State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 3864

02/26/2020 Authored by Schultz
The bill was read for the first time and referred to the Long-Term Care Division

A bill for an act

relating to human services; modifying resident assessments and classifications provisions; requiring certain related party disclosures; establishing interim and settle-up payment rates for new owners and operators; appropriating money for improved financial integrity of nursing facility payments; amending Minnesota Statutes 2018, sections 144.0724, subdivisions 4, 5, 8; 256R.08, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 256R.

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

Section 1. Minnesota Statutes 2018, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health MDS assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment;

(2) an annual assessment which must have an assessment reference date (ARD) within 92 days of the previous assessment and the previous comprehensive assessment;

(3) a significant change in status assessment must be completed within 14 days of the identification of a significant change, whether improvement or decline, and regardless of the amount of time since the last significant change in status assessment. Effective for rehabilitation therapy completed on or after January 1, 2021, a facility must complete a significant change in status assessment if for any reason all speech, occupational, and physical therapies have ended. The ARD of the significant change in status assessment must be the eighth day after all speech, occupational, and physical therapies have ended. The last day on which rehabilitation therapy was furnished is considered day zero when determining the ARD for the significant change in status assessment;

(4) all quarterly assessments must have an ~~assessment reference date (ARD)~~ ARD within 92 days of the ARD of the previous assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; ~~and~~

(6) any significant correction to a prior quarterly assessment, if the assessment being corrected is the current one being used for RUG classification~~.~~; and

(7) modifications to the most recent assessment in clauses (1) to (6).

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Sec. 2. Minnesota Statutes 2018, section 144.0724, subdivision 5, is amended to read:

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an admission assessment for all residents who stay in the facility 14 days or less.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make this election annually.

(c) Nursing facilities must elect one of the options described in paragraphs (a) and (b) by reporting to the commissioner of health, as prescribed by the commissioner. The election is effective on July 1 each year.

(d) An admission assessment is not required regardless of the facility's election status when a resident is admitted to and discharged from the facility on the same day.

EFFECTIVE DATE. This section is effective for admissions on or after July 1, 2020.

Sec. 3. Minnesota Statutes 2018, section 144.0724, subdivision 8, is amended to read:

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification, including any items changed during the audit process. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, and documentation supporting the request. The documentation accompanying the reconsideration request is limited to ~~a copy of the MDS that determined the classification and other~~ documents that would support or change the MDS findings.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information listed in item (iii) with the reconsideration request, the commissioner may request that the facility provide the information within 14 calendar days. The reconsideration request must be denied if the information is then not provided, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the assessment that determined the classification and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing facility level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Sec. 4. Minnesota Statutes 2018, section 256R.08, subdivision 1, is amended to read:

Subdivision 1. **Reporting of financial statements.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "profit and loss statement" means the most recent annual statement on profits and losses finalized by a related party for the most recent year available; and

(2) "related party" means an organization related to the licensee provider or that is under common ownership or control, as defined in Code of Federal Regulations, title 42, section 413.17(b).

~~(a)~~ (b) No later than February 1 of each year, a nursing facility shall:

(1) provide the state agency with a copy of its audited financial statements or its working trial balance;

(2) provide the state agency with a statement of ownership for the facility;

(3) provide the state agency with separate, audited financial statements or working trial balances for every other facility owned in whole or in part by an individual or entity that has an ownership interest in the facility;

(4) provide the state agency with information regarding whether the licensee, or a general partner, director, or officer of the licensee, has an ownership or control interest of five percent or more in a related party or related organization that provides a service to the skilled nursing facility. If the licensee, or the general partner, director, or officer of the licensee, has such an interest, the licensee shall disclose all services provided to the skilled nursing facility, the number of individuals who provide that service at the skilled nursing facility, and any other information requested by the state agency. If goods, fees, and services collectively worth $10,000 or more per year are delivered to the skilled nursing facility, the disclosure required under this subdivision shall include the related party and related organization profit and loss statement and the payroll-based journal public use data;

~~(4)~~ (5) upon request, provide the state agency with separate, audited financial statements or working trial balances for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

~~(5)~~ (6) provide the state agency with copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility; and

~~(6)~~ (7) upon request, provide the state agency with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs.

~~(b)~~ (c) Audited financial statements submitted under paragraph ~~(a)~~ (b) must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statement of cash flows, notes to the financial statements, audited applicable supplemental information, and the public accountant's report. Public accountants must conduct audits in accordance with chapter 326A. The cost of an audit shall not be an allowable cost unless the nursing facility submits its audited financial statements in the manner otherwise specified in this subdivision. A nursing facility must permit access by the state agency to the public accountant's audit work papers that support the audited financial statements submitted under paragraph ~~(a)~~ (b).

~~(c)~~ (d) Documents or information provided to the state agency pursuant to this subdivision shall be public.

~~(d)~~ (e) If the requirements of paragraphs ~~(a)~~ (b) and ~~(b)~~ (c) are not met, the reimbursement rate may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting period and the reduction shall continue until the requirements are met.

(f) Licensees shall provide the information required in this section to the commissioner in a manner prescribed by the commissioner.

EFFECTIVE DATE. This section is effective November 1, 2020.

Sec. 5. **[256R.28] INTERIM AND SETTLE-UP PAYMENT RATES FOR NEW OWNERS AND OPERATORS.**

Subdivision 1. **Generally.** (a) A nursing facility that undergoes a change of ownership or operator resulting in a change of licensee, as determined by the commissioner of health under chapter 144A, must receive interim payment rates and settle-up payment rates according to this section.

(b) The effective date of the interim rates is the effective date of the new license. The interim payment rates must not be in effect for more than 26 months.

(c) The nursing facility must continue to receive the interim payment rates until the settle-up payment rates are determined under subdivision 3.

(d) The settle-up payment rates are effective retroactively from the effective date of the new license and remain effective until the end of the interim rate period.

(e) For the 15-month period following the settle-up payment, rates must be determined according to subdivision 3, paragraph (c).

(f) The total operating and external fixed costs payment rates for the rate year beginning January 1 following the 15-month period in paragraph (e) must be determined under section 256R.21.

Subd. 2. **Determination of interim payment rates.** The interim total payment rates must be the rates established under section 256R.21.

Subd. 3. **Determination of settle-up payment rates.** (a) When the effective date of the new license is between May 1 and September 30, the nursing facility shall file a settle-up cost report for the period from the beginning of the interim payment rates through September 30 of the following year.

(b) When the effective date of the new license is between October 1 and April 30, the nursing facility shall file a settle-up cost report for the period from the beginning of the interim payment rates to the first September 30 following the beginning of the interim payment rates.

(c) The settle-up payment rates are determined according to sections 256R.21 to 256R.25, except that:

(1) the allowable costs and resident days reported on the settle-up cost report and the standardized days as defined by section 256R.02, subdivision 50, must be used for the interim and settle-up period;

(2) the commissioner shall use the allowable costs and standardized days in clause (1) to determine the allowable historical direct care cost per standardized day as determined under section 256R.23, subdivision 2;

(3) the commissioner shall use the allowable costs and the allowable resident days to determine both the allowable historical other care-related cost per resident day as determined under section 256R.23, subdivision 3;

(4) the commissioner shall use the allowable costs and the allowable resident days to determine the allowable historical external fixed costs per day under section 256R.25, paragraphs (b) to (e), (j), (k), (n), and (o);

(5) the commissioner shall allow the new licensee to assume the previous licensee's external fixed per day rate components that the new licensee qualifies for under section 256R.25, paragraphs (f) to (i) and (l). The new licensee may be permitted to assume the previous licensee rate component from section 256R.25, paragraph (m), at the commissioner's discretion;

(6) the total care-related payment limits established in section 256R.23, subdivision 5, are the limits for the settle-up reporting periods; and

(7) the other operating payment rate as determined under section 256R.24 in effect for the rate year must be used for the other operating cost per day.

EFFECTIVE DATE. This section is effective for changes of ownership or operator that occur on or after January 1, 2021.

Sec. 6. **APPROPRIATION; IMPROVED FINANCIAL INTEGRITY OF NURSING FACILITY RATES AND PAYMENTS.**

$600,000 in fiscal year 2021 is appropriated from the general fund to the commissioner of human services to hire additional auditing staff to improve financial integrity of nursing facility rates and payments, for auditor travel to conduct audits, and for investigative software.