Sec. 29. **EFFECTIVE DATES.**

Sections 1, 10, 11, and 14 are effective for dates of injury on or after October 1, 2000. Section 9 is effective for written notices of claims for legal services that were filed on or after August 1, 2000. Sections 16, 17, and 18 are effective for dates of injury on or after the day following final enactment. Sections 23 to 28 are effective the day following final enactment.

Presented to the governor April 25, 2000

Signed by the governor April 27, 2000, 11:42 a.m.

CHAPTER 448—S.F.No. 2385

VETOED

CHAPTER 449—H.F.No. 3020

An act relating to human services; modifying provisions in long-term care; amending Minnesota Statutes 1998, sections 256B.411, subdivision 2; and 256B.431, subdivisions 1, 3a, 10, 16, 18, 21, 22, and 25; Minnesota Statutes 1999 Supplement, sections 256B.0913, subdivision 5; 256B.431, subdivisions 17 and 26; and 256B.434, subdivisions 3 and 4; repealing Minnesota Statutes 1998, sections 256B.03, subdivision 2; 256B.431, subdivisions 2, 2a, 2f, 2h, 2m, 2p, 2q, 3, 3b, 3d, 3h, 3j, 4, 5, 7, 8, 9, 9a, 12, and 24; 256B.48, subdivision 9; 256B.50, subdivision 3; and 256B.74, subdivision 3.

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

Section 1. Minnesota Statutes 1999 Supplement, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. **SERVICES COVERED UNDER ALTERNATIVE CARE.** (a) Alternative care funding may be used for payment of costs of:

(1) adult foster care;

(2) adult day care;

(3) home health aide;

(4) homemaker services;

(5) personal care;

(6) case management;

(7) respite care;

(8) assisted living;

(9) residential care services;

(10) care-related supplies and equipment;

(11) meals delivered to the home;

(12) transportation;

(13) skilled nursing;

(14) chore services;

(15) companion services;

(16) nutrition services;

(17) training for direct informal caregivers;

(18) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits; and

(19) other services including direct cash payments to clients, approved by the county agency, subject to the provisions of paragraph (m). Total annual payments for other services for all clients within a county may not exceed either ten percent of that county's annual alternative care program base allocation or $5,000, whichever is greater. In no case shall this amount exceed the county's total annual alternative care program base allocation.

(b) The county agency must ensure that the funds are used only to supplement and not supplant services available through other public assistance or services programs.

(c) Unless specified in statute, the service standards for alternative care services shall be the same as the service standards defined in the elderly waiver. Except for the county agencies' approval of direct cash payments to clients, persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program.

(d) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care daily rate shall be negotiated between the county agency and the foster care provider. The rate established under this section shall not exceed 75 percent of the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned, and it must allow for other alternative care services to be authorized by the case manager.

(e) Personal care services may be provided by a personal care provider organization. A county agency may contract with a relative of the client to provide personal care services, but must ensure nursing supervision. Covered personal care services defined in section 256B.0627, subdivision 4, must meet applicable standards in Minnesota Rules, part 9505.0335.

(f) A county may use alternative care funds to purchase medical supplies and equipment without prior approval from the commissioner when: (1) there is no other funding source; (2) the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, item A; and (3) the supplies and equipment represent an effective and appropriate use of alternative care funds. A county may use alternative care funds to purchase supplies and equipment from a non-Medicaid certified vendor if the cost for the items is less than that of a Medicaid vendor. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

(g) For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services. Residential care services are defined as "supportive services" and "health-related services." "Supportive services" means the provision of up to 24-hour supervision and oversight. Supportive services includes: (1) transportation, when provided by the residential care center only; (2) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate. Health-related services are limited to minimal assistance with dressing, grooming, and bathing and providing reminders to residents to take medications that are self-administered or providing storage for medications, if requested. Individuals receiving residential care services cannot receive ~~both personal care services and residential care~~ homemaking services.

(h) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D. Assisted living services are defined as up to 24-hour supervision, and oversight, supportive services as defined in clause (1), individualized home care aide tasks as defined in clause (2), and individualized home management tasks as defined in clause (3) provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

(1) Supportive services include:

(i) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature;

(ii) assisting clients in setting up meetings and appointments; and

(iii) providing transportation, when provided by the residential center only.

Individuals receiving assisted living services will not receive both assisted living services and homemaking ~~or personal care~~ services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions.

(2) Home care aide tasks means:

(i) preparing modified diets, such as diabetic or low sodium diets;

(ii) reminding residents to take regularly scheduled medications or to perform exercises;

(iii) household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

(iv) household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

(v) assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

(3) Home management tasks means:

(i) housekeeping;

(ii) laundry;

(iii) preparation of regular snacks and meals; and

(iv) shopping.

Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

(i) For establishments registered under chapter 144D, assisted living services under this section means the services described and licensed under section 144A.4605.

(j) For the purposes of this section, reimbursement for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident. The rate shall not exceed the nonfederal share of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate of the case mix resident class to which the 180-day eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, unless the services are provided by a home care provider licensed by the department of health and are provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision.

(k) For purposes of this section, companion services are defined as nonmedical care, supervision and oversight, provided to a functionally impaired adult. Companions

may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the recipient. This service must be approved by the case manager as part of the care plan. Companion services must be provided by individuals or organizations who are under contract with the local agency to provide the service. Any person related to the waiver recipient by blood, marriage or adoption cannot be reimbursed under this service. Persons providing companion services will be monitored by the case manager.

(l) For purposes of this section, training for direct informal caregivers is defined as a classroom or home course of instruction which may include: transfer and lifting skills, nutrition, personal and physical cares, home safety in a home environment, stress reduction and management, behavioral management, long-term care decision making, care coordination and family dynamics. The training is provided to an informal unpaid caregiver of a 180-day eligible client which enables the caregiver to deliver care in a home setting with high levels of quality. The training must be approved by the case manager as part of the individual care plan. Individuals, agencies, and educational facilities which provide caregiver training and education will be monitored by the case manager.

(m) A county agency may make payment from their alternative care program allocation for other services provided to an alternative care program recipient if those services prevent, shorten, or delay institutionalization. These services may include direct cash payments to the recipient for the purpose of purchasing the recipient's services. The following provisions apply to payments under this paragraph:

(1) a cash payment to a client under this provision cannot exceed 80 percent of the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause (7);

(2) a county may not approve any cash payment for a client who has been assessed as having a dependency in orientation, unless the client has an authorized representative under section 256.476, subdivision 2, paragraph (g), or for a client who is concurrently receiving adult foster care, residential care, or assisted living services;

(3) any service approved under this section must be a service which meets the purpose and goals of the program as listed in subdivision 1;

(4) cash payments must also meet the criteria of and are governed by the procedures and liability protection established in section 256.476, subdivision 4, ~~paragraph~~ paragraphs (b) through (h), and recipients of cash grants must meet the requirements in section 256.476, subdivision 10; and

(5) the county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

Upon implementation of direct cash payments to clients under this section, any person determined eligible for the alternative care program who chooses a cash payment

approved by the county agency shall receive the cash payment under this section and not under section 256.476 unless the person was receiving a consumer support grant under section 256.476 before implementation of direct cash payments under this section.

Sec. 2. Minnesota Statutes 1998, section 256B.411, subdivision 2, is amended to read:

Subd. 2. **REQUIREMENTS.** No medical assistance payments shall be made to any nursing facility unless the nursing facility is certified to participate in the medical assistance program under title XIX of the federal Social Security Act and has in effect a provider agreement with the commissioner meeting the requirements of state and federal statutes and rules. No medical assistance payments shall be made to any nursing facility unless the nursing facility complies with all requirements of Minnesota Statutes including, but not limited to, this chapter and rules adopted under it that govern participation in the program. This section applies whether the nursing facility participates fully in the medical assistance program or is withdrawing from the medical assistance program. No future payments may be made to any nursing facility which has withdrawn or is withdrawing from the medical assistance program except as provided in section 256B.48, subdivision 1a; ~~provided, however, that,~~ or federal law. Payments may also be made under a court order entered on or before June 7, 1985, unless the court order is reversed on appeal.

Sec. 3. Minnesota Statutes 1998, section 256B.431, subdivision 1, is amended to read:

Subdivision 1. **IN GENERAL.** The commissioner shall determine prospective payment rates for resident care costs. ~~In determining the rates, the commissioner shall group nursing facilities according to different levels of care and geographic location until July 1, 1985.~~ For rates established on or after July 1, 1985, the commissioner shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs, geographic location, and other factors as determined by the commissioner. The commissioner shall consider whether the fact that a facility is attached to a hospital or has an average length of stay of 180 days or less should be taken into account in determining rates. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. ~~Until the commissioner establishes procedures for determining operating cost payment rates, the commissioner shall group all convalescent and nursing care units attached to hospitals into one group for purposes of determining reimbursement for operating costs. On or before June 15, 1983, the commissioner shall mail notices to each nursing facility of the rates to be effective from July 1 of that year to June 30 of the following year. In subsequent years,~~ The commissioner shall provide notice to each nursing facility on or before May 1 of the rates effective for the following rate year. ~~If a statute enacted after May 1 affects the rates, the commissioner shall provide a revised notice to each nursing facility as soon as possible~~ except that if legislation is pending on May 1 that may affect rates for nursing facilities, the commissioner shall set the rates after the legislation is enacted and provide notice to each facility as soon as possible.

New language is indicated by underline, **deletions by** ~~strikeout.~~

~~The commissioner shall establish, by rule, limitations on compensation recognized in the historical base for top management personnel. For rate years beginning July 1, 1985, the commissioner shall not provide, by rule, limitations on top management personnel.~~ Compensation for top management personnel shall continue to be categorized as a general and administrative cost and is subject to any limits imposed on that cost category. ~~The commissioner shall also establish, by rule, limitations on allowable nursing hours for each level of care for the rate years beginning July 1, 1983 and July 1, 1984. For the rate year beginning July 1, 1984, nursing facilities in which the nursing hours exceeded 2.9 hours per day for skilled nursing care or 2.3 hours per day for intermediate care for the reporting year ending on September 30, 1983, shall be limited to a maximum of 3.2 hours per day for skilled nursing care and 2.6 hours per day for intermediate care.~~

Sec. 4. Minnesota Statutes 1998, section 256B.431, subdivision 3a, is amended to read:

Subd. 3a. **PROPERTY-RELATED COSTS AFTER JULY 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner, by permanent rule, shall reimburse nursing facility providers that are vendors in the medical assistance program for the rental use of real estate and depreciable equipment. "Real estate" means land improvements, buildings, and attached fixtures used directly for resident care. "Depreciable equipment" means the standard movable resident care equipment and support service equipment generally used in long-term care facilities.

(b) In developing the method for determining payment rates for the rental use of nursing facilities, the commissioner shall consider factors designed to:

(1) simplify the administrative procedures for determining payment rates for property-related costs;

(2) minimize discretionary or appealable decisions;

(3) eliminate any incentives to sell nursing facilities;

(4) recognize legitimate costs of preserving and replacing property;

(5) recognize the existing costs of outstanding indebtedness allowable under the statutes and rules in effect on May 1, 1983;

(6) address the current value of, if used directly for patient care, land improvements, buildings, attached fixtures, and equipment;

(7) establish an investment per bed limitation;

(8) reward efficient management of capital assets;

(9) provide equitable treatment of facilities;

(10) consider a variable rate; and

(11) phase-in implementation of the rental reimbursement method.

~~(c) No later than January 1, 1984, the commissioner shall report to the legislature on any further action necessary or desirable in order to implement the purposes and provisions of this subdivision.~~

~~(d)~~ (c) For rate years beginning on or after July 1, 1987, a nursing facility which has reduced licensed bed capacity after January 1, 1986, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed prior to the reduction; and

(2) establish capacity days for each rate year following the licensure reduction based on the number of beds licensed on the previous April 1 if the commissioner is notified of the change by April 4. The notification must include a copy of the delicensure request that has been submitted to the commissioner of health.

~~(e) Until the rental reimbursement method is fully phased in, a nursing facility whose final property-related payment rate is the rental rate shall continue to have its property-related payment rates established based on the rental reimbursement method.~~

~~(f)~~ (d) For rate years beginning on or after July 1, 1989, the interest expense that results from a refinancing of a nursing facility's demand call loan, when the loan that must be refinanced was incurred before May 22, 1983, is an allowable interest expense if:

(1) the demand call loan or any part of it was in the form of a loan that was callable at the demand of the lender;

(2) the demand call loan or any part of it was called by the lender through no fault of the nursing facility;

(3) the demand call loan or any part of it was made by a government agency operating under a statutory or regulatory loan program;

(4) the refinanced debt does not exceed the sum of the allowable remaining balance of the demand call loan at the time of payment on the demand call loan and refinancing costs;

(5) the term of the refinanced debt does not exceed the remaining term of the demand call loan, had the debt not been subject to an on-call payment demand; and

(6) the refinanced debt is not a debt between related organizations as defined in Minnesota Rules, part 9549.0020, subpart 38.

Sec. 5. Minnesota Statutes 1998, section 256B.431, subdivision 10, is amended to read:

Subd. 10. **PROPERTY RATE ADJUSTMENTS AND CONSTRUCTION PROJECTS.** A nursing facility's request for a property-related payment rate adjustment and the related supporting documentation of project construction cost information must be submitted to the commissioner within 60 days after the construction project's completion date to be considered eligible for a property-related payment rate adjustment. Construction projects with completion dates within one year of the

completion date associated with the property rate adjustment request and phased projects with project completion dates within three years of the last phase of the phased project must be aggregated for purposes of the minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section 144A.071, subdivision 2. "Construction project~~,~~" and "project construction costs~~,~~" ~~and "phased project"~~ have the meanings given them in Minnesota ~~Rules, part 4655.1110 (Emergency)~~ Statutes, section 144A.071, subdivision 1a.

Sec. 6. Minnesota Statutes 1998, section 256B.431, subdivision 16, is amended to read:

Subd. 16. **MAJOR ADDITIONS AND REPLACEMENTS; EQUITY INCENTIVE.** For rate years beginning after June 30, 1993, if a nursing facility acquires capital assets in connection with a project approved under the moratorium exception process in section 144A.073 or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of those capital asset additions exceeds the lesser of $150,000 or ten percent of the most recent appraised value, the nursing facility shall be eligible for an equity incentive payment rate as in paragraphs (a) to (d). This computation is separate from the determination of the nursing facility's rental rate. An equity incentive payment rate as computed under this subdivision is limited to one in a 12-month period.

(a) An eligible nursing facility shall receive an equity incentive payment rate equal to the allowable historical cost of the capital asset acquired, minus the allowable debt directly identified to that capital asset, multiplied by the equity incentive factor as described in paragraphs (b) and (c), and divided by the nursing facility's occupancy factor under subdivision 3f, paragraph (c). This amount shall be added to the nursing facility's total payment rate and shall be effective the same day as the incremental increase in paragraph (d) or subdivision 17. The allowable historical cost of the capital assets and the allowable debt shall be determined as provided in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) The equity incentive factor shall be determined under clauses (1) to (4):

(1) divide the initial allowable debt in paragraph (a) by the initial historical cost of the capital asset additions referred to in paragraph (a), then cube the quotient,

(2) subtract the amount calculated in clause (1) from the number one,

(3) determine the difference between the rental factor and the lesser of two percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on the first day of the month the debt or cost is incurred, or 16 percent,

(4) multiply the amount calculated in clause (2) by the amount calculated in clause (3).

(c) The equity incentive payment rate shall be limited to the term of the allowable debt in paragraph (a), not greater than 20 years nor less than ten years. If no debt is

incurred in acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The sale of a nursing facility under subdivision 14 shall terminate application of the equity incentive payment rate effective on the date provided in subdivision 4 14, paragraph (f), for the sale.

(d) A nursing facility with an addition to or a renovation of its buildings, attached fixtures, or land improvements meeting the criteria in this subdivision and not receiving the property-related payment rate adjustment in subdivision 17, shall receive the incremental increase in the nursing facility's rental rate as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section. The incremental increase shall be added to the nursing facility's property-related payment rate. The effective date of this incremental increase shall be the first day of the month following the month in which the addition or replacement is completed.

Sec. 7. Minnesota Statutes 1999 Supplement, section 256B.431, subdivision 17, is amended to read:

Subd. 17. **SPECIAL PROVISIONS FOR MORATORIUM EXCEPTIONS.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 3, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that (1) has completed a construction project approved under section 144A.071, subdivision 4a, clause (m); (2) has completed a construction project approved under section 144A.071, subdivision 4a, and effective after June 30, 1995; or (3) has completed a renovation, replacement, or upgrading project approved under the moratorium exception process in section 144A.073 shall be reimbursed for costs directly identified to that project as provided in subdivision 16 and this subdivision.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

(1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed six percent of the total historical cost of the project; and

(2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight-line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

(c) Debt incurred for costs under paragraph (b) is not subject to Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (5) or (6).

(d) The incremental increase in a nursing facility's rental rate, determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, resulting from the

acquisition of allowable capital assets, and allowable debt and interest expense under this subdivision shall be added to its property-related payment rate and shall be effective on the first day of the month following the month in which the moratorium project was completed.

(e) Notwithstanding subdivision 3f, paragraph (a), for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Minnesota Rules, part 9549.0060, subpart 4, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process in section 144A.073, or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the most recent appraised value, must be $47,500 per licensed bed in multiple-bed rooms and $71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

~~(f) A nursing facility that completes a project identified in this subdivision and, as of April 17, 1992, has not been mailed a rate notice with a special appraisal for a completed project, or completes a project after April 17, 1992, but before September 1, 1992, may elect either to request a special reappraisal with the corresponding adjustment to the property-related payment rate under the laws in effect on June 30, 1992, or to submit their capital asset and debt information after that date and obtain the property-related payment rate adjustment under this section, but not both.~~

~~(g)~~ (f) For purposes of this paragraph, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant or the transfer of the nursing facility's license from one physical plant location to another. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a, paragraph ~~(d)~~ (c), shall apply. If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this part, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (1) to (3):

(1) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage.

(2) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant.

(3) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (1) by clause (2).

In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of this subdivision shall also apply. For purposes of the moratorium exception authorized under section 144A.071, subdivision 4a, paragraph (s), if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

~~(h)~~ (g) Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in paragraph ~~(g)~~ (f), authorized under section 144A.071 or 144A.073 after July 1, 1999, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

~~(i)~~ (h) For a total replacement, as defined in paragraph ~~(g)~~ (f), authorized under section 144A.073 for a 96-bed nursing home in Carlton county, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident's beds, and $111,420 per licensed bed in a single room. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement-costs-new multiplied by 1.25 shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

Sec. 8. Minnesota Statutes 1998, section 256B.431, subdivision 18, is amended to read:

Subd. 18. **~~APPRAISALS;~~ UPDATING APPRAISALS, ADDITIONS, AND REPLACEMENTS.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subparts 1 to 3, the appraised value, routine updating of the appraised value, and special reappraisals are subject to this subdivision.

~~(1) For rate years beginning after June 30, 1993, the commissioner shall permit a nursing facility to appeal its appraisal. Any reappraisals conducted in connection with that appeal must utilize the comparative unit method as described in the Marshall Valuation Service published by Marshall-Swift in establishing the nursing facility's depreciated replacement cost.~~

~~Nursing facilities electing to appeal their appraised value shall file written notice of appeal with the commissioner of human services before December 30, 1992. The cost of the reappraisal, if any, shall be considered an allowable cost under Minnesota Rules, parts 9549.0040, subpart 9, and 9549.0061.~~

~~(2) The redetermination of a nursing facility's appraised value under this paragraph shall have no impact on the rental payment rate determined under subdivision 13 but shall only be used for calculating the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section for rate years beginning after June 30, 1993.~~

~~(3)~~ For all rate years after June 30, 1993, the commissioner shall no longer conduct any appraisals under Minnesota Rules, part 9549.0060, for the purpose of determining property-related payment rates.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 2, for rate years beginning after June 30, 1993, the commissioner shall routinely update the appraised value of each nursing facility by adding the cost of capital asset acquisitions to its allowable appraised value.

The commissioner shall also annually index each nursing facility's allowable appraised value by the inflation index referenced in subdivision 3f, paragraph (a), for the purpose of computing the nursing facility's annual rental rate. In annually adjusting the nursing facility's appraised value, the commissioner must not include the historical cost of capital assets acquired during the reporting year in the nursing facility's appraised value.

In addition, the nursing facility's appraised value must be reduced by the historical cost of capital asset disposals or applicable credits such as public grants and insurance proceeds. Capital asset additions and disposals must be reported on the nursing facility's annual cost report in the reporting year of acquisition or disposal. The incremental increase in the nursing facility's rental rate resulting from this annual adjustment as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section shall be added to the nursing facility's property-related payment rate for the rate year following the reporting year.

Sec. 9. Minnesota Statutes 1998, section 256B.431, subdivision 21, is amended to read:

Subd. 21. **INDEXING THRESHOLDS.** Beginning January 1, 1993, and each January 1 thereafter, the commissioner shall annually update the dollar thresholds in subdivisions 15, paragraph ~~(d)~~ (e), 16, and 17, and in section 144A.071, subdivisions 2 and 4a, clauses (b) and (e), by the inflation index referenced in subdivision 3f, paragraph (a).

Sec. 10. Minnesota Statutes 1998, section 256B.431, subdivision 22, is amended to read:

Subd. 22. **CHANGES TO NURSING FACILITY REIMBURSEMENT.** The nursing facility reimbursement changes in paragraphs (a) to ~~(e)~~ (d) apply to Minnesota

Rules, parts 9549.0010 to 9549.0080, and this section, and are effective for rate years beginning on or after July 1, 1993, unless otherwise indicated.

(a) In addition to the approved pension or profit sharing plans allowed by the reimbursement rule, the commissioner shall allow those plans specified in Internal Revenue Code, sections 403(b) and 408(k).

(b) The commissioner shall allow as workers' compensation insurance costs under section 256B.421, subdivision 14, the costs of workers' compensation coverage obtained under the following conditions:

(1) a plan approved by the commissioner of commerce as a Minnesota group or individual self-insurance plan as provided in section 79A.03;

(2) a plan in which:

(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) a related organization to the nursing facility reinsures the workers' compensation coverage purchased, directly or indirectly, by the nursing facility; and

(iii) all of the conditions in clause (4) are met;

(3) a plan in which:

(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) the insurance premium is calculated retrospectively, including a maximum premium limit, and paid using the paid loss retro method; and

(iii) all of the conditions in clause (4) are met;

(4) additional conditions are:

(i) the costs of the plan are allowable under the federal Medicare program;

(ii) the reserves for the plan are maintained in an account controlled and administered by a person which is not a related organization to the nursing facility;

(iii) the reserves for the plan cannot be used, directly or indirectly, as collateral for debts incurred or other obligations of the nursing facility or related organizations to the nursing facility;

(iv) if the plan provides workers' compensation coverage for non-Minnesota nursing facilities, the plan's cost methodology must be consistent among all nursing facilities covered by the plan, and if reasonable, is allowed notwithstanding any reimbursement laws regarding cost allocation to the contrary;

(v) central, affiliated, corporate, or nursing facility costs related to their administration of the plan are costs which must remain in the nursing facility's administrative cost category and must not be allocated to other cost categories;

(vi) required security deposits, whether in the form of cash, investments, securities, assets, letters of credit, or in any other form are not allowable costs for purposes of establishing the facilities payment rate; and

(vii) for the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures workers' compensation may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are reimbursed under this section or section 256B.434. The method of cost allocation shall be based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly allocated within each nursing facility's operating cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate method of allocation of self-insurance costs must be received by the commissioner no later than May 1, 1998, to take effect July 1, 1998, or such costs shall continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its workers' compensation self-insurance costs, it shall remain in effect until such time as the group no longer self-insures these costs;

(5) any costs allowed pursuant to clauses (1) to (3) are subject to the following requirements:

(i) if the nursing facility is sold or otherwise ceases operations, the plan's reserves must be subject to an actuarially based settle-up after 36 months from the date of sale or the date on which operations ceased. The facility's medical assistance portion of the total excess plan reserves must be paid to the state within 30 days following the date on which excess plan reserves are determined;

(ii) any distribution of excess plan reserves made to or withdrawals made by the nursing facility or a related organization are applicable credits and must be used to reduce the nursing facility's workers' compensation insurance costs in the reporting period in which a distribution or withdrawal is received;

(iii) if reimbursement for the plan is sought under the federal Medicare program, and is audited pursuant to the Medicare program, the nursing facility must provide a copy of Medicare's final audit report, including attachments and exhibits, to the commissioner within 30 days of receipt by the nursing facility or any related organization. The commissioner shall implement the audit findings associated with the plan upon receipt of Medicare's final audit report. The department's authority to implement the audit findings is independent of its authority to conduct a field audit.

(c) In the determination of incremental increases in the nursing facility's rental rate as required in subdivisions 14 to 21, except for a refinancing permitted under subdivision 19, the commissioner must adjust the nursing facility's property-related payment rate for both incremental increases and decreases in recomputations of its rental rate;

(d) A nursing facility's administrative cost limitation must be modified as follows:

(1) if the nursing facility's licensed beds exceed 195 licensed beds, the general and administrative cost category limitation shall be 13 percent;

(2) if the nursing facility's licensed beds are more than 150 licensed beds, but less than 196 licensed beds, the general and administrative cost category limitation shall be 14 percent; or

(3) if the nursing facility's licensed beds is less than 151 licensed beds, the general and administrative cost category limitation shall remain at 15 percent.

(e) ~~The care related operating rate shall be increased by eight cents to reimburse facilities for unfunded federal mandates, including costs related to hepatitis B vaccinations.~~

~~(f)~~ For the rate year beginning on July 1, 1998, a group of nursing facilities related by common ownership that self-insures group health, dental, or life insurance may allocate its directly identified costs of self-insuring its Minnesota nursing facility workers among those nursing facilities in the group that are reimbursed under this section or section 256B.434. The method of cost allocation shall be based on the ratio of each nursing facility's total allowable salaries and wages to that of the nursing facility group's total allowable salaries and wages, then similarly allocated within each nursing facility's operating cost categories. The costs associated with the administration of the group's self-insurance plan must remain classified in the nursing facility's administrative cost category. A written request of the nursing facility group's election to use this alternate method of allocation of self-insurance costs must be received by the commissioner no later than May 1, 1998, to take effect July 1, 1998, or those self-insurance costs shall continue to be allocated under the existing cost allocation methods. Once a nursing facility group elects this method of cost allocation for its group health, dental, or life insurance self-insurance costs, it shall remain in effect until such time as the group no longer self-insures these costs.

Sec. 11. Minnesota Statutes 1998, section 256B.431, subdivision 25, is amended to read:

Subd. 25. **CHANGES TO NURSING FACILITY REIMBURSEMENT BEGINNING JULY 1, 1995.** ~~The nursing facility reimbursement changes in paragraphs (a) to (g) shall apply in the sequence specified to Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, beginning July 1, 1995.~~

~~(a) The eight-cent adjustment to care-related rates in subdivision 22, paragraph (e), shall no longer apply.~~

~~(b) For rate years beginning on or after July 1, 1995, the commissioner shall limit a nursing facility's allowable operating per diem for each case mix category for each rate year as in clauses (1) to (3).~~

~~(1) For the rate year beginning July 1, 1995, the commissioner shall group nursing facilities into two groups, freestanding and nonfreestanding, within each geographic group, using their operating cost per diem for the case mix A classification. A nonfreestanding nursing facility is a nursing facility whose other operating cost per~~

~~diem is subject to the hospital attached, short length of stay, or the rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities in each grouping by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem:~~

~~(i) is at or below the median minus 1.0 standard deviation of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by six percentage points, or the current reporting year's corresponding allowable operating cost per diem;~~

~~(ii) is between minus .5 standard deviation and minus 1.0 standard deviation below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by four percentage points, or the current reporting year's corresponding allowable operating cost per diem; or~~

~~(iii) is equal to or above minus .5 standard deviation below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by three percentage points, or the current reporting year's corresponding allowable operating cost per diem.~~

~~(2) For the rate year beginning on July 1, 1996, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by one percentage point or the current reporting year's corresponding allowable operating cost per diems; and~~

~~(3) For rate years beginning on or after July 1, 1997, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the reporting year prior to the current reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), or the current reporting year's corresponding allowable operating cost per diems.~~

~~(c) For rate years beginning on July 1, 1995, the commissioner shall limit the allowable operating cost per diems for high cost nursing facilities. After application of the limits in paragraph (b) to each nursing facility's operating cost per diems, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diems are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered~~

~~freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A operating cost per diems. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by two percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by one percent.~~

~~(d) For rate years beginning on or after July 1, 1996, the commissioner shall limit the allowable operating cost per diems for high cost nursing facilities. After application of the limits in paragraph (b) to each nursing facility's operating cost per diems, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diems are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A operating cost per diems. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). In those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by three percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by two percent.~~

~~(e) For rate years beginning on or after July 1, 1995, the commissioner shall determine a nursing facility's efficiency incentive by first computing the allowable difference, which is the lesser of $4.50 or the amount by which the facility's other operating cost limit exceeds its nonadjusted other operating cost per diem for that rate year. The commissioner shall compute the efficiency incentive by:~~

~~(1) subtracting the allowable difference from $4.50 and dividing the result by $4.50;~~

~~(2) multiplying 0.20 by the ratio resulting from clause (1), and then;~~

~~(3) adding 0.50 to the result from clause (2); and~~

~~(4) multiplying the result from clause (3) times the allowable difference.~~

~~The nursing facility's efficiency incentive payment shall be the lesser of $2.25 or the product obtained in clause (4).~~

New language is indicated by underline, **deletions by** ~~strikeout.~~

~~(f) For rate years beginning on or after July 1, 1995, the forecasted price index for a nursing facility's allowable operating cost per diems shall be determined under clauses (1) to (3) using the change in the Consumer Price Index-All Items (United States city average) (CPI-U) or the change in the Nursing Home Market Basket, both as forecasted by Data Resources Inc., whichever is applicable. The commissioner shall use the indices as forecasted in the fourth quarter of the calendar year preceding the rate year, subject to subdivision 2l, paragraph (e). If, as a result of federal legislative or administrative action, the methodology used to calculate the Consumer Price Index-All Items (United States city average) (CPI-U) changes, the commissioner shall develop a conversion factor or other methodology to convert the CPI-U index factor that results from the new methodology to an index factor that approximates, as closely as possible, the index factor that would have resulted from application of the original CPI-U methodology prior to any changes in methodology. The commissioner shall use the conversion factor or other methodology to calculate an adjusted inflation index. The adjusted inflation index must be used to calculate payment rates under this section instead of the CPI-U index specified in paragraph (d). If the commissioner is required to develop an adjusted inflation index, the commissioner shall report to the legislature as part of the next budget submission the fiscal impact of applying this index.~~

~~(1) The CPI-U forecasted index for allowable operating cost per diems shall be based on the 21-month period from the midpoint of the nursing facility's reporting year to the midpoint of the rate year following the reporting year.~~

~~(2) The Nursing Home Market Basket forecasted index for allowable operating costs and per diem limits shall be based on the 12-month period between the midpoints of the two reporting years preceding the rate year.~~

~~(3) For rate years beginning on or after July 1, 1996, the forecasted index for operating cost limits referred to in subdivision 21, paragraph (b), shall be based on the CPI-U for the 12-month period between the midpoints of the two reporting years preceding the rate year.~~

~~(g) After applying these provisions for the respective rate years, the commissioner shall index these allowable operating costs per diems by the inflation factor provided for in paragraph (f), clause (1), and add the nursing facility's efficiency incentive as computed in paragraph (e).~~

~~(h)~~(1) A nursing facility licensed for 302 beds on September 30, 1993, that was approved under the moratorium exception process in section 144A.073 for a partial replacement, and completed the replacement project in December 1994, is exempt from Minnesota Statutes 1998, section 256B.431, subdivision 25, paragraphs (b) to (d) for rate years beginning on or after July 1, 1995.

~~(2)~~ For the rate year beginning July 1, 1997, after computing this nursing facility's payment rate according to section 256B.434, the commissioner shall make a one-year rate adjustment of $8.62 to the facility's contract payment rate for the rate effect of operating cost changes associated with the facility's 1994 downsizing project.

~~(3)~~ For rate years beginning on or after July 1, 1997, the commissioner shall add 35 cents to the facility's base property related payment rate for the rate effect of reducing its licensed capacity to 290 beds from 302 beds and shall add 83 cents to the facility's real estate tax and special assessment payment rate for payments in lieu of real estate taxes. The adjustments in this clause shall remain in effect for the duration of the facility's contract under section 256B.434.

~~(i) Notwithstanding Laws 1996, chapter 451, article 3, section 11, paragraph (h), for the rate years beginning on July 1, 1996, July 1, 1997, and July 1, 1998, a nursing facility licensed for 40 beds effective May 1, 1992, with a subsequent increase of 20 Medicare/Medicaid certified beds, effective January 26, 1993, in accordance with an increase in licensure is exempt from paragraphs (b) to (d).~~

Sec. 12. Minnesota Statutes 1999 Supplement, section 256B.431, subdivision 26, is amended to read:

Subd. 26. **CHANGES TO NURSING FACILITY REIMBURSEMENT BEGINNING JULY 1, 1997.** The nursing facility reimbursement changes in paragraphs (a) to ~~(f)~~ (e) shall apply in the sequence specified in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, beginning July 1, 1997.

(a) For rate years beginning on or after July 1, 1997, the commissioner shall limit a nursing facility's allowable operating per diem for each case mix category for each rate year. The commissioner shall group nursing facilities into two groups, freestanding and nonfreestanding, within each geographic group, using their operating cost per diem for the case mix A classification. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diem is subject to the hospital attached, short length of stay, or the rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities in each grouping by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem:

(1) is at or below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diem as specified in Laws 1996, chapter 451, article 3, section 11, paragraph (h), plus the inflation factor as established in paragraph (d), clause (2), increased by two percentage points, or the current reporting year's corresponding allowable operating cost per diem; or

(2) is above the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diem as specified in Laws 1996, chapter 451, article 3, section 11, paragraph (h), plus the inflation factor as established in paragraph (d), clause (2), increased by one percentage point, or the current reporting year's corresponding allowable operating cost per diem.

For purposes of paragraph (a), if a nursing facility reports on its cost report a reduction in cost due to a refund or credit for a rate year beginning on or after July 1, 1998, the commissioner shall increase that facility's spend-up limit for the rate year following the current rate year by the amount of the cost reduction divided by its resident days for the reporting year preceding the rate year in which the adjustment is to be made.

(b) For rate years beginning on or after July 1, 1997, the commissioner shall limit the allowable operating cost per diem for high cost nursing facilities. After application of the limits in paragraph (a) to each nursing facility's operating cost per diem, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diem are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diem by three percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diem by two percent. However, in no case shall a nursing facility's operating cost per diem be reduced below its grouping's limit established at 0.5 standard deviations above the median.

(c) For rate years beginning on or after July 1, 1997, the commissioner shall determine a nursing facility's efficiency incentive by first computing the allowable difference, which is the lesser of $4.50 or the amount by which the facility's other operating cost limit exceeds its nonadjusted other operating cost per diem for that rate year. The commissioner shall compute the efficiency incentive by:

(1) subtracting the allowable difference from $4.50 and dividing the result by $4.50;

(2) multiplying 0.20 by the ratio resulting from clause (1), and then;

(3) adding 0.50 to the result from clause (2); and

(4) multiplying the result from clause (3) times the allowable difference.

The nursing facility's efficiency incentive payment shall be the lesser of $2.25 or the product obtained in clause (4).

(d) For rate years beginning on or after July 1, 1997, the forecasted price index for a nursing facility's allowable operating cost per diem shall be determined under clauses (1) and (2) using the change in the Consumer Price Index-All Items (United States city average) (CPI-U) as forecasted by Data Resources, Inc. The commissioner

shall use the indices as forecasted in the fourth quarter of the calendar year preceding the rate year, subject to subdivision 21, paragraph (c).

(1) The CPI-U forecasted index for allowable operating cost per diem shall be based on the 21-month period from the midpoint of the nursing facility's reporting year to the midpoint of the rate year following the reporting year.

(2) For rate years beginning on or after July 1, 1997, the forecasted index for operating cost limits referred to in subdivision 21, paragraph (b), shall be based on the CPI-U for the 12-month period between the midpoints of the two reporting years preceding the rate year.

(e) After applying these provisions for the respective rate years, the commissioner shall index these allowable operating cost per diem by the inflation factor provided for in paragraph (d), clause (1), and add the nursing facility's efficiency incentive as computed in paragraph (c).

~~(f) For rate years beginning on or after July 1, 1997, the total operating cost payment rates for a nursing facility shall be the greater of the total operating cost payment rates determined under this section or the total operating cost payment rates in effect on June 30, 1997, subject to rate adjustments due to field audit or rate appeal resolution. This provision shall not apply to subsequent field audit adjustments of the nursing facility's operating cost rates for rate years beginning on or after July 1, 1997.~~

~~(g)~~ (f) For the rate years beginning on July 1, 1997, July 1, 1998, and July 1, 1999, a nursing facility licensed for 40 beds effective May 1, 1992, with a subsequent increase of 20 Medicare/Medicaid certified beds, effective January 26, 1993, in accordance with an increase in licensure is exempt from paragraphs (a) and (b).

~~(h)~~ (g) For a nursing facility whose construction project was authorized according to section 144A.073, subdivision 5, paragraph (g), the operating cost payment rates for the new location shall be determined based on Minnesota Rules, part 9549.0057. The relocation allowed under section 144A.073, subdivision 5, paragraph (g), and the rate determination allowed under this paragraph must meet the cost neutrality requirements of section 144A.073, subdivision 3c. Paragraphs (a) and (b) shall not apply until the second rate year after the settle-up cost report is filed. Notwithstanding subdivision 2b, paragraph (g), real estate taxes and special assessments payable by the new location, a 501(c)(3) nonprofit corporation, shall be included in the payment rates determined under this subdivision for all subsequent rate years.

~~(i)~~ (h) For the rate year beginning July 1, 1997, the commissioner shall compute the payment rate for a nursing facility licensed for 94 beds on September 30, 1996, that applied in October 1993 for approval of a total replacement under the moratorium exception process in section 144A.073, and completed the approved replacement in June 1995, with other operating cost spend-up limit under paragraph (a), increased by $3.98, and after computing the facility's payment rate according to this section, the commissioner shall make a one-year positive rate adjustment of $3.19 for operating costs related to the newly constructed total replacement, without application of paragraphs (a) and (b). The facility's per diem, before the $3.19 adjustment, shall be

used as the prior reporting year's allowable operating cost per diem for payment rate calculation for the rate year beginning July 1, 1998. A facility described in this paragraph is exempt from paragraph (b) for the rate years beginning July 1, 1997, and July 1, 1998.

~~(j)~~ (i) For the purpose of applying the limit stated in paragraph (a), a nursing facility in Kandiyohi county licensed for 86 beds that was granted hospital-attached status on December 1, 1994, shall have the prior year's allowable care-related per diem increased by $3.207 and the prior year's other operating cost per diem increased by $4.777 before adding the inflation in paragraph (d), clause (2), for the rate year beginning on July 1, 1997.

~~(k)~~ (j) For the purpose of applying the limit stated in paragraph (a), a 117 bed nursing facility located in Pine county shall have the prior year's allowable other operating cost per diem increased by $1.50 before adding the inflation in paragraph (d), clause (2), for the rate year beginning on July 1, 1997.

~~(l)~~ (k) For the purpose of applying the limit under paragraph (a), a nursing facility in Hibbing licensed for 192 beds shall have the prior year's allowable other operating cost per diem increased by $2.67 before adding the inflation in paragraph (d), clause (2), for the rate year beginning July 1, 1997.

Sec. 13. Minnesota Statutes 1999 Supplement, section 256B.434, subdivision 3, is amended to read:

Subd. 3. **DURATION AND TERMINATION OF CONTRACTS.** (a) Subject to available resources, the commissioner may begin to execute contracts with nursing facilities November 1, 1995.

(b) All contracts entered into under this section are for a term of one year. Either party may terminate a contract at any time without cause by providing 90 calendar days advance written notice to the other party. The decision to terminate a contract is not appealable. Notwithstanding section 16C.05, subdivision 2, paragraph (a), clause (5), the contract shall be renegotiated for additional one-year terms, unless either party provides written notice of termination. The provisions of the contract shall be renegotiated annually by the parties prior to the expiration date of the contract. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

(c) If a nursing facility fails to comply with the terms of a contract, the commissioner shall provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance. If the facility fails to come into compliance or to remain in compliance, the commissioner may terminate the contract. If a contract is terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was terminated, but in all other respects the provisions of this section do not apply to that facility effective the date the contract is terminated. The contract shall contain a provision governing the transition back to the cost-based reimbursement system established under section 256B.431~~, subdivision 25,~~ and Minnesota Rules, parts 9549.0010 to 9549.0080. A contract

entered into under this section may be amended by mutual agreement of the parties.

Sec. 14. Minnesota Statutes 1999 Supplement, 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, ~~subdivision 25,~~ 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, ~~subdivision 25~~.

(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. 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 Data Resources, Inc., 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, and July 1, 2000, this paragraph shall apply only to the property-related payment rate. 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.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The specified facility-specific outcomes must be measurable and approved by the commissioner. The commissioner may establish, for each contract, various levels of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive-based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

(1) improved cost effectiveness and quality of life as measured by improved clinical outcomes;

(2) successful diversion or discharge to community alternatives;

(3) decreased acute care costs;

(4) improved consumer satisfaction;

(5) the achievement of quality; or

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

Sec. 15. **REPEALER.**

Minnesota Statutes 1998, sections 256B.03, subdivision 2; 256B.431, subdivisions 2, 2a, 2f, 2h, 2m, 2p, 2q, 3, 3b, 3d, 3h, 3j, 4, 5, 7, 8, 9, 9a, 12, and 24; 256B.48, subdivision 9; 256B.50, subdivision 3; and 256B.74, subdivision 3, are repealed effective July 1, 2000.

Sec. 16. **REVISOR INSTRUCTIONS.**

In the next and subsequent editions of Minnesota Statutes and Minnesota Rules, the revisor of statutes shall make any necessary statutory cross-reference changes required as a result of the provisions in this bill.

Sec. 17. **EFFECTIVE DATE.**

The amendment in section 1 to Minnesota Statutes, section 256B.0913, subdivision 5, paragraph (g), is effective July 1, 2000, or upon federal approval of amendments to Minnesota's home and community-based waiver for elderly persons at risk of nursing home level of care, health care financing administration control number 0025.91.R3, whichever occurs later. The remainder of section 1, and sections 2 to 15 are effective July 1, 2000.

Presented to the governor April 27, 2000

Signed by the governor May 1, 2000, 2:45 p.m.

CHAPTER 450—H.F.No. 3047

An act relating to real property; title insurance; modifying mortgage release certificate language to include assignment of rents and profits; modifying common interest ownership resale disclosure certificate requirements; amending Minnesota Statutes 1998, sections 507.401, subdivisions 1, 3, 6, and 7; and 559.17, by adding a subdivision; Minnesota Statutes 1999 Supplement, section 515B.4-107.

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

Section 1. Minnesota Statutes 1998, section 507.401, subdivision 1, is amended to read:

Subdivision 1. **DEFINITIONS.** (a) The definitions in this subdivision apply to this section.

(b) "Assignment of rents and profits" means an assignment, whether in a separate document or in a mortgage, of any of the benefits accruing under a recorded or unrecorded lease or tenancy existing, or subsequently created, on property encumbered