INFORMATION BRIEF
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Nursing Facility Reimbursement and Regulation

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.

Table of Contents

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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 compliance monitoring and quality of care in nursing facilities. Both DHS and MDH are responsible for encouraging quality improvement.

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.

The majority of the state's nursing homes participate in MA. However, there are 17 nursing homes in Minnesota that are licensed by MDH, but not certified to serve MA residents—five are Minnesota veterans homes and 12 are privately owned.

Types of Payments Nursing Facilities Receive

Nursing facilities receive payments for operating costs, external fixed costs, and property costs. The operating payment rate includes the following:

- costs for nursing, social services activities, dietary, housekeeping, laundry, building maintenance, and administration
- salaries and wages of persons performing these services
- fringe benefits and payroll taxes
- other related costs such as costs for supplies, food, utilities, and consultants

External fixed payment rate includes the following:

- costs related to the nursing facility surcharge (an annual charge on licensed nursing home beds set in statute)
- licensure fees
- long-term care consultation fees (until the federal government approves a change in how this is financed)
- family advisory council fee
- scholarships
- planned closure rate adjustments
- single-bed room incentives

Nursing Home License Surcharge

Since July 1, 1993, certain nursing facilities have had to pay a license surcharge. Each nonstate-operated nursing home 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.

- property taxes and property insurance
- Public Employee Retirement Act costs

Property payment rate includes interest expense and return on equity.

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 (1) for a single room and (2) 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.

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, subject to various limits. 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 supposed to be adjusted annually for inflation. However, effective July 1, 1999, through September 30, 2011, the automatic inflation adjustment was applied only to the property-related rate. Inflation adjustments for operating costs must be authorized by the legislature; the legislature most recently authorized adjustments in 2008 and 2013. In addition, the 2011 Legislature suspended the automatic inflation of property payment rates for rate years beginning October 1, 2011, and October 1, 2012. The 2013 Legislature suspended the automatic inflation of the operating and property portions of the payment rate for rate years beginning October 1, 2013, through October 1, 2016.

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 by facility and by resident case-mix classification (see below) and incorporated reimbursement for care-related, other operating, external fixed, and property costs.

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 MA on a resident-per-day basis. The nursing home reimbursement levels are adjusted under the Resource Utilization Groups (RUG) case-mix system to reflect the varying care needs of residents. Since January 1, 2012, the RUG system has been used to classify nursing facility residents into 48 groups based on information collected using the federally required Minimum Data Set assessment. There are also penalty and default groups for a total of 50 RUG levels (a penalty class for late completion or submission of an assessment and a default class for newly admitted residents with stays less than 14 days). The RUG case-mix reimbursement system for nursing homes is described in Minnesota Statutes, sections 144.0724 and 256B.438.

All applicants to nursing facilities are assessed upon admission and at least every 90 days thereafter and assigned to a case-mix classification based on the level of their dependence in activities of daily living (ADL), the severity of their cognitive and/or behavior management needs, 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 nondirect care-related components across all RUG groups within a facility's rate set.

Rebasing

The 2007 Legislature required DHS to rebase nursing facility rates, meaning that operating payment rates for nursing facilities would be calculated using the statistical and cost report filed by each nursing facility for the report period ending one year prior to the rate year. Similar to the APS, these reimbursement rates would vary with resident case-mix and incorporate reimbursement for care-related, other operating, external fixed, and property costs. Rebasing would allow 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 would be limited to 120 percent of the median for the facility's peer[1] and facility type[2] group and 105 percent of the peer group median for other operating costs. Rebasing for operating cost payment rates began October 1, 2008, and was designed to be phased in over eight years, through the rate year beginning October 1, 2015. During the phase-in period, nursing facilities were to 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 were to be held harmless—a facility could not receive an operating cost payment rate that was less than what the facility would have received without rebasing. Property rates will be rebased beginning October 1, 2014.

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 was supposed to resume October 1, 2013, with 65 percent of the payment rate reflecting rebased costs. Through unallotment, Governor Tim Pawlenty 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. The 2011 Legislature prohibited all further steps phasing in rebased operating payment rates. This was projected to save the state in excess of $100 million per year in fiscal years 2014 and 2015. The savings result from cancelling scheduled rate increases.

[1] Facilities are classified in statute into three groups by county. The groups consist of:

- 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 counties;
- 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 counties; and
- Group three: Facilities in all other counties.

[2] Facilities are classified in statute 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.

Phase-in of Rebased Operating Payment Rates

	Original Law		Actual Payments*	
Years	% of Rate Based on APS	% of Rate Based on Value-based System	% of Rate Based on APS	% of Rate Based on Value-Based System
FY 2009	87%	13%	87%	13%
FY 2010	86	14	87	13
FY 2011	86	14	87	13
FY 2012	69	31	87	13
FY 2013	52	48	87	13
FY 2014	35	65	87	13
FY 2015	18	82	87	13
FY 2016	0	100	87	13

*The percentage of the rate based on APS vs. the value-based system was calculated for FY 2009 and has not been recalculated since then.

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 (rebased) 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 disparities[3] between nursing facilities in various regions of the state. It is unclear what effect the peer groupings have on rates.

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 area, 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 the state. In addition, the Commissioner of Health may grant construction project exceptions to the nursing facility moratorium if legislation authorizes and funds those projects. In fiscal year 2013, the

[3] For more information on this topic, see the DHS report, *Nursing Facility Rate Disparities*, March 2010 (http://archive.leg.state.mn.us/docs/2010/mandated/100487.pdf).

Commissioner of Health was given the authority to approve moratorium exception projects for which the full annualized state share of MA costs does not exceed $1 million. The legislature has also, at times, authorized statutory exceptions to the moratorium. (See Minn. Stat. § 144A.071.)

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.

Planned closure rate adjustments provide incentive payments for the planned closure of nursing home beds in an area of the state where excess bed capacity exists or where a rebalancing of long-term care services is desired. This incentive was discontinued in 2011 and restored in 2013.

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. Layaway beds may be put back into active service anytime after six months and for up to ten years. Placing beds on layaway status allows a facility to change its single-bed election for use in calculating capacity days. It also allows the facility 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 resulting from the layaway of beds. Nursing facilities are prohibited from discharging residents for purposes of placing beds on layaway status. In a situation where some type of disaster leads to a nursing facility evacuation, nursing facilities may place or remove beds from layaway status and certain timing requirements are waived. This allows facilities to avoid having to pay the bed surcharge and license fee while a facility is evacuated.

Payments for Nursing Facility Quality

In recent years there have been a few attempts to improve and reward nursing facility quality. The rebased 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. The quality add-on was funded in 2006 to allow a quality add-on of up to 2.4 percent and in 2007 to allow a quality add-on of up to 0.3 percent. 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.

Since July 1, 2006, the performance-based incentive payment program (PIPP) has allowed nursing facilities to compete to contract with DHS to earn performance-based incentive payments of up to 5 percent of their operating payment rate. Individual nursing facilities or a collaboration of multiple facilities are eligible to apply for PIPP funding for innovative quality improvement programs. The incentive payments are time-limited rate adjustments. Facilities must achieve measurable program outcomes to retain full funding. The rate add-on amount, duration, and outcomes are negotiated with DHS.

The 2013 Legislature provided a quality add-on operating payment rate increase beginning September 1, 2013, of up to 3.2 percent for each RUGS rate in effect on August 31, 2013. The actual amount of a quality add-on that a facility will receive will depend on how well the facility performs on these quality measures: Minnesota Quality Indicators; resident quality of life and satisfaction; and MDH inspection results. These are measures that are included in the Nursing Home Report Card published by DHS. The average quality add-on is expected to be 1.25 percent.

Quality Add-on Payment Rate

	Rate Year 2006/07	**Rate Year 2007/08**	**Rate Year 2008/09**	**Rate Year 2009/10**	**Rate Year 2010/11**	**Rate Year 2011/12**	**Rate Year 2012/13**	**Rate Year 2013/14**
% of Operating Payment Rate	Up to 2.4%	Up to 0.3%	0%	0%	0%	0%	0%	Up to 3.2%

The 2013 Legislature also directed DHS to develop a Quality Improvement Incentive Program, in consultation with stakeholders, to be effective October 1, 2015. DHS plans to work with the existing Nursing Facility Advisory Committee to design this program and to complete the design work by the end of 2013.

Recent Legislative Changes

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 or alternative care once the new criteria are implemented beginning January 1, 2014.

The 2010 Legislature authorized the equitable cost-sharing for publicly owned nursing facilities (ECPN) program. This program enables nursing facilities owned by nonstate governmental entities to benefit from a federal match of subsidies provided to the facility by the owner.

The 2011 Legislature made several changes to nursing facility policy and rates, including:

- laying out new criteria and a new process for MDH and DHS to authorize hardship exceptions to the nursing facility moratorium and to determine payment rates for new facilities and facilities that are allowed to add beds;
- authorizing consolidation projects for two or more nursing facilities in which one or more is closed and the remaining facility or facilities are upgraded;
- making changes to the equitable cost-sharing for publicly owned nursing facilities program to conform to the conditions under which federal approval was granted;
- reducing MA payments for nursing facility leave days and increasing the occupancy rate needed to be eligible;
- eliminating the planned closure rate adjustment program;

- authorizing the transition to the 48-group RUG-IV case mix classification model;
- increasing operating payment rates by up to 2.45 percent, effective October 1, 2011, for nursing facilities with rates below the 18th percentile of operating payment rates with a RUG weight of 1.00; and
- requiring DHS to provide recommendations to the legislature on how to develop a pilot project to test a model of care between nursing facility care and assisted living.

The 2012 Legislature provided funding for moratorium exception projects and gave DHS the authority to designate certain nursing facilities as critical access nursing facilities. There was onetime-only funding appropriated for this benefit. This program will end by the end of calendar year 2013.

The 2013 Legislature made several changes to nursing facility policy and rates, including:

- increasing operating payment rates by 3.75 percent, effective September 1, 2013, and by 2.4 percent, effective October 1, 2015;
- providing a quality add-on operating payment rate increase of up to 3.2 percent, effective September 1, 2013;
- instructing DHS to develop a Quality Improvement Incentive Program, effective October 1, 2015;
- suspending automatic inflation adjustments to the operating and property payment rates;
- reinstating the planned closure rate adjustment;
- updating the nursing facility resident relocation statute to incorporate new provisions, align with new federal requirements, and make clarifying changes;
- simplifying the due date for the annual statistical and cost report;
- changing the financing of long-term care consultation by removing costs associated with long-term care consultation from external fixed payment rates;
- modifying the effective date of rate adjustments for approved nursing facility consolidation projects;
- granting the Commissioner of Human Services the authority to limit certain penalties for not submitting timely reports;
- modifying nursing facility bed layaway timelines; and
- creating a health facility construction plan review fee.

Nursing Facility Statistics

As of September 30, 2012, there were 375 MA-certified and state-licensed nursing facilities in Minnesota with a total of 30,351 active beds. The average statewide occupancy rate for nursing facilities was 90.1 percent. The average number of MA recipients served in nursing facilities during fiscal year 2012 was 17,053.

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