

INFORMATION BRIEF

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Nursing Facility Reimbursement

This information brief explains how nursing facilities in Minnesota are reimbursed. It includes information on how nursing facilities are reimbursed for residents on Medical Assistance (MA), the types of payments nursing facilities receive, rate equalization, the alternative payment system, rebasing, and the nursing facility moratorium and rebalancing.

Nursing Facility Regulation

The Minnesota Department of Human Services (DHS) is responsible for administering the MA reimbursement system for nursing facilities and for establishing the reimbursement rates for each facility. The Minnesota Department of Health (MDH) is responsible for quality of care in nursing facilities.

All nursing facilities in Minnesota must be licensed by MDH. Qualifications for licensure are listed in [Minnesota Statutes, chapter 144A](#). These include meeting minimum health, sanitation, safety, and comfort standards. MDH is also the state agency charged with certifying that nursing facilities meet federal standards for participation in the MA program and the federal Medicare program.

Types of Payments Nursing Facilities Receive

Nursing facilities receive payments for operating costs, external fixed costs, and property costs. Operating costs include:

- costs for nursing, housekeeping, laundry, nursing equipment, and supplies;
- salaries and wages of persons performing nursing services;

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- fringe benefits and payroll taxes related to nursing services; and
- other care-related costs such as costs for social services, therapies, food costs, and dietary consultant fees.

External fixed costs include:

- costs related to the nursing facility surcharge;
- licensure fees;
- long-term care consultation fees;
- family advisory council fee;
- scholarships;
- planned closure rate adjustments;
- single-bed room incentives;
- property taxes and property insurance; and
- Public Employee Retirement Act costs.

Property costs include:

- a base property rate; and
- an equity incentive that applies to nursing facility moratorium exception projects approved by the Commissioner of Health and to major additions to, or replacements of, buildings, attached fixtures, technology, or land improvements.

Rate Equalization Law

MA rates and private pay rates do not vary within a facility. This is due to Minnesota's rate equalization law, which prohibits nursing facilities that participate in the MA program from charging private pay residents more than MA residents. Nursing facilities are however allowed to charge private pay residents a higher rate for a single room and for special services that are not included in the daily rate if MA residents are charged separately at the same rate for the same services in addition to the daily rate paid by DHS.

While nursing facilities are allowed to charge private pay residents less than an MA resident, in actual practice, private pay rates are set at the level of the MA rate. This is because federal and state rules prohibit nursing facilities from charging MA residents more than private pay residents for similar services. In cases where the rate charged to private pay residents is less than the MA rate, the MA rate is made equal to the private pay rate. MA reimbursement policy is therefore relevant to private payers as well as to MA recipients, since a change in MA per diem reimbursement paid to nursing facilities leads to a corresponding change in the per diem charged to private payers.

The Alternative Payment System

The Alternative Payment System (APS), sometimes referred to as the contract system, was authorized by the legislature in 1995. The goal of the APS was to determine whether a reimbursement system based upon contracts between individual facilities and DHS could reduce

nursing facility regulation and give nursing facilities more fiscal flexibility, while promoting consumer satisfaction and good health care outcomes.

Since October 1, 2006, all nursing facilities participating in MA have been reimbursed under the APS. APS was developed as an alternative to an existing cost-based system (sometimes referred to as Rule 50). Under the cost-based system, reimbursement to facilities was based on their reported costs, and at times, certain statutory, geographically based limits applied to the rate of increase in operating costs. Under APS, facilities are exempt from certain statutory requirements of the cost-based system and are reimbursed at the level of their payment rate in effect just prior to entering into an APS contract with the commissioner. These contractual payment rates are adjusted annually for inflation, subject to limitations specified in law. Effective July 1, 1999, through September 30, 2013, the automatic inflation adjustment is applied only to the property-related rate; inflation adjustments for operating costs must be authorized by the legislature and have been at times.

The initial reimbursement rate under the APS was the total per diem payment rate the facility was receiving under the cost-based system at the time the contract was signed. This initial rate varied with resident case-mix and incorporated reimbursement for care-related, other operating, pass-through, and property costs. Initial property-related payment rates are adjusted for inflation each October 1 by the consumer price index for urban consumers (CPI-U).

Case-Mix Classifications and Nursing Costs

Reimbursement rates are facility- and resident-specific. Rates vary with the facility's historical costs, with the amount of care needed by a resident (as measured by a case-mix classification), and reflect any statutory facility-specific rate adjustments authorized by the legislature. Nursing facilities receive higher levels of reimbursement for residents who need more care and lower levels of reimbursement for residents who need less care. This creates an incentive for nursing facilities to admit individuals who most need nursing facility care.

Nursing facilities are reimbursed by Medical Assistance (MA) on a resident-per-day basis. The nursing home reimbursement levels are adjusted under the Resource Utilization Groups (RUGS) case-mix system to reflect the varying care needs of residents. RUGS classifies nursing facility residents into 34 groups based on information collected using the federally required minimum data set. (However, as of October 1, 2010, the number of RUGS increased from 34 groups to 48 groups due to federal changes.) The RUGS case-mix reimbursement system for nursing homes is described in [Minnesota Statutes, sections 144.0724 and 256B.438](#).

All applicants to nursing facilities are screened and assigned to a case-mix classification based on the level of their dependence in activities of daily living (ADL), the severity of their disabilities, and the complexity of their nursing needs. Each case-mix classification is assigned a case-mix weight, with the lowest level of care receiving the lowest weight and the highest level of care receiving the highest weight. Reimbursement for care-related costs for each classification is proportional to the case-mix weight; per diem reimbursement for nursing care is therefore lowest for the case-mix classification needing the lowest level of care and highest for the case-

mix classification needing the highest level of care. Rates are the same for all noncare-related components across all RUGS groups within a facility’s rate set.

Rebasing

The 2007 Legislature required DHS to rebase nursing facility rates. Rebasing allows nursing facilities to have new or currently unreimbursed expenditures recognized in the facility payment rate, subject to certain statutory limits. A facility’s total care-related per diem will be limited to 120 percent of the median for the facility’s peer¹ and facility type² group and 105 percent of the peer group median for other operating costs. Rebasing for operating cost payment rates began October 1, 2008, and will be phased in over eight years, through the rate year beginning October 1, 2015. During the phase-in period, nursing facilities will receive a blended rate—based partially on the APS reimbursement system and partially on the new value-based reimbursement system. Also during the phase-in period, facilities will be held harmless—a facility cannot receive an operating cost payment rate that is less than what the facility would have received without rebasing. Property rates will be rebased beginning October 1, 2014.

The 2008 Legislature set a rebasing floor for the rate year beginning October 1, 2008, of 1 percent, funded by setting a limit on the maximum increase a facility can receive under rebasing.

The phase-in of rebased rates was suspended for October 1, 2009, through September 30, 2013, but the legislature retained (and did not delay) the phase-in formula currently in law, so that rebasing will resume October 1, 2013, with 65 percent of the payment rate reflecting rebased costs. The governor, through unallotment, suspended the phase-in of rebasing for fiscal year 2010. This had the effect of eliminating an increase of 1 percent (from 13 percent to 14 percent) in the proportion of a nursing facility’s payment rate that uses rebased costs. The 2010 Legislature voided this allotment reduction and eliminated the phase-in of rebasing for fiscal year 2010.

Phase-In of Rebased Operating Rates
(reflects legislative suspension of the phase-in)

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
% of Rate Based on APS	87	87	87	87	87	35	18	0
% Rate Based on Value-Based System	13	13	13	13	13	65	82	100

¹ Facilities are classified into three groups by county. The groups consist of: (1) group one: facilities in Anoka, Benton, Carlton, Carver, Chisago, Dakota, Dodge, Goodhue, Hennepin, Isanti, Mille Lacs, Morrison, Olmsted, Ramsey, Rice, Scott, Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright County; (2) group two: facilities in Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay, Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard, Itasca, Kanabec, Koochiching, Lake, Lake of the Woods, Le Sueur, Martin, McLeod, Meeker, Mower, Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan, or Wilkin County; and (3) group three: facilities in all other counties.

² Facilities are classified into two groups, called “facility type groups,” which consist of: (1) facilities that are hospital-attached, or are licensed under [Minnesota Rules, parts 9570.2000 to 9570.3400](#); and (2) all other facilities.

Geographic Location and Nursing Facility Rates

Under the old cost-based system, there were reimbursement limits based on three geographic, county-based groups—metro, rural, and deep rural. These limits continue to affect reimbursement rates under the APS system since the initial contracts with nursing facilities were based on their reimbursement rates under the cost-based system. Under the new value-based system, facilities are classified into three newly defined peer groups by county, with a limit placed on the total care-related per diem determined for each peer group. These peer groups are similar to, but not identical to, the old geographic groups. When the new peer groups were created, there was concern among legislators and others that the groupings would create rate disparities³ between nursing facilities in various regions of the state. It is unclear what affect the peer groupings will have on rates at this time.

Nursing Facility Moratorium and Rebalancing

Currently, there is a moratorium on the licensure and MA certification of new nursing home beds and construction projects that exceed \$1.4 million. However, there are certain exceptions to the moratorium including for facilities built to address an extreme hardship situation in a particular county, to license or certify beds in a new facility constructed to replace a facility, or to license or certify beds that are moved from one location to another within a nursing facility. In addition, the Commissioner of Health may grant construction project exceptions to the nursing facility moratorium if legislation authorizes and funds those projects. The legislature has also, at times, authorized statutory exceptions to the moratorium.

There is an incentive for nursing facilities to create single-bed rooms as a result of bed closures. Facilities that create single-bed rooms as a result of bed closures receive an increase in their operating payment rate. Nursing facilities are prohibited from discharging residents for purposes of establishing single-bed rooms.

DHS has the authority to provide a planned closure rate adjustment that is an increase in a nursing facility's operating rates resulting from a planned closure or planned partial closure of another facility. The facility that is closing or partially closing must apply to DHS for the planned closure rate adjustment and must specify in the application to which facilities the rate adjustment will apply.

Finally, nursing facilities may place beds on layaway status in order to have those beds treated as being delicensed for as long as they remain on layaway. Placing beds on layaway status allows a facility to change its single-bed election for use in calculating capacity days and to receive a property payment rate increase equal to the incremental increase in the facility's rental per diem resulting from the recalculation of the facility's rental per diem applying only the changes

³ For more information on this topic, see the DHS report, *Nursing Facility Rate Disparities*, March 2010 (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&noSaveAs=1&Rendition=Primary&allowInterrupt=1&dDocName=dhs16_149196).

resulting from the layaway of beds. Nursing facilities are prohibited from discharging residents for purposes of placing beds on layaway status.

Nursing Home License Surcharge

Each nonstate-operated nursing facility licensed by MDH must pay to the state an annual surcharge of \$2,815 per licensed bed. Payments must be made to the state in monthly installments and must be equal to the annual surcharge divided by 12. However, it is important to note that nursing facilities receive an amount to offset this surcharge as part of their external fixed cost reimbursement.

Recent Legislative Changes

The value-based nursing facility reimbursement system that was enacted in 2005 includes a quality add-on that allows nursing facilities to receive a higher payment rate based on their quality score. DHS determines a quality score for each nursing facility using quality measures established in statute. The payment rate for the quality add-on is a variable amount based on each facility's quality score. In addition, DHS and MDH have an online Nursing Home Report Card that shows how each Minnesota nursing facility scored on each of the quality measures.

The 2008 Legislature increased nursing facility operating payment rates by 1 percent effective October 1, 2008, and also temporarily increased the rate by an additional 1 percent; the temporary increase only applied from October 1, 2008, to September 30, 2009.

The 2009 Legislature created nursing facility level of care criteria that will make it more difficult for people to be assessed as needing nursing facility care once the new criteria are implemented.

Nursing Facility Statistics

As of September 30, 2009, there were 381 MA-certified and state-licensed nursing facilities in Minnesota with a total of 32,342 active beds. The average statewide occupancy rate for nursing facilities is 92 percent. The monthly average number of MA recipients served in nursing facilities during fiscal year 2009 was 18,786.

For more information about nursing facilities, visit the health and human services area of our web site, www.house.mn/hrd/hrd.htm.