

# **Value-Based Reimbursement: A Proposal for a New Nursing Facility Reimbursement System**

**March 1, 2004**

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## **COST TO PREPARE REPORT**

Minnesota Statutes, Chapter 3.197, requires disclosure of the cost to prepare this report. The cost of this report is based on the costs of salaries and fringe benefits for Department of Human Services employees for the time spent preparing the text of the report. The cost also includes the cost of printing the report. The estimated cost for the Department of Human Services for preparing this report is \$7,664.

## **COSTS TO DEVELOP THE DESIGN OF THE NEW VALUE BASED REIMBURSEMENT SYSTEM FOR NURSING FACILITIES**

In 2001, the Legislature instructed DHS to develop recommendations for a new reimbursement system and provided funding for consultants to assist in its development. In addition, the Legislature appropriated funds for the development of quality profiles and measures that are to be used in the proposed reimbursement system. Total appropriations for development of these two projects for fiscal years 2003 and 2004 are \$1,025,000.

Costs to develop the new value-based reimbursement system for nursing facilities and the associated quality profiles are detailed below. Drafting of the proposed legislation to implement this project has been included in the development costs.

Consultant fees (University of Minnesota Schools of Public Health and Nursing and subcontract with Myers and Stauffer LC):	\$788,572*
DHS staff salaries and fringe benefits:	\$110,233

\*Note: \$345,000 of consulting fees is related to the development of quality profiles for nursing facilities. The quality profile work is continuing throughout fiscal years 2004 and 2005 and is intended to not only impact the nursing facility reimbursement system but be a source of consumer information. Minnesota Statutes, Section 256B.439 requires the commissioner of Human Services in cooperation with the commissioner of Health to develop and implement a quality profile system for nursing facilities and other providers of long-term care services. This work is approximately 60 percent complete.

**This report to the Legislature, is required under Laws of Minnesota 2001, First Special Session, Chapter 9, Article 5, Section 35.**

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## **EXECUTIVE SUMMARY**

### **I. Background: Why a New Reimbursement System is Needed**

This is a proposal for a new nursing facility reimbursement system. A new system is needed because the current system no longer meets the needs of nursing facilities, consumers, and policy makers.

Over time, the nursing facility industry has responded to the changing regulatory system and its incentives and pressures. Today, current levels of reimbursement are largely the result of business decisions made over many years and under rate setting methods that have also changed.

Stakeholders have asked for changes in the current system and there is strong interest in developing a value-based approach to reimbursing facilities for the care they provide. A reimbursement system that considers a facility's quality, and can determine "value" when setting rates, would also be beneficial to the state.

### **II. Overview of Proposed Value-based Reimbursement System**

The proposed nursing facility reimbursement system:

- Recognizes legitimate costs;
- Encourages efficiency and quality;
- Reduces rate disparities;
- Gives providers financial incentives for delivering quality services and achieving good outcomes for residents; and
- Provides the legislature with a means to manage overall expenditures.

This Value-Based Nursing Facility Reimbursement System (VBR) will pay for services based on:

- Target price;
- Quality;
- Efficiency; and
- Each nursing facility's specific costs.

Characteristics of the new system:

- |   |  |
|---|--|
| <ul style="list-style-type: none"><li>• <b>Four cost categories:</b><ul style="list-style-type: none"><li>- Direct care services</li><li>- Support services</li><li>- External Fixed</li><li>- Property</li></ul></li></ul> | <ul style="list-style-type: none"><li>• <b>Rates set annually (October 1)</b></li><li>• <b>MDS case mix retained</b></li><li>• <b>Four-year phase-in</b></li></ul> |
|---|--|

### **III. How Does the New Reimbursement System Work?**

The new nursing facility reimbursement system will pay for services based on target price, quality, efficiency and a facility's specific costs. It looks at the difference between a facility's own costs and the target price and may provide for a portion of that difference in the facility's rate depending on the efficiency and quality of the facility. The higher the quality or the greater the efficiency, the more the facility is paid.

Here are the steps for determining the rate:

#### **1. Quality information is collected.**

- DHS collects statistical information on quality from nursing facilities and other sources.
- Quality is measured by staff/resident ratio, staff turnover, staff retention, use of nursing pools, quality indicators, percentage of single rooms in the facility, and deficiency data.
- A quality score is calculated on a scale of 0 to 100.
- Each facility is placed in one of 10 quality tiers.

#### **2. Cost information is collected.**

- DHS collects cost information from each facility.
- The new cost report will be simpler than that used for Rule 50, a previous reimbursement model, and will be the type of information nursing facilities already collect.

#### **3. Target prices are established for each of the 10 quality tiers.**

- DHS uses cost data from all nursing facilities to set the target price for each quality tier.
- The target price is the amount to which all nursing facilities in that quality tier are compared.

#### **4. Rates are determined for both Direct Care and Support Services categories.**

- Nursing facilities get the lesser of their costs or the target price, plus a portion of the difference based on their level of quality or efficiency.

#### **5. External Fixed Costs rate is determined.**

- This rate component covers costs of license fees, the scholarship program, long-term care consultation, property taxes, property insurance, and PERA on a cost basis.
- In addition, allowances are included to cover costs related to the surcharge, planned closure rate adjustments, family council fee, and equipment.

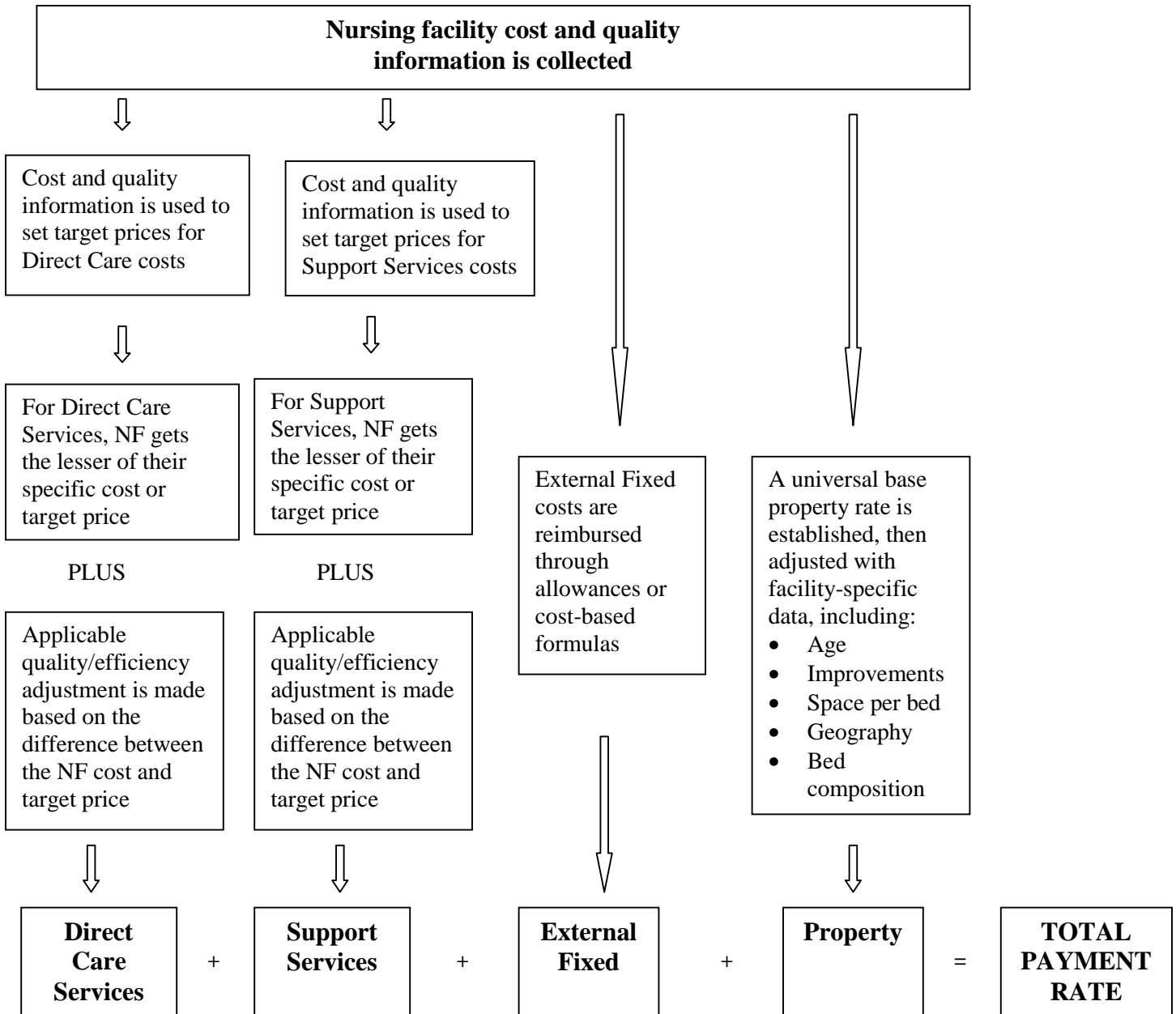
**6. Property rate is calculated.**

- A universal base rate is established based on investment-per-bed limits, currently about \$76,000.
- For each facility, the base rate is adjusted for facility specific cost factors--the age of facility, major improvements, space per bed, bed composition (single versus double rooms) and geography.
- Nursing facilities get a payment based on the value of their investment (currently about 7.3 percent.)
- Nursing facilities will receive a higher rate for single-bed rooms.

**7. The total payment rate is determined, based on the sum of the four cost categories--Direct Care, Support Services, External Fixed and Property.**

The following chart shows how the reimbursement system works.

### HOW RATES ARE SET



#### **IV. Other Features**

This proposal includes a four-year phase in. This is needed because some facilities will receive higher reimbursement than under the current payment system, while others will receive less. Time will be needed for facilities to recognize in advance any changes in reimbursement that will be experienced under the new system and adapt their individual business models as needed.

This proposal does not include a factor to provide automatic inflation adjustments. It is recognized that the Legislature will make decisions on inflation increases or other adjustments each time it adopts a biennial budget.

In designing the new reimbursement system, the department sought to achieve budget neutrality. The intent was neither to achieve savings nor to increase spending to implement the proposal, but rather to offer a “frame work” that would:

- Provide flexibility for decision makers to adjust total spending as needed; and
- Provide confidence that new dollars would be used in a manner that would result in the best outcomes.

#### **V. Conclusion**

Value-Based Reimbursement is an approach that considers quality of services provided when establishing payment rates. This proposal provides direct incentives to encourage both quality and efficiency and balances the tension between them. This is done by measuring and considering quality in how a target price is determined and in how payment rates are set.

Its greatest benefit will be to nursing facility residents because the nursing facilities they live in will be paid based on the quality of services that the nursing facility residents receive.



## **I. BACKGROUND: WHY A NEW REIMBURSEMENT SYSTEM IS NEEDED**

This is a proposal for a new nursing facility reimbursement system. A new reimbursement system is needed because the current system no longer meets the needs of nursing facilities, consumers, and policy makers.

Historically, Minnesota paid nursing facilities based on their allowable, reported costs plus inflation under a system called Rule 50. The state functioned as a “payor.” Nursing homes submitted detailed cost reports and were reimbursed for allowed costs. Although recognizing a facility’s costs was a desirable feature, the system:

- Was inflationary and prescriptive;
- Led to many appeals due to its complexity;
- Did not directly recognize quality; and
- Resulted in rate disparities for similar services.

Because the system provided no direct tie between payment and the quality of the services, nursing facilities with higher rates didn’t necessarily provide better quality services.

In 1999 a law change ended the practice of setting operating rates based on costs. Today, under Rule 50, nursing facilities receive last year’s rate plus any adjustments passed by the Legislature. Only property rates are set using cost information.

In 1996 Minnesota implemented the voluntary Alternative Payment System (APS), a contract system in which nursing facilities receive their historic rates plus inflation or other rate adjustments determined by the Legislature. About 75 percent of all nursing facilities are in APS. The benefit of APS is simplicity. There are no cost reports and very few appeals. However, the APS is a “rate-on-rate” system; there is no recognition of changes in costs and nothing is built into APS to address unusual situations. After a few years under APS, more nursing facilities began requesting legislation for facility-specific rate adjustments.

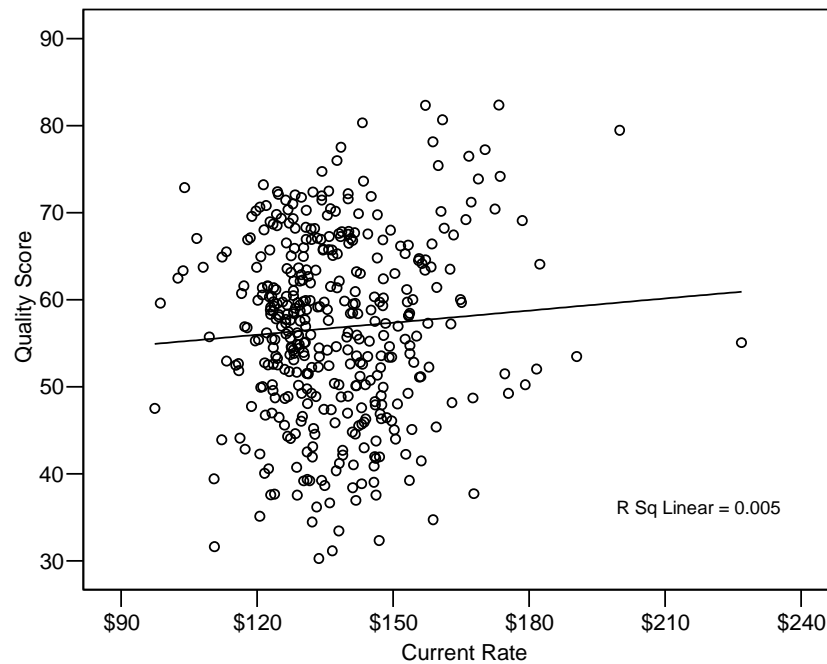
APS contracts require nursing facilities to have quality improvement plans. This was a first step in factoring quality into the payment system. APS also creates more of a purchaser/contractor relationship. However, there is still no direct tie between the quality of care in a facility and how much the facility is paid.

Over time, the nursing facility industry has responded to the changing regulatory system and its incentives and pressures. Today, current levels of reimbursement are largely the result of business decisions made over many years and under rate setting methods that have also changed. As a result, rates differ widely, even when serving people with similar needs. For example, for a case mix weight of 1.0, rates range from about \$97 per day to \$227 per day depending upon the facility.

There is nothing inherently wrong with rates being different if there is a reasonable explanation for these differences. Unfortunately, the differences in our system cannot be

explained based on efficiency, quality, or other facility-specific quantitative measures. Currently there seems to be no relationship between payment rates and quality. The following graph<sup>1</sup> shows the relationship between the current payment rates and quality. The rate difference between the facility with the highest quality score and the facility with the lowest quality score is only \$20. In addition, the facility with the highest rate, about \$230, and the facility with the lowest rate, about \$100, have quality scores that are almost equal.

### Minnesota Nursing Facilities: Quality Score by Current Rates



Stakeholders have asked for changes in the current system and there is strong interest in developing a value-based approach to reimbursing facilities for the care they provide. A reimbursement system that considers a facility's quality, and can determine "value" when setting rates, would also be beneficial to the state and, most importantly, to nursing facility residents.

## II. OVERVIEW OF THE PROPOSED "VALUE-BASED" REIMBURSEMENT SYSTEM

In 2001, the Legislature instructed DHS to develop recommendations for a new reimbursement system<sup>2</sup> and provided funding for consultants to assist in its development. DHS contracted with the University of Minnesota to assist in developing a system that

<sup>1</sup> This chart is based on nursing facilities' 7/1/03 rates and quality scores determined using the quality measures proposed in this report.

<sup>2</sup> See appendix A for a description of the statutory requirements and goals for the new reimbursement system.

factors both cost and quality into its rate setting. With input from many stakeholders, this proposal has been developed.

The proposed nursing facility reimbursement system:

- Recognizes legitimate costs;
- Encourages efficiency and quality;
- Reduces rate disparities;
- Gives providers financial incentives for delivering quality services and achieving good outcomes for residents; and
- Provides the Legislature a means to manage overall expenditures.

This Value-Based Nursing Facility Reimbursement System (VBR) will pay for services based on:

- Target price;
- Quality;
- Efficiency; and
- Each nursing facility's specific costs.

VBR provides direct incentives to encourage both quality and efficiency by establishing standardized, "target prices" and by allowing variations from those prices depending on level of quality. It is a hybrid between a pricing system and a cost-based system.

The system provides facility specific, prospective rates. Rates will be determined annually using a statistical and simplified cost report filed by each nursing facility.

**Annual cycle for determining rates:**

Cost reporting year	October 1 through September 30
Cost reports will be filed	January 15
Rate notices will be distributed	August 15
Rate year	October 1 through September 30

**The total payment rate is composed of four cost categories:**

- Direct Care Services
- Support Services
- External Fixed
- Property

**III. HOW DOES THE NEW REIMBURSEMENT SYSTEM WORK?**

**A. DATA COLLECTION**

**1. Quality information is collected and scored.**

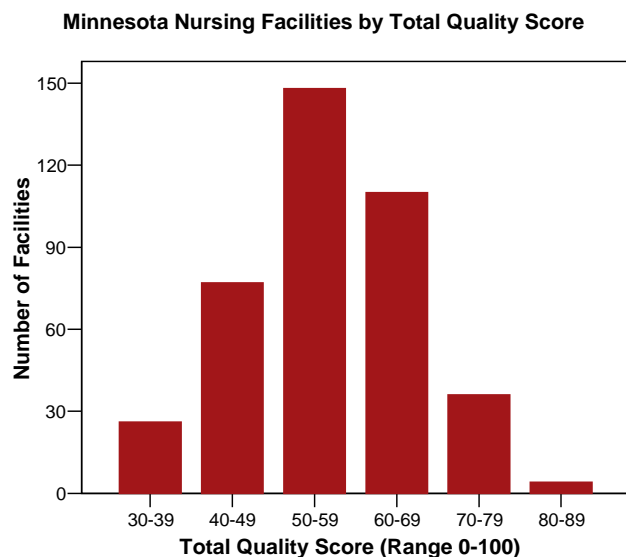
DHS collects statistical information on quality from nursing facilities and other sources. Information is collected for seven quality areas. Facilities receive points for their performance in each area.

The department worked with consultants and a stakeholder workgroup to select appropriate quality measures and to assign their relative point scores. These measures were chosen because they reflect quality, are readily available, and the data are available.

Quality Measure	Maximum Quality Points Available
1. Nursing Hours per Standardized Resident Day	30
2. Staff Turnover	12
3. Staff Retention	12
4. Use of Pool Staff	9
5. Proportion of Single Rooms	13
6. Quality Indicators from the MDS	14
7. Survey Deficiencies	10
<b>total</b>	<b>100 points</b>

A quality score between 0 and 100 is calculated for each facility. The scores are used to place a facility into one of 10 quality tiers. Tiers are established in 10 point increments, so that Quality Tier One will be assigned to facilities with scores of 0 to 10, Quality Tier Two will be assigned to facilities with scores of 11 to 20, and so on.<sup>3</sup>

To test these measures, quality information was collected for all nursing facilities and preliminary scores were determined. The following chart shows the distribution of facilities based on their quality scores. Although a few facilities have quite low quality scores (below 40) and others have relatively high scores (70 and above), most facilities fall in the average range (40 to 69).



<sup>3</sup> For more information on how the quality measures were developed, see appendix B.

While the initial set of quality measures is good, there is room for improvement. Over time, the department intends to build in measures addressing such areas as “quality of life” and “consumer satisfaction.” This may involve reweighting points or replacing certain measures to better focus on consumer outcomes. A stakeholder work group is participating in this process.<sup>4</sup>

## **2. Cost information is collected.**

Nursing facilities will submit cost reports annually. The new cost report will be simpler than Rule 50 and will be consistent with information nursing facilities already collect. For example, costs for the day-to-day operation of a facility will be reduced to two categories, Direct Care Services and Support Services. This will allow for a simpler rate calculation and more flexibility for providers in managing their businesses. It will also reduce the likelihood of disputes over cost classification.

In total, cost information will be collected for four cost categories.

Direct Care Services includes expenses for:

- Nursing; and
- Other care-related services, including social services and activities.

Support Services includes expenses for:

- Dietary services;
- Housekeeping;
- Laundry and linen services;
- Plant operations and maintenance; and
- General and administrative.

External Fixed are add-on’s to the rate and include expenses for:

- License fees;
- The surcharge;
- The scholarship program;
- Long-term care consultation;
- The family council fee;
- Property taxes;
- Property insurance;
- Closure rate adjustments;
- The moveable equipment and technology allowance; and
- The Public Employees Retirement Association.

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<sup>4</sup> For information on how “quality of life” and “consumer satisfaction” measures might be developed, see appendix C.

Property includes expenses for:

- Land;
- Buildings;
- Improvements; and
- Fixed equipment.

### **3. Target prices are established for each of the 10 quality tiers**

VBR pays a higher rate for nursing facilities that offer high quality care. It does this by linking quality to payment by setting “target prices” for each of the 10 quality tiers. Nursing facilities that demonstrate high quality have higher target prices and those with lower quality have lower prices. Cost data from all nursing facilities is used when setting target prices so that target prices will reflect costs that facilities actually incur.<sup>5</sup> Compensation-related cost information is modified to account for differences in wages based on geographic location, so that all facilities are on a level playing field.

To more fairly compare certain types of facilities, separate target prices are set for:

- Facilities that have three or more admissions per bed per year, are hospital attached or provide special care under Rule 80;
- Facilities with more than 50 percent of their beds licensed as Boarding Care Home beds; and
- All other facilities.

## **B. RATE DETERMINATION**

### **1. Direct Care Services rates are determined.**

To determine a facility’s Direct Care Services rate, it is first necessary to determine its direct service costs. Information from the cost report is used to determine the facility’s costs per resident day.<sup>6</sup>

A facility’s Direct Care Services rate is based on its:

- Specific costs;
- Target price;
- Quality tier; and
- Efficiency.

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<sup>5</sup> A description of the mathematical calculations used to set target prices is in appendix D.

<sup>6</sup> These costs are already case mix adjusted, to reflect the level of acuity of each facility’s residents. Therefore, the costs must be further adjusted so that facilities that serve high need people can be fairly compared with facilities that serve lower need people. This is accomplished by adjusting each facility’s case mix cost to a common index of 1.0 so that fair comparisons can be made.

To set a facility's Direct Care Services rate, its costs are compared to the target price of its quality tier. The facility gets the lesser of its costs or the target price, plus a portion of the difference based on its level of quality and efficiency.

The following examples show how this works.

**Example 1. High cost, low quality.** This facility is in quality tier 3.

Facility's specific costs	\$69
Target price	\$59
Facility gets lesser of its own costs or the target price.	Facility gets <b>\$59</b> .
Facility gets a portion of the difference between its costs and the price.	Use the matrix (on next page) to see the additional payment. The facility gets 20% of the first \$5, or <b>\$1</b> and no adjustment for the next \$5.

The Direct Care Services rate is  $\$59 + \$1 = \$60$ . This facility will receive \$9 less than its costs. To be successful, this facility will need to either improve its quality or reduce its costs.

**Example 2. High cost, high quality.** This facility is in quality tier 9.

Facility's specific costs	\$81
Target price	\$71
Facility gets lesser of its own costs or the target price.	Facility gets <b>\$71</b> .
Facility gets a portion of the difference between its costs and the price.	Use the matrix (on next page) to see the additional payment. The facility gets 110% of the first \$5, or <b>\$5.50</b> and 100% of the next \$5, or <b>\$5</b> .

The Direct Care Services rate is  $\$71 + \$5.50 + \$5 = \$81.50$ . This facility will receive \$.50 more than its costs. Even though it is high cost, it is also high quality, so the reimbursement system allows the facility to cover its costs.

**Example 3. Low cost, low quality facility.** This facility is in quality tier 3.

Facility's specific costs	\$54
Target price	\$59
Facility gets lesser of its own costs or the target price.	Facility gets <b>\$54</b> .
Facility gets a portion of the difference between its costs and the price.	Use the matrix (on next page) to see the additional payment. The facility gets 20% of the first \$5 difference, or <b>\$1</b> .

The Direct Care Services rate is  $\$54 + \$1 = \$55$ . This facility will receive \$1 more than its costs. This facility is not high quality but it gets a small additional

payment because it operates efficiently. This facility would get a higher payment if it improved its quality score.

**Example 4. Low cost, high quality facility.** This facility is in quality tier 8.

Facility's specific costs	\$59
Target price	\$69
Facility gets lesser of its own costs or the target price.	Facility gets <b>\$59</b> .
Facility gets a portion of the difference between its costs and the price.	Use the matrix (below) to see the additional payment. The facility gets 80% of the first \$5 difference, or <b>\$4</b> and 40% of the next \$5, or <b>\$2</b> .

The Direct Care Services rate is  $\$59 + \$4 + 2 = \$65$ . This facility will receive \$6 more than its costs. This system provides the greatest rewards to facilities that are both low cost and high quality.

**Matrix for Determining Direct Care  
Additional Payments based on Quality or Efficiency**

	Quality Tier	1	2	3	4	5	6	7	8	9	10
	Quality Score	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
<b>For amounts between:</b>		<b>Additional payment will be:</b>									
If cost is greater than target price:	\$25.01 to \$35								10%	20%	30%
	\$20.01 to \$25							10%	30%	40%	50%
	\$15.01 to \$20						20%	30%	50%	60%	80%
	\$10.01 to \$15					20%	40%	50%	70%	90%	100%
	\$5.01 to \$10				20%	50%	70%	70%	90%	100%	100%
	0 to \$5			20%	40%	70%	100%	105%	110%	110%	120%
If cost is less than target price:	0 to \$5	10%	10%	20%	30%	50%	50%	60%	80%	90%	100%
	\$5.01 to \$10			10%	15%	25%	25%	30%	40%	45%	50%

**2. Support Services rates are determined.**

The Support Services rate is determined using a process similar to that used for determining the Direct Care Services rate. First it is necessary to determine each facility's support services reported costs. Information from the cost report is used to determine each facility's costs per resident day.

A facility's Support Services rate is based on its:

- Specific costs;
- Target price;
- Quality tier; and
- Efficiency.



In setting a facility's Support Services rate, its costs are compared to the target price of the quality tier assigned. The facility gets the lesser of its costs or the target price, plus a portion of the difference based on its level of quality or efficiency.

The matrix, below, is used to determine the additional payment that would be added to the rate. The process to determine this additional payment is the same as that used to calculate Direct Care rates. The only differences are in the incremental amounts in the left-hand column.

**Matrix for Determining Support Services  
Additional Payments based on Quality or Efficiency**

	Quality Tier	1	2	3	4	5	6	7	8	9	10
	Quality Score	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
<b>For amounts between:</b>		<b>Additional payment will be:</b>									
If cost is greater than target price:	\$10.01 to \$14								10%	20%	30%
	\$8.01 to \$10							10%	30%	40%	50%
	\$6.01 to \$8						20%	30%	50%	60%	80%
	\$4.01 to \$6					20%	40%	50%	70%	90%	100%
	\$2.01 to \$4				20%	50%	70%	70%	90%	100%	100%
	0 to \$2			20%	40%	70%	100%	105%	110%	110%	120%
If cost is less than target price:	0 to \$2	10%	10%	20%	30%	50%	50%	60%	80%	90%	100%
	\$2.01 to \$4			10%	15%	25%	25%	30%	40%	45%	50%

**3. External Fixed rate is determined.**

The third category is External Fixed costs. This component of the rate includes various types of allowances to cover costs related to the surcharge, planned closure rate adjustments, the family council fee, and equipment. It also covers costs for license fees, scholarships, long-term care consultation, property taxes, property insurance, and PERA. The rate paid for these items is determined under existing law and simply added onto the rate.<sup>7</sup>

**4. Property rate is calculated.**

Changes to property rates are proposed because the current property rates have little to do with either costs or value. Current levels of property reimbursement are largely the result of business decisions made over many years and changes in rate setting methods. Facilities in APS receive annual inflation on their prior year's property rate. If costs go down through refinancing debt, for example, the facility

<sup>7</sup> One new item on this list is the moveable equipment allowance. See appendix F for more information.

keeps all the savings. Facilities in Rule 50 are reimbursed for interest expense and receive a return on equity. Neither system offers incentives to hold costs down or to provide greater value to consumers.

The new property payment system approximates a rental value for the property and pays a rate based on that value. It is a proposal that provides a more equitable method for setting property rates.

Under the proposed system, the property rate is based on the current investment per bed limit (currently about \$76,000). That value is adjusted for each facility's:

- Age (age may be reduced when major improvements to the facility are made, creating a lower effective age);
- Space per bed;
- Geographic location; and
- Number of beds in "split double" bed rooms (rooms with two beds that share access to the hallway where there is a fixed, floor-to-ceiling partition separating the two beds.)

Based on these adjustments, each facility's rental value is determined. Nursing facilities get a payment based on the value of their property. This payment is based on a 12-quarter average of the 10-year treasury bond rate plus 2 percent. (Currently, the payment for property using this method would be about 7.3 percent.)<sup>8</sup>

Higher Rates for Private and Single-Bed Rooms. Nursing facilities will automatically receive higher rates for single-bed rooms with shared bathrooms and private rooms with private bathrooms. This change will simplify the property reimbursement process and eliminate administrative processes for both the state and providers. A determination of medical necessity and prior approval for a single-bed room for Medical Assistance recipients will no longer be required. In addition, rates charged to private paying residents in single or private bed rooms are not limited to Medical Assistance payment rates for single or private bed rooms. This limits the applicability of rate equalization to non-single-bed rooms, an option already available to facilities under current law.

## **5. Total payment rate is determined.**

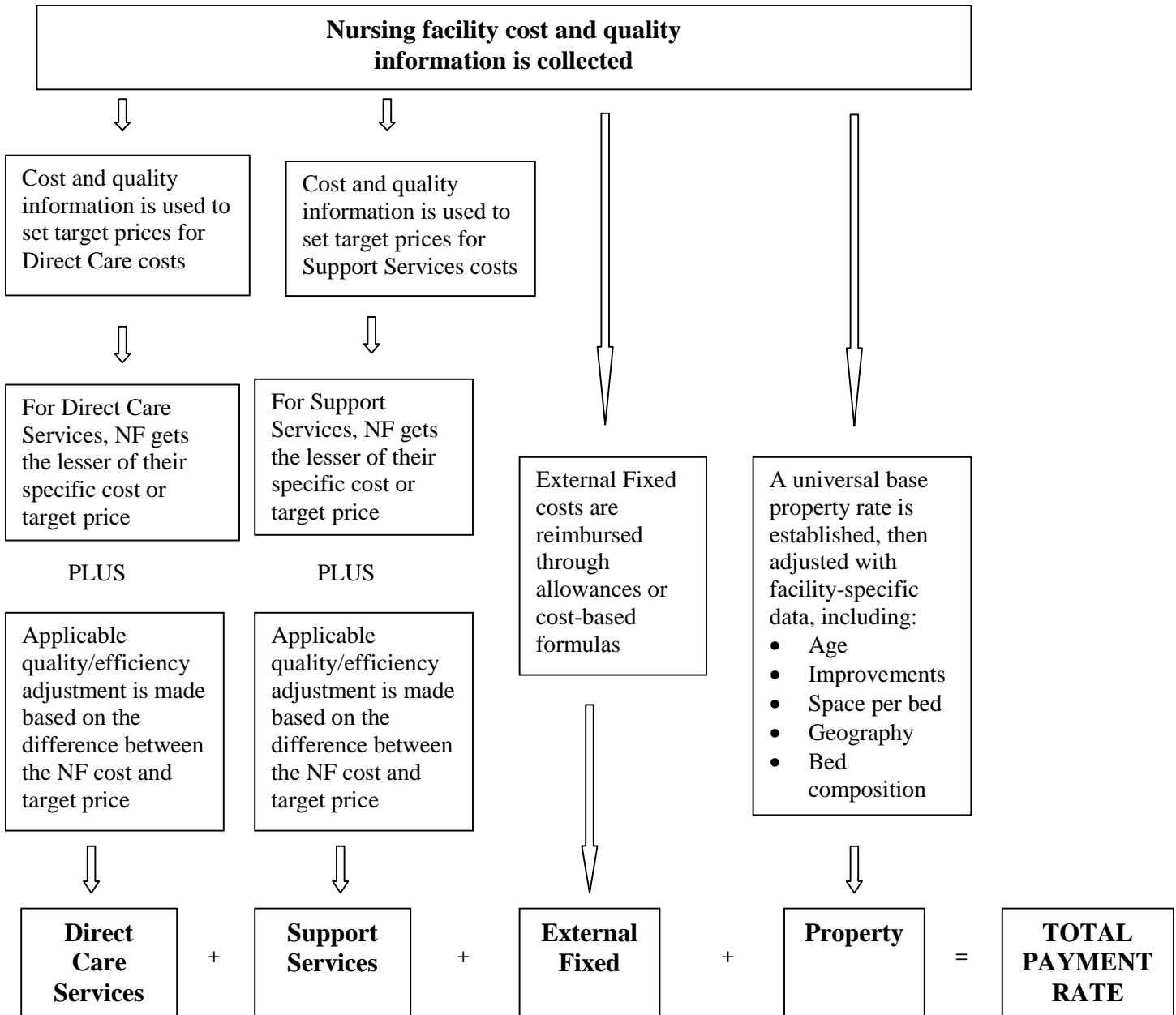
The total payment rate is the sum of the Direct Care Services, Support Services, External Fixed, and Property rate components.

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<sup>8</sup> For more detailed information on calculating property rates, see appendix F.

The following chart shows how the reimbursement system works.

### HOW RATES ARE SET



#### **IV. OTHER FEATURES OF THE REIMBURSEMENT SYSTEM**

**A. Negotiated Rates for Specialized Facilities.** A small number of facilities offer highly specialized and costly programs for people with rare diagnoses or other conditions. In VBR, the commissioner may negotiate higher rates with a small number of such facilities on a competitive basis. Negotiated rates will be limited to two years, at which time the facilities will have to compete again to negotiate higher rates.

**B. Interim Rates for Newly Purchased Facilities.** Some nursing facilities that have low quality scores and high costs may not succeed in adapting to this new system. However, closure of facilities in under-bedded parts of the state could result in a lack of access to long-term care services. To address this concern, the new reimbursement system permits the commissioner to negotiate interim rates for these facilities with a qualified new owner or operator.

#### **V. PHASE IN**

This proposal includes a four-year phase in. This is needed because some facilities will receive higher reimbursement than under the current payment system, while others will receive less. Time will be needed for facilities to recognize in advance any changes in reimbursement that will be experienced under the new system and adapt their individual business models as needed. For example, a facility with low quality can make changes to improve its quality and receive a higher rate.

During the transition period, each facility's actual payment rate will be a blending of their rate under the prior method and their rate under the new method. The following table presents a preliminary timeline for the phase-in to the new system.

<b>Transition Period</b>	<b>Percent of Prior System Rate</b>	<b>Percent of New System Rate</b>
April 2004 Enacted	100%	0%
October 2005	90%	10%
October 2006	60%	40%
October 2007	30%	70%
October 2008	0%	100%

#### **VI. METHOD FOR ADJUSTING RATES FOR CHANGES OVER TIME**

This proposal does not include a factor to provide automatic inflation adjustments. It is recognized that the Legislature will make decisions on inflation increases or other adjustments each time it adopts a biennial budget. Adjustments could be applied:

- To the Direct Care and Support Services rates (“across the board”);
- To target prices; and
- In other ways determined through legislation.

## VII. BUDGET NEUTRALITY

In designing the new reimbursement system, the department sought to achieve budget neutrality. The intent was neither to achieve savings or to increase spending to implement the proposal, but rather to offer a “framework” that would:

- Provide flexibility for decision makers to adjust total spending as needed; and
- Provide confidence that new dollars would be used in a manner that would result in the best outcomes for clients.

**A. Budget Neutrality Factor.** To assure budget neutrality upon implementation, a “budget neutrality factor” will be applied when determining the target prices. This is needed because some nursing facilities will have rates that go up while others will have rates that go down. The proportion of facilities with lower or higher rates will not come out equally. Therefore, under a budget neutral proposal, this factor must be applied.

In addition, existing funding will be used to fund higher, negotiated rates for up to 10 facilities serving special populations (see section III). The budget neutrality factor will take these additional costs into account.

**B. Other Budget Considerations.** Several other provisions have been built into the new reimbursement system that affect budget neutrality:

- The ability to make property improvements up to \$1 million becomes available to all facilities, however the automatic property increases some facilities receive are modified;
- The commissioner will have discretion to negotiate interim rates when facilities in under-bedded areas are sold; and
- The method for setting Medical Assistance payment for single bed rooms has been modified.

Some of these factors have costs while others have savings. Together they net out to be close to budget neutral. The department has completed a fiscal note and will make that information available to the Legislature.

All these factors result in essentially a budget neutral proposal with small savings and costs balancing each other over the next four years. It should be noted that, over time, providers may significantly invest resources to improve quality, resulting in rate increases in subsequent years. These potential costs cannot be quantified and the forecast bears that risk. However, potential future payments that are tied to improved quality of care for nursing facility residents would be a better investment than increased costs that have no direct relationship to improving client care.

**C. Provisions Considered that were Not Budget Neutral.** Stakeholders have expressed strong interest in several areas that were not included in the proposal because of costs. They include:

- Funding to improve quality;
- Automatic cost-of-living adjustments;

- Funding for moratorium exceptions, facility replacement and improvements;
- Funding to ease the transition. With additional funding, there would still be some rate decreases, but there would be fewer, and the rate decreases would be smaller. A safety net concept has been discussed, which would prevent facilities from receiving rate reductions beyond a certain amount in any one year; and
- Funding to improve quality measures. Additional funding could be set aside to accelerate the improvement of the quality measures.

## **VIII. RECOMMENDATIONS REGARDING RELATED TOPICS**

No changes are proposed to the following related areas.

- Surcharge
- Intergovernmental transfers
- Ventilator rates policy
- Bed-hold policy
- Medicare co-payment policy
- Enhanced rates for new admissions
- Notification requirements for rate increases for private pay residents

Layaway policies should be retained, but amended in accordance with the new method of setting property rates.<sup>9</sup>

Given the changes in treatment of private pay rates for single-bed rooms, no further changes in rate equalization are included in this proposal.

## **IX. TECHNICAL DETAIL AND STATISTICAL ANALYSES**

This report to the Legislature provides an overview of Value-Based Reimbursement system, explains why a new system is needed, and describes how it works. The technical detail and statistical analyses for developing this system are not included in this report.

The department worked with the University of Minnesota and its subcontractor, Meyers and Stauffer, LC to conduct the detailed fiscal analyses used in the design and evaluation of this proposal. Because Medicaid cost report data is not available for all Minnesota nursing facilities, these analyses included modeling of the new reimbursement system using:

- Cost data from Medicare nursing facility cost reports;
- Cost data filed by some facilities with DHS;
- Statistical data filed with DHS;
- Resident assessment data from the Minimum Data Set; and
- Limited property data provided voluntarily by about 75 percent of facilities.

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<sup>9</sup> Appendix H provides bill language to accomplish this.

Summary data of the modeling and the impact of the new system on individual nursing facility rates are available and have been shared with stakeholders. This data is available from the department.

## **X. CONCLUSION**

Value-Based Reimbursement is an approach that considers quality of services provided when establishing payment rates. This proposal provides direct incentives to encourage both quality and efficiency and balances the tension between them. As described in this report, this is done by measuring and considering quality in determining target prices and setting payment rates. While there are still details to consider and refinements that can be made, this proposal provides a solid framework on which to create the new reimbursement system.

Many states have considered ways of recognizing quality when paying for long-term care services but few have been successful in implementing such a system. VBR represents a major long-term care policy initiative for Minnesota. This new reimbursement system:

- Encourages efficiency and quality;
- Recognizes legitimate costs;
- Reduces rate disparities; and
- Gives providers financial incentives for delivering quality services and achieving good outcomes for residents.

Its greatest benefit will be to nursing facility residents because the nursing facilities they live in will be paid based on the quality of services that the nursing facility residents receive.<sup>10</sup>

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<sup>10</sup> See appendix H for draft bill language to implement this proposal.

# **Appendices**



**STATUTORY REQUIREMENTS AND GOALS\_**

Legislation enacted in Laws of Minnesota 2001, First Special Session, Chapter 9, Article 5, Section 35, states, in part:

- (a) The commissioner of human services shall develop and report to the legislature by January 15, 2003, [later revised to 2004 in Laws of Minnesota 2002, Chapter 220, Article 14, Section 19] a system to replace the current nursing facility reimbursement system established under Minnesota Statutes, sections 256B.431, 256B.434, and 256B.435.
- (b) The system must be developed in consultation with the long-term care task force and with representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioner may employ consultants to assist with this project.
- (c) The new reimbursement system must:
  - (1) provide incentives to enhance quality of life and quality of care;
  - (2) recognize cost differences in the care of different types of populations, including subacute care and dementia care;
  - (3) establish rates that are sufficient without being excessive;
  - (4) be affordable for the state and for private-pay residents;
  - (5) be sensitive to changing conditions in the long-term care environment;
  - (6) avoid creating access problems related to insufficient funding;
  - (7) allow providers maximum flexibility in their business operations;
  - (8) recognize the need for capital investment to improve physical plants; and
  - (9) provide incentives for the development and use of private rooms.

The Department identified several additional considerations important to the development of this proposal:

- (a) The system is consumer-based, meaning that it emphasizes features that are important to consumers.
- (b) The proposal is budget neutral.
- (c) It encourages both efficiency and quality in a way that all facilities can be winners. High quality is based on achieving excellence, rather than just a percentile ranking. The system uses absolute standards rather than relative ones.
- (d) It provides for differences in rates that can be explained by such factors as differences in labor market in various parts of the state, efficiency, quality, and acuity of residents served.
- (e) The system is as simple as possible. Stakeholders are able to understand the new reimbursement system and incentives are clear so that providers know what they need to do to succeed.
- (f) The system minimizes the need for dispute resolution.
- (g) Additional infrastructure within the state agency is not necessary to implement the new reimbursement system.
- (h) There is no additional administrative burden on providers.

## DEVELOPMENT OF THE QUALITY MEASURES

The first step in establishing payment rates is the determination of quality scores. Various quality indicators are combined into a single point score, whereby higher points would earn greater rewards. Quality scores, using the most recent data available, are a composite of several measures designed to:

- Capture different dimensions of quality;
- Use measures that are widely recognized as reflecting quality;
- Use routinely collected data;
- Use data that are believed to be valid and reliable; and
- Be based on fixed standards where every facility can achieve a high score if it meets the standards.

Quality information may include information on the technical quality of care, expressed as outcomes or process measures, or even structural indicators (e.g. staffing). It can include established quality indicators, which may be either outcome or process measures, or it can include aspects of satisfaction (clients and/or family) and quality of life. After careful review of potential quality information, the following seven quality measures were selected for the initial development of this proposal.

- Nursing hours per standardized resident day
- Staff turnover
- Staff retention
- Use of pool staff
- Proportion of single bed rooms
- Quality indicators from the Minimum Data Set
- Deficiencies from certification surveys

Creating a single comprehensive quality measure required some means of determining the relative importance of each component. For this type of reward system to be effective, there should be general agreement among stakeholders about the quality measures. A workgroup was formed that included representatives from all stakeholder groups. Potential quality information was discussed with the group and a written survey instrument was distributed to the group. This survey asked for responses on what quality information should be included in the quality measures and what relative importance each measure should be given. With a total possible score of 100 points, each measure has a maximum number of points reflecting the relative priority assigned.

The definitions of the measures are shown in Table 1. Table 2 presents a list of the 18 quality indicators (QIs) that were used for the QI measure, and Table 3 shows the care-related deficiencies (F-tags) used for the certification survey deficiency measure.

**Table 1. Quality Measures**

<b>Quality Measure</b>	<b>Brief Definition</b>	<b>Quality Points</b>	<b>Minimum Points</b>	<b>Maximum Points</b>	<b>Points between Minimum and Maximum</b>	<b>Source</b>
Nursing Hours per Standardized Resident Day	Facility average (mean) nursing hours per resident day for RN, LPN, CAN and TMA (adjusted for facility case mix)	30	0 points if facility is below 2.00 hrs PPD	30 points if facility is at or above 4.50 hrs PPD	Points distributed proportionately according to hours between 2.00 and 4.50	DHS Annual Facility Survey 2001-2002 (R-50 Cost Report, APS Data Collection report)
Staff Turnover	Nursing staff who left between 10/1 of one year and 9/30 of the following year divided by number of staff	12	0 points if facility has turnover rate equal to or greater than .70	12 points if facility has a turnover rate equal to or less than .20	Points distributed proportionately according to rates between .70 and .20	DHS Annual Facility Survey 2001-2002
Staff Retention	Nursing staff on 10/1 who were still employed on 9/30 of the following year divided by number of staff	12	0 points if facility has a retention rate less than 50%	12 points if facility has a retention rate equal to or greater than 85%	Points distributed proportionately according to rates between 50% and 85%	DHS Annual Facility Survey 2001-2002
Use of Pool Staff	Pool staff hours as a percentage of total nursing hours	9	0 points if facility had greater than 10% pool staff hours	9 points if facility had no pool staff hours	Points distributed proportionately according to percentage pool staff from 10% to 0%	DHS Annual Facility Survey 2001-2002
Proportion of Single Rooms	Proportion of all beds that were in single rooms	13	0 points if facility had no beds in single room	13 points if facility had 75% or more beds in single rooms	Points distributed proportionately according to percentage of beds in single rooms from 0% to 75%	DHS Annual Facility Survey 2001-2002
Quality Indicators from MDS	The proportion of quality indicators where the facility was better than the national average (based on 18 QIs)	14	0 points if facility did not do better than national average on any QI.	14 points if facility did better than national average on all 18 QIs	Points distributed proportionately according to percentage of QIs where facility did better than national average (0% to 100%)	MN MDS Data and CMS QI Reports (National)
Survey Deficiencies	Survey deficiencies at Level F or higher for patient care related F-tags	10	0 Point if facility had deficiencies at level H or higher	10 points if all facility deficiencies were below level F	5 points if facility had deficiencies at level F or G	State Health Department Nursing Home Surveys

**Table 2. Quality Indicators Included in QI Score**

<b>Quality Indicator</b>	<b>Source</b>
Prevalence of Incontinence of Bowel/Bladder Hi Risk	CMS – Quality Measures
Prevalence of Incontinence of Bowel/Bladder Lo Risk	CMS – Quality Measures
Prevalence of Infections	CMS – Quality Measures
Prevalence of Pressure Sores Hi Risk	CMS – Quality Measures
Prevalence of Pressure Sores Lo Risk	CMS – Quality Measures
Prevalence of Burns, Skin Tears, Cuts	CMS – Quality Measures
Prevalence of Anti-Psychotic w/o Psychiatric Dx Hi Risk	CMS – Quality Measures
Prevalence of Anti-Psychotic w/o Psychiatric Dx Lo Risk	CMS – Quality Measures
Incidence of Loss of ADL Function	CMS – Quality Measures
Incidence of New Fractures	CHSRA Qis
Prevalence of Falls	CHSRA Qis
Prevalence of Depression w/o Anti-Depressant Medication	CHSRA Qis
Prevalence of Incontinence w/o a Toilet Plan	CHSRA Qis
Prevalence of Fecal Impact	CHSRA Qis
Prevalence of Weight Loss	CHSRA Qis
Prevalence of Dehydration	CHSRA Qis
Prevalence of Physical Restraints	CHSRA Qis
Prevalence of Little or No Activity	CHSRA Qis

**Table 3. Care-Related Deficiencies used in Deficiency Measure**

<b>Deficiencies</b>
F-221: Physical Restraints
F-222: Chemical Restraints
F-223: Abuse
F-241: Dignity
F-242: Choice of activities & schedules
F-310: ADLs
F-311: Maintain or improve physical abilities
F-314: Pressure sores
F-315: Catheters
F-316: Bladder treatment
F-321: NG tubes
F-325: Nutrition
F-327: Hydration
F-329: Drug prescribing
F-330: Antipsychotic use
F-332: Medication errors
F-353: Sufficient staff

## PROPOSAL FOR REFINING QUALITY MEASURES

This proposal for Value-Based Reimbursement requires information about quality and relies on data that is already available. Many stakeholders agree that while additional quality measures are important in developing a well-balanced picture of the quality of services provided by a nursing facility, additional data collection efforts would be required. This appendix provides suggestions from the department's consultant, the University of Minnesota, regarding additional quality measures that can be incorporated into the proposed system.

Consumers have indicated that the elements of care that are most germane include quality of life, consumer satisfaction, and family satisfaction. Measures for quality of life have been developed and tested. Measures for satisfaction are available but none meet all the criteria one would want in such a tool. Both require direct contact with residents. Information collected from proxy observers cannot capture the feelings of the residents themselves.

Measuring consumer satisfaction will require annual in-person interviews with residents in each nursing home in the state. At least 25 residents from each nursing home should be interviewed. Except for those who are unable to respond (i.e., comatose or vegetative), the residents should not be pre-selected on the basis of cognitive impairment; many cognitively impaired residents have been able to provide usable responses. Quality of life may be measured using an instrument developed by the University of Minnesota.

In measuring family satisfaction, a sample of at least 25 persons per facility should be used, possibly weighted to include more families of severely cognitively impaired residents. This data could be collected using a mailed survey form.

## METHOD FOR DETERMINING TARGET PRICES

The method of determining the target price is the same for both operating rate components. The costs per resident day for each provider are arrayed from low to high for each of the two rate components. Before putting costs into the array, they are adjusted to create a level playing field around geographic and case mix differences. The per diem cost for the provider at the 30<sup>th</sup> percentile is determined and is then used to set the target price for the lowest quality tier that is populated. Similarly, the per diem cost for the provider at the 70<sup>th</sup> percentile is determined and is then used to set the target price for the highest quality tier that is populated. Target prices for all the other quality tiers are calculated by a straight-line interpolation from these two target prices.

This method of establishing target prices is designed to ensure that all facilities will have a target price that realistically allows them to operate, while providing higher target prices for higher quality facilities. However, this mechanism might either increase or decrease total costs. To prevent this, both percentile values are multiplied by a budget neutrality factor to establish the actual target prices. The budget neutrality factor is a percentage amount that will, on October 1, 2005, balance total Medicaid spending under the new system relative to the actual budget. This is done by looking at the forecasted average Medicaid charge per day and using a multiplier on the percentile values so that the target prices will result in the same average charge per MA day on the new system. The same budget neutrality factor will be used in subsequent years, until the quality score methodology changes. Then new percentiles may be used and a new budget neutrality factor will be determined.

**SPECIAL CONSIDERATIONS FOR CERTAIN TYPES OF FACILITIES**

The current reimbursement system provides advantages for facilities that are either attached to hospitals, have short lengths of stay or are licensed under Rule 80 to provide services to younger adults with disabilities. Higher spending limits were provided to allow for higher payment rates. It is proposed to isolate this group of facilities and establish target prices for them, based on arrays of just their per diem costs. Likewise, facilities that are predominantly boarding care homes would be arrayed separately.

Under the reimbursement system, three separate arrays are used for three groups of facilities. For this purpose, the definitions for hospital-attached and Rule 80 facilities are unchanged. Short length of stay is currently defined as including facilities with an average length of stay of under 180 days. Because short stays have become much more common in recent years, we propose to redefine this to include only facilities with three or more admissions per bed in their reporting year. This simpler definition would include about 30 short length of stay facilities in the separate group.

## DESCRIPTION OF PROPERTY RATE CALCULATION

In determining the property rate, a common rental value per bed is set for all facilities, and then adjusted using facility specific measures. These adjustments result in a facility specific rental value per bed which is then converted to a daily payment rate. The common rental value for the rate year beginning on October 1, 2005, will be computed based upon the replacement cost new per bed limit ( a technical term in current law that sets a limit on how much investment the state will recognize in setting property payment rates) in effect at the end of the reporting year for multiple-bed rooms, as found in Minnesota Statutes, Section 256B.431, Subdivision 17 (g). In subsequent rate years, the multiple-bed replacement cost new limit will be adjusted annually by the percentage change in the Bureau of the Census: Composite fixed-weighted price index as published in the C30 Report, Value of New Construction Put in Place. This method is retained from current law.

Since payment for the costs related to moveable equipment is included in the external fixed costs category through an allowance, the value of those assets is taken out of the multiple-bed replacement cost new limit to arrive at the common rental value per bed. The value used for moveable equipment will be the median of the per bed value of each facility's costs of moveable equipment divided by the number of active beds.

The facility specific measures used to convert the common rental value per bed to the facility specific rental value per bed will be:

- **Age** - Starting from the date of construction, a facility value will be depreciated by 1.5 percent per year for up to 40 years. The age will be reduced when major improvements to the facility are made, creating a lower effective age.
- **Space** – Each facility will report the total square footage (directly used by the nursing facility) of their building and the number of beds. Square feet per bed will be calculated for each facility and the weighted median will be determined. The space factor for each facility will be its square feet per bed divided by the median square feet per bed and then modified to have one-fourth of the impact. The space factor will be limited so as to always be within a range between 0.85 and 1.15.
- **Geographic location** - Construction costs are higher in urban areas of the state than in rural areas. Using the RS Means Adjuster (an index on construction costs from an economics consultant) for geographic areas, the geographic location factor will be determined for all facilities.
- **Split-double bed room adjuster** – A “split-double-bed room” is a room with two licensed beds that share access to the corridor where there is a fixed, floor-to-ceiling partition separating the two beds. Each facility will report the number of split-double bed rooms. The adjuster will be between 1.0 for facilities with no split-double-bed rooms to 1.25 for facilities with all split-double bed rooms.

The facility specific rental value per bed is now converted to a daily property payment rate. This is done by multiplying it by a rate of return factor, the United States Treasury bond 10- year amortization constant maturity rate plus 2 percent. This amount is divided by 365 to get a daily rate and then divided by a capacity factor of 0.95, to account for the fact that no facility can ever be 100 percent occupied. The result of this calculation is the property component of the payment rate.

Three property rates will be set for each facility. The facility's rental rate as computed above, will apply to all beds in non-single bed rooms, and will be multiplied by 1.35 to determine the Medicaid payment rate for a single-bed room. A single-bed room is a room with one licensed bed that does not share access to the corridor or hallway with another bed. The rental rate will be multiplied by 1.65 to determine the Medicaid payment rate for a private bed room. A private bed room is a room with one licensed bed that does not share access to the corridor with another bed and has a toileting area that is not shared with another bed. A determination of medical necessity for a single-bed room for Medicaid recipients will no



longer be required. The base property rate will no longer be adjusted to reflect an election by the facility to allow additional charges for single-bed rooms to private paying residents. Rates charged to private paying residents in single- or private bed rooms are not limited to Medicaid payment rates for those rooms.

## STAKEHOLDER REPRESENTATIVES PARTICIPATING IN DEVELOPMENT OF VBR

**Allen, Karina;** AARP  
**Amann, Jeff;** Courage Residence  
**Anderson, Dennis;** Pathway Health Services  
**Aretz, Doug;** St. Benedict's Senior Community  
**Beckmann, Kristin;** SEIU Local 113  
**Bergien, Tricia;** Benedictine Health System  
**Bergstrom, Todd;** Care Providers of Minnesota  
**Birchem, Jim;** Elder Care of Bemidji  
**Blaha, James;** Walker Methodist Health Center  
**Bostic, Jeff;** Minnesota Health & Housing Alliance  
**Brennan, Dave;** City of Lakes Transitional Care Center  
**Brown, Greg;** Tealwood Care Centers  
**Callies, Dewey;** The Evangelical Lutheran Good Samaritan Society  
**Cowen, Chris;** AFSCME  
**Cuccia, Jan;** SEIU Local 113  
**Cullen, Patti;** Care Providers of Minnesota  
**Diemert, Carol;** Minnesota Nurses Association  
**Dixon, Dan;** Guardian Angels of Elk River  
**Ehn, Jerry;** Parkview Care Center - Albert Lea  
**Elsey, Debbie;** Larsen, Allen Weishair & Company  
**Field, Jan;** Fairview University Transitional Services  
**Freeman, Iris;** Advocacy Strategy for Seniors & Workers for Quality  
**George, Mary Jo;** Minnesota Nurses Association  
**Giel, David;** Senate Counsel and Research  
**Gilbertson, Steven;** UFCW Local 1116  
**Greene, Mark;** Extendicare Health Services, Inc.  
**Groff, Howie;** Tealwood Care Centers  
**Guyer, Pam;** Care Providers of Minnesota  
**Hetchler, Jayne;** SEIU Local 113  
**Hustad, John;** Minnesota Health & Housing Alliance  
**Jensen, Joel;** Voigt, Jensen & Klegon, LLC  
**Johnson, Brian;** HealthEast Care Center of White Bear Lake  
**Kelso, Kathleen;** Advocacy for Long Term Care  
**Kennedy, Mary Ellen;** Advocacy for Long Term Care  
**Klefsaas, Sharon;** Ebenezer Society  
**Larsen, Caroline;** UFCW Local 789  
**Lindeman, Lance;** SEIU Local 113  
**Lundberg, John;** Walker Methodist Health Center  
**McGowen, Vince;** Beverly Healthcare  
**Meyer, Lori;** Minnesota Health & Housing Alliance  
**Michlin, Maria;** Office of Ombudsman For Older Minnesotans  
**Reiman, Dennis;** Good Shepherd Lutheran Services  
**Rymanowski, Kevin;** Benedictine Health System  
**Schelde, June;** HealthEast Care Center Of White Bear Lake  
**Shreve, Darrell;** Minnesota Health & Housing Alliance  
**Sims, Jim;** Minnesota Department of Health  
**Solberg, Penny;** Spring Valley Care Center  
**Spohn, Renae;** The Evangelical Lutheran Good Samaritan Society  
**Toulouse, Molly;** Tealwood Care Centers  
**Varco, Rick;** SEIU Local 113  
**Vossen, Jim;** UFCW Local 653  
**Weigel, Keith;** AARP  
**Woolverton, Carol;** Minnesota Department of Health  
**Youngdahl, John;** SEIU Minnesota State Council  
**Zoesch, Sharon;** Office of Ombudsman for Older Minnesotans



**PROPOSED BILL LANGUAGE**

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

Section 1. 256B.440 NURSING FACILITY REIMBURSEMENT SYSTEM EFFECTIVE OCTOBER 1, 2005.

Subdivision 1. (a) **In general.** The commissioner shall establish a value-based nursing facility reimbursement system which will provide facility specific, prospective payment rates for nursing facilities participating in the medical assistance program. The rates shall be determined using an annual statistical and cost report filed by each nursing facility. The total payment rate shall be composed of four cost categories: direct care, support services, external fixed and property related costs. The payment rate shall be derived from statistical measures of actual costs incurred in facility operation of nursing facilities. From this cost basis, the components of the total payment rate shall be adjusted for quality of services provided, actual costs of operation of each facility, geographic variation in labor costs, rental value and acuity.

(b) Rates shall be rebased. Each cost reporting year shall begin on October 1 and end on the following September 30. A cost report shall be filed by each nursing facility by January 15. Notice of rates shall be distributed by August 15 and the rates shall go into effect on October 1 for one year.

(c) Nursing facilities shall file the first statistical and cost report on or before January 15, 2005. The commissioner shall begin to phase-in the new reimbursement system beginning October 1, 2005. Full phase-in shall be complete by October 1, 2008.

Subdivision. 2. **Definitions.** For purposes of this section, the following terms have the meanings given in Subdivisions 2a to 2f unless otherwise provided for by the text of this section.

Subdivision 2a. (a) **Active beds** "Active beds" means licensed beds that are not currently in layaway status.

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

(c). **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 and business office employees 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, training, voice and data communication or transmission, office supplies, liability insurance and other forms of insurance not designated to other areas, personnel recruitment, legal services, accounting services, management or business consultants, data processing, 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 and other miscellaneous costs not assigned elsewhere that are directly related to the operation of the facility.

(d). **Allowed costs.** "Allowed costs" means the amounts reported by the facility which are necessary for the operation of the facility and the care of residents and which are reviewed by

the department for accuracy, reasonableness, and compliance with this section and Generally Accepted Accounting Principles.

(e). **Center for Medicare and Medicaid Services.** "Center for Medicare and Medicaid Services" is the federal agency, in the Department of Health and Human Services, that administers Medicaid, also known by the acronym "CMS."

(f). **Commissioner.** "Commissioner" means the commissioner of human services unless specified otherwise.

Subdivision 2b (a). **Depreciation guidelines.** "Depreciation guidelines" means the most recent publication of "The Estimated Useful Lives of Depreciable Hospital Assets," issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611.

(b). **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.

(c). **Dietary costs.** "Dietary costs" means the salaries and wages of the dietary supervisor, dietitians, chefs, cooks, dishwashers, and other employees assigned to the kitchen and dining room, and associated fringe benefits and payroll taxes. Dietary costs also includes the salaries or fees of dietary consultants, direct costs of raw food (both normal and special diet food), dietary supplies, and food preparation and serving. Also included are special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician.

(d). **Direct care costs category.** "Direct care costs category" means costs for nursing, activities, and social services.

(e). **Effective age.** "Effective age" means the age of a nursing facility adjusted for improvements made to the property since it was originally constructed, purchased, or leased.

(f). **External fixed costs category.** "External fixed costs category" means costs related to the nursing home surcharge under section 256.9657, Subd. 1; licensure fees under section 144.122; long-term care consultation fees under section. 256B.0911, Subd. 6; family council fee under section 144A.335; scholarships under section 256B.431, Subd. 36; planned closure rate adjustments under section 256B.437, Subd. 6; property taxes and property insurance; PERA; and equipment allowance.

(g). **Facility average case mix index.** "Facility average case mix index" means a numerical value score that describes the relative resource use for all residents within the groups under the Resource Utilization Group (RUG-III) classification system prescribed by the commissioner based on an assessment of each resident. The facility average CMI shall be computed as the standardized days divided by total days for all residents in the facility.

(h). **Field audit.** "Field audit" means the on-site examination, verification, and review of the financial records, statistical records, and related supporting documentation on the nursing home and any related organization.

(i). **Final rate.** "Final rate" means the rate established after any adjustment by the commissioner, including but not limited to adjustments resulting from amendments, desk audits and field audits.

(j). **Fringe benefit costs.** "Fringe benefit costs" means group life, health, dental, and workers' compensation insurance, pension, profit-sharing, and retirement plans generally available to all employees who work at least twenty hours per week.

Subdivision 2c (a). **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.

(b). **Historical cost.** "Historical cost" means the direct costs incurred by the nursing facility of acquiring services, supplies, or assets.

(c). **Hospital attached facility.** "Hospital attached facility" means a nursing facility which is under common ownership and operation with a licensed hospital and shares with the

hospital the cost of common service areas such as nursing, dietary, housekeeping, laundry, plant operations, or administrative services and which is required to use the stepdown method of allocation by the Medicare program, title XVIII of the Social Security Act, provided that the stepdown results in part of the cost of the shared areas to be allocated between the hospital and the nursing home, and that the stepdown numbers are the numbers used for Medicare reimbursement.

(d). **“Housekeeping costs”** means 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 cleaning and lavatory supplies and contract services.

(e).. **Laundry costs.** “Laundry costs” means the salaries and wages of the laundry supervisor, and other laundry employees and 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.

(f). **Licensee.** “Licensee” means the individual or organization listed on the form issued by the Minnesota Department of Health under section.144A.

(g).. **Maintenance and Plant Operations costs.** “Maintenance and Plant Operations costs” means 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 fuel, electricity, medical waste and garbage removal, water, sewer, supplies, tools, and repairs.

(h). **Metropolitan statistical area.** "Metropolitan statistical area" or MSA means a regional area as determined by the centers for Medicare and Medicaid services.

Subdivision 2d (a). **Moveable equipment.** “Moveable equipment” means the direct cost to the nursing facility to purchase items listed as major movable equipment in the depreciation guidelines and technology. Technology is defined in section 144A.071, subdivision 1a, item (j) and must be used directly for resident care.

(b). **Multiple bed room** “Multiple bed room” means a room with two or more licensed beds that does not meet the definition of a split-double bed room

(c). **Normalized direct care costs.** “Normalized direct care costs” means direct care costs divided by standardized days. It is the costs for direct care services associated with a RUGs index of 1.00.

(d). **Nursing costs.** “Nursing costs” means costs for the wages of nursing administration, staff education and direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides; mental health workers and other direct care employees and associated fringe benefits and payroll taxes; services from a supplemental nursing services agency and supplies that are stocked at nursing stations or on the floor and distributed or used individually, including: 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, and clinical reagents or similar diagnostic agents, and drugs which are not paid on a separate fee schedule by the medical assistance program or any other payor.

(e). **Nursing facility.** “Nursing facility” means a facility with a medical assistance provider agreement that is licensed under section 144A or as a boarding care home under section 144.50 to 144.56.

(f). **Operating costs.** “Operating costs” means costs associated with the case mix adjusted costs category and the support services costs category.

(g). **Payroll taxes.** “Payroll taxes” means the employer's share of the FICA and Medicare withholding tax, and state and federal unemployment compensation taxes.

(h). **Prior rate setting method.** "Prior rate setting method" means the rate determination process in effect prior to October 1, 2005, under Minnesota Rules and Minnesota Statutes.

Subdivision 2e (a) **Private bed room** "Private bed room" means a room with one licensed bed that does not share access to the corridor with another bed and has a toileting area that is not shared with another bed.

(b) **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.

(c). **Property related costs.** "Property related costs" means the cost of purchasing buildings, attached fixtures, and land improvements used directly for resident care. The costs of improvements to those assets, after the date of construction, are called additional property related costs.

(d). **Quality tiers.** "Quality tiers" means groups of facilities with quality scores within specified ranges. Tier 1 shall refer to facilities with scores in the lowest ten percent of the maximum available quality points, and tier ten shall refer to facilities with scores in the highest ten percent of the maximum available quality points.

(e). **Rate year.** "Rate year" means the twelve month period beginning on October 1 following the second most recent reporting year.

(f). **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:

1) An "affiliate" is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with another person.

2) A "person" is an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

3) A "close relative of an affiliate of a nursing facility" is 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.

4) "Control" including the terms "controlling," "controlled by," and "under common control with" is 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, or to influence in any manner other than through an arms length, legal, transaction.

(g). **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.

(h). **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.

(i). **Salaries and wages.** "Salaries and wages" means amounts earned by and paid to employees or on behalf of employees to compensate for necessary services provided. Salaries and wages include accrued vested vacation and accrued vested sick leave pay. Salaries and wages must be paid within forty five days of the end of the reporting period in order to be allowable costs of the reporting period.

(j). **Single bed room** "Single bed room" means a room with one licensed bed that does not share access to the corridor with another bed.

Subdivision 2f (a) **Social Services costs.** "Social Services costs" means costs for the salaries and wages of the supervisor and other social work employee, associated fringe benefits and payroll taxes, supplies, services, and consultants.

(b). **Split-double bed room** “Split-double bed room” means a room with two licensed beds that share access to the corridor where there is a fixed, floor-to-ceiling partition separating the two beds, and each bed has its own window.

(c). **Stakeholders.** “Stakeholders” means individuals and representatives of organizations interested in long term care, including nursing homes, consumers and labor unions.

(d). **Standardized days.** “Standardized days” means the sum of resident days by case mix category multiplied by the RUG index for each category.

(e). **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.

(f). **Support services costs category.** “Support services costs category” means costs for dietary, housekeeping, laundry, maintenance and administration.

(g). **Target prices.** “Target prices” means the measures of costs for the case mix adjusted cost category and for support services costs category determined as a statistical measure of per diem costs for groups of facilities.

(h). **Unadjusted facility age.** “Unadjusted facility age” means the age of the nursing facility before considering additional property related costs.

(i). **Value of New Construction Put in Place.** “Value of New Construction Put in Place” means the statistic published by the Federal Bureau of Labor Statistics.

### Subdivision 3. **Reporting of statistical and cost information.**

(a) Beginning January 15, 2005, 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 sub-set of the items in the annual report on a semi-annual 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, MA or other payors. Allocations of costs from central, affiliated, or corporate office and related organization transactions shall be reported in accordance with section 256B.432. The commissioner may grant to facilities one extension of up to 15 days for the filing of this report if the extension is requested by December 15 and the commissioner determines that the extension will not prevent the commissioner from establishing rates in a timely fashion as required by law.. The commissioner may separately require facilities to submit, in a manner specified by the commissioner, documentation of statistical and cost information included in the report to ensure accuracy in establishing payment rates and to perform audit and appeal review functions under this section. Facilities shall retain all records necessary to document statistical and cost information on the report for a period no less than seven years. The commissioner may amend information in the report according to subdivision 16. 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 report is rejected under this subdivision or is not submitted in a timely manner, the commissioner shall reduce the reimbursement rates to a nursing facility to 85 percent of its most recently established rates until the information is completely and accurately filed. The reinstatement of the total reimbursement rates shall be retroactive for no more than 90 days.

(b) **Amended reports.** Nursing facilities may, within twelve 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 results in a rate increase of at least 20 cents per resident day in a case mix category with a weight of 1.00, and shall, at any time, file an amendment which would result in a rate reduction of at least twenty cents per resident day in a case mix category with a weight of 1.00. The commissioner shall make retroactive adjustments to the total payment rates 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 to 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) **False reports.** 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 rates 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.

Subdivision 4. **Calculation of direct care per diem costs.** The commissioner shall calculate, for each nursing facility, the normalized per diem cost for direct care services by dividing the total allowable reported costs for direct care services by the number of standardized days for the same reporting period. The labor portion of this result is divided by the facility's MSA wage index and, the quotient is added to the non-labor portion.

Subdivision 5. **Calculation of support services per diem costs.** The commissioner shall calculate, for each nursing facility, the per diem cost for support services by dividing the total allowable reported costs for support service by the number of resident days for the same reporting period. The labor portion of this result is divided by the facility's MSA wage index and, the quotient is added to the non-labor portion.

Subdivision. 6. **Calculation of a quality score.** The commissioner shall determine a quality score, for each nursing facility, using quality measures established in 256B.439, in accordance with methods determined by the commissioner in consultation with stakeholders and experts. These methods shall be exempt from the rulemaking requirements of Minnesota Statutes, chapter 14 and Minnesota Statutes, sections 14.385 and 14.386. For each quality measure a score shall be determined, with a maximum number of points available and numbers of points assigned as determined by the commissioner using the methodology established according to this subdivision. The scores determined for all quality measures shall be totaled. Ten quality tiers shall be established in increments of 10% of the maximum available points. Quality scores shall be used to assign facilities to quality tiers. The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner. The commissioner shall publish the methodology in the State Register at least fifteen months prior to the start of the rate year for which the revised methodology is effective. The quality score used for purposes of determining payment rates shall be established for a rate year, using data submitted by the facility in the Statistical and Cost Report from the associated reporting year and using data from other sources related to the reporting year.

Subdivision 7. **Calculation of target prices.** Annually, the commissioner shall calculate target prices to be associated with each quality tier for direct care and for support services costs.

a) The costs calculated in subdivisions 4 and 5 shall be arranged from lowest to highest. The commissioner shall include in the array all facilities that have filed a complete statistical and cost report within eight weeks of the date specified under subdivision 3. Amendments and audits corrections after that date shall not be incorporated into the costs in the array.

- b) For each operating cost category, the target price for the quality tier associated with the facility with the highest quality score shall be the per diem costs of the facility with costs at the 70<sup>th</sup> percentile multiplied by the budget factor in paragraph (d).
- c) For each operating cost category, the target price for the quality tier associated with the facility with the lowest quality score shall be the per diem costs of the facility with costs at the 30<sup>th</sup> percentile multiplied by the budget factor in paragraph (d).
- d) For the rate year beginning on 10/1/2005, the budget neutrality factor to be used in paragraphs (b) and (c) shall be a percentage amount that will result in an average per diem rate \$1.55 less than the case mix and MSA normalized medical assistance average charge per resident day used to determine the nursing facility forecast published in February 2005 for the 2006 state fiscal year. The case mix normalized medical assistance average charge per resident day shall be equal to the average MA payment per day, plus the average MA recipient contribution per day, divided by the average MA RUGs weight. The same percentage amount shall be used each year as in the previous year, except that in the event that the commissioner publishes a new methodology under subdivision 6, the commissioner may increase the percentile referenced in paragraph (b) by as much as five percentile points and shall reduce the percentile referenced in paragraph (c) by an equal amount, and a new budget neutrality factor shall be determined. This new budget neutrality factor shall be the percentage amount that will result in an average per diem rate equal to the average per diem used to determine the most recently published nursing facility forecast. In no event shall the percentile amount in paragraph (b) exceed the 90<sup>th</sup> percentile. The same budget neutrality factor shall be used for all three groups of facilities in paragraph (f).
- e) The target prices for the remaining quality tiers shall be calculated by using a straight line interpolation from the target prices determined in paragraphs (b) and (c).
- f) The calculations in paragraphs (a), (b), (c) and (e) shall be performed separately for three groups of facilities, to establish different target prices for each group for direct care costs:
1. Facilities that have three or more admissions per bed per year, are hospital attached or are licensed under Minnesota Rules, parts 9570.2000 to 9570.3600.
  2. Facilities that have more that 50% of their beds licensed as Boarding Care Homes, and
  3. All other facilities.
- g) For facilities with both nursing home and boarding care home licensed beds the target price shall be the average of the target prices under paragraph (f) clause (2) and clauses (1) or (3), weighted for the number of beds of each type.

**Subdivision 8. Calculation of uninflated payment rates for operating costs.** The commissioner shall determine the uninflated payment rates for direct care costs and for support services costs for each facility in accordance with (a) to (j).

- a) For direct care costs, determine the lesser of the target price for the quality tier assigned to the facility or the per diem costs in subdivision 4.
- b) Determine the difference between the two amounts in paragraph (a).
- c) For direct care costs, for facilities with costs greater than the target price, determine the portion of the difference determined in paragraph (b) to be included in the payment rate with this table:

For Quality Tier	The rate shall include this portion of differences of :					
	\$0 - \$5	\$5.01 - \$10	\$10.01 - \$15.01 - \$20 \$15	\$20.01 - \$25.01 - \$25	\$25.01 - \$30.01 - \$30	\$30.01 - \$35.01 - \$35
1	0%	0%	0%	0%	0%	0%
2	0%	0%	0%	0%	0%	0%
3	20%	0%	0%	0%	0%	0%
4	40%	20%	0%	0%	0%	0%
5	70%	50%	20%	0%	0%	0%
6	100%	70%	40%	20%	0%	0%
7	105%	70%	50%	30%	10%	0%
8	110%	90%	70%	50%	30%	10%
9	110%	100%	90%	60%	40%	20%
10	120%	100%	100%	80%	50%	30%

d) For direct care costs, for facilities with costs less than the target price, determine the portion of the difference determined in paragraph (b) to be included in the payment rate with this table:

For Quality Tier	The rate shall include this portion of differences of :		
	\$0 - \$5	\$5.01 - \$10	>\$10
1	10%	0%	0%
2	10%	0%	0%
3	20%	10%	0%
4	30%	15%	0%
5	50%	25%	0%
6	50%	25%	0%
7	60%	30%	0%
8	80%	40%	0%
9	90%	45%	0%
10	100%	50%	0%

e) The payment rate for direct care costs shall be the amount determined in paragraph (a) plus the amount determined in either paragraphs (c) or (d).

f) For support services costs, determine the lesser of the target price for the quality tier assigned to the facility or the per diem costs in subdivision 5.

g) Determine the difference between the two amounts in paragraph (f).

h) For support services costs, for facilities with costs greater than the target price, determine the portion of the difference determined in paragraph (g) to be included in the payment rate with this table:

For Quality Tier	The rate shall include this portion of differences of :					
	\$0 - \$2	\$2.01 - \$4	\$4.01 - \$6	\$6.01 - \$8	\$8.01 - \$10	\$10.01 - \$14
1	0%	0%	0%	0%	0%	0%
2	0%	0%	0%	0%	0%	0%
3	20%	0%	0%	0%	0%	0%
4	40%	20%	0%	0%	0%	0%
5	70%	50%	20%	0%	0%	0%
6	100%	70%	40%	20%	0%	0%
7	105%	70%	50%	30%	10%	0%
8	110%	90%	70%	50%	30%	10%
9	110%	100%	90%	60%	40%	20%
10	120%	100%	100%	80%	50%	30%

i) For support services costs, for facilities with costs less than the target price, determine the portion of the difference determined in paragraph (g) to be included in the payment rate with this table:

For Quality Tier	The rate shall include this portion of differences of :		
	\$0 - \$2	\$2.01 - \$4	>\$4
1	10%	0%	0%
2	10%	0%	0%
3	20%	10%	0%
4	30%	15%	0%
5	50%	25%	0%
6	50%	25%	0%
7	60%	30%	0%
8	80%	40%	0%
9	90%	45%	0%
10	100%	50%	0%

j) The payment rate for support services costs shall be the amount determined in paragraph (f) plus the amount determined in either paragraphs (h) or (i).

**Subdivision 9. Geographic Adjustments.** The commissioner shall determine the labor related share of the operating rate in accordance with the labor related share statistics published by the Center for Medicare and Medicaid Services in the Federal Register effective on the October 1 prior to the start of the year for which rates are established. The commissioner shall multiply the labor related share of the operating rate by the wage index, for the MSA in which the facility is located, published by the Center for Medicare and Medicaid Services in the Federal Register effective on the October 1 prior to the start of the year for which rates are established.

**Subdivision 10. Adjuster for operating payment rates.** The commissioner shall provide information to the appropriate committee chairs of the legislature by January 15 of odd numbered years specifying adjusters that may be multiplied by the uninflated payment rates, by the target prices, or by any other factor the commissioner deems appropriate, for direct care and support care service costs determined in subdivision 8. The information shall include:

- a) Projected change in the CPI-U, between the mid-point of the reporting years and the mid-point of the rate years, as determined by the national economic consultant used by the Commissioner of Finance, for the years in the next biennium.
- b) The costs or savings to the state of using any factor other than 100%.
- c) The commissioner may also describe other factors that the commissioner recommends for consideration in establishing the adjuster.

**Subdivision 11. Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

- a) For facilities licensed as nursing homes, the portion related to section 256.9657 shall be equal to \$8.86. For facilities licensed as both nursing homes and boarding care homes the portion related to section 256.9657 shall be equal to \$8.86 multiplied by the ratio of their number of nursing home beds divided by their total number of licensed beds.
- b) The portion related to the licensure fee under 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.
- c) The portion related to scholarships shall be determined under section 256B.431, subd. 36.
- d) The portion related to long-term care consultation shall be determined according to section 256B.0911, subd.6.
- e) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be \$5.00 divided by 365.
- f) The portion related to planned closure rate adjustments shall be as determined under section 256B.437, subd. 6.
- g) The portions related to property insurance, real estate taxes, special assessments and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.
- h) The portion related to the provision of moveable equipment shall be an equipment allowance. Each facility shall report the cumulative purchase price of all moveable equipment in active use in the facility. This amount shall be divided by the product of ten, 365 and the number of licensed beds not in layaway, in the facility on the last day of the reporting period. These values shall be arrayed and the median determined. The equipment allowance shall be this value multiplied by the property budget neutrality factor determined in subd. 12, paragraph (g), (6).
- i) The portion related to PERA shall be actual costs divided by resident days.
- j) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to (i).

**Subdivision 12. Calculation of payment rate for property related costs.** The commissioner shall calculate a payment rate for property related costs according to paragraphs (a) to (h).

**(a) Determine common rental value per bed.**

The commissioner shall determine a common rental value that will be used for all facilities. The common rental value for the rate year beginning on October 1, 2005, will be computed based upon the replacement cost new per bed limit in effect at the end of the reporting year for multiple-bed rooms as found in section 256B.431, subd. 17, paragraph (g). In subsequent rate years, the multiple-bed replacement cost new limit will be adjusted annually by the percentage change in the Bureau of the Census: Composite fixed-weighted price index as published in the C30 Report, Value of New Construction Put in Place.

The equipment allowance determined under subdivision 11, paragraph h, shall be multiplied by 365 and by ten. This amount shall be deducted from the multiple-bed replacement cost new limit to determine the common rental value.

**(b) Compute each facility’s specific rental value per bed.**

Each nursing facility’s specific rental value shall equal the common rental value multiplied by its space adjuster, location adjuster, split-double bed room adjuster, and age adjuster as described in paragraphs (c), (d), (e), and (f).

**(c) Space adjuster.**

Each nursing facility shall have a space adjuster computed that will be used to convert the common rental value to its facility specific rental value. A facility’s square footage of space used for the operation of the nursing facility shall be divided by the number of its active beds. Each of these values shall be arrayed from lowest to highest and the median value determined. The space adjuster is one fourth of the sum of the number three plus the quotient of the facility’s square footage per active bed divided by the median square footage per active bed. The minimum adjuster shall be 0.85 and the maximum adjuster shall be 1.15.

**(d) Location adjuster.**

Each nursing facility shall have a location adjuster assigned that will be used to convert the common rental value to its facility specific rental value. The location adjuster shall be the value published by RS Means and assigned to each Metropolitan Statistical Area (MSA) published by CMS and used for the Medicare prospective payment system for skilled nursing facilities. The RS Means location factor is assigned to each MSA as follows:

MSA Region	RS Means Location Adjuster	Applies to the counties of
2240	1.033	St. Louis
2520	0.983	Clay
2985	0.940	Polk, Red Lake
3870	1.021	Houston
5120	1.124	Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, Wright
6820	1.021	Olmsted
6980	1.054	Benton, Stearns
Rural	0.960	All other counties not listed above

**(e) Split-double bed room adjuster.**

Each nursing facility shall have a split-double bed room adjuster computed that will be used to convert the common rental value to its facility specific rental value. The amount for a facility shall be the number 1 plus the quotient of the number of active beds in split-double bed rooms divided by 4 times the number of total active beds.

**(f) Age adjuster.**

Each nursing facility shall have an age adjuster computed that will be used to convert the common rental value to its facility specific rental value. A facility's age shall be the number of days between the date of completion of construction and the beginning of the rate year divided by 365.25, rounded to the nearest tenth.

For facilities that have been sold since completion of construction, if the licensee reports that the date of completion of construction is unknown, and the commissioner agrees the date is unknown, the most recent purchase date of the facility shall be used to determine the presumed age as follows:

- (1) the purchase price of the facility will be reduced by 20% to account for moveable equipment, technology, and the business operations;
- (2) the adjusted purchase price in clause (1) shall be divided by the number of active beds;
- (3) the common rental value computed in paragraph(a) will be indexed backward from the beginning of the rate year to the date of the facility's purchase using the indices described in paragraph (a);
- (4) multiply the facility's location adjuster in paragraph (d) by its space adjuster in paragraph (c);
- (5) the adjusted purchase price per active bed in clause (2) shall be divided by the product of the location adjuster and space adjuster in clause (4);
- (6) divide the value in clause (5) by the indexed common rental value in clause (3);
- (7) the value in clause (6) is subtracted from 1.0;
- (8) the age at the time of purchase shall be the value in clause (7) divided by 0.015;
- (9) the age as of the beginning of the rate year shall be the value computed in clause (8) plus the quotient of the number of days between the date of purchase and the start of the rate year divided by 365.25.

For facilities that are used by the current licensee, under an operating lease according to Generally Accepted Accounting Principles, and for which the licensee reports that the date of completion of construction is unknown and that the most recent date and price of sale is also unknown, and the commissioner agrees that these facts are unknown, the presumed age shall be computed as follows:

- (1) compute the present value of the minimum lease payments according to Generally Accepted Accounting Principles using an interest rate equal to the ten year United States Treasury Bond Rate plus two percent and a term of 20 years;
- (2) The present value in clause (1) shall be reduced by 10% to account for moveable equipment and technology;
- (3) The adjusted present value in clause (2) shall be divided by the number of active beds;
- (4) the common rental value computed in paragraph (a) will be indexed backward from the beginning of the rate year to the date of the facility's lease using the indices described in paragraph (a);
- (5) multiply the facility's location adjuster by its space adjuster;
- (6) the adjusted present value per active bed in clause (3) shall be divided by the product of the location adjuster and space adjuster in clause (5);
- (7) divide the value in clause (6) by the indexed common rental value in clause (4);
- (8) the value in clause (7) is subtracted from 1.0;
- (9) the age at the time of the inception of the lease shall be the value in clause (8) divided by 0.015;
- (10) the age as of the beginning of the rate year shall be the value computed in clause (9) plus the quotient of the number of days between the date of lease inception and the start of the rate year divided by 365.25.

For the rate year beginning on October 1, 2005, the age or presumed age of the facility shall be adjusted for the value of property related costs added since the date of construction, purchase, or lease to determine the effective age. The additions allowed in this calculation shall be those

recognized as improvements, and not as repairs, under Generally Accepted Accounting Principles. The effective age shall be computed as follows:

- (1) the depreciated portion of the facility shall be computed as the common rental value multiplied by the facility's space adjuster, location adjuster, split-double bed room adjuster, and the product of the unadjusted facility age computed above and 0.015; the allowable additional property related costs that were purchased between the date of construction, purchase, or lease and October 1, 2005, shall be the costs divided by 2;
- (3) the allowable additions are divided by the value in clause (1) and rounded to the nearest whole number;
- (4) the number of active beds are reduced by the value in clause (3). If this results in a value that is less than zero; use zero.
- (5) the value in clause (4) is multiplied by the unadjusted facility age;
- (6) the effective age is the value in clause (5) divided by the number of active beds.

For rate years beginning on or after October 1, 2006, the facility's age can be adjusted for additional property related costs incurred during the rate year using the method for the rate year beginning on October 1, 2005, in (1) to (6) above. If a facility's age has been adjusted in a prior rate year, the unadjusted facility age referred to in (1) is the age produced by steps (1) to (6) in that prior rate year. The allowable additions in (2) are the property related costs incurred during the reporting year.

The age adjuster shall be the number 1 minus the product of the effective age and 0.015. The age adjuster cannot be less than 0.4.

**(g) Compute the property related rate.**

The property related payment rate for a facility is computed as:

1. an interest rate shall be computed that is the mean of the United States Treasury Bond 10 Year Rates for the most recent twelve quarters ending with the July 1 date immediately preceding the beginning of the rate year. The rates to be used are those published on the first business day of each quarter;
2. the amount in clause (1) shall be increased by two percent;
3. a facility's specific rental value shall be multiplied by the value in clause (2);
4. a divisor for all facilities will be 365 multiplied by 0.95;
5. the value in clause (3) divided by the value in clause (4);
6. the property related rate shall be the value in clause (5) multiplied by a property budget neutrality factor. The budget neutrality factor equals the median property payment rate under the prior rate setting method for October 1, 2005 divided by the median of the values in clause (5) plus the equipment allowance in subd. 11, paragraph (h), for October 1, 2005. This budget neutrality factor shall be used in subsequent years.

**(h) Private bed room and single bed room payment adjustment.** The commissioner shall allow a private bed room payment rate by increasing the property related rate computed in paragraph (g) by 1.65 for a medical assistance recipient in a private bed room. The commissioner shall allow a single bed room payment rate by increasing the property related rate computed in paragraph (g) by 1.35 for a medical assistance recipient in a single bed room. Rates charged to private paying residents in private bed or single bed rooms are not limited.

**(i) Additions to property related costs during the phase-in period.** If a facility makes additions to property related costs during the period October 1, 2005, through September 30, 2007, the commissioner will compute the change to the property related rate as described in paragraph (f). Notwithstanding the requirements of the rate setting method for property related



costs in Minnesota Rules and Minnesota Statutes, the amount of the rate change computed in paragraph (f) shall be recognized as an additional rate change under the prior rate setting method for the calculation of rates in subdivision 14, paragraph (c).

**Subdivision 13. Calculation of total payment rate.** The commissioner shall calculate the total payment rate by adding together the payment rates determined in subdivisions 8, 11 and 12.

**Subdivision 14. Phase-In.** The commissioner shall implement the rate setting methods in this section according to paragraphs (a) to (j).

- a) Rates effective on June 30, 2005, shall remain in effect through September 30, 2005.
- b) By August 15, of 2005, 2006 and 2007 the commissioner shall notify nursing facilities of the rates they will receive under both this section and under the prior rate setting method, and of the actual rates that will apply based on a blending of these two rate sets.
- c) For purposes of determining payment rates under the prior rate setting method, for rate years beginning after June 30, 2005, the rate adjustment under 256B.434, Subd. 4, paragraph (c) shall apply only to the property related payment rate, and this method shall be used for computing property payment rates under the prior rate setting method for all facilities.
- d) For rate years beginning October 1 of 2005, 2006 and 2007, for operating payment rate components under the prior rate setting method, the commissioner shall use the amounts in effect on June 30, 2005.
- e) Notwithstanding the requirements of the prior rate setting method, facilities with property related rates computed under Minnesota Rules, Parts 9549.0010 to 9549.0080 for the rate year beginning on July 1, 2004, will have the equity incentive under section 256B.431 subd.16, the refinancing incentive under section 256B.431, subd.19, and the capital repairs and replacements rate under section 256B.431, subd. 15, held constant until September 30, 2008.
- f) For the determination of the rate under the prior rate setting method, the real estate and special assessments payment rate under section 256B.431 subd. 2b, item (g) and section 256B.0911, subd. 6 will be computed as described in these sections of statute.
- g) The actual total payment rate that will apply on October 1, 2005 shall consist of ten percent of the amount determined under this section and 90% of the amount determined under the prior rate setting method.
- h) The actual total payment rate that will apply on October 1, 2006 shall consist of 40% of the amount determined under this section and 60% of the amount determined under the prior rate setting method.
- i) The actual total payment rate that will apply on October 1, 2007 shall consist of 70% of the amount determined under this section and 30% of the amount determined under the prior rate setting method.
- j) The actual total payment rate that will apply on October 1, 2008 shall be the amount determined under this section.
- k) The additional payment for a private bed room or a single bed room allowed in subd. 12, paragraph (h) shall be added to the amounts determined under both this section and the prior rate setting method.

**Subdivision 15. Exception allowing contracting for specialized care.** (a) The commissioner shall publish a request for proposals, annually, and may negotiate operating payment rates with up to 2.5% of nursing facilities that provide specialized care. Rate negotiations must be based on costs. In selecting facilities to negotiate with the commissioner shall consider the following criteria:

- 1) The facility should have a high quality score;

- 2) The facility should have high direct care per diem costs;
- 3) The facility must serve residents with diagnoses or other circumstances that require care costing more than normal in a nursing home setting; and
- 4) The facility must provide a specialized program or programs to meet the needs of these individuals and that serve a large portion of the individuals residing in the facility.

(b) Negotiated rate adjustments shall not exceed 50% of the direct care portion of the payment rate associated with the RUGs group with the highest index, that would otherwise be established under this section. Negotiated rates shall apply to the entire facility. The commissioner may negotiate rates that will apply for either one or two years. Facilities with negotiated rates under this subdivision shall not be included in determining target prices under subdivision 7.

Subdivision 16. **Audit authority.** 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 findings would result in a rate adjustment of at least twenty cents per resident day in a case mix category with a weight of 1.00. 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 either calculate the total payment rate by disallowing the cost of the items for which access to the supporting documentation is not provided or applying the reimbursement rate reduction in subdivision 3, whichever would result in the least amount of change in the total payment rate.

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 3 for purposes of performing field audits as necessary to enforce section [256B.48](#), with written notice to the facility postmarked no less than 90 days prior to the expiration of the record retention requirement.

Subdivision 17. **Remedies for disputes.** The commissioner shall provide remedies for disputes under this section.

- a) A provider may appeal a determination of a payment rate established under this section if the appeal, if successful, would result in a change to the provider's payment rate. Appeals must be filed according to procedures in this subdivision.
- b) To appeal, the provider shall file with the commissioner a written notice of appeal; the appeal must be postmarked or received by the commissioner within 60 days of the date

- the determination of the payment rate was mailed or personally received by a provider, whichever is earlier.
- c) The notice of appeal must specify:
    - 1) each disputed item;
    - 2) the reason for the dispute;
    - 3) the computation that the provider believes is correct;
    - 4) the authority in statute or rule upon which the provider relies for each disputed item;
    - 5) the name and address of the person or firm with whom contacts may be made regarding the appeal; and
    - 6) additional information the provider wishes to offer with the appeal to support their position. The commissioner may request additional information to clarify the provider's position.
  - d) The commissioner shall review appeals and issue a written appeal determination on each appealed item within 180 days of the due date of the appeal. Upon mutual agreement, the commissioner and the provider may extend the time for issuing a determination for a specified period. The appeal determination takes effect 30 days following the date of issuance specified in the determination.
  - e) For an appeal item on which the provider disagrees with the appeal determination, the provider may request reconsideration. A request for reconsideration must be postmarked or received by the commissioner within 30 days of the date of issuance of the determination. A request for reconsideration delays the date on which the determination takes effect. The appeal determination and any changes resulting from reconsideration will become effective 30 days following the issuance of the reconsideration response.
  - f) For an appeal item on which the provider disagrees with the appeal determination and the reconsideration response, if any, the provider may file with the commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the commissioner within 30 days of the date of issuance specified in the determination or within 30 days of the issuance of the reconsideration response, if reconsideration was requested. A demand for a contested case hearing for an appeal item nullifies the written appeal determination issued by the commissioner for that appeal item. The commissioner shall refer any demand for a contested case hearing to the Office of the Attorney General.
  - g) A contested case hearing shall be heard by an administrative law judge according to sections 14.48 to 14.56. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the determination of a payment rate is incorrect.
  - h) Regardless of any rate appeal, the rate established must be the rate paid and must remain in effect until final resolution of the appeal or a subsequent rate determination.
  - i) A provider shall not use this process to challenge the method of determining a quality score under subdivision 6; the calculation of target prices under subdivision 7; the application of an adjuster determined according to subdivision 10; the determination of the weighted median square feet per bed under subdivision 12; or the commissioner's determination under subdivision 15 or 18 to negotiate rates. This process does not apply to a request from a resident or nursing facility for reconsideration of the classification of a resident under section 144.0722 or 144.0724.
  - j) Target prices must not be recalculated to reflect changes to cost or statistical data resulting from an appeal resolution.

Subdivision 18. **Interim rates.** (a) The commissioner shall determine interim payment rates for nursing facilities that have no cost history. The facilities shall provide statistical and cost information, according to subdivision 3, on a prospective basis. The commissioner shall

establish an interim rate using the quality tier of the nursing facility with a quality score at the 60<sup>th</sup> percentile, costs according to a budget negotiated with the provider, and the methods provided in subdivision 8, 11 and 12. The interim rate shall apply until a rate can be established under this section. Upon providing final information under subdivision 3 for the interim rate period, the commissioner shall determine that an overpayment has occurred if per diem costs for total operating cost categories were less than budgeted by an amount greater than 4%, and shall recover any overpayment subject to the following limitations:

1. Based upon the actual quality score, the commissioner shall adjust the quality tier to be used, but may not reduce the quality tier by more than one level.
2. In establishing the final rate for the interim period, the commissioner shall use target prices as provided under subdivision 7; and
3. In the event of an overpayment, the commissioner may allow up to six months for complete repayment if the provider demonstrates that immediate repayment of the overpayment would result in an undue hardship to the operation of the facility.

(b) The commissioner may negotiate an interim rate with a nursing facility, according to the process in paragraph (a), when that facility has been purchased by an unrelated party within the last six months. In determining if negotiations shall be initiated, the commissioner shall consider:

1. The potential inadequacy of current rates as evidenced by the position in the arrays of operating costs of the rates of the requesting facility,
2. Preventing closure of facilities in under-bedded areas of the state, as measured by the number of beds per 1000 elderly in the county or in contiguous counties in which the facility is located,
3. The ability of the purchaser to provide high quality services as evidenced by high quality scores of other facility or facilities under the control of the purchaser operating in Minnesota,
4. The ability of the purchaser to operate efficiently as evidenced by the difference between the operating costs and target prices of the other facility or facilities under the control of the purchaser operating in Minnesota,
5. Previous success of the purchaser with negotiated interim rates,
6. The financial soundness of the purchaser,
7. Avoiding negotiating interim rates with purchasers who have sold facilities that then requested interim rate negotiation, and
8. Avoiding too much consolidation of the nursing facility industry within any small number of providers

Section 3 Minnesota Statutes 2003 Supplement, section 256B.431, Subd. 30 is amended to read:

Subdivision 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after ~~July 1, 2000, October 1, 2005~~ a nursing facility reimbursed under this section which has placed beds on layaway ~~or removed beds from layaway, or delicensed beds~~ shall, for purposes of ~~determination of the payment rate for property related costs under 256B.440, subd. 12 application of the downsizing incentive in subdivision 3a, paragraph (c), and calculation of the rental per diem,~~ have those beds placed in layaway given the same effect as if the beds had been delicensed so long as the beds remain on layaway, and have the number of beds used in the calculation in 256B.440, subd. 12, (f) be based on the number of licensed beds less the number that are in layaway. ~~At the time of a layaway, a facility may change its single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase changes shall be effective the April 1st day of the month following the month in which~~ for the layaway of the beds, the removal of beds from layaway and the

delicensure of beds that becomes effective under section 144A.071, subdivision 4b between the prior August 1st and January 31st. The property payment rate changes shall be effective October 1st for the layaway of the beds, the removal of beds from layaway and the delicensure of beds that become effective under section 144A.071, subdivision 4b between the prior February 1st and July 31st.

~~(b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section which has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed to:-~~  
~~(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;-~~  
~~(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and-~~  
~~(3) establish capacity days based on the number of beds immediately prior to the layaway and the number of beds after the layaway.-~~

~~The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month following the month in which the layaway of the beds becomes effective.~~

~~(c) If a nursing facility removes a bed from layaway status in accordance with section 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the number of licensed and certified beds in the facility not on layaway and shall reduce the nursing facility's property payment rate in accordance with paragraph (b).-~~

~~(d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision to the contrary under section 256B.434, a nursing facility reimbursed under that section, which has delicensed beds after July 1, 2000, by giving notice of the delicensure to the commissioner of health according to the notice requirements in section 144A.071, subdivision 4b, shall be allowed to:-~~

~~(1) aggregate the applicable investment per bed limits based on the number of beds licensed immediately prior to entering the alternative payment system;-~~  
~~(2) retain or change the facility's single bed election for use in calculating capacity days under Minnesota Rules, part 9549.0060, subpart 11; and-~~  
~~(3) establish capacity days based on the number of beds immediately prior to the delicensure and the number of beds after the delicensure.-~~

~~The commissioner shall increase the facility's property payment rate by the incremental increase in the rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes resulting from the delicensure of beds and clauses (1), (2), and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception project after its base year, the base year property rate shall be the moratorium project property rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4, paragraph (c). The property payment rate increase shall be effective the first day of the month following the month in which the delicensure of the beds becomes effective.-~~

~~(e) For nursing facilities reimbursed under this section or section 256B.434, any beds placed on layaway shall not be included in calculating facility occupancy as it pertains to leave days defined in Minnesota Rules, part 9505.0415.-~~

~~(f) For nursing facilities reimbursed under this section or section [256B.434](#), the rental rate calculated after placing beds on layaway may not be less than the rental rate prior to placing beds on layaway.~~

~~(g) (b) A nursing facility receiving a rate adjustment as a result of this section shall comply with section [256B.47](#), subdivision 2.~~

~~(h) A facility that does not utilize the space made available as a result of bed layaway or delicensure under this subdivision to reduce the number of beds per room or provide more common space for nursing facility uses or perform other activities related to the operation of the nursing facility shall have its property rate increase calculated under this subdivision reduced by the ratio of the square footage made available that is not used for these purposes to the total square footage made available as a result of bed layaway or delicensure.~~

Minnesota Statutes 2002, section 256B.434, is amended by adding a subdivision to read:

Subdivision 18. **Phase-out of Alternative Payment System Contracts.** Nursing facilities who have entered into a contract with the commissioner under this section will cease their contractual agreement with the commissioner 12 months following the effective date of the contract in effect on October 1, 2005. Nursing facilities with a contract in effect on October 1, 2005 shall be paid the contract payment rate for the remainder of the phase-in period according to the provisions of section. 256B.440, subdivision 14, except as p[rovided in section 256B.440, subd. 12, paragraph (i).

Section 5 Minnesota Statutes 2003 Supplement, section 256B.47, Subd. 2 is amended to read:

Subdivision 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](#), [256B.440](#) 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](#), [256B.440](#) , 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.

Section x Minnesota Statutes 2003 Supplement, section 256B.432, is amended to read:  
**256B.432 Long-term care facilities; central, affiliated, or corporate 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 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 non-related nursing facility measures and methods for improving the operations of the nursing facility.

(c) "Nursing facility" means a nursing facility whose medical assistance rates are determined according to section 256B.440.

Subdivision 2. **Effective date.** For rate years beginning on or after October 1, 2005, the central, affiliated, or corporate office cost allocations in subdivisions 3 to 6 must be used when determining medical assistance rates under section 256B.440.

Subdivision 3. **Allocation; direct identification of costs of nursing facilities; 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.

A. Central, affiliated, or corporate office costs representing services of consultants in operating areas may be allocated to the appropriate cost category, but only to the extent that those costs are directly identified by the nursing facility.

B. Except as provided in item A, central, affiliated, or corporate office costs must be allocated to the general and administrative cost category of each nursing facility within the group served by the central, affiliated, or corporate office according to subdivisions (4) to (6).

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. 4(a). Allocation; costs allocable on a functional basis.** (1) Costs that have not been directly identified must be allocated to nursing facilities on a basis designed to equitably allocate the costs over 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. (2) 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, and costs that can be allocated on a functional basis according to subdivision 4(a) 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 non-nursing facility related organizations;

(3) for a central, affiliated, or corporate office providing goods or services to unrelated nursing facilities under a consulting agreement, the numerator of the allocation ratio 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 cost 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.** 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.

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 non-allowable 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 reported 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.

Section x. Minnesota Statutes 2003 Supplement, section 256B.431, Subd. 35 is amended to read:

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 constructing and array, determining a median, or otherwise performing a statistical measure of nursing facility payment rates to be used to determine future rate increases 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 on religious beliefs. For rate determined under 256B.440, the amount determined under subdivision 2b, paragraph (h), shall not be included in the support services per diem cost determined in 256B.440, subdivision 5, and shall be added to the external fixed costs payment rate determined in 245B.440, subdivision 11, paragraph (i).

Rider, to set aside \$12 million for 10/1/05 target prices in setting budget neutrality factor, for negotiated rates

Section x Minnesota Statutes 2003 Supplement, section 256B.431, Subd. 28 is amended to read:

**Subd. 28. Nursing facility rate increases beginning July 1, 1999, and July 1, 2000.** (a) For the rate years beginning July 1, 1999, and July 1, 2000, the commissioner shall make available to each nursing facility reimbursed under this section or section [256B.434](#) an adjustment to the total operating payment rate. For nursing facilities reimbursed under this section or section [256B.434](#), the July 1, 2000, operating payment rate increases provided in this subdivision shall be applied to each facility's June 30, 2000, operating payment rate. For each facility, total operating costs shall be separated into costs that are compensation related and all other costs. Compensation-related costs include salaries, payroll taxes, and fringe benefits for all employees except management fees, the administrator, and central office staff.

(b) For the rate year beginning July 1, 1999, the commissioner shall make available a rate increase for compensation-related costs of 4.843 percent and a rate increase for all other operating costs of 3.446 percent.

(c) For the rate year beginning July 1, 2000, the commissioner shall make available:

(1) a rate increase for compensation-related costs of [3.632](#) percent;

(2) an additional rate increase for each case mix payment rate which must be used to increase the per-hour pay rate of all employees except management fees, the administrator, and central office staff by an equal dollar amount and to pay associated costs for FICA, the Medicare tax, workers' compensation premiums, and federal and state unemployment insurance, to be calculated according to clauses (i) to (iii):

(i) the commissioner shall calculate the arithmetic mean of the 11 June 30, 2000, operating rates for each facility;

(ii) the commissioner shall construct an array of nursing facilities from highest to lowest, according to the arithmetic mean calculated in clause (i). A numerical rank shall be assigned to each facility in the array. The facility with the highest mean shall be assigned a numerical rank of one. The facility with the lowest mean shall be assigned a numerical rank equal to the total number of nursing facilities in the array. All other facilities shall be assigned a numerical rank in accordance with their position in the array;

(iii) the amount of the additional rate increase shall be \$1 plus an amount equal to \$3.13 multiplied by the ratio of the facility's numeric rank divided by the number of facilities in the array; and

(3) a rate increase for all other operating costs of [2.585](#) percent.

Money received by a facility as a result of the additional rate increase provided under clause (2) shall be used only for wage increases implemented on or after July 1, 2000, and shall not be used for wage increases implemented prior to that date.

(d) The payment rate adjustment for each nursing facility must be determined under clause (1) or (2):

(1) for each nursing facility that reports salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the commissioner shall determine the payment rate adjustment using the categories specified in paragraph (a) multiplied by the rate increases specified in paragraph (b) or (c), and then dividing the resulting amount by the nursing facility's actual resident days. In determining the amount of a payment rate adjustment for a nursing facility reimbursed under section [256B.434](#), the commissioner shall determine the proportions of the facility's rates that are compensation-related costs and all other operating costs based on the facility's most recent cost report; and

(2) for each nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the payment rate adjustment shall be computed using the facility's total operating costs, separated into the categories specified in paragraph (a) in proportion to the weighted average of all facilities determined under clause (1), multiplied by the rate increases specified in paragraph (b) or (c), and then dividing the resulting amount by the nursing facility's actual resident days.

(e) A nursing facility may apply for the compensation-related payment rate adjustment calculated under this subdivision. The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the compensation-related portion of the payment rate adjustment to employees of the nursing facility. For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. For the second rate year, a negotiated agreement constitutes the plan only if the agreement is finalized after the date of enactment of all rate increases for the second rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in paragraphs (a) to (c). To be eligible, a facility must submit its plan for the compensation distribution by December 31 each year. A facility may amend its plan for the second rate year by submitting a revised plan by December 31, 2000. If a facility's plan for compensation distribution is effective for its employees after July 1 of the year that the funds are available, the payment rate adjustment per diem shall be effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees. This must be done by giving each employee a copy or by posting it in an area of the nursing facility to which all employees have access. If an employee does not receive the compensation adjustment described in their facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or phone number provided by the commissioner and included in the approved plan.

(g) If the reimbursement system under section [256B.435](#) is not implemented until July 1, 2001, the salary adjustment per diem authorized in subdivision 2i, paragraph (c), shall continue until June 30, 2001.

(h) For the rate year beginning July 1, 1999, the following nursing facilities shall be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if subdivision 26, paragraph (a), was not applied:

(1) a nursing facility in Carver County licensed for 33 nursing home beds and four boarding care beds;

(2) a nursing facility in Faribault County licensed for 159 nursing home beds on September 30, 1998; and

(3) a nursing facility in Houston County licensed for 68 nursing home beds on September 30, 1998.

(i) For the rate year beginning July 1, 1999, the following nursing facilities shall be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if subdivision 26, paragraphs (a) and (b), were not applied:

(1) a nursing facility in Chisago County licensed for 135 nursing home beds on September 30, 1998; and

(2) a nursing facility in Murray County licensed for 62 nursing home beds on September 30, 1998.

(j) For the rate year beginning July 1, 1999, a nursing facility in Hennepin County licensed for 134 beds on September 30, 1998, shall:

(1) have the prior year's allowable care-related per diem increased by \$3.93 and the prior year's other operating cost per diem increased by \$1.69 before adding the inflation in subdivision 26, paragraph (d), clause (2); and

(2) be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if subdivision 26, paragraphs (a) and (b), were not applied.

The increases provided in paragraphs (h), (i), and (j) shall be included in the facility's total payment rates for the purposes of determining future rates under this section ~~or any other section~~.

(k) For the rate years beginning on or after July 1, 2000, a nursing home facility in Goodhue County that was licensed for 104 beds on February 1, 2000, shall have its employee pension benefit costs reported on its Rule 50 cost report treated as PERA contributions for the purpose of computing its payment rates.

Section x Minnesota Statutes 2003 Supplement, section 256B.431, Subd. 29 is amended to read:

**Subd. 29. Facility rate increases effective July 1, 2000.** Following the determination under subdivision 28 of the payment rate for the rate year beginning July 1, 2000, for a facility in Roseau County licensed for 49 beds, the facility's operating cost per diem shall be increased by the following amounts:

- (1) case mix class A, \$1.97;
- (2) case mix class B, \$2.11;
- (3) case mix class C, \$2.26;
- (4) case mix class D, \$2.39;
- (5) case mix class E, \$2.54;
- (6) case mix class F, \$2.55;
- (7) case mix class G, \$2.66;
- (8) case mix class H, \$2.90;
- (9) case mix class I, \$2.97;
- (10) case mix class J, \$3.10; and
- (11) case mix class K, \$3.36.

These increases shall be included in the facility's total payment rates for the purpose of determining future rates under this section ~~or any other section~~.

Section x Minnesota Statutes 2003 Supplement, section 256B.434, Subd. 4a is amended to read:

**Subd. 4a. Facility rate increases.** For the rate year beginning July 1, 1999, the nursing facilities described in clauses (1) to (5) shall receive the rate increases indicated. The increases provided under this subdivision shall be included in the facility's total payment rates for the purpose of determining future rates under this section ~~or any other section~~:

- (1) a nursing facility in Becker County licensed for 102 nursing home beds on September 30, 1998, shall receive an increase of \$1.30 in its case mix class A payment rate; an increase of \$1.33 in its case mix class B payment rate; an increase of \$1.36 in its case mix class C payment rate; an increase of \$1.39 in its case mix class D payment rate; an increase of \$1.42 in its case mix class E payment rate; an increase of \$1.42 in its case mix class F payment rate; an increase of \$1.45 in its case mix class G payment rate; an increase of \$1.49 in its case mix class H payment rate; an

increase of \$1.51 in its case mix class I payment rate; an increase of \$1.54 in its case mix class J payment rate; and an increase of \$1.59 in its case mix class K payment rate;

(2) a nursing facility in Chisago County licensed for 101 nursing home beds on September 30, 1998, shall receive an increase of \$3.67 in each case mix payment rate;

(3) a nursing facility in Canby, licensed for 75 beds shall have its property-related per diem rate increased by \$1.21. This increase shall be recognized in the facility's contract payment rate under this section;

(4) a nursing facility in Golden Valley with all its beds licensed to provide residential rehabilitative services to young adults under Minnesota Rules, parts [9570.2000](#) to [9570.3400](#), shall have the payment rate computed according to this section increased by \$14.83; and

(5) a county-owned 130-bed nursing facility in Park Rapids shall have its per diem contract payment rate increased by \$1.02 for costs related to compliance with comparable worth requirements.

Section x Minnesota Statutes 2003 Supplement, section 256B.434, Subd. 4b is amended to read:

**Subd. 4b. Facility rate increases effective July 1, 2000.** For the rate year beginning July 1, 2000, the nursing facilities described in clauses (1) to (6) shall receive the rate increases indicated. The increases under this subdivision shall be added following the determination under section [256B.431](#), subdivision 28, of the payment rate for the rate year beginning July 1, 2000, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section ~~or any other section~~:

- (1) a nursing facility in Hennepin County licensed for 290 beds shall receive an operating cost per diem increase of 5.9 percent, provided that the facility delicensures, decertifies, or places on layaway status, if that status is otherwise permitted by law, 70 beds;
- (2) a nursing facility in Goodhue County licensed for 84 beds shall receive an increase of \$1.54 in each case mix payment rate;
- (3) a nursing facility located in Rochester and licensed for 103 beds on January 1, 2000, shall receive an increase in its case mix resident class A payment of \$3.78, and an increase in the payment rate for all other case mix classes of that amount multiplied by the class weight for that case mix class established in Minnesota Rules, part [9549.0058](#), subpart 3;
- (4) a nursing facility in Wright County licensed for 154 beds shall receive an increase of \$2.03 in each case mix payment rate to be used for employee wage and benefit enhancements;
- (5) a facility in Todd County licensed for 78 beds, shall have its operating cost per diem increased by the following amounts:
  - (i) case mix class A, \$1.16;
  - (ii) case mix class B, \$1.50;
  - (iii) case mix class C, \$1.89;
  - (iv) case mix class D, \$2.26;
  - (v) case mix class E, \$2.63;
  - (vi) case mix class F, \$2.65;
  - (vii) case mix class G, \$2.96;
  - (viii) case mix class H, \$3.55;
  - (ix) case mix class I, \$3.76;
  - (x) case mix class J, \$4.08; and
  - (xi) case mix class K, \$4.76; and
- (6) a nursing facility in Pine City that decertified 22 beds in calendar year 1999 shall have its property-related per diem payment rate increased by \$1.59.

Section x Minnesota Statutes 2003 Supplement, section 256B.434, Subd. 4c is amended to read:

Subd. 4c. **Facility rate increases effective January 1, 2002.** For the rate period beginning January 1, 2002, and for the rate year beginning July 1, 2002, a nursing facility in Morrison County licensed for 83 beds as of March 1, 2001, shall receive an increase of \$2.54 in each case mix payment rate to offset property tax payments due as a result of the facility's conversion from nonprofit to for-profit status. The increase under this subdivision shall be added following the determination under this chapter of the payment rate for the rate year beginning July 1, 2001, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section ~~or any other section.~~

Section x Minnesota Statutes 2003 Supplement, section 256B.434, Subd. 4d is amended to read:

Subd. 4d. **Facility rate increases effective July 1, 2001.** For the rate year beginning July 1, 2001, a nursing facility in Hennepin County licensed for 302 beds shall receive an increase of 29 cents in each case mix payment rate to correct an error in the cost-reporting system that occurred prior to the date that the facility entered the alternative payment demonstration project. The increase under this subdivision shall be added following the determination under this chapter of the payment rate for the rate year beginning July 1, 2001, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section ~~or any other section.~~