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ARTICLE 5
NURSING FACILITY PAYMENT REFORM AND WORKFORCE DEVELOPMENT

Section 1. **[144.1503] HOME AND COMMUNITY-BASED SERVICES EMPLOYEE SCHOLARSHIP PROGRAM.**

Subdivision 1. **Creation.** The home and community-based services employee scholarship grant program is established for the purpose of assisting qualified provider applicants to fund employee scholarships for education in nursing and other health care fields.

Subd. 2. **Provision of grants.** The commissioner shall make grants available to qualified providers of older adult services. Grants must be used by home and community-based service providers to recruit and train staff through the establishment of an employee scholarship fund.

Subd. 3. **Eligibility.** (a) Eligible providers must primarily provide services to individuals who are 65 years of age and older in home and community-based settings, including housing with services establishments as defined in section 144D.01, subdivision 4; adult day care as defined in section 245A.02, subdivision 2a; and home care services as defined in section 144A.43, subdivision 3.

(b) Qualifying providers must establish a home and community-based services employee scholarship program, as specified in subdivision 4. Providers that receive funding under this section must use the funds to award scholarships to employees who work an average of at least 16 hours per week for the provider.

Subd. 4. **Home and community-based services employee scholarship program.** Each qualifying provider under this section must propose a home and community-based services employee scholarship program. Providers must establish criteria by which funds are to be distributed among employees. At a minimum, the scholarship program must cover employee costs related to a course of study that is expected to lead to career advancement with the provider or in the field of long-term care, including home care, care of persons with disabilities, or nursing.

Subd. 5. **Participating providers.** The commissioner shall publish a request for proposals in the State Register, specifying provider eligibility requirements, criteria for a qualifying employee scholarship program, provider selection criteria, documentation required for program participation, maximum award amount, and methods of evaluation. The commissioner must publish additional requests for proposals each year in which funding is available for this purpose.

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Subd. 6. **Application requirements.** Eligible providers seeking a grant shall submit an application to the commissioner. Applications must contain a complete description of the employee scholarship program being proposed by the applicant, including the need for the organization to enhance the education of its workforce, the process for determining which employees will be eligible for scholarships, any other sources of funding for scholarships, the expected degrees or credentials eligible for scholarships, the amount of funding sought for the scholarship program, a proposed budget detailing how funds will be spent, and plans for retaining eligible employees after completion of their scholarship.

Subd. 7. **Selection process.** The commissioner shall determine a maximum award for grants and make grant selections based on the information provided in the grant application, including the demonstrated need for an applicant provider to enhance the education of its workforce, the proposed employee scholarship selection process, the applicant's proposed budget, and other criteria as determined by the commissioner. Notwithstanding any law or rule to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires.

Subd. 8. **Reporting requirements.** Participating providers shall submit an invoice for reimbursement and a report to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner. The report shall include the amount spent on scholarships; the number of employees who received scholarships; and, for each scholarship recipient, the name of the recipient, the current position of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, and the expected or actual program completion date. During the grant period, the commissioner may require and collect from grant recipients other information necessary to evaluate the program.

Sec. 2. Minnesota Statutes 2014, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

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(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(v) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed $1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;

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(g) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

(h) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis Community Development Agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed $1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

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(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass County and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;

(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.

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The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;

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(t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

(v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to a 160-bed facility in Crow Wing County, provided all the affected beds are under common ownership;

(w) to license and certify a total replacement project of up to 49 beds located in Norman County that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

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(x) to license and certify ~~a total~~ to the licensee of a nursing home in Polk County that was destroyed by flood in 1997 replacement ~~project~~ projects with a total of up to 129 beds, with at least 25 beds to be located in Polk County ~~that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes.~~ and up to 104 beds distributed among up to three other counties. These beds may only be distributed to counties with fewer than the median number of age intensity adjusted beds per thousand, as most recently published by the commissioner of human services. If the licensee chooses to distribute beds outside of Polk County under this paragraph, prior to distributing the beds, the commissioner of health must approve the location in which the licensee plans to distribute the beds. The commissioner of health shall consult with the commissioner of human services prior to approving the location of the proposed beds. The licensee may combine these beds with beds relocated from other nursing facilities as provided in section 144A.073, subdivision 3c. The operating ~~cost~~ payment rates for the new nursing ~~facility~~ facilities shall be determined based on the interim and settle-up payment provisions of section 256B.431, 256B.434, or 256B.441 or Minnesota Rules, ~~part~~ 9549.0057~~, and the reimbursement provisions of section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;~~ parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under section 256B.431, 256B.434, or 256B.441. If the replacement beds permitted under this paragraph are combined with beds from other nursing facilities, the rates shall be calculated as the weighted average of rates determined as provided in this paragraph and section 256B.441, subdivision 60;

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

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(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;

(bb) to license and certify a new facility in St. Louis County with 44 beds constructed to replace an existing facility in St. Louis County with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;

(cc) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary;

(dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;

(ee) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256B.437;

(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin County that are in need of relocation from a nursing home significantly damaged by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

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(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka County. Operating and property rates shall be determined and allowed under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, or section 256B.434 or 256B.441; or

(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. The receiving facility must receive statutory authorization before removing these beds from layaway status, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.

Sec. 3. Minnesota Statutes 2014, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision 4e, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding $500,000 as stated in section 256B.056;

(5) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

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(6) except for individuals described in clause (7), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(7) for individuals assigned a case mix classification A as described under section 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed $593 per month for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section 256B.0915, subdivision 3a, ~~paragraph~~ paragraphs (a) and (e). This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (6) for case mix classification A; and

(8) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the lead agency to ensure prompt fee payments.

The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

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(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 4. Minnesota Statutes 2014, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) ~~The monthly limit for the cost of waivered services to an individual elderly waiver client except for individuals described in paragraphs (b) and (d) shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented.~~ Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the ~~rate~~ monthly limit of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment.

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(b) The monthly limit for the cost of waivered services under paragraph (a) to an individual elderly waiver client assigned to a case mix classification A ~~under paragraph (a)~~ with:

(1) no dependencies in activities of daily living; or

(2) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911 shall be $1,750 per month effective on July 1, 2011, for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in ~~paragraph~~ paragraphs (a) and (e).

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (a) ~~or~~, (b), (d), or (e), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a) ~~or~~, (b), (d), or (e).

(d) Effective July 1, 2013, the monthly cost limit of waiver services, including any necessary home care services described in section 256B.0651, subdivision 2, for individuals who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1, paragraph (g), shall be the average of the monthly medical assistance amount established for home care services as described in section 256B.0652, subdivision 7, and the annual average contracted amount established by the commissioner for nursing facility services for ventilator-dependent individuals. This monthly limit shall be increased annually as described in ~~paragraph~~ paragraphs (a) and (e).

(e) Effective July 1, 2016, and each July 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous June 30 shall be adjusted by the greater of the difference between any legislatively adopted home and community-based provider rate increase effective on July 1 and the average statewide percentage increase in nursing facility operating payment rates under sections 256B.431, 256B.434, and 256B.441, effective the previous January 1.

EFFECTIVE DATE. This section is effective July 1, 2016.

Sec. 5. Minnesota Statutes 2014, section 256B.0915, subdivision 3e, is amended to read:

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Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a)~~, until the July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented~~. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented and July 1 of each subsequent state fiscal year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) Effective July 1, 2011, the individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

(f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

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(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (d), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(h) Effective July 1, 2016, and each July 1 thereafter, individualized service rate limits for customized living services under this subdivision shall be adjusted by the greater of the difference between any legislatively adopted home and community-based provider rate increase effective on July 1 and the average statewide percentage increase in nursing facility operating payment rates under sections 256B.431, 256B.434, and 256B.441, effective the previous January 1.

EFFECTIVE DATE. This section is effective July 1, 2016.

Sec. 6. Minnesota Statutes 2014, section 256B.0915, subdivision 3h, is amended to read:

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

(1) intermittent assistance with toileting, positioning, or transferring;

(2) cognitive or behavioral issues;

(3) a medical condition that requires clinical monitoring; or

(4) for all new participants enrolled in the program on or after July 1, 2011, and all other participants at their first reassessment after July 1, 2011, dependency in at least three of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

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House Language UES1458-1

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0050 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0050 to 9549.0059, to determine the applicable payment rate maximum. ~~Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.~~

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in housing with services establishments which are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

(1) licensed corporate adult foster homes; or

(2) specialized dementia care units which meet the requirements of section 144D.065 and in which:

(i) each resident is offered the option of having their own apartment; or

(ii) the units are licensed as board and lodge establishments with maximum capacity of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

(h) Twenty-four-hour customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

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(i) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(j) Effective July 1, 2016, and each July 1 thereafter, individualized service rate limits for 24-hour customized living services under this subdivision shall be adjusted by the greater of the difference between any legislatively adopted home and community-based provider rate increase effective on July 1 and the average statewide percentage increase in nursing facility operating payment rates under sections 256B.431, 256B.434, and 256B.441, effective the previous January 1.

EFFECTIVE DATE. This section is effective July 1, 2016.

Sec. 7. Minnesota Statutes 2014, section 256B.431, subdivision 2b, is amended to read:

Subd. 2b. **Operating costs after July 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner shall establish procedures for determining per diem reimbursement for operating costs.

(b) The commissioner shall contract with an econometric firm with recognized expertise in and access to national economic change indices that can be applied to the appropriate cost categories when determining the operating cost payment rate.

(c) The commissioner shall analyze and evaluate each nursing facility's cost report of allowable operating costs incurred by the nursing facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective.

(d) The commissioner shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs for the reporting year that begins October 1, 1983, taking into consideration relevant factors including resident needs, geographic location, and size of the nursing facility. In developing the geographic groups for purposes of reimbursement under this section, the commissioner shall ensure that nursing facilities in any county contiguous to the Minneapolis-St. Paul seven-county metropolitan area are included in the same geographic group. The limits established by the commissioner shall not be less, in the aggregate, than the 60th percentile of total actual allowable historical operating cost per diems for each group of nursing facilities established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year. For rate years beginning on or after July 1, 1989, facilities located in geographic group I as described in Minnesota Rules, part 9549.0052, on January 1, 1989, may choose to have the commissioner apply either the care related limits or the other operating cost limits calculated for facilities located in geographic group II, or both, if either of the limits calculated for the group II facilities is higher. The efficiency incentive for geographic group I nursing facilities must be calculated based on geographic

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group I limits. The phase-in must be established utilizing the chosen limits. For purposes of these exceptions to the geographic grouping requirements, the definitions in Minnesota Rules, parts 9549.0050 to 9549.0059 (Emergency), and 9549.0010 to 9549.0080, apply. The limits established under this paragraph remain in effect until the commissioner establishes a new base period. Until the new base period is established, the commissioner shall adjust the limits annually using the appropriate economic change indices established in paragraph (e). In determining allowable historical operating cost per diems for purposes of setting limits and nursing facility payment rates, the commissioner shall divide the allowable historical operating costs by the actual number of resident days, except that where a nursing facility is occupied at less than 90 percent of licensed capacity days, the commissioner may establish procedures to adjust the computation of the per diem to an imputed occupancy level at or below 90 percent. The commissioner shall establish efficiency incentives as appropriate. The commissioner may establish efficiency incentives for different operating cost categories. The commissioner shall consider establishing efficiency incentives in care related cost categories. The commissioner may combine one or more operating cost categories and may use different methods for calculating payment rates for each operating cost category or combination of operating cost categories. For the rate year beginning on July 1, 1985, the commissioner shall:

(1) allow nursing facilities that have an average length of stay of 180 days or less in their skilled nursing level of care, 125 percent of the care related limit and 105 percent of the other operating cost limit established by rule; and

(2) exempt nursing facilities licensed on July 1, 1983, by the commissioner to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3600, from the care related limits and allow 105 percent of the other operating cost limit established by rule.

For the purpose of calculating the other operating cost efficiency incentive for nursing facilities referred to in clause (1) or (2), the commissioner shall use the other operating cost limit established by rule before application of the 105 percent.

(e) The commissioner shall establish a composite index or indices by determining the appropriate economic change indicators to be applied to specific operating cost categories or combination of operating cost categories.

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(f) Each nursing facility shall receive an operating cost payment rate equal to the sum of the nursing facility's operating cost payment rates for each operating cost category. The operating cost payment rate for an operating cost category shall be the lesser of the nursing facility's historical operating cost in the category increased by the appropriate index established in paragraph (e) for the operating cost category plus an efficiency incentive established pursuant to paragraph (d) or the limit for the operating cost category increased by the same index. If a nursing facility's actual historic operating costs are greater than the prospective payment rate for that rate year, there shall be no retroactive cost settle up. In establishing payment rates for one or more operating cost categories, the commissioner may establish separate rates for different classes of residents based on their relative care needs.

(g) The commissioner shall include the reported actual real estate tax liability or payments in lieu of real estate tax of each nursing facility as an operating cost of that nursing facility. Allowable costs under this subdivision for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes. For rate years beginning on or after July 1, 1987, the reported actual real estate tax liability or payments in lieu of real estate tax of nursing facilities shall be adjusted to include an amount equal to one-half of the dollar change in real estate taxes from the prior year. The commissioner shall include a reported actual special assessment, and reported actual license fees required by the Minnesota Department of Health, for each nursing facility as an operating cost of that nursing facility. For rate years beginning on or after July 1, 1989, the commissioner shall include a nursing facility's reported Public Employee Retirement Act contribution for the reporting year as apportioned to the care-related operating cost categories and other operating cost categories multiplied by the appropriate composite index or indices established pursuant to paragraph (e) as costs under this paragraph. Total adjusted real estate tax liability, payments in lieu of real estate tax, actual special assessments paid, the indexed Public Employee Retirement Act contribution, and license fees paid as required by the Minnesota Department of Health, for each nursing facility (1) shall be divided by actual resident days in order to compute the operating cost payment rate for this operating cost category, (2) shall not be used to compute the care-related operating cost limits or other operating cost limits established by the commissioner, and (3) shall not be increased by the composite index or indices established pursuant to paragraph (e), unless otherwise indicated in this paragraph.

~~(h) For rate years beginning on or after July 1, 1987, the commissioner shall adjust the rates of a nursing facility that meets the criteria for the special dietary needs of its residents and the requirements in section 31.651. The adjustment for raw food cost shall be the difference between the nursing facility's allowable historical raw food cost per diem and 115 percent of the median historical allowable raw food cost per diem of the corresponding geographic group.~~

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~~The rate adjustment shall be reduced by the applicable phase-in percentage as provided under subdivision 2h.~~

Sec. 8. Minnesota Statutes 2014, section 256B.431, subdivision 36, is amended to read:

Subd. 36. **Employee scholarship costs and training in English as a second language.** (a) For the period between July 1, 2001, and June 30, 2003, the commissioner shall provide to each nursing facility reimbursed under this section, section 256B.434, or any other section, a scholarship per diem of 25 cents to the total operating payment rate. For the two rate years beginning on or after October 1, 2015, through September 30, 2017, the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing facility with no scholarship per diem that is requesting a scholarship per diem to be added to the external fixed payment rate to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least ~~20~~ ten hours per week at the facility except the administrator, ~~department supervisors, and registered nurses~~ and to reimburse student loan expenses for newly hired and recently graduated registered nurses and licensed practical nurses, and training expenses for nursing assistants as defined in section 144A.61, subdivision 2, who are newly hired and have graduated within the last 12 months; and

(ii) the course of study is expected to lead to career advancement with the facility or in long-term care, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) ~~A facility receiving~~ All facilities may annually request a rate adjustment under this subdivision ~~may submit~~ by submitting information to the commissioner on a schedule ~~determined by the commissioner~~ and ~~on~~ in a form supplied by the commissioner ~~a calculation of the scholarship per diem, including: the amount received from this rate adjustment; the amount used for training in English as a second language; the number of persons receiving the training; the name of the person or entity providing the training; and for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the program completion date, and a determination of the per diem amount of these costs based on actual resident days~~. The commissioner shall allow a scholarship payment rate equal to the reported and allowable costs divided by resident days.

(c) ~~On July 1, 2003, the commissioner shall remove the 25 cent scholarship per diem from the total operating payment rate of each facility.~~

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~~(d) For rate years beginning after June 30, 2003, the commissioner shall provide to each facility the scholarship per diem determined in paragraph (b).~~ In calculating the per diem under paragraph (b), the commissioner shall allow ~~only~~ costs related to tuition ~~and~~, direct educational expenses, and reasonable costs as defined by the commissioner for child care costs and transportation expenses related to direct educational expenses.

(d) The rate increase under this subdivision is an optional rate add-on that the facility must request from the commissioner in a manner prescribed by the commissioner. The rate increase must be used for scholarships as specified in this subdivision.

(e) Nursing facilities that close beds during a rate year may request to have their scholarship adjustment under paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect the reduction in resident days compared to the cost report year.

Sec. 9. Minnesota Statutes 2014, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** ~~(a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.~~

~~(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.~~

~~(c)~~ A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of management and budget's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the property-related payment rate. For the rate years beginning on October 1, 2011, October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, ~~and October~~ January 1, 2016, and January 1, 2017, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

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~~(d) The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time-limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:~~

~~(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;~~

~~(2) adoption of new technology to improve quality or efficiency;~~

~~(3) improved quality as measured in the Nursing Home Report Card;~~

~~(4) reduced acute care costs; and~~

~~(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.~~

~~(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or federal regulations governing sprinkler systems must receive reimbursement for the costs associated with compliance if all of the following conditions are met:~~

~~(1) the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;~~

~~(2) the costs were not otherwise reimbursed under subdivision 4f or section 144A.071 or 144A.073; and~~

~~(3) the total allowable costs reported under this paragraph are less than the minimum threshold established under section 256B.431, subdivision 15, paragraph (e), and subdivision 16.~~

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~~The commissioner shall use money appropriated for this purpose to provide to qualifying nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Nursing facilities that have spent money or anticipate the need to spend money to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of this money on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the money paid to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.~~

Sec. 10. Minnesota Statutes 2014, section 256B.434, is amended by adding a subdivision to read:

Subd. 4i. **Construction project rate adjustments for certain nursing facilities.** (a) This subdivision applies to nursing facilities with at least 120 active beds as of January 1, 2015, that have projects approved in 2015 under the nursing facility moratorium exception process in section 144A.073. When each facility's moratorium exception construction project is completed, the facility must receive the rate adjustment allowed under subdivision 4f. In addition to that rate adjustment, facilities with at least 120 active beds, but not more than 149 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional $4; and facilities with at least 150 active beds, but not more than 160 active beds, as of January 1, 2015, must have their construction project rate adjustment increased by an additional $12.50.

(b) Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2015 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increases allowed in this subdivision.

Sec. 11. Minnesota Statutes 2014, section 256B.441, subdivision 1, is amended to read:

Subdivision 1. **~~Rebasing~~ Calculation of nursing facility operating payment rates.** (a) The commissioner shall ~~rebase nursing facility operating payment rates to align payments to facilities with the cost of providing care. The rebased~~ calculate operating payment rates ~~shall 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.

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(b) The ~~new~~ operating payment rates based on this section shall take effect ~~beginning~~ with the rate year beginning ~~October 1, 2008, and shall be phased in over eight rate years through October 1, 2015. For each year of the phase-in, the operating payment rates shall 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~~ January 1, 2016.

~~(c) Operating payment rates shall be rebased on October 1, 2016, and every two years after that date.~~

~~(d)~~ (c) Each cost reporting year shall begin on October 1 and end on the following September 30. ~~Beginning in 2014,~~ A statistical and cost report shall be filed by each nursing facility by February 1 in a form and manner specified by the commissioner. Notice of rates shall be distributed by ~~August~~ November 15 and the rates shall go into effect on ~~October~~ January 1 for one year.

~~(e) Effective October 1, 2014, property rates shall be rebased in accordance with section 256B.431 and Minnesota Rules, chapter 9549. The commissioner shall determine what the property payment rate for a nursing facility would be had the facility not had its property rate determined under section 256B.434. The commissioner shall allow nursing facilities to provide information affecting this rate determination that would have been filed annually under Minnesota Rules, chapter 9549, and nursing facilities shall report information necessary to determine allowable debt. The commissioner shall use this information to determine the property payment rate.~~

Sec. 12. Minnesota Statutes 2014, section 256B.441, subdivision 5, is amended to read:

Subd. 5. **Administrative costs.** "Administrative costs" means the direct costs for administering the overall activities of the nursing home. These costs include salaries and wages of the administrator, assistant administrator, business office employees, security guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related to business office functions, licenses, and permits except as provided in the external fixed costs category, employee recognition, travel including meals and lodging, all training except as specified in subdivision 11, voice and data communication or transmission, office supplies, property and liability insurance and other forms of insurance not designated to other areas, personnel recruitment, legal services, accounting services, management or business consultants, data processing, information technology, Web site, central or home office costs, business meetings and seminars, postage, fees for professional organizations, subscriptions, security services, advertising, board of director's fees, working capital interest expense, and bad debts and bad debt collection fees.

Sec. 13. Minnesota Statutes 2014, section 256B.441, subdivision 6, is amended to read:

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Subd. 6. **Allowed costs.** (a) "Allowed costs" means the amounts reported by the facility which are necessary for the operation of the facility and the care of residents and which are reviewed by the department for accuracy; reasonableness, in accordance with the requirements set forth in title XVIII of the federal Social Security Act and the interpretations in the provider reimbursement manual; and compliance with this section and generally accepted accounting principles. All references to costs in this section shall be assumed to refer to allowed costs.

(b) For facilities where employees are represented by collective bargaining agents, costs related to the salaries and wages, payroll taxes, and employer's share of fringe benefit costs, except employer health insurance costs, for facility employees who are members of the bargaining unit are allowed costs only if:

(1) these costs are incurred pursuant to a collective bargaining agreement. The commissioner shall allow until March 1 following the date on which the cost report was required to be submitted for a collective bargaining agent to notify the commissioner if a collective bargaining agreement, effective on the last day of the cost reporting year, was in effect; or

(2) the collective bargaining agent notifies the commissioner by October 1 following the date on which the cost report was required to be submitted that these costs are incurred pursuant to an agreement or understanding between the facility and the collective bargaining agent.

(c) In any year when a portion of a facility's reported costs are not allowed costs under paragraph (b), when calculating the operating payment rate for the facility, the commissioner shall use the facility's allowed costs from the facility's second most recent cost report in place of the nonallowed costs. For the purpose of setting the price for other operating costs under subdivision 51, the price shall be reduced by the difference between the nonallowed costs and the allowed costs from the facility's second most recent cost report.

Sec. 14. Minnesota Statutes 2014, section 256B.441, is amended by adding a subdivision to read:

Subd. 11a. **Employer health insurance costs.** "Employer health insurance costs" means premium expenses for group coverage and reinsurance, actual expenses incurred for self-insured plans, and employer contributions to employee health reimbursement and health savings accounts. Premium and expense costs and contributions are allowable for employees who meet the definition of full-time employees and their families under the federal Affordable Care Act, Public Law 111-148, and part-time employees.

Sec. 15. Minnesota Statutes 2014, section 256B.441, subdivision 13, is amended to read:

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Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; ~~until September 30, 2013, long-term care consultation fees under section 256B.0911, subdivision 6;~~ family advisory council fee under section 144A.33; scholarships under section 256B.431, subdivision 36; planned closure rate adjustments under section 256B.437; ~~or~~ single bed room incentives under section 256B.431, subdivision 42; property taxes ~~and property insurance~~, assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under subdivision 46c; performance-based incentive payments under subdivision 46d; special dietary needs under subdivision 51b; and PERA.

Sec. 16. Minnesota Statutes 2014, section 256B.441, subdivision 14, is amended to read:

Subd. 14. **Facility average case mix index.** "Facility average case mix index" or "CMI" means a numerical ~~value~~ score that describes the relative resource use for all residents within the groups under the resource utilization group ~~(RUG-III)~~ (RUG) classification system prescribed by the commissioner based on an assessment of each resident. The facility average CMI shall be computed as the standardized days divided by total days for all residents in the facility. The RUG's weights used ~~in this section shall be as follows for each RUG's class: SE3 1.605; SE2 1.247; SE1 1.081; RAD 1.509; RAC 1.259; RAB 1.109; RAA 0.957; SSC 1.453; SSB 1.224; SSA 1.047; CC2 1.292; CC1 1.200; CB2 1.086; CB1 1.017; CA2 0.908; CA1 0.834; IB2 0.877; IB1 0.817; IA2 0.720; IA1 0.676; BB2 0.956; BB1 0.885; BA2 0.716; BA1 0.673; PE2 1.199; PE1 1.104; PD2 1.023; PD1 0.948; PC2 0.926; PC1 0.860; PB2 0.786; PB1 0.734; PA2 0.691; PA1 0.651; BC1 0.651; and DDF 1.000~~ shall be based on the system prescribed in section 256B.438.

Sec. 17. Minnesota Statutes 2014, section 256B.441, subdivision 17, is amended to read:

Subd. 17. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life, ~~health,~~ dental, workers' compensation, and other employee insurances and pension, except for the Public Employees Retirement Association and employer health insurance costs; profit sharing~~,~~; and retirement plans for which the employer pays all or a portion of the costs.

Sec. 18. Minnesota Statutes 2014, section 256B.441, subdivision 30, is amended to read:

Subd. 30. ~~**Peer groups**~~ **Median total care-related cost per diem and other operating per diem determined.** ~~Facilities shall be classified into three groups by county. The groups shall consist of:~~

~~(1) group one: facilities in Anoka, Benton, Carlton, Carver, Chisago, Dakota, Dodge, Goodhue, Hennepin, Isanti, Mille Lacs, Morrison, Olmsted, Ramsey, Rice, Scott, Sherburne, St. Louis, Stearns, Steele, Wabasha, Washington, Winona, or Wright County;~~

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~~(2) group two: facilities in Aitkin, Beltrami, Blue Earth, Brown, Cass, Clay, Cook, Crow Wing, Faribault, Fillmore, Freeborn, Houston, Hubbard, Itasca, Kanabec, Koochiching, Lake, Lake of the Woods, Le Sueur, Martin, McLeod, Meeker, Mower, Nicollet, Norman, Pine, Roseau, Sibley, Todd, Wadena, Waseca, Watonwan, or Wilkin County; and~~

~~(3) group three: facilities in all other counties~~ (a) The commissioner shall determine the median total care-related per diem to be used in subdivision 50 and the median other operating per diem to be used in subdivision 51 using the cost reports from nursing facilities in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

(b) The median total care-related per diem shall be equal to the median direct care cost for a RUG's weight of 1.00 for facilities located in the counties listed in paragraph (a).

(c) The median other operating per diem shall be equal to the median other operating per diem for facilities located in the counties listed in paragraph (a). The other operating per diem shall be the sum of each facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by each facility's resident days.

Sec. 19. Minnesota Statutes 2014, section 256B.441, subdivision 31, is amended to read:

Subd. 31. **Prior system operating cost payment rate.** "Prior system operating cost payment rate" means the operating cost payment rate in effect on ~~September 30, 2008~~ December 31, 2015, under Minnesota Rules and Minnesota Statutes~~, not including planned closure rate adjustments under section 256B.437 or single bed room incentives under section 256B.431, subdivision 42~~.

Sec. 20. Minnesota Statutes 2014, section 256B.441, subdivision 33, is amended to read:

Subd. 33. **Rate year.** "Rate year" means the 12-month period beginning on ~~October~~ January 1 following the second most recent reporting year.

Sec. 21. Minnesota Statutes 2014, section 256B.441, subdivision 35, is amended to read:

Subd. 35. **Reporting period.** "Reporting period" means the one-year period beginning on October 1 and ending on the following September 30 during which incurred costs are accumulated and then reported on the statistical and cost report. If a facility is reporting for an interim or settle-up period, the reporting period beginning date may be a date other than October 1. An interim or settle-up report must cover at least five months, but no more than 17 months, and must always end on September 30.

Sec. 22. Minnesota Statutes 2014, section 256B.441, subdivision 40, is amended to read:

Senate Language s1458-2

House Language UES1458-1

Subd. 40. **Standardized days.** "Standardized days" means the sum of resident days by case mix category multiplied by the RUG index for each category. When a facility has resident days at a penalty classification, these days shall be reported as resident days at the RUG class established immediately after the penalty period, if available, and otherwise, at the RUG class in effect before the penalty began.

Sec. 23. Minnesota Statutes 2014, section 256B.441, subdivision 44, is amended to read:

Subd. 44. **Calculation of a quality score.** (a) The commissioner shall determine a quality score for each nursing facility using quality measures established in section 256B.439, according to methods determined by the commissioner in consultation with stakeholders and experts, and using data as provided in the Minnesota Nursing Home Report Card. These methods shall be exempt from the rulemaking requirements under chapter 14.

(b) For each quality measure, a score shall be determined with ~~a maximum~~ the number of points ~~available and number of points~~ assigned as determined by the commissioner using the methodology established according to this subdivision. ~~The scores determined for all quality measures shall be totaled.~~ The determination of the quality measures to be used and the methods of calculating scores may be revised annually by the commissioner.

(c) ~~For the initial rate year under the new payment system, the quality measures shall include:~~

~~(1) staff turnover;~~

~~(2) staff retention;~~

~~(3) use of pool staff;~~

~~(4) quality indicators from the minimum data set; and~~

~~(5) survey deficiencies.~~

~~(d)~~ Beginning ~~July 1, 2013~~ January 1, 2016, the quality score shall ~~be a value between zero and 100, using data as provided in the Minnesota nursing home report card, with~~ include up to 50 ~~percent derived from~~ points related to the Minnesota quality indicators score, up to 40 ~~percent derived from~~ points related to the resident quality of life score, and up to ten ~~percent derived from~~ points related to the state inspection results score.

~~(e)~~ (d) The commissioner, in cooperation with the commissioner of health, may adjust the formula in paragraph ~~(d)~~ (c), or the methodology for computing the total quality score, effective July 1 of any year beginning in ~~2014~~ 2017, with five months advance public notice. In changing the formula, the commissioner shall consider quality measure priorities registered by report card users, advice of stakeholders, and available research.

Sec. 24. Minnesota Statutes 2014, section 256B.441, subdivision 46c, is amended to read:

Senate Language s1458-2

House Language UES1458-1

Subd. 46c. **Quality improvement incentive system beginning October 1, 2015.** The commissioner shall develop a quality improvement incentive program in consultation with stakeholders. The annual funding pool available for quality improvement incentive payments shall be equal to 0.8 percent of all operating payments, not including any rate components resulting from equitable cost-sharing for publicly owned nursing facility program participation under subdivision 55a, critical access nursing facility program participation under subdivision 63, or performance-based incentive payment program participation under section 256B.434, subdivision 4, paragraph (d). For the period from October 1, 2015, to December 31, 2016, rate adjustments provided under this subdivision shall be effective for 15 months. Beginning ~~October 1, 2015~~ January 1, 2017, annual rate adjustments provided under this subdivision shall be effective for one year, starting ~~October~~ January 1 and ending the following ~~September 30~~ December 31. The increase in this subdivision shall be included in the external fixed payment rate under subdivisions 13 and 53.

Sec. 25. Minnesota Statutes 2014, section 256B.441, is amended by adding a subdivision to read:

Subd. 46d. **Performance-based incentive payments.** The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit proposals and select those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this subdivision to operate the incentive payments within funds appropriated for this purpose. The commissioner shall approve proposals through a memorandum of understanding which shall specify various levels of payment for various levels of performance. Incentive payments to facilities under this subdivision shall be in the form of time-limited rate adjustments which shall be included in the external fixed payment rate under subdivisions 13 and 53. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Minnesota Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Sec. 26. Minnesota Statutes 2014, section 256B.441, subdivision 48, is amended to read:

Senate Language s1458-2

House Language UES1458-1

Subd. 48. **Calculation of ~~operating~~ care-related per diems.** The direct care per diem for each facility shall be the facility's direct care costs divided by its standardized days. The other care-related per diem shall be the sum of the facility's activities costs, other direct care costs, raw food costs, therapy costs, and social services costs, divided by the facility's resident days. ~~The other operating per diem shall be the sum of the facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by the facility's resident days.~~

Sec. 27. Minnesota Statutes 2014, section 256B.441, subdivision 50, is amended to read:

Subd. 50. **Determination of total care-related limit.** (a) The ~~limit on the~~ median total care-related per diem shall be determined ~~for each peer group and facility type group combination. A facility's total care-related per diems shall be limited to 120 percent of the median for the facility's peer and facility type group. The facility-specific direct care costs used in making this comparison and in the calculation of the median shall be based on a RUG's weight of 1.00. A facility that is above that limit shall have its total care-related per diem reduced to the limit. If a reduction of the total care-related per diem is necessary because of this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem~~ according to subdivision 30.

(b) ~~Beginning with rates determined for October 1, 2016, the~~ A facility's total care-related limit shall be a variable amount based on each facility's quality score, as determined under subdivision 44, in accordance with clauses (1) to ~~(4)~~ (3):

(1) ~~for each facility, the commissioner shall determine the quality score, subtract 40, divide by 40, and convert to a percentage~~ the quality score shall be multiplied by 0.5625;

(2) ~~if the value determined in clause (1) is less than zero, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group~~ add 89.375 to the amount determined in clause (1), and divide the total by 100; and

(3) ~~if the value determined in clause (1) is greater than 100 percent, the total care-related limit shall be 125 percent of the median for the facility's peer and facility type group; and~~ multiply the amount determined in clause (2) by the median total care-related per diem determined in subdivision 30, paragraph (b).

~~(4) if the value determined in clause (1) is greater than zero and less than 100 percent, the total care-related limit shall be 105 percent of the median for the facility's peer and facility type group plus one-fifth of the percentage determined in clause (1).~~

(c) A RUG's weight of 1.00 shall be used in the calculation of the median total care-related per diem, and in comparisons of facility-specific direct care costs to the median.

(d) A facility that is above its total care-related limit as determined according to paragraph (b) shall have its total care-related per diem reduced to its limit. If a reduction of the total care-related per diem is necessary due to this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem.

Senate Language s1458-2

House Language UES1458-1

Sec. 28. Minnesota Statutes 2014, section 256B.441, subdivision 51, is amended to read:

Subd. 51. **Determination of other operating ~~limit~~ price.** ~~The limit on the~~ A price for other operating ~~per diem~~ costs shall be determined ~~for each peer group~~. ~~A facility's other operating per diem shall be limited to~~ The price shall be calculated as 105 percent of the median ~~for its peer group~~ other operating per diem described in subdivision 30, paragraph (c). ~~A facility that is above that limit shall have its other operating per diem reduced to the limit.~~

Sec. 29. Minnesota Statutes 2014, section 256B.441, subdivision 51a, is amended to read:

Subd. 51a. **Exception ~~allowing contracting~~ for specialized care facilities.** (a) For rate years beginning on or after ~~October~~ January 1, 2016, ~~the commissioner may negotiate increases to the care-related limit for nursing facilities that provide specialized care, at a cost to the general fund not to exceed $600,000 per year. The commissioner shall publish a request for proposals annually, and may negotiate increases to the limits that shall apply for either one or two years before the increase shall be subject to a new proposal and negotiation.~~ the care-related limit ~~may~~ for specialized care facilities shall be increased by ~~up to~~ 50 percent.

(b) ~~In selecting facilities with which to negotiate, the commissioner shall consider:~~ "Specialized care facilities" are defined as a facility having a program licensed under chapter 245A and Minnesota Rules, chapter 9570, or a facility with 96 beds on January 1, 2015, located in Robbinsdale that specializes in the treatment of Huntington's Disease.

~~(1) the diagnoses or other circumstances of residents in the specialized program that require care that costs substantially more than the RUG's rates associated with those residents;~~

~~(2) the nature of the specialized program or programs offered to meet the needs of these individuals; and~~

~~(3) outcomes achieved by the specialized program.~~

Sec. 30. Minnesota Statutes 2014, section 256B.441, is amended by adding a subdivision to read:

Subd. 51b. **Special dietary needs.** The commissioner shall adjust the rates of a nursing facility that meets the criteria for the special dietary needs of its residents and the requirements in section 31.651. The adjustment for raw food cost shall be the difference between the nursing facility's most recently reported allowable raw food cost per diem and 115 percent of the median allowable raw food cost per diem. For rate years beginning on or after January 1, 2016, this amount shall be removed from allowable raw food per diem costs under operating costs and included in the external fixed per diem rate under subdivisions 13 and 53.

Senate Language s1458-2

House Language UES1458-1

Sec. 31. Minnesota Statutes 2014, section 256B.441, subdivision 53, is amended to read:

Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

(a) For a facility licensed as a nursing home, the portion related to section 256.9657 shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to $8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

(c) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.

(d) The portion related to scholarships shall be determined under section 256B.431, subdivision 36.

~~(d) Until September 30, 2013, the portion related to long-term care consultation shall be determined according to section 256B.0911, subdivision 6.~~

~~(e) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.~~

~~(f)~~ (e) The portion related to planned closure rate adjustments shall be as determined under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436. ~~Planned closure rate adjustments that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Planned closure rate adjustments that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.~~

(f) The single bed room incentives shall be as determined under section 256B.431, subdivision 42.

(g) The portions related to ~~property insurance,~~ real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

(h) The portion related to employer health insurance costs shall be the allowable costs divided by resident days.

(i) The portion related to the Public Employees Retirement Association shall be actual costs divided by resident days.

Senate Language s1458-2

House Language UES1458-1

~~(i) The single bed room incentives shall be as determined under section 256B.431, subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.~~

(j) The portion related to quality improvement incentive payment rate adjustments shall be as determined under subdivision 46c.

(k) The portion related to performance-based incentive payments shall be as determined under subdivision 46d.

(l) The portion related to special dietary needs shall be the per diem amount determined under subdivision 51b.

~~(j)~~ (m) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to ~~(i)~~ (l).

Sec. 32. Minnesota Statutes 2014, section 256B.441, subdivision 54, is amended to read:

Subd. 54. **Determination of total payment rates.** ~~In rate years when rates are rebased,~~ The total care-related per diem, other operating price, and external fixed per diem for each facility shall be converted to payment rates. The total payment rate for a RUG's weight of 1.00 shall be the sum of the total care-related payment rate, other operating payment rate, ~~efficiency incentive,~~ external fixed cost rate, and the property rate determined under section 256B.434. To determine a total payment rate for each RUG's level, the total care-related payment rate shall be divided into the direct care payment rate and the other care-related payment rate, and the direct care payment rate multiplied by the RUG's weight for each RUG's level ~~using the weights in subdivision 14~~.

Sec. 33. Minnesota Statutes 2014, section 256B.441, subdivision 55a, is amended to read:

Subd. 55a. **Alternative to phase-in for publicly owned nursing facilities.** (a) For operating payment rates implemented between October 1, 2011, and the day before ~~the phase-in under subdivision 55 is complete~~ operating payment rates are determined under this section, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local governmental entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply shall be eligible to select an operating payment rate, with a weight of 1.00, up to the rate calculated in subdivision 54, without application of the phase-in under subdivision 55. The rates for the other RUGs shall be computed as provided under subdivision 54.

Senate Language s1458-2

House Language UES1458-1

(b) For operating payment rates implemented beginning the day when the ~~phase-in under subdivision 55 is complete~~ operating payment rates are determined under this section, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local governmental entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply are eligible to select an operating payment rate with a weight of 1.00, up to an amount determined by the commissioner to be allowable under the Medicare upper payment limit test. The rates for the other RUGs shall be computed under subdivision 54. The rate increase allowed in this paragraph shall take effect only upon federal approval.

(c) Rates determined under this subdivision shall take effect beginning October 1, 2011, based on cost reports for the reporting year ending September 30, 2010, and in future rate years, rates determined for nursing facilities participating under this subdivision shall take effect on October 1 of each year, based on the most recent available cost report.

(d) Eligible nursing facilities that wish to participate under this subdivision shall make an application to the commissioner by August 31, 2011, or by June 30 of any subsequent year.

(e) For each participating nursing facility, the public entity that owns the physical plant or is the license holder of the nursing facility shall pay to the state the entire nonfederal share of medical assistance payments received as a result of the difference between the nursing facility's payment rate under paragraph (a) or (b), and the rates that the nursing facility would otherwise be paid without application of this subdivision under subdivision 54 ~~or 55~~ as determined by the commissioner.

(f) The commissioner may, at any time, reduce the payments under this subdivision based on the commissioner's determination that the payments shall cause nursing facility rates to exceed the state's Medicare upper payment limit or any other federal limitation. If the commissioner determines a reduction is necessary, the commissioner shall reduce all payment rates for participating nursing facilities by a percentage applied to the amount of increase they would otherwise receive under this subdivision and shall notify participating facilities of the reductions. If payments to a nursing facility are reduced, payments under section 256B.19, subdivision 1e, shall be reduced accordingly.

Sec. 34. Minnesota Statutes 2014, section 256B.441, subdivision 56, is amended to read:

Subd. 56. **Hold harmless.** (a) For the rate years beginning ~~October 1, 2008, to October~~ on or after January 1, 2016, no nursing facility shall receive an operating cost payment rate less than its prior system operating cost payment rate ~~under section 256B.434. For rate years beginning between October 1, 2009, and October 1, 2015, no nursing facility shall receive an operating payment rate less than its operating payment rate in effect on September 30, 2009~~. The comparison of operating payment rates under this section shall be made for a RUG's rate with a weight of 1.00.

Senate Language s1458-2

House Language UES1458-1

(b) For rate years beginning on or after January 1, 2016, no facility shall be subject to a care-related payment rate limit reduction greater than five percent of the median determined in subdivision 30.

Sec. 35. Minnesota Statutes 2014, section 256B.441, subdivision 63, is amended to read:

Subd. 63. **Critical access nursing facilities.** (a) The commissioner, in consultation with the commissioner of health, may designate certain nursing facilities as critical access nursing facilities. The designation shall be granted on a competitive basis, within the limits of funds appropriated for this purpose.

(b) The commissioner shall request proposals from nursing facilities every two years. Proposals must be submitted in the form and according to the timelines established by the commissioner. In selecting applicants to designate, the commissioner, in consultation with the commissioner of health, and with input from stakeholders, shall develop criteria designed to preserve access to nursing facility services in isolated areas, rebalance long-term care, and improve quality. Beginning in fiscal year 2015, to the extent practicable, the commissioner shall ensure an even distribution of designations across the state.

(c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities designated as critical access nursing facilities:

(1) partial rebasing, with the commissioner allowing a designated facility operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with subdivision 54 and at least 40 percent, with the sum of the two portions being equal to 100 percent, of the operating payment rate that would have been allowed had the facility not been designated. The commissioner may adjust these percentages by up to 20 percent and may approve a request for less than the amount allowed;

(2) enhanced payments for leave days. Notwithstanding section 256B.431, subdivision 2r, upon designation as a critical access nursing facility, the commissioner shall limit payment for leave days to 60 percent of that nursing facility's total payment rate for the involved resident, and shall allow this payment only when the occupancy of the nursing facility, inclusive of bed hold days, is equal to or greater than 90 percent;

(3) two designated critical access nursing facilities, with up to 100 beds in active service, may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner of health will consider each waiver request independently based on the criteria under Minnesota Rules, part 4658.0040;

(4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall be 40 percent of the amount that would otherwise apply; and

(5) ~~notwithstanding subdivision 58, beginning October 1, 2014,~~ the quality-based rate limits under subdivision 50 shall apply to designated critical access nursing facilities.

Senate Language s1458-2

House Language UES1458-1

(d) Designation of a critical access nursing facility shall be for a period of two years, after which the benefits allowed under paragraph (c) shall be removed. Designated facilities may apply for continued designation.

(e) This subdivision is suspended and no state or federal funding shall be appropriated or allocated for the purposes of this subdivision from January 1, 2016, to December 31, 2017.

Sec. 36. Minnesota Statutes 2014, section 256B.441, is amended by adding a subdivision to read:

Subd. 65. **Nursing facility in Golden Valley.** Effective for the rate year beginning January 1, 2016, and all subsequent rate years, the operating payment rate for a facility located in the city of Golden Valley at 3915 Golden Valley Road with 44 licensed rehabilitation beds as of January 7, 2015, must be calculated without the application of subdivisions 50 and 51.

Sec. 37. Minnesota Statutes 2014, section 256B.441, is amended by adding a subdivision to read:

Subd. 66. **Nursing facilities in border cities.** Effective for the rate year beginning January 1, 2016, and annually thereafter, operating payment rates of a nonprofit nursing facility that exists on January 1, 2015, is located anywhere within the boundaries of the city of Breckenridge, and is reimbursed under this section, section 256B.431, or section 256B.434, shall be adjusted to be equal to the median RUG's rates, including comparable rate components as determined by the commissioner, for the equivalent RUG's weight of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities contiguous to the adjacent city. The Minnesota facility's operating payment rate with a weight of 1.0 shall be computed by dividing the adjacent city's nursing facilities median operating payment rate with a weight of 1.02 by 1.02. If the adjustments under this subdivision result in a rate that exceeds the limits in subdivisions 50 and 51 in a given rate year, the facility's rate shall not be subject to those limits for that rate year. This subdivision shall apply only if it results in a rate increase.

Sec. 38. Minnesota Statutes 2014, section 256B.441, is amended by adding a subdivision to read:

Subd. 67. **Nursing facility; contract with insurance provider.** Within the projected cost of nursing facility payment reform under this section, for a facility that did not provide employee health insurance coverage as of May 1, 2015, if the facility has a signed contract with a health insurance provider to begin providing employee health insurance coverage by January 1, 2016, the facility shall be paid for the employer health insurance costs portion of external fixed costs under subdivisions 13 and 53 beginning January 1, 2016.

Sec. 39. Minnesota Statutes 2014, section 256B.50, subdivision 1, is amended to read:

Senate Language s1458-2

House Language UES1458-1

Subdivision 1. **Scope.** A provider may appeal from a determination of a payment rate established pursuant to this chapter or allowed costs under section 256B.441 and reimbursement rules of the commissioner if the appeal, if successful, would result in a change to the provider's payment rate or to the calculation of maximum charges to therapy vendors as provided by section 256B.433, subdivision 3. Appeals must be filed in accordance with procedures in this section. This section does not apply to a request from a resident or long-term care facility for reconsideration of the classification of a resident under section 144.0722.

EFFECTIVE DATE. This section is effective July 1, 2015, and applies to appeals filed on or after that date.

Sec. 40. Minnesota Statutes 2014, section 256I.05, subdivision 2, is amended to read:

Subd. 2. **Monthly rates; exemptions.** This subdivision applies to a residence that on August 1, 1984, was licensed by the commissioner of health only as a boarding care home, certified by the commissioner of health as an intermediate care facility, and licensed by the commissioner of human services under Minnesota Rules, parts 9520.0500 to 9520.0690. Notwithstanding the provisions of subdivision 1c, the rate paid to a facility reimbursed under this subdivision shall be determined under section 256B.431, ~~or under section~~ 256B.434, or 256B.441, if the facility is accepted by the commissioner for participation in the alternative payment demonstration project. The rate paid to this facility shall also include adjustments to the group residential housing rate according to subdivision 1, and any adjustments applicable to supplemental service rates statewide.

Sec. 41. **DIRECTION TO COMMISSIONER; NURSING FACILITY PAYMENT REFORM REPORT.**

By January 1, 2017, the commissioner of human services shall evaluate and report to the house of representatives and senate committees and divisions with jurisdiction over nursing facility payment rates on:

(1) the impact of using cost report data to set rates without accounting for cost report to rate year inflation;

(2) the impact of the quality adjusted care limits;

(3) the ability of nursing facilities to attract and retain employees, including how rate increases are being passed through to employees, under the new payment system;

(4) the efficacy of the critical access nursing facility program under Minnesota Statutes, section 256B.441, subdivision 63, given the new nursing facility payment system;

(5) creating a process for the commissioner to designate certain facilities as specialized care facilities for difficult-to-serve populations; and

Senate Language s1458-2

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(6) limiting the hold harmless in Minnesota Statutes, section 256B.441, subdivision 56.

Sec. 42. **PROPERTY RATE SETTING.**

The commissioner shall conduct a study, in consultation with stakeholders and experts, of property rate setting, based on a rental value approach for Minnesota nursing facilities, and shall report the findings to the house of representatives and senate committees and divisions with jurisdiction over nursing facility payment rates by March 1, 2016, for a system implementation date of January 1, 2017. The commissioner shall:

(1) contract with at least two firms to conduct appraisals of all nursing facilities in the medical assistance program. Each firm shall conduct appraisals of approximately equal portions of all nursing facilities assigned to them at random. The appraisals shall determine the value of the land, building, and equipment of each nursing facility, taking into account the quality of construction and current condition of the building;

(2) use the information from the appraisals to complete the design of a fair rental value system and calculate a replacement value and an effective age for each nursing facility. Nursing facilities may request an appraisal by a second firm which shall be assigned randomly by the commissioner. The commissioner shall use the findings of the second appraisal. If the second firm increases the appraisal value by more than five percent, the state shall pay for the second appraisal. Otherwise, the nursing facility shall pay the cost of the appraisal. Results of appraisals are not otherwise subject to appeal under section 256B.50; and

(3) include in the report required under this section the following items:

(i) a description of the proposed rental value system;

(ii) options for adjusting the system parameters that vary the cost of implementing the new property rate system and an analysis of individual nursing facilities under the current property payment rate and the rates under various approaches to calculating rates under the rental value system;

(iii) recommended steps for transition to the rental value system;

(iv) an analysis of the expected long-term incentives of the rental value system for nursing facilities to maintain and replace buildings, including how the current exceptions to the moratorium process under Minnesota Statutes, section 144A.073, may be adapted; and

(v) bill language for implementation of the rental value system.

Sec. 43. **REVISOR'S INSTRUCTION.**

Senate Language s1458-2

House Language UES1458-1

The revisor of statutes, in consultation with the House Research Department, Office of Senate Counsel, Research, and Fiscal Analysis, Department of Human Services, and stakeholders, shall prepare legislation for the 2016 legislative session to recodify laws governing nursing home payments and rates in Minnesota Statutes, chapter 256B, and in Minnesota Rules, chapter 9549.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 44. **REPEALER.**

Minnesota Statutes 2014, sections 256B.434, subdivision 19b; and 256B.441, subdivisions 14a, 19, 50a, 52, 55, 58, and 62, are repealed.