State of Minnesota

# HOUSE OF REPRESENTATIVES

**EIGHTY-NINTH SESSION**

**H. F. No. 1321**

03/02/2015 Authored by Gruenhagen, Quam, Pelowski, Nornes, Dean, M., and others
The bill was read for the first time and referred to the Committee on Aging and Long-Term Care Policy

A bill for an act

relating to human services; phasing out nursing facility rate equalization; amending Minnesota Statutes 2014, sections 256.9657, subdivision 1; 256B.433, subdivision 3; 256B.48, subdivisions 1, 1b.

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

Section 1. Minnesota Statutes 2014, section 256.9657, subdivision 1, is amended to read:

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

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

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

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

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

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

Sec. 2. Minnesota Statutes 2014, section 256B.433, subdivision 3, is amended to read:

Subd. 3. **Separate billings for therapy services.** Until new procedures are developed under subdivision 4, payment for therapy services provided to nursing facility residents that are billed separate from nursing facility's payment rate or according to Minnesota Rules, parts 9505.0170 to 9505.0475, shall be subject to the following requirements:

(a) The practitioner invoice must include, in a format specified by the commissioner, the provider number of the nursing facility where the medical assistance recipient resides regardless of the service setting.

(b) Nursing facilities that are related by ownership, control, affiliation, or employment status to the vendor of therapy services shall report, in a format specified by the commissioner, the revenues received during the reporting year for therapy services provided to residents of the nursing facility. For rate years beginning on or after July 1, 1988, the commissioner shall offset the revenues received during the reporting year for therapy services provided to residents of the nursing facility to the total payment rate of the nursing facility by dividing the amount of offset by the nursing facility's actual resident days. Except as specified in paragraphs (d) and (f), the amount of offset shall be the revenue in excess of 108 percent of the cost removed from the cost report resulting from the requirement of the commissioner to ensure the avoidance of double payments as determined

by section 256B.47. Therapy revenues that are specific to mental health services shall be subject to this paragraph for rate years beginning after June 30, 1993. In establishing a new base period for the purpose of setting operating cost payment rate limits and rates, the commissioner shall not include the revenues offset in accordance with this section.

(c) For rate years beginning on or after July 1, 1987, nursing facilities shall limit charges in total to vendors of therapy services for renting space, equipment, or obtaining other services during the rate year to 108 percent of the annualized cost removed from the reporting year cost report resulting from the requirement of the commissioner to ensure the avoidance of double payments as determined by section 256B.47. If the arrangement for therapy services is changed so that a nursing facility is subject to this paragraph instead of paragraph (b), the cost that is used to determine rent must be adjusted to exclude the annualized costs for therapy services that are not provided in the rate year. The maximum charges to the vendors shall be based on the commissioner's determination of annualized cost and may be subsequently adjusted upon resolution of appeals. Mental health services shall be subject to this paragraph for rate years beginning after June 30, 1993.

(d) The commissioner shall require reporting of all revenues relating to the provision of therapy services and shall establish a therapy cost, as determined by section 256B.47, to revenue ratio for the reporting year ending in 1986. For subsequent reporting years, the ratio may increase five percentage points in total until a new base year is established under paragraph (e). Increases in excess of five percentage points may be allowed if adequate justification is provided to and accepted by the commissioner. Unless an exception is allowed by the commissioner, the amount of offset in paragraph (b) is the greater of the amount determined in paragraph (b) or the amount of offset that is imputed based on one minus the lesser of (1) the actual reporting year ratio or (2) the base reporting year ratio increased by five percentage points, multiplied by the revenues.

(e) The commissioner may establish a new reporting year base for determining the cost to revenue ratio.

(f) If the arrangement for therapy services is changed so that a nursing facility is subject to the provisions of paragraph (b) instead of paragraph (c), an average cost to revenue ratio based on the ratios of nursing facilities that are subject to the provisions of paragraph (b) shall be imputed for paragraph (d).

(g) This section does not allow unrelated nursing facilities to reorganize related organization therapy services and provide services among themselves to avoid offsetting revenues. Nursing facilities that are found to be in violation of this provision shall be subject to the penalty requirements of section 256B.48, subdivision 1, paragraph ~~(f)~~ (h).

Sec. 3. Minnesota Statutes 2014, section 256B.48, subdivision 1, is amended to read:

Subdivision 1. **Prohibited practices.** (a) A nursing facility is not eligible to receive medical assistance payments unless it ~~refrains from all of the following:~~ complies with the prohibitions and requirements in this subdivision.

~~(a) Charging~~ (b) A nursing facility must not charge private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate, except under the following circumstances:

(1) the nursing facility may ~~(1)~~ (i) charge private paying residents a higher rate for a private room, and ~~(2)~~ (ii) charge private paying residents for special services ~~which~~ that are not included in the daily rate if, in addition to the daily rate paid by the commissioner, medical assistance residents are charged separately at the same rate for the same special services ~~in addition to the daily rate paid by the commissioner.~~;

(2) effective October 1, 2015, nursing facilities may charge private paying residents rates up to two percent higher than the sum of the medical assistance allowable payment rate in effect on September 30, 2015, and an adjustment equal to the incremental increase of any other rate increase provided in law, for the RUGs group currently assigned to the resident;

(3) effective October 1, 2016, nursing facilities may charge private paying residents rates up to four percent higher than the sum of the medical assistance allowable payment rate in effect on September 30, 2016, and an adjustment equal to the incremental increase of any other rate increase provided in law, for the RUGs group currently assigned to the resident;

(4) effective October 1, 2017, nursing facilities may charge private paying residents rates up to six percent higher than the sum of the medical assistance allowable payment rate in effect on September 30, 2017, and an adjustment equal to the incremental increase of any other rate increase provided in law, for the RUGs group currently assigned to the resident; and

(5) effective October 1, 2018, nursing facilities may charge private paying residents rates up to eight percent higher than the sum of the medical assistance allowable payment rate in effect on September 30, 2018, and an adjustment equal to the incremental increase of any other rate increase provided in law, for the RUGs group currently assigned to the resident.

Nothing in this paragraph precludes a nursing facility from charging a rate allowable under the nursing facility's single room election option under Minnesota Rules, part 9549.0060, subpart 11, or the enhanced rates under section 256B.431, subdivision 32.

Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be available to all residents in all areas of the nursing facility and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing facility in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing facility. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting year. A nursing facility that charges a private paying resident a rate in violation of this ~~clause~~ paragraph is subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing facility that charges the resident rates in violation of this ~~clause~~ paragraph. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorney fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing facility may request a hearing to determine the allowed rate or rates at issue in the cause of action. Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of an administrative law judge under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The administrative law judge shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this ~~clause~~ paragraph shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance.

~~(b)~~ (c) Effective October 1, 2019, paragraph (b) no longer applies, except that special services, if offered, must be available to all residents of the nursing facility and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services that must be provided by the nursing facility in order to comply with licensure or certification standards and that, if not provided, would result in a deficiency or violation by the nursing facility. Nothing in this paragraph precludes a nursing facility from charging a rate allowable under the nursing facility's single room election option under Minnesota Rules, part 9549.0060, subpart 11, or the enhanced rates under section 256B.431, subdivision 32.

(d) A nursing facility shall refrain from all of the following:

(1) charging, soliciting, accepting, or receiving from an applicant for admission to the facility, or from anyone acting in behalf of the applicant, as a condition of admission,

expediting the admission, or as a requirement for the individual's continued stay, any fee, deposit, gift, money, donation, or other consideration not otherwise required as payment under the state plan. For residents on medical assistance, payment of the medical assistance rate according to the state plan must be accepted as payment in full for services included in the daily rate for continued stay, except where otherwise provided for in statute;

(2) requiring an individual, or anyone acting in behalf of the individual, to loan any money to the nursing facility;

(3) requiring an individual, or anyone acting in behalf of the individual, to promise to leave all or part of the individual's estate to the facility; or

(4) requiring a third-party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

Nothing in this paragraph would prohibit discharge for nonpayment of services in accordance with state and federal regulations.

~~(c) Requiring~~ (e) A nursing facility must not require any resident of the nursing facility to utilize a vendor of health care services chosen by the nursing facility. A nursing facility may require a resident to use pharmacies that utilize unit dose packing systems approved by the Minnesota Board of Pharmacy, and may require a resident to use pharmacies that are able to meet the federal regulations for safe and timely administration of medications such as systems with specific number of doses, prompt delivery of medications, or access to medications on a 24-hour basis. Notwithstanding the provisions of this paragraph, nursing facilities shall not restrict a resident's choice of pharmacy because the pharmacy utilizes a specific system of unit dose drug packing.

~~(d) Providing~~ (f) A nursing facility must not provide differential treatment on the basis of status with regard to public assistance.

~~(e) Discriminating~~ (g) A nursing facility must not discriminate in admissions, services offered, or room assignment on the basis of status with regard to public assistance ~~or refusal to purchase special services~~. Discrimination in admissions ~~discrimination~~ shall include, but is not limited to~~:~~

~~(1)~~ basing admissions decisions upon ~~assurance by the applicant to the nursing facility, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek~~ information or assurances regarding current or future eligibility for public assistance for payment of nursing facility care ~~costs; and~~.

~~(2) engaging in preferential selection from waiting lists based on an applicant's ability to pay privately or an applicant's refusal to pay for a special service.~~

The collection and use by a nursing facility of financial information of any applicant pursuant to a preadmission screening program established by law shall not raise an

inference that the nursing facility is utilizing that information for any purpose prohibited by this paragraph.

~~(f) Requiring~~ (h) A nursing facility must not require any vendor of medical care as defined by section 256B.02, subdivision 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any amount based on utilization or service levels or any portion of the vendor's fee to the nursing facility except as payment for renting or leasing space or equipment or purchasing support services from the nursing facility as limited by section 256B.433. All agreements must be disclosed to the commissioner upon request of the commissioner. Nursing facilities and vendors of ancillary services that are found to be in violation of this provision shall each be subject to an action by the state of Minnesota or any of its subdivisions or agencies for treble civil damages on the portion of the fee in excess of that allowed by this provision and section 256B.433. Damages awarded must include three times the excess payments together with costs and disbursements including reasonable attorney fees or their equivalent.

~~(g) Refusing~~ (i) A nursing facility must not refuse, for more than 24 hours, to accept a resident returning to the same bed or a bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.

(j) For a period not to exceed 180 days, the commissioner may continue to make medical assistance payments to a nursing facility or boarding care home ~~which~~ that is in violation of this ~~section~~ subdivision if extreme hardship to the residents would result. In these cases the commissioner shall issue an order requiring the nursing facility to correct the violation. The nursing facility shall have 20 days from its receipt of the order to correct the violation. If the violation is not corrected within the 20-day period the commissioner may reduce the payment rate to the nursing facility by up to 20 percent. The amount of the payment rate reduction shall be related to the severity of the violation and shall remain in effect until the violation is corrected. The nursing facility or boarding care home may appeal the commissioner's action pursuant to the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of notice of the commissioner's proposed action.

In the event that the commissioner determines that a nursing facility is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing facility to receive reimbursement on a temporary basis until the resident can be relocated to a participating nursing facility.

Certified beds in facilities ~~which~~ that do not allow medical assistance intake on July 1, 1984, or after shall be deemed to be decertified for purposes of section 144A.071 only.

Sec. 4. Minnesota Statutes 2014, section 256B.48, subdivision 1b, is amended to read:

Subd. 1b. **Exception.** Notwithstanding any agreement between a nursing facility and the Department of Human Services or the provisions of this section or section 256B.411, other than subdivision 1a, the commissioner may authorize continued medical assistance payments to a nursing facility which ceased intake of medical assistance recipients prior to July 1, 1983, and which charges private paying residents rates that exceed those permitted by subdivision 1, paragraph ~~(a)~~ (b), for (i) residents who resided in the nursing facility before July 1, 1983, or (ii) residents for whom the commissioner or any predecessors of the commissioner granted a permanent individual waiver prior to October 1, 1983. Nursing facilities seeking continued medical assistance payments under this subdivision shall make the reports required under subdivision 2, except that on or after December 31, 1985, the financial statements required need not be audited by or contain the opinion of a certified public accountant or licensed public accountant, but need only be reviewed by a certified public accountant or licensed public accountant. In the event that the state is determined by the federal government to be no longer eligible for the federal share of medical assistance payments made to a nursing facility under this subdivision, the commissioner may cease medical assistance payments, under this subdivision, to that nursing facility.