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State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 1575

03/14/2013 Authored by Huntley
The bill was read for the first time and referred to the Committee on Health and Human Services Finance

A bill for an act

relating to human services; modifying hospital, nursing home, ICF/DD, and health maintenance organization provider surcharges; providing a medical assistance rate increase; amending Minnesota Statutes 2012, sections 256.9657, subdivisions 1, 2, 3, 3a; 256.9685, subdivision 2; 256.969, subdivisions 3a, 21, 30, by adding subdivisions; 256B.441, subdivision 53; 256B.5012, by adding a subdivision; 256B.69, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2012, section 256.9657, subdivision 1, is amended to read:

Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is ~~reduced~~ changed, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that the number of beds ~~have been delicensed~~ has been changed. The nursing home must notify the commissioner of health in writing when the number of beds ~~are delicensed~~ is changed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the ~~15th~~ third of the month, the invoice for the second following month must be ~~reduced~~ changed to recognize the ~~delicensing~~ change in the number of beds. ~~Beds on layaway status continue to be subject to the surcharge.~~ The commissioner of human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

(c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to $990.

(d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased to $2,815.

(e) Effective July 15, 2013, the surcharge under paragraph (d) shall be increased to $.....

(f) The commissioner may reduce, and may subsequently restore, the surcharge under paragraph ~~(d)~~ (e) based on the commissioner's determination of a permissible surcharge.

~~(f)~~ (g) Between ~~April 1, 2002, and August 15, 2004~~ July 1, 2013, and June 30, 2014, a facility governed by this subdivision may elect to assume full participation in the medical assistance program by agreeing to comply with all of the requirements of the medical assistance program, including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements established in law or rule, and to begin intake of new medical assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. Rate calculations will be subject to limits as prescribed in rule and law. Other than the adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization of rates, facilities assuming full participation in medical assistance under this paragraph are not eligible for any rate adjustments until the July 1 following their settle-up period.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 2. Minnesota Statutes 2012, section 256.9657, subdivision 2, is amended to read:

Subd. 2. **Hospital surcharge.** (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the medical assistance account a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Effective July 1, 2013, the surcharge under paragraph (b) is increased to ... percent for all nongovernment-owned hospitals.

(d) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 3. Minnesota Statutes 2012, section 256.9657, subdivision 3, is amended to read:

Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each community integrated service network licensed by the commissioner under chapter 62N shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of the health maintenance organization or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

(b) Effective July 1, 2013:

(1) the surcharge under paragraph (a) is increased to ... percent; and

(2) each county-based purchasing plan authorized under section 256B.692 shall pay to the commissioner a surcharge equal to ... percent of the total premium revenues of the plan, as reported to the commissioner of health, according to the payment schedule in subdivision 4.

(c) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization or community integrated service network from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wraparound subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization or a community integrated service network and the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

~~(e)~~ (d) When a health maintenance organization or community integrated service network merges or consolidates with or is acquired by another health maintenance organization or community integrated service network, the surviving corporation or the new corporation shall be responsible for the annual surcharge originally imposed on each of the entities or corporations subject to the merger, consolidation, or acquisition, regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

~~(d)~~ (e) Effective July 1 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the second previous calendar year by all of the entities or corporations subject to the merger, consolidation, or acquisition regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N until the total premium revenues of the surviving corporation include the total premium revenues of all the merged entities as reported to the commissioner of health.

~~(e)~~ (f) When a health maintenance organization or community integrated service network, which is subject to liability for the surcharge under this chapter, transfers, assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer of the health maintenance organization or community integrated service network.

~~(f)~~ (g) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

~~(g)~~ (h) The surcharge assessed to a health maintenance organization or community integrated service network ends when the entity ceases providing services for premiums and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 4. Minnesota Statutes 2012, section 256.9657, subdivision 3a, is amended to read:

Subd. 3a. **~~ICF/MR~~ ICF/DD license surcharge.** (a) Effective July 1, 2003, each non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay

to the commissioner an annual surcharge according to the schedule in subdivision 4, paragraph (d). The annual surcharge shall be $1,040 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The facility must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. The commissioner may reduce, and may subsequently restore, the surcharge under this subdivision based on the commissioner's determination of a permissible surcharge.

(b) Effective July 1, 2013, the surcharge under paragraph (a) is increased to $..... per licensed bed.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 5. Minnesota Statutes 2012, section 256.9685, subdivision 2, is amended to read:

Subd. 2. **Federal requirements.** (a) If it is determined that a provision of this section or section 256.9686, 256.969, or 256.9695 conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, ~~in the aggregate,~~ prospectively and retrospectively, reduce payment rates and payments to avoid reduced federal financial participation resulting from rates and payments determined by the commissioner that are in excess of the Medicare upper payment limitations.

(b) For rates and payments determined by the commissioner to be in excess of the Medicare upper payment limits for the nongovernment-owned limit category, rates and payments shall be reduced to the limits according to clauses (1) to (4):

(1) rates and payments under section 256.969, subdivisions 3a, paragraph (j); 21, paragraph (b); 30, paragraph (e); 31; and 32, shall be reduced proportionately;

(2) if rates and payments remain above the limit, medical education payments under section 62J.692, subdivision 8, shall be the first reduction for the government-owned limit category;

(3) if rates and payments remain above the limit, rates and payments not included under clause (1) shall be reduced in total; and

(4) the state share of payments under clauses (1) and (2) shall be returned to the hospital.

Sec. 6. Minnesota Statutes 2012, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. ~~This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991.~~ Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates by December 1 of the year preceding the rate year. The rate setting data must reflect the admissions data used to establish relative values. Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase under subdivision 1. The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

(b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for inpatient services is reduced by .5 percent from the current statutory rates.

(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432, and facilities defined under subdivision 16 are excluded from this paragraph.

(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. ~~Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical assistance does not include general assistance medical care.~~ Payments made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.

(e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 3.46 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.

Payments made to managed care plans shall be reduced for services provided on or after July 1, 2011, to reflect this reduction.

(h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced one percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.

(i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, to reflect this reduction.

(j) In order to offset the rateable reductions provided for in this subdivision, the total payment rate for medical assistance admissions for nongovernment-owned hospitals occurring on or after July 1, 2013, made to Minnesota hospitals for inpatient services before third-party liability and spenddown, shall be increased by ... percent from the current statutory rates. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner shall adjust rates and payments in excess of the Medicare upper limits on payments according to section 256.9685, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 7. Minnesota Statutes 2012, section 256.969, subdivision 21, is amended to read:

Subd. 21. **Mental health or chemical dependency admissions; rates.** (a) Admissions under ~~the general assistance medical care program occurring on or after July 1, 1990, and admissions under~~ medical assistance~~, excluding general assistance medical care,~~ occurring on or after July 1, 1990, and on or before September 30, 1992, that are classified to a diagnostic category of mental health or chemical dependency shall have rates established according to the methods of subdivision 14, except the per day rate shall be multiplied by a factor of 2, provided that the total of the per day rates shall not exceed the per admission rate. This methodology shall also apply when a hold or commitment is ordered by the court for the days that inpatient hospital services are medically necessary. Stays which are medically necessary for inpatient hospital services and covered by medical assistance shall not be billable to any other governmental entity.

Medical necessity shall be determined under criteria established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

(b) In order to ensure adequate access for the provision of mental health services and to encourage broader delivery of these services outside the nonstate governmental hospital setting, payment rates for medical assistance admissions occurring on or after July 1, 2013, at a Minnesota nongovernment-owned hospital above the 75th percentile of all Minnesota private, nonprofit hospitals for diagnosis-related groups 424 to 432 and 521 to 523 admissions paid by medical assistance for admissions occurring in calendar year 2010, shall be increased for these diagnosis-related groups at a percentage calculated to cost an average of not more than $..... each year after rateable reductions under subdivision 3a, including state and federal shares. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner shall adjust rates and payments in excess of the Medicare upper limits on payments according to section 256.9685, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 8. Minnesota Statutes 2012, section 256.969, subdivision 30, is amended to read:

Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after October 1, 2009, the total operating and property payment rate, excluding disproportionate population adjustment, for the following diagnosis-related groups, as they fall within the diagnostic categories: (1) 371 cesarean section without complicating diagnosis; (2) 372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without complicating diagnosis, shall be no greater than $3,528.

(b) The rates described in this subdivision do not include newborn care.

(c) Payments to managed care and county-based purchasing plans under section 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in paragraph (a).

(d) Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

(e) Notwithstanding paragraph (a), for medical assistance admissions occurring on or after July 1, 2013, the commissioner shall increase rates for inpatient hospital services at Minnesota nongovernment-owned hospitals by a dollar amount for each admission calculated not to exceed an average of $..... each year, after rateable reductions under subdivision 3a, including state and federal shares. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments

provided in this subdivision. The commissioner shall adjust rates and payments in excess of the Medicare upper limits on payments according to section 256.9685, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 9. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 31. **Critical access hospitals.** As designated under section 144.1483, clause (9), for medical assistance admissions to critical access hospitals occurring on or after July 1, 2013, the commissioner shall increase rates for inpatient hospital services at Minnesota nongovernment-owned hospitals by a dollar amount for each admission calculated not to exceed an average of $..... each year, after rateable reductions under subdivision 3a, including state and federal shares.

The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this subdivision. The commissioner shall adjust rates and payments in excess of the Medicare upper limits on payments according to section 256.9685, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 10. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 32. **Pediatric care.** For medical assistance admissions occurring on or after July 1, 2013, the commissioner shall increase rates at Minnesota nongovernment-owned hospitals above the 85th percentile for patient days for patients under 18 years of age in calendar year 2012 of all Minnesota private, nonprofit hospitals. The increase shall be a percentage calculated to cost an average of not more than $..... each year.

The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this subdivision. The commissioner shall adjust rates and payments in excess of the Medicare upper limits on payments according to section 256.9685, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 11. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 33. **Pediatric orthopedic care.** For medical assistance admissions occurring on or after July 1, 2013, the commissioner shall increase rates at Minnesota

nongovernment-owned hospitals above the 90th percentile for patient days for patients under 18 years of age in calendar year 2011 of all Minnesota private, nonprofit hospitals for diagnosis-related groups 453 to 517, 533 to 541, 906, and 956. The increase shall be a percentage calculated to cost an average of not more than $..... each year.

The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this subdivision. The commissioner shall adjust rates and payments in excess of the Medicare upper limits on payments according to section 256.9685, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 12. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 34. **Trauma-designated hospitals.** For medical assistance admissions occurring on or after July 1, 2013, the commissioner shall increase rates at Minnesota nongovernment-owned hospitals verified by the American College of Surgeons as a Level I trauma center. The increase shall be $..... each year for each nongovernment-owned hospital with the Level I trauma center designation.

The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this subdivision. The commissioner shall adjust rates and payments in excess of the Medicare upper limits on payments according to section 256.9685, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 13. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 35. **Medicare volume.** For medical assistance admissions occurring on or after July 1, 2013, the commissioner shall increase rates at Minnesota nongovernment-owned hospitals that serve large Medicare populations. The increase shall be based on the percentage-to-total of Medicare admissions for all Minnesota private, nonprofit hospitals, calculated to cost an average of not more than $..... each year.

The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this subdivision. The commissioner shall adjust rates and payments in excess of the Medicare upper limits on payments according to section 256.9685, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 14. Minnesota Statutes 2012, 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 scholarships shall be determined under section 256B.431, subdivision 36.

(d) 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) 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.

(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 the Public Employees Retirement Association shall be actual costs divided by resident days.

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

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 15. Minnesota Statutes 2012, section 256B.5012, is amended by adding a subdivision to read:

Subd. 14. **Rate increase effective July 1, 2013.** For rate periods beginning on or after July 1, 2013, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by $..... per day. The increase shall not be subject to any annual percentage increase.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 16. Minnesota Statutes 2012, section 256B.69, is amended by adding a subdivision to read:

Subd. 5l. **Rate modification.** For services rendered on or after July 1, 2013, to December 31, 2014, the total payment made to managed care plans under the medical assistance program and under MinnesotaCare for families with children shall be increased by ... percent.

EFFECTIVE DATE. This section is effective July 1, 2013.