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Nursing Facility Reimbursement and Regulation

This information brief explains how nursing facilities in Minnesota are reimbursed. It includes information on nursing facility regulation, MA reimbursement for nursing facility services under the value-based reimbursement system, the types of payments nursing facilities receive, rate equalization, case mix classifications, the impact of geographic location on nursing facility rates, nursing facility moratorium and rebalancing, payments for nursing facility quality, historical reimbursement systems, and recent legislative changes.

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Introduction

Medical Assistance (MA), the state's Medicaid program, provides payment for nursing facility services provided to low-income elderly and disabled persons who meet income and asset limits and other eligibility requirements.

Nursing facility services under MA are a package of room and board and nursing services. In order to be eligible for nursing facility care, an MA enrollee must:

- be screened by a long-term care consultation team; and
- be determined by the team to need nursing facility-level care.

The federal government pays a share of the cost of state MA expenditures. This is referred to as the federal medical assistance percentage (FMAP). Minnesota's FMAP for covered services is 50 percent. Minnesota pays the remaining 50 percent for most services (some services have a county share).[1]

Over the last 30 years, the state has used a number of different systems to reimburse nursing facilities for covering MA patients. These systems are important to nursing facilities because almost all facilities in the state participate in the MA program, and MA enrollees represent a large share of nursing facility residents. In the 2014 rate year, just under 60 percent of all nursing facility days were paid for by MA. Reimbursement rates also matter for residents who are not on MA, because Minnesota has a rate equalization law, which prohibits nursing facilities from charging private pay residents more than residents whose care is paid for by MA.

As of September 30, 2015, there were 368 MA-certified and state-licensed nursing facilities in Minnesota with a total of 28,869 active beds. The average statewide occupancy rate for nursing facilities was 87.5 percent for the federal fiscal year ending on September 30, 2015. The monthly average number of MA recipients served in nursing facilities during fiscal year 2015 was 15,152. In that year the state share of MA spending on nursing facilities was $361.5 million.

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.

[1] For example, counties are responsible for 20 percent of the cost of nursing facility placements of persons with disabilities under age 65 that exceed 90 days. For this and other required county shares, see Minnesota Statutes, section 256B.19, subdivision 1.

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 15 nursing homes in Minnesota that are licensed by MDH, but not certified to serve MA residents—five are Minnesota veterans homes and ten are privately owned.

The Value-based Reimbursement System

Overview

The 2015 Legislature authorized a new system for nursing facility reimbursement rates, which DHS calls the value-based reimbursement system. The 2016 rate year, which began on January 1, 2016, was the first year that DHS reimbursed nursing facilities under the new system. Under the value based-system, DHS sets facility reimbursement rates based on the cost of providing care to residents. Although the new system ties a facility's rate to its costs, DHS will not reimburse the facility for unlimited costs; a facility's rate will only reflect its care-related costs up to a limit. If a facility's care-related costs are greater than its limit, the facility's rate would not reflect the portion of the costs in excess of the limit. As with previous systems, facilities' rates are case-mix adjusted—facilities receive higher rates to care for more-resource intensive patients.

DHS Sets Rates Using Facilities' Historical Cost Reports

At a minimum, there is a 15-month lag between when a facility accrues a cost and when the cost is reflected in the facility's rate. This is due both to the differences between the rate year and the reporting period, and the time allowed for DHS to calculate facilities' rates. The table below shows an example of the timeline DHS uses to set rates.

Nursing facilities in Minnesota must file a cost report with DHS by February 1 of each year. A facility's cost report covers the previous reporting year, which runs from October 1 to September 30. DHS uses these cost reports to calculate a facility's rate for the following rate year. The rate year runs from January 1 to December 31.

Example Timeline for the 2017 Rate Year

Date	Step in the Process
October 1, 2014 - September 30, 2015	Facility cares for residents and accrues costs by employing nurses, paying rent, purchasing food, etc.
February 1, 2016	Facility files a cost report with DHS detailing its costs during the 2014-2015 reporting period.
November 15, 2016	DHS sends facility "notice of rates" for the 2017 rate year. Facilities' rates are calculated using the cost report filed on February 1, 2016, which reflect the costs accrued during the 2014-2015 reporting period.
January 1, 2017	The 2017 rate year begins, and new rate takes effect. When a facility cares for MA residents during the 2017 rate year, it is reimbursed for these services at the new rate.

Because of this reporting cycle, a facility's reimbursement rate will always reflect its historical costs, rather than its present costs. If a facility's costs increase from one year to the next, its rates will lag behind the facility's costs.

Under previous cost-based reimbursement systems, DHS adjusted facilities' rates to account for this lag between reporting and rate setting. Rates were increased by multiplying a facility's payment rate by the rate of inflation between when it submitted a cost report and when its rate took effect. The current value-based system does not include such an inflationary adjustment.

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 (Minn. Stat. § 256.9657, subd. 1). 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 $8.86 per resident day to offset this surcharge as part of their external fixed cost reimbursement.

The Components of a Facility's Rate

A nursing facility's rate has five components: direct care, other care, other operating, external fixed costs, and property. Most of the rate components correspond to a category of a facility's costs. The table below summarizes the components of a facility's rates, and explains the costs for which each rate component is intended to reimburse a facility.

Facility Rate Components

Rate Component	Description
Direct Care	The direct care component corresponds to the facility's costs associated with the provision of care. This includes the wages of nurses, CNAs, and health care staff. It also covers technology related to the provision of care and medical supplies used by nursing staff such as dressings, bandages, water pitchers, and soap.
Other Care	The other care rate component is intended to reimburse a facility for activities costs, raw food costs, therapy costs, social services costs, and "other direct care" costs. "Other direct care" costs consist of the wages, salaries, fringe benefits, and payroll taxes of mental health workers, religious personnel, and other direct care employees not included in the "direct care" rate component.
Other Operating	The other operating component is intended to reimburse a facility for its administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs.
External Fixed Costs	The external fixed costs rate component is actually a group of miscellaneous smaller rate components. The phrase "external fixed" is confusing, because not all external fixed costs are fixed costs in the economic sense of the word. The external fixed portion of a facility's rate includes: • Reimbursement for nursing facility surcharges • Reimbursement for licensure fees • Reimbursement for family advisory council fees • Scholarships offered under the nursing facility scholarship program • Single-bed room incentives • Planned closure rate adjustments • Reimbursement for property taxes • Reimbursement for employer health insurance costs • Quality improvement payment rate adjustments • Performance-based incentive payments • Special dietary needs • Reimbursement for contributions to PERA
Property	This rate component is intended to reflect a facility's costs related to its use of property, including construction projects, return on equity, and interest expenses.

The part of a facility's rate captured by the first three components—direct care, other care, and other operating—are collectively called its "operating rate." These rate components make up well over half of a typical facility's rate. Past legislative changes focused on adjusting facility operating rates.

Calculation of Rate Components

Rate Component	How Rate is Calculated
Direct Care	$$\textbf{\textit{Direct Care Rate}} = \frac{\textbf{\textit{Facility's Direct Care Costs}}}{\textbf{\textit{Facility's Standardized Days}}}$$ A facility's direct care rate is equal to its total costs in the most recently submitted cost report, divided by the number of "standardized days" in that period. Standardized days are the sum of the number of days each individual resides in a facility, but weighted to reflect how resource-intensive it is to care for the specific resident.
Other Care	$$\textbf{\textit{Other Care Rate}} = \frac{\textbf{\textit{Facility's Other Care Costs}}}{\textbf{\textit{Facility's Resident Days}}}$$ A facility's other care rate is equal to its total other care costs in the most recently submitted cost report, divided by the total number of resident days in that period. A facility's other care costs are not expected to vary significantly from resident to resident. As a result, a facility's other care costs are divided by resident days, which are not weighted.
Other Operating	$$\textbf{\textit{Other Operating Rate}} = \textbf{105}\% * (\textbf{\textit{Median Other Operating Costs in the 7-county Metro per resident day}})$$ All facilities are reimbursed at 105 percent of the median other operating cost for facilities located in the seven-county metro area.
External Fixed Costs	$$\textbf{\textit{External Fixed Costs Rate}} = \textbf{\textit{Sum of External Fixed Rate Components}}$$
Property	A nursing facility's property rate is set according to the previous "contract-based" or "alternative payment system." Under the system, a facility agrees to be reimbursed at a rate established in a contract between the facility and DHS.

Facilities' Care-related Rates Are Subject to Limits

To control the costs of providing care under the value-based system, the legislature established a **total care-related limit** for a facility's rate. A facility's "total care-related" payment rate is the sum of its direct care and other care rates. If a facility's total care-related rate exceeds the facility's limit, the sum of its direct and other care rates are reduced to the level of the limit, with proportional reductions in each rate component.

The value-based reimbursement system also limits reimbursement for the portion of the rate that corresponds to a facility's "other operating" costs. Rather than setting a facility's other operating rate based on the facility's costs, every facility is reimbursed at the same other operating rate. This rate for all facilities in the state is 105 percent of the median other operating costs per day

for facilities in the seven-county metro area. As a result, facilities with higher "other operating" costs will not see such costs fully reflected in their other operating rate. Likewise, facilities with relatively low other operating costs per day may receive an other operating rate that exceeds their other operating costs.

DHS Calculates Facility Limits Using Facilities' Quality Scores

Under the value-based reimbursement system, DHS sets a nursing facility's total care-related limit based on the nursing facility's **quality score,** which is calculated using the department's nursing facility quality profiles.[2] The quality scores are measured on a scale from 0 to 100. Fifty points of the score are based on a facility's "quality indicators score" from the Minimum Data Set comprehensive assessments conducted at the facility. Forty points of the score are based on the "resident quality of life score" from the survey of the facility's residents. Ten points are based on the facility's "state inspection results score."

By statute, a facility's total care-related limit is calculated using the following formula:

$$\frac{89.375 + [.5625 * (Facility's\ Quality\ Score)]}{100} * (7\text{-}county\ Metro\ Area\ Median\ Care\text{-}Related\ Rate)$$

The limit for all facilities in the state are pegged to the median total-care related rate in the seven-county metro area. The limit for a facility with a quality score of 10 would be 95 percent of the seven-county metro median. The limit for a facility with a quality score of 90 would be 140 percent of the seven-county metro area median. The limits for facilities in between these numbers would vary depending on the facility's quality score.

The new value-based reimbursement law includes two provisions that protect facilities from large rate reductions due to application of their limit. First, the law prevents any facility from receiving a rate under the new system that is lower than its rate on December 31, 2015—the day before the new system went into effect. Second, if a facility's limit is reduced due to a change in the facility's quality score, DHS cannot reduce the limit at any one time by more than 5 percent of the median total care-related rate for facilities in the seven-county metro area.

Residents Are Assigned Weights Based on How Much Care They Require[3]

Different nursing facility residents require different levels of care, and certain residents cost more to take care of. As a result, DHS reimburses nursing facilities at different rates depending on the level of care a resident requires. Each resident at a nursing facility is assigned a "resource utilization group" (RUG) class depending on the level of care the resident requires. Each of these RUG groups is associated with a weight, ranging from 0.45 for the least resource-intensive residents to 3.0 for the most resource-intensive residents.

[2] For more information on nursing facility quality profiles, see the "Payments for Nursing Facility Quality" section on page 10.

[3] For more information on the case mix system, see the section of this publication titled "Case-Mix Classifications and Nursing Costs" on page 9.

Payment Rates Are Adjusted to Account for Resource-intensive Residents

$$\begin{aligned} &Total\ Payment\ Rate \\ &\quad = Direct\ Care\ Rate + Other\ Care\ Rate + Other\ Operating\ Rate \\ &\quad + External\ Fixed\ Rate + Property\ Rate \end{aligned}$$

A facility's "total payment rate" is the rate a facility receives to care for a resident with a RUG weight of 1.00. The total payment rate is not the rate that facilities receive in practice. In practice, facilities are reimbursed at the case-mix adjusted total payment rate.

$$\begin{aligned} &Case\text{-}Mix\ Adjusted\ Total\ Payment\ Rate \\ &\quad = [Direct\ Care\ Rate * RUG\ Weight\ of\ Resident] + Other\ Care\ Rate \\ &\quad + Other\ Operating\ Rate + External\ Fixed\ Rate + Property\ Rate \end{aligned}$$

The case-mix adjusted total payment rate accounts for how resource-intensive it is to care for a particular resident. More resource-intensive residents have RUG weights of greater than 1.00. As a result, DHS reimburses a facility at a daily rate that is higher than the total payment rate. Likewise, less resource intensive residents have RUG weights of less than 1.00, which results in lower payment rates for such residents.

Only a facility's direct care rate is adjusted for the RUG weight of a particular resident. This is because the other components of a facility's rate are not expected to change significantly from resident to resident.

Geographic Location and Nursing Facility Rates

DHS uses the same formula to calculate facilities' rates, regardless of their geographic location. There are no longer any limits or factors based on geographic or peer groups.

Rate Equalization Law

Nursing facilities in Minnesota must charge the same rate to residents with MA and those who pay for their stays privately. MA reimbursement policy is therefore relevant to private payers as well as to MA recipients, since a change in MA reimbursement rates paid to nursing facilities leads to a corresponding change in the rates charged to private payers. Minnesota's rate equalization law prohibits nursing facilities that participate in the MA program from charging private pay residents rates higher than the rates of residents with MA. Nursing facilities are 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 laws and rules prohibit nursing facilities from charging rates for MA residents greater 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 reduced to the private pay rate.

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 system neutralizes the incentive for nursing facilities to admit individuals who least 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 256R.17.

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, 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 components of a facility's rate other than its direct care-related rate, across all RUG groups within a facility's rate set.

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 $1.565 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 2017, the 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 external fixed 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 any time 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

Currently, DHS and the legislature have attempted to improve and reward nursing facility quality using three main strategies. First, DHS encourages facilities to improve their quality of care by publishing the Minnesota Nursing Home Report Card system. Second, the new value-based reimbursement system sets a limit on a facility's care-related reimbursement rate, and this limit is tied to the facility's quality score. Third, DHS operates two incentive programs that reward facilities who undertake quality improvement projects with rate increases.

The Minnesota Nursing Home Report Card

Since 2001, DHS has been required to establish and implement a system of quality profiles for long-term care facilities. DHS quality profiles are based on three separate data sources—a survey of residents in every facility in the state conducted by an independent contractor, state inspections by the Minnesota Department of Health (MDH), and quality indicators that DHS derives from the comprehensive assessments conducted by MDH. DHS has published the nursing facility quality profile data on its Minnesota Nursing Home Report Card website since 2006.

Quality in the Value-based Reimbursement System

The value-based reimbursement system, effective January 1, 2016, builds a quality component into the operating payment rate by placing limits on care-related rates using a facility's quality score. A facility with a higher quality score is subject to higher limits (see Facility Limits on page 7).

Incentive Programs: PIPP and QIIP

DHS administers two programs that offer facilities time-limited rate adjustments to implement projects that improve the quality and efficiency of care. The Nursing Home Performance-based Incentive Payment Program (PIPP) awards rate increases on a competitive basis and is available to a limited number of facilities each year. In contrast, the Quality Improvement Incentive Program (QIIP) is a broader program that is open to any facility reimbursed under Medical Assistance.

Since July 1, 2006, PIPP has allowed facilities to apply for a time-limited rate increase in exchange for implementing a project to improve the facility's quality. DHS uses a competitive application process to select which projects will be funded. Individual nursing facilities or a collaboration of multiple facilities are eligible to apply for PIPP funding. A facility may request a performance-based incentive payment of up to 5 percent of their operating payment rate, but facilities must achieve measurable program outcomes to retain full funding. The rate add-on amount, duration, and outcomes are negotiated with DHS. In the past, DHS has funded projects to improve employee recruitment and retention, reduce the rate of falls among residents, and improve residents' dining experiences.

The 2013 Legislature also directed DHS to develop a QIIP in consultation with stakeholders. QIIP went into effect on October 1, 2015. QIIP is a broader quality incentive program than PIPP and is designed to be easier to participate in than PIPP. To participate in QIIP, a facility must select one quality measure to improve.[4] Unlike PIPP, there is no competitive application process—to participate a facility only needs to select a single quality indicator and work to improve that measure. The amount of a facility's rate increase is based on the amount of improvement in the quality indicator relative to the previous year. A facility's goal is to improve its selected quality measure by one standard deviation. In general, the amount of its rate increase

[4] A facility may pick from a list of 26 "quality indicators" or 12 "quality of life domain scores."

will usually be equal to the percent of its goal achieved times $3.50. The annual funding pool available for QIIP payments is equal to 0.8 percent of all operating payments.[5]

Historical Reimbursement Systems

1986 to 1999: The Cost-based System

From fiscal year 1986 to fiscal year 1999, DHS reimbursed nursing facilities using a cost-based system, which was also known as "Rule 50." Under the cost-based system, DHS set reimbursement rates based upon what it cost a facility to care for its residents. Each year, a facility was required to file a cost report with DHS, and the agency used these reports to calculate a facility's rate for the following year.

Reimbursement rates under Rule 50 had two components—property rates and operating rates. The property component covered the cost of renting real estate and the use of depreciable equipment or facilities. The operating component covered the costs of the care provided to nursing home residents. Operating rates were divided into two components—"care-related" and "other operating" costs. These components of the operating rate were treated differently in two ways. First, the two components of the rate were subject to different cost limits. Second, the care-related component of a facility's rate varied depending on the level of care required by a given resident.

To hold down costs in the system, DHS set limits on how much it would reimburse a facility for its operating costs. DHS established separate limits for the care-related and other-operating components of a facility's rate. The formulas DHS used to calculate the limits changed several times over the years, but the basic structure was consistent. DHS divided facilities into three geographic groups, and set limits based on the distribution of costs for facilities in the same regions. DHS also set separate limits for different types of nursing facilities (e.g., hospital-attached or free-standing).

1999 to 2015: The Alternative Payment System (APS)

The legislature authorized a new payment system in 1995, which it called the Alternative Payment System (APS). The APS was also known as "the contract system." The goal of APS was to reduce nursing facility regulation, give facilities more fiscal flexibility, and promote consumer satisfaction and good health care outcomes. Participating facilities received an exemption from certain statutory requirements of the cost-based system.

In effect, APS decoupled payment rates from a facility's annual cost reports. Under the APS, DHS agreed to reimburse a nursing facility at a payment rate set in a contract with the facility. In a facility's first year in the program, this rate was equal to the rate the facility received under the

[5] Not including any rate components from equitable cost-sharing for publicly owned nursing facility program participation, critical access nursing facility program participation, or performance-based incentive payment program participation.

cost-based system just prior to entering into a contract with DHS. In subsequent years, DHS would increase the payment rates to account for inflation.

Under APS, facilities gave up the assurance that their reimbursement rates would keep up with their reported costs. In exchange, they were no longer required to file annual cost reports with DHS. This provided facilities more flexibility in how they spent and allocated their resources. Facilities who participated also received a partial exemption from Minnesota's moratorium on the licensure and certification of new nursing facility beds.

The legislature initially made participation in APS voluntary, but later required all nursing facilities to participate. At the start of the program, nursing facilities could apply to join APS or continue to be reimbursed under the cost-based system. In 2005, the legislature required all nursing facilities participating in MA to be reimbursed under the APS beginning October 1, 2006.[6]

When APS was first enacted, the legislature required DHS to annually adjust payment rates for inflation.[7] Ultimately, the legislature chose to prevent most of the inflationary increases from taking effect. From July 1, 1999, through September 30, 2011, the legislature only permitted inflationary increases in the property component of reimbursement rates. The legislature suspended all inflationary rate increases from October 1, 2011, to January 1, 2017.

Although the legislature suspended annual inflationary increases under APS, it did periodically raise reimbursement rates. For example, in 2011, the legislature enacted a rate increase for certain "low-rate" facilities,[8] and in 2013, it raised rates for all facilities by a statewide average of 5 percent.[9]

2007 to 2015: "Rebasing"

Rate increases under the APS did not keep pace with growth in the cost of providing care to nursing facility residents. As a result, the 2007 Legislature required DHS to "rebase" nursing facility rates, meaning that DHS would reestablish the connection between a facility's rates and its costs. In practice, DHS would calculate operating payment rates for nursing facilities using the cost report filed by each facility for the prior rate year. These reimbursement rates would vary with resident case-mix and incorporate reimbursement for care-related, other operating, external fixed, and property costs.

Rebasing for operating cost payment rates was originally designed to be phased in over eight years, but was suspended before it was fully implemented. During the phase-in period, nursing facilities were to receive a blended rate—based partially on the APS reimbursement system and partially on the rebased system. Also during the phase-in period, facilities were to be held

[6] Laws 2005, 1st spec. sess., ch. 4, art. 7, § 42.

[7] Laws 1995, ch. 207, art. 7, § 32, subd. 4, para. (c).

[8] Laws 2011, 1st spec. sess., ch. 9, art. 7, § 36.

[9] Laws 2013, ch. 108, art. 7, § 25.

harmless—a facility could not receive an operating payment rate that was less than what the facility would have received without rebasing.

Under the original law, rebasing was supposed to begin on October 1, 2008, and be fully implemented by October 1, 2015. However, the 2009 Legislature suspended implementation from October 1, 2009, through September 30, 2013. At that time, rebasing was supposed to resume October 1, 2013, with 65 percent of the payment rate reflecting rebased costs. The 2011 Legislature prohibited all further steps phasing in rebased operating payment rates.

The 2015 payment reform transitioned the state to a new, 100 percent cost-based system.

Historical Nursing Facility Rates Based on Geographic Location

Under the old cost-based system, there were reimbursement limits based on three geographic, county-based groups—metro, rural, and deep rural. These limits affected 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 partially rebased system, facilities were 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 were similar to, but not identical to, the old geographic groups.

Historical Quality "Add-ons" to Facility Rates

Under the previous reimbursement system, the legislature offered quality "add-ons" to facilities with higher quality scores to reward quality.

The rebased nursing facility reimbursement system that was enacted in 2005 included a quality add-on that allowed 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 was 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 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 received depended on how well the facility performed 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 was 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%

Onetime Quality "Add-Ons" to Rate Increases

Under the previous nursing facility reimbursement system, most increases in nursing facility rates were directly approved by the legislature.[10] Starting in 2005, a number of legislatively approved rate increases included add-ons for nursing facility quality. These add-ons provided facilities that had high quality scores with larger rate increases, and facilities with lower quality scores with smaller increases.

Recent Legislative Changes

The 2009 Legislature created nursing facility level of care criteria that made it more difficult for people to be assessed as needing nursing facility or alternative care once the new criteria were 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;

[10] For more information, see the section on historical reimbursement systems on page 12. There is a specific section on historical quality add-ons on page 14.

- 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.

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 assessments;
- modifying nursing facility bed layaway timelines; and
- creating a health facility construction plan review fee.

The 2014 Legislature created annual operating payment rate adjustments to address changes in compensation costs for nursing facility employees paid less than $14 per hour, expanded the critical access nursing facility program, and provided moratorium-exception project funding.

The 2015 Legislature made several changes to nursing facility policy and rates, including:

- creating a new cost-based reimbursement system—referred to as value-based reimbursement, effective January 1, 2016;
- expanding the nursing facility employee scholarship program;
- modifying the nursing facility moratorium exception for replacement beds for a facility located in Polk County;
- providing a construction project rate adjustment for certain nursing facilities;
- directing DHS to study property rate setting and report to the legislature by March 1, 2016;

- directing DHS to evaluate and report to the legislature on specified aspects of the new value-based reimbursement system by January 1, 2017;
- directing the Revisor of Statutes, in consultation with others, to prepare legislation for the 2016 legislative session to recodify laws governing nursing facility payments and rates; and
- repealing a nursing facility operating payment rate increase scheduled to become effective October 1, 2015.

The 2016 Legislature recodified nursing facility payment rate language, provided funding for moratorium exception projects, modified the nursing facility moratorium exception for replacement beds for a facility in Goodhue County, and modified the nursing assistants reimbursable expenses program.

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