on or after October 1, 2014, shall no~~

12.1 longer be included in the payment rate for external fixed costs beginning on October 1 of
 12.2 the first year not less than two years after their effective date.

12.3 (f) The single bed room incentives shall be as determined under section 256B.431,
 12.4 subdivision 42.

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

12.8 (h) The portion related to employer health insurance costs shall be the allowable
 12.9 costs divided by resident days.

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

12.12 ~~(i) The single bed room incentives shall be as determined under section 256B.431,~~
 12.13 ~~subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall~~
 12.14 ~~no longer be included in the payment rate for external fixed costs beginning October 1,~~
 12.15 ~~2016. Single bed room incentives that take effect on or after October 1, 2014, shall no~~
 12.16 ~~longer be included in the payment rate for external fixed costs beginning on October 1 of~~
 12.17 ~~the first year not less than two years after their effective date.~~

12.18 (j) The portion related to special dietary needs shall be the per diem amount
 12.19 determined under section 256B.431, subdivision 2b, paragraph (h).

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

12.22 Sec. 17. Minnesota Statutes 2014, section 256B.441, subdivision 54, is amended to read:

12.23 Subd. 54. **Determination of total payment rates.** ~~In rate years when rates are~~
 12.24 ~~rebased,~~ The total care-related per diem, other operating price, and external fixed per diem
 12.25 for each facility shall be converted to payment rates by multiplying each by the forecast
 12.26 increase in the CPI-U index from the midpoint of the reporting year to the midpoint of
 12.27 the rate year. The total payment rate for a RUG's weight of 1.00 shall be the sum of
 12.28 the total care-related payment rate, other operating payment rate, ~~efficiency incentive,~~
 12.29 external fixed cost rate, and the property rate determined under section 256B.434. To
 12.30 determine a total payment rate for each RUG's level, the total care-related payment rate
 12.31 shall be divided into the direct care payment rate and the other care-related payment rate,
 12.32 and the direct care payment rate multiplied by the RUG's weight for each RUG's level
 12.33 ~~using the weights in subdivision 14.~~

12.34 Sec. 18. Minnesota Statutes 2014, section 256B.441, subdivision 56, is amended to read:

13.1 Subd. 56. **Hold harmless.** For the rate ~~years~~ year beginning on or after October 1,
13.2 ~~2008, to October 1, 2016~~ 2015, no nursing facility shall receive an operating cost payment
13.3 rate less than its prior system operating cost payment rate ~~under section 256B.434~~. For
13.4 ~~rate years beginning between October 1, 2009, and October 1, 2015, no nursing facility~~
13.5 ~~shall receive an operating payment rate less than its operating payment rate in effect on~~
13.6 ~~September 30, 2009~~ as defined in subdivision 31. The comparison of operating payment
13.7 rates under this section shall be made for a RUG's rate with a weight of 1.00.

13.8 Sec. 19. Minnesota Statutes 2014, section 256I.05, subdivision 2, is amended to read:

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

13.19 Sec. 20. **REPEALER.**

13.20 Minnesota Statutes 2014, section 256B.441, subdivisions 14a, 19, 50a, 52, 55,
13.21 58, and 62, are repealed.

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

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

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

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

- (1) the nursing facility is recognized by the federal Medicare program to be a hospital-based nursing facility;
- (2) the hospital and nursing facility are physically attached or connected by a corridor;
- (3) a nursing facility and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year, shall be considered a hospital-attached nursing facility for purposes of setting payment rates under this section. The nursing facility must file its cost report for that reporting year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital-based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the definition requirements in clauses (1) and (2). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility according to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility;
- (4) if a nonprofit or community-operated hospital and attached nursing facility suspend operation of the hospital, the remaining nursing facility must be allowed to continue its status as hospital-attached for rate calculations in the three rate years subsequent to the one in which the hospital ceased operations.

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

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

- (1) determine the difference between the limits;
- (2) determine the distance between the two facilities, by the shortest driving route. If the distance exceeds 20 miles, no adjustment shall be made;
- (3) subtract the value in clause (2) from 20 miles, divide by 20, and convert to a percentage; and

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

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

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

Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined

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under section 256B.434. For purposes of this subdivision, the rate to be used that is determined under section 256B.434 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 256B.434. For the rate period from October 1, 2009, to September 30, 2013, no rate adjustments shall be implemented under this section, but shall be determined under section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

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

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

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

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

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

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

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

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

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

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

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

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incentives from external fixed costs under subdivision 53 shall not go into effect until 82 percent of the operating payment rate from this section is phased in as described in subdivision 55.

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