SENATE
STATE OF MINNESOTA
EIGHTY-NINTH SESSION

S.F. No. 273

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DATE	D-PG	OFFICIAL STATUS
01/22/2015	116	Introduction and first reading Referred to Finance
02/19/2015	369	Withdrawn and re-referred to Health, Human Services and Housing
03/16/2015		Comm report: To pass as amended and re-refer to Finance

A bill for an act

relating to human services; modifying the nursing facility reimbursement system; amending Minnesota Statutes 2014, sections 256B.0915, subdivision 3a; 256B.441, subdivisions 1, 5, 13, 14, 17, 30, 31, 35, 48, 50, 51, 51a, 53, 54, 56, by adding a subdivision; repealing Minnesota Statutes 2014, section 256B.441, subdivisions 14a, 19, 50a, 52, 55, 58, 62.

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

Section 1. 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 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 the greater of any legislatively adopted home and community-based services percentage rate adjustment or the average statewide percentage increase in nursing facility operating payment rates under section 256B.441.

(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 (a).

(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), 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) 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 (a).

Sec. 2. 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.

(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~~ 2015.

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

~~(d)~~ 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. Notice of rates shall be distributed by August 15 and the rates shall go into effect on October 1 for one year.

~~(e)~~ (d) Effective October 1, ~~2014~~ 2016, 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~~ recalculated based on a new property rate system to be developed by the commissioner in consultation with nursing facility providers and other stakeholders. The new property system shall be designed to provide payment rates that allow providers to efficiently meet consumer needs and preferences throughout the state.

Sec. 3. 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. 4. 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 the employer health insurance cost for full-time employees as defined by the Affordable Care Act and their family's insurance, including premium expenses for group coverage and reinsurance, actual expenses incurred for self-insured plans, and employer contributions to employee health reimbursement and savings accounts.

Sec. 5. Minnesota Statutes 2014, section 256B.441, subdivision 13, is amended to read:

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; assessments on employers under the Affordable Care Act; and PERA.

Sec. 6. 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. 7. 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,

profit sharing, and retirement plans for which the employer pays all or a portion of the costs, except for health insurance and PERA.

Sec. 8. Minnesota Statutes 2014, section 256B.441, subdivision 30, is amended to read:

Subd. 30. **Peer groups.** Facilities shall be classified into ~~three~~ two groups by county. The groups shall consist of:

(1) group one: facilities in Anoka, Benton, Blue Earth, Carlton, Carver, Chisago, Clay, Cook, Crow Wing, Dakota, Dodge, Goodhue, Hennepin, Isanti, Kanabec, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Morrison, Nicollet, Olmsted, Pine, Ramsey, Rice, Scott, Sherburne, Sibley, St. Louis, Stearns, Steele, Wabasha, Waseca, Washington, Winona, or Wright County; and

(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~~ two: facilities in all other counties.

Sec. 9. 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~~ 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. 10. 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. 11. Minnesota Statutes 2014, section 256B.441, subdivision 48, is amended to read:

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. 12. 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~~.

(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;~~

~~(2) if the value determined in clause (1) is less than zero~~ (1) for each facility with a quality score of ten or less, the total care-related limit shall be ~~105~~ 95 percent of the median for the facility's peer ~~and facility type~~ group;

~~(3) if the value determined in clause (1) is greater than 100 percent~~ (2) for each facility with a quality score of 90 or more, the total care-related limit shall be ~~125~~ 140 percent of the median for the facility's peer ~~and facility type~~ group; and

~~(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)~~ (3) for each facility with a quality score of more than ten and less than 90, the total care-related limit shall be computed by:

(i) computing the difference between the facility's quality score and ten;

(ii) dividing the amount in item (i) by the difference between the maximum score listed in clause (2) and ten;

(iii) multiplying the amount in item (ii) by the difference between the maximum limit in clause (2) and ten; and

(iv) adding the amount in item (iii) to ten.

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

Sec. 13. 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 other operating per diem for ~~its~~ a facility's peer group. ~~A facility that is above that limit shall have its other operating per diem reduced to the limit~~ 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. 14. 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 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~~ 2015, 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 having a Rule 80 program license with the Department of Human Services or a facility with 96 beds on January 1, 2015, 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. 15. 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.

~~(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).

Sec. 16. 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 by multiplying each by the forecast increase in the CPI-U index from the midpoint of the reporting year to the midpoint of the rate year. 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. 17. Minnesota Statutes 2014, section 256B.441, subdivision 56, is amended to read:

Subd. 56. **Hold harmless.** For the rate ~~years~~ year beginning October 1, ~~2008, to October 1, 2016~~ 2015, 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~~ as defined in subdivision 31. The comparison of operating payment rates under this section shall be made for a RUG's rate with a weight of 1.00.

Sec. 18. **REPEALER.**

Minnesota Statutes 2014, section 256B.441, subdivisions 14a, 19, 50a, 52, 55, 58, and 62, are repealed.

256B.441 VALUE-BASED NURSING FACILITY REIMBURSEMENT SYSTEM.

Subd. 14a. **Facility type groups.** Facilities shall be classified into two groups, called "facility type groups," which shall consist of:

(1) C&NC/R80: facilities that are hospital-attached, or are licensed under Minnesota Rules, parts 9570.2000 to 9570.3400; and

(2) freestanding: all other facilities.

Subd. 19. **Hospital-attached nursing facility status.** (a) For the purpose of setting rates under this section, for rate years beginning after September 30, 2006, "hospital-attached nursing facility" means a nursing facility which meets the requirements of clauses (1) and (2); or (3); or (4), or had hospital-attached status prior to January 1, 1995, and has been recognized as having hospital-attached status by CMS continuously since that date:

(1) the nursing facility is recognized by the federal Medicare program to be a hospital-based nursing facility;

(2) the hospital and nursing facility are physically attached or connected by a corridor;

(3) a nursing facility and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year, shall be considered a hospital-attached nursing facility for purposes of setting payment rates under this section. The nursing facility must file its cost report for that reporting year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital-based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the definition requirements in clauses (1) and (2). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility according to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility;

(4) if a nonprofit or community-operated hospital and attached nursing facility suspend operation of the hospital, the remaining nursing facility must be allowed to continue its status as hospital-attached for rate calculations in the three rate years subsequent to the one in which the hospital ceased operations.

(b) The nursing facility's cost report filed as hospital-attached facility shall use the same cost allocation principles and methods used in the reports filed for the Medicare program. Direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

Subd. 50a. **Determination of proximity adjustments.** (a) For a nursing facility located in close proximity to another nursing facility of the same facility group type but in a different peer group and that has higher limits for care-related or other operating costs, the commissioner shall adjust the limits in accordance with clauses (1) to (4):

(1) determine the difference between the limits;

(2) determine the distance between the two facilities, by the shortest driving route. If the distance exceeds 20 miles, no adjustment shall be made;

(3) subtract the value in clause (2) from 20 miles, divide by 20, and convert to a percentage; and

(4) increase the limits for the nursing facility with the lower limits by the value determined in clause (1) multiplied by the value determined in clause (3).

(b) Effective October 1, 2011, nursing facilities located no more than one-quarter mile from a peer group with higher limits under either subdivision 50 or 51, may receive an operating rate adjustment. The operating payment rates of a lower-limit peer group facility must be adjusted to be equal to those of the nearest facility in a higher-limit peer group if that facility's RUG rate with a weight of 1.00 is higher than the lower-limit peer group facility. Peer groups are those defined in subdivision 30. The nearest facility must be determined by the most direct driving route.

Subd. 52. **Determination of efficiency incentive.** Each facility shall be eligible for an efficiency incentive based on its other operating per diem. A facility with an other operating per diem that exceeds the limit in subdivision 51 shall receive no efficiency incentive. All other facilities shall receive an incentive calculated as 50 percent times the difference between the facility's other operating per diem and its other operating per diem limit, up to a maximum incentive of $3.

Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined

under section 256B.434. For purposes of this subdivision, the rate to be used that is determined under section 256B.434 shall not include the portion of the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 256B.434. For the rate period from October 1, 2009, to September 30, 2013, no rate adjustments shall be implemented under this section, but shall be determined under section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

(b) For the rate year beginning October 1, 2008, the commissioner shall apply limits to the operating payment rate increases under paragraph (a) by creating a minimum percentage increase and a maximum percentage increase.

(1) Each nursing facility that receives a blended October 1, 2008, operating payment rate increase under paragraph (a) of less than one percent, when compared to its operating payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00, shall receive a rate adjustment of one percent.

(2) The commissioner shall determine a maximum percentage increase that will result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the maximum percentage increase.

(3) Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than one percent and less than the maximum percentage increase determined by the commissioner, when compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the blended October 1, 2008, operating payment rate increase determined under paragraph (a).

(4) The October 1, 2009, through October 1, 2015, operating payment rate for facilities receiving the maximum percentage increase determined in clause (2) shall be the amount determined under paragraph (a) less the difference between the amount determined under paragraph (a) for October 1, 2008, and the amount allowed under clause (2). This rate restriction does not apply to rate increases provided in any other section.

(c) A portion of the funds received under this subdivision that are in excess of operating payment rates that a facility would have received under section 256B.434, as determined in accordance with clauses (1) to (3), shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h).

(1) Determine the amount of additional funding available to a facility, which shall be equal to total medical assistance resident days from the most recent reporting year times the difference between the blended rate determined in paragraph (a) for the rate year being computed and the blended rate for the prior year.

(2) Determine the portion of all operating costs, for the most recent reporting year, that are compensation related. If this value exceeds 75 percent, use 75 percent.

(3) Subtract the amount determined in clause (2) from 75 percent.

(4) The portion of the fund received under this subdivision that shall be subject to the requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal the amount determined in clause (1) times the amount determined in clause (3).

Subd. 58. **Implementation delay.** Within six months prior to the effective date of (1) rebasing of property payment rates under subdivision 1; (2) quality-based rate limits under subdivision 50; and (3) the removal of planned closure rate adjustments and single bed room incentives from external fixed costs under subdivision 53, the commissioner shall compare the average operating cost for all facilities combined from the most recent cost reports to the average medical assistance operating payment rates for all facilities combined from the same time period. Each provision shall not go into effect until the average medical assistance operating payment rate is at least 92 percent of the average operating cost. The rebasing of property payment rates under subdivision 1, and the removal of planned closure rate adjustments and single-bed room

incentives from external fixed costs under subdivision 53 shall not go into effect until 82 percent of the operating payment rate from this section is phased in as described in subdivision 55.

Subd. 62. **Repeal of rebased operating payment rates.** Notwithstanding subdivision 54 or 55, no further steps toward phase-in of rebased operating payment rates shall be taken.