MN HOUSE RESEARCH

Nursing Facility Reimbursement and Regulation

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Executive Summary

Medical Assistance (MA), the state's Medicaid program, provides payment for nursing facility services for low-income elderly and disabled persons who meet income and asset limits and other eligibility requirements. MA enrollees represent a large share of nursing facility residents.

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 51.49 percent. Minnesota pays the remaining 48.51 percent for most services (some services have a county share).[1]

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. Over the last 30 years, the state has used a number of different systems to reimburse nursing facilities for covering MA patients. These reimbursements can make up a significant portion of nursing facility revenue. In the 2022 rate year, just under 56 percent of all nursing facility days were paid for by MA. Reimbursement rates also affect residents who are not on MA, because Minnesota has a rate equalization law that prohibits nursing facilities from charging private pay residents more than residents whose care is paid for by MA.

As of July 25, 2023, there were 338 MA-certified and state-licensed nursing facilities in Minnesota with a total of 23,926 active beds. The average statewide occupancy rate for nursing facilities was 75.9 percent in the 2022 rate year. The monthly average number of MA recipients served in nursing facilities during fiscal year 2023 was 11,335. In that year, the state share of MA spending on nursing facilities was $437.9 million.

[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.

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This publication 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, nursing facility moratorium and rebalancing, payments for nursing facility quality, and recent legislative changes.

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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 14 nursing homes in Minnesota that are licensed by MDH, but not certified to serve MA residents—five are Minnesota veterans homes, one is the state-operated psychiatric nursing facility, and the remainder are privately owned.

The Value-based Reimbursement System

he 2015 Legislature authorized a new system for nursing facility reimbursement rates, which DHS calls the value-based reimbursement system.[2] 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 this 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 2023 Rate Year

Date	Step in the Process
October 1, 2020 - September 30, 2021	Facility cares for residents and accrues costs by employing nurses, paying rent, purchasing food, etc.
February 1, 2022	Facility files a cost report with DHS detailing its costs during the 2020-2021 reporting period.
November 15, 2022	DHS sends facility "notice of rates" for the 2023 rate year. Facilities' rates are calculated using the cost report filed on February 1, 2022, which reflect the costs accrued during the 2020-2021 reporting period.
January 1, 2023	The 2023 rate year begins, and new rate takes effect. When a facility cares for MA residents during the 2023 rate year, it is reimbursed for these services at the new rate.

[2] The previous reimbursement rate system was a contract-based system referred to as the alternative payment system.

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

Certain nursing facilities are required 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, certified nursing assistants, 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.

Rate Component	Description
External Fixed Costs	The external fixed costs rate component is actually a group of miscellaneous smaller rate components. Despite the name, some components of external fixed costs do change from year to year. The external fixed costs 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 ▪ Consolidation rate adjustments ▪ Reimbursement for property taxes ▪ Reimbursement for employer health insurance costs ▪ Quality improvement incentive payment rate adjustments ▪ Performance-based incentive payments ▪ Special dietary needs ▪ Reimbursement for contributions to PERA ▪ Border city facility rate adjustments ▪ Critical access nursing facility rate adjustments
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	$$\textit{Direct Care Rate} = \frac{\textit{Facility's Direct Care Costs}}{\textit{Facility's Standardized Days}}$$ 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.

Rate Component	How Rate Is Calculated
Other Care-Related	$$\textit{Other Care Rate} = \frac{\textit{Facility's Other Care-Related Costs}}{\textit{Facility's Resident Days}}$$ A facility's other care-related rate is equal to its total other care-related costs in the most recently submitted cost report, divided by the total number of resident days in that period. A facility's other care-related costs are not expected to vary significantly from resident to resident. As a result, a facility's other care-related costs are divided by resident days, which are not weighted.
Other Operating	*Other Operating Rate* = *105%* x *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 per resident day for facilities located in the seven-county metro area.
External Fixed Costs	*External Fixed Costs Rate* = *Sum of External Fixed Costs Rate Components* (See preceding table for a list of external fixed costs.)
Property	A nursing facility's property rate is set according to the previous "contract-based" or "alternative payment system." Under that system, a facility agrees to be reimbursed at a rate established in a contract between the facility and DHS. However, a nursing facility that completes a moratorium exception project that is authorized after March 1, 2020, receives a property rate using the fair rental value property rate methodology. As of October 1, 2023, 28 nursing facilities have had moratorium exception projects approved under the fair rental value property rate methodology.[3]

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 payment rate limit** for a facility's rate. A facility's "total care-related" payment rate is the sum of its direct care and other care-related payment rates. If a facility's total care-related rate exceeds the facility's limit, the sum of its direct care and other care-related payment rates are reduced to the level of the limit, with proportional reductions in each rate component.

[3] The fair rental value property rate does not become effective until a facility's moratorium exception project is completed and certified for occupancy by MDH and the new property rate is calculated by DHS. As of January 1, 2024, five facilities will be reimbursed under the fair rental value property rate.

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 cost 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 cost rate. Likewise, facilities with relatively low other operating costs per day may receive an "other operating" cost 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.[4] The quality scores are measured on a scale from zero 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 payment rate limit is calculated using the following formula:

$$\left(\frac{89.375 + [.5625 \times \textit{Facility's Quality Score}]}{100} \right) \times \textit{7-county Metro Area Median Total Care-Related Cost Per Day}$$

The limit for all facilities in the state is pegged to the median total care-related payment 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 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 that is lower than its rate on December 31, 2015—the day before the current reimbursement 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 payment rate for facilities in the seven-county metro area.

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

Residents Are Assigned Weights Based on How Much Care They Require

Different nursing facility residents require different levels of care, and certain residents cost more to take care of.[5] 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.

Payment Rates Are Adjusted to Account for Resource-intensive Residents

Total Payment Rate = *Direct Care Rate* + *Other Care-Related Rate* + *Other Operating Cost Rate* + *External Fixed Costs Rate* + *Property Rate*

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 because, in practice, facilities are reimbursed at the case-mix adjusted total payment rate.

Case-Mix Adjusted Total Payment Rate = [*Direct Care Rate x RUG Weight of Resident*] + *Other Care-Related Rate* + *Other Operating Cost Rate* + *External Fixed Costs Rate* + *Property Rate*

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. The removal of

[5] For more information on the case mix system, see the section of this publication titled "Case-Mix Classifications and Nursing Costs" on page 8.

geographic location as a factor in the reimbursement rate system was included in the move to the value-based reimbursement system.

Rate Equalization Law

Nursing facilities in Minnesota must charge the same rate to residents with MA and those who pay for their stays privately.[6] 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. 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. However, the RUG case mix system will no longer be supported by the federal Centers for Medicare and Medicaid Services as of October 1, 2023. Beginning on that date, nursing facilities in Minnesota must fill out the Optional State Assessment each time a nursing facility assessment is completed until the state transitions to the new Patient-Driven Payment Model reimbursement methodology on October 1, 2025.

[6] 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. See Minn. Stat. § 256R.06, subd. 2.

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 case mix classifications within a facility's rate set.

Nursing Facility Moratorium and Rebalancing

Minnesota began a policy of rightsizing the nursing home industry 40 years ago when the nursing home moratorium was first enacted. At that time, Minnesota had the fifth highest number of beds per capita for elderly people in the United States, and nursing facility reimbursement and ancillary services accounted for over half of MA costs.[7] In addition to the nursing facility moratorium, other measures that have been taken to rightsize the industry include the single-bed room incentive, planned closure rate adjustments, and the bed layaway program.

Currently, there is a moratorium on the licensure and MA certification of new nursing home beds and construction projects that exceed $2.36 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 2024, 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 $4.985 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.[8]

[7] See Laws 1983, ch. 199, § 1.

[8] See Minn. Stat. § 256R.41.

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.

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.[9] 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 that results 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. If a 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, 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 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 that 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 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 6).

[9] See Minn. Stat. § 256B.431, subd. 30.

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.

PIPP allows 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.[10] 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.

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.[11] 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 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.[12]

Recent Legislative Changes

The 2023 Legislature made changes to nursing facility rates and provided onetime funding for nursing homes, including:

- modifying critical access nursing facility rate adjustments for facilities designated as critical access nursing facilities by the commissioner and including this rate adjustment in the external fixed costs payment rate;
- modifying the operating payment rate for a specific nursing facility located in Red Wing;

[10] See Minn. Stat. § 256R.38.

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

[12] 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.

- establishing the Nursing Home Workforce Standards Board;[13]
- establishing the financially distressed nursing facility loan program to provide operating loans to eligible nursing facilities;[14]
- requiring the commissioner to conduct a nursing facility rates study and provide recommendations to adjust the MA nursing facility payment rate methodology to the legislature by January 1, 2025;[15]
- establishing the nursing facility workforce incentive grant program and appropriating $74,500,000 in onetime funding for the grant program;[16]
- providing a onetime payment of $173,137,000 to nursing facilities to be used for specified purposes including covering operating- or property-related long-term debt payments, closing lines of credit, debt restructuring, and physical plant improvements and maintenance not claimed for a rate increase;[17] and
- providing a temporary rate add-on for nursing facilities in an amount equal to $12.35 per resident day.[18] The temporary rate add-on expires December 31, 2024.

[13] See Laws 2023, ch. 53, art. 3

[14] See Laws 2023, ch. 61, art. 2, § 12.

[15] See Laws 2023, ch. 61, art. 2, § 41.

[16] See Laws 2023, ch. 74, § 1.

[17] See Laws 2023, ch. 74, § 2.

[18] See Laws 2023, ch. 74, § 3.