State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 3442

March 8, 2010
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The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight

A bill for an act

relating to human services; modifying personal care assistance requirements; modifying nursing assistant requirements; modifying housing with services registration fees and certain other license fees; requiring long-term care transitional assistance; modifying customized living services; modifying housing with services; changing the rate a nursing facility may charge a private-pay resident; amending Minnesota Statutes 2008, sections 144A.4605, subdivision 5; 144A.61, by adding a subdivision; 144D.03, subdivisions 1, 2, by adding a subdivision; 144D.04, subdivision 2; 144G.06; 256B.0915, by adding a subdivision; 256B.441, subdivision 48, by adding subdivisions; 256B.48, subdivision 1; Minnesota Statutes 2009 Supplement, sections 256.975, subdivision 7; 256B.0625, subdivision 19a; 256B.0659, subdivision 11; 256B.0911, subdivision 3c; 256B.441, subdivision 55; proposing coding for new law in Minnesota Statutes, chapter 144D.

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

Section 1. Minnesota Statutes 2008, section 144A.4605, subdivision 5, is amended to read:

Subd. 5. **License fees.** The license fees for class F home care providers shall be as follows:

(1) ~~$125~~ $250 annually for those providers serving a monthly average of 15 or fewer clients, and for class F providers of all sizes during the first year of operation;

(2) ~~$200~~ $400 annually for those providers serving a monthly average of 16 to 30 clients;

(3) ~~$375~~ $750 annually for those providers serving a monthly average of 31 to 50 clients; and

(4) ~~$625~~ $1,250 annually for those providers serving a monthly average of 51 or more clients.

Sec. 2. Minnesota Statutes 2008, section 144A.61, is amended by adding a subdivision to read:

Subd. 9. **Registry fee.** Nursing assistants required to register with the Department of Health shall pay a $50 annual registration fee. All fee revenue collected under this subdivision shall be deposited into the state general fund.

EFFECTIVE DATE. This section is effective August 1, 2010.

Sec. 3. Minnesota Statutes 2008, section 144D.03, subdivision 1, is amended to read:

Subdivision 1. **Registration procedures.** The commissioner shall establish forms and procedures for annual registration of housing with services establishments. The commissioner shall charge an annual registration fee of ~~$155~~ $2,000. No fee shall be refunded. A registered establishment shall notify the commissioner within 30 days of the date it is no longer required to be registered under this chapter or of any change in the business name or address of the establishment, the name or mailing address of the owner or owners, or the name or mailing address of the managing agent. There shall be no fee for submission of the notice. All fee revenue collected under this subdivision shall be deposited into the state general fund.

Sec. 4. Minnesota Statutes 2008, section 144D.03, subdivision 2, is amended to read:

Subd. 2. **Registration information.** The establishment shall provide the following information to the commissioner in order to be registered:

(1) the business name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

(4) verification that the establishment has entered into a housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) verification that the establishment is complying with the requirements of section 325F.72, if applicable;

(6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to

144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any; ~~and~~

(7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner; and

(8) whether services are included in the base rate to be paid by the resident.

Personal service on the person identified under clause (6) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The designation of one or more individuals under this subdivision shall not affect the legal responsibility of the owner or owners under sections 144D.01 to 144D.06.

Sec. 5. Minnesota Statutes 2008, section 144D.03, is amended by adding a subdivision to read:

Subd. 3. **Certificate of transitional consultation.** A housing with services establishment shall not execute a contract or allow a prospective resident to move in until the establishment has received certification from the Senior LinkAge Line that transition to housing with services consultation under section 256B.0911, subdivision 3c, has been completed. The housing with services establishment shall maintain copies of contracts and certificates for audit for a period of three years.

Sec. 6. Minnesota Statutes 2008, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

(9) a description of the process through which the contract may be modified, amended, or terminated;

(10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

(11) the resident's designated representative, if any;

(12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

Sec. 7. **[144D.08] UNIFORM CONSUMER INFORMATION GUIDE.**

All housing with services establishments shall make available to all prospective and current residents information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06.

Sec. 8. **[144D.09] TERMINATION OF LEASE.**

The housing with services establishment shall include with notice of termination of lease information about how to contact the ombudsman for long-term care, including

the address and phone number along with a statement of how to request problem solving assistance.

Sec. 9. Minnesota Statutes 2008, section 144G.06, is amended to read:

144G.06 UNIFORM CONSUMER INFORMATION GUIDE.

(a) The commissioner of health shall establish an advisory committee consisting of representatives of consumers, providers, county and state officials, and other groups the commissioner considers appropriate. The advisory committee shall present recommendations to the commissioner on:

(1) a format for a guide to be used by individual providers of assisted living, as defined in section 144G.01, that includes information about services offered by that provider, which services may be covered by Medicare, service costs, and other relevant provider-specific information, as well as a statement of philosophy and values associated with assisted living, presented in uniform categories that facilitate comparison with guides issued by other providers; and

(2) requirements for informing assisted living clients, as defined in section 144G.01, of their applicable legal rights.

(b) The commissioner, after reviewing the recommendations of the advisory committee, shall adopt a uniform format for the guide to be used by individual providers, and the required components of materials to be used by providers to inform assisted living clients of their legal rights, and shall make the uniform format and the required components available to assisted living providers.

Sec. 10. Minnesota Statutes 2009 Supplement, section 256.975, subdivision 7, is amended to read:

Subd. 7. **Consumer information and assistance and long-term care options counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a statewide service to aid older Minnesotans and their families in making informed choices about long-term care options and health care benefits. Language services to persons with limited English language skills may be made available. The service, known as Senior LinkAge Line, must be available during business hours through a statewide toll-free number and must also be available through the Internet.

(b) The service must provide long-term care options counseling by assisting older adults, caregivers, and providers in accessing information and options counseling about choices in long-term care services that are purchased through private providers or available through public options. The service must:

(1) develop a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and make these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options;

(8) link callers with quality profiles for nursing facilities and other providers developed by the commissioner of health;

(9) incorporate information about the availability of housing options, as well as registered housing with services and consumer rights within the MinnesotaHelp.info network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall provide ~~information to the commissioner of human services that is consistent with information required by the commissioner of health under section 144G.06, the Uniform Consumer Information Guide~~ information that will facilitate price comparisons, including delineation of charges for rent and for services available. The commissioners of health and human services shall align the data elements required by section 144G.06, the Uniform Consumer Information Guide, and this section to provide consumers standardized information and ease of comparison of long-term care options. The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database;

(10) provide long-term care options counseling. Long-term care options counselors shall:

(i) for individuals not eligible for case management under a public program or public funding source, provide interactive decision support under which consumers, family members, or other helpers are supported in their deliberations to determine appropriate

long-term care choices in the context of the consumer's needs, preferences, values, and individual circumstances, including implementing a community support plan;

(ii) provide Web-based educational information and collateral written materials to familiarize consumers, family members, or other helpers with the long-term care basics, issues to be considered, and the range of options available in the community;

(iii) provide long-term care futures planning, which means providing assistance to individuals who anticipate having long-term care needs to develop a plan for the more distant future; and

(iv) provide expertise in benefits and financing options for long-term care, including Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages, private pay options, and ways to access low or no-cost services or benefits through volunteer-based or charitable programs; and

(11) using risk management and support planning protocols, provide long-term care options counseling to current residents of nursing homes deemed appropriate for discharge by the commissioner. In order to meet this requirement, the commissioner shall provide designated Senior LinkAge Line contact centers with a list of nursing home residents appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a preference to receive long-term care options counseling, with initial assessment, review of risk factors, independent living support consultation, or referral to:

(i) long-term care consultation services under section 256B.0911;

(ii) designated care coordinators of contracted entities under section 256B.035 for persons who are enrolled in a managed care plan; or

(iii) the long-term care consultation team for those who are appropriate for relocation service coordination due to high-risk factors or psychological or physical disability.

Sec. 11. Minnesota Statutes 2009 Supplement, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. **Personal care assistance services.** Medical assistance covers personal care assistance services in a recipient's home. Effective January 1, 2010, to qualify for personal care assistance services, a recipient must require assistance and be determined dependent in one activity of daily living as defined in section 256B.0659, subdivision 1, paragraph (b), or in a Level I behavior as defined in section 256B.0659, subdivision 1, paragraph (c). Beginning July 1, ~~2011~~ 2010, to qualify for personal care assistance services, a recipient must require assistance and be determined dependent in at least two activities of daily living as defined in section 256B.0659. Recipients or responsible parties

must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home. To use personal care assistance services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistance services in an in-home setting according to sections 256B.0651 to 256B.0656. Medical assistance does not cover personal care assistance services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistance services or forgoes the facility per diem for the leave days that personal care assistance services are used. All personal care assistance services must be provided according to sections 256B.0651 to 256B.0656. Personal care assistance services may not be reimbursed if the personal care assistant is the spouse or paid guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the family foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Notwithstanding the provisions of section 256B.0659, the unpaid guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be reimbursed to provide personal care assistance services to the recipient if the guardian or conservator meets all criteria for a personal care assistant according to section 256B.0659, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Sec. 12. Minnesota Statutes 2009 Supplement, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study and pay an annual $50 registration fee to the department. All fee revenue collected under this subdivision shall be deposited into the state general fund. Before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient within the first seven days after the services begin; and

(10) be limited to providing and being paid for up to 310 hours per month of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Effective January 1, 2010, persons who do not qualify as a personal care assistant include parents and stepparents of minors, spouses, paid legal guardians, family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential setting.

EFFECTIVE DATE. This section is effective August 1, 2010.

Sec. 13. Minnesota Statutes 2009 Supplement, section 256B.0911, subdivision 3c, is amended to read:

Subd. 3c. **Transition to housing with services.** (a) Housing with services establishments ~~offering or providing assisted living under chapter 144G~~ shall inform all prospective residents of the ~~availability of and contact information for transitional consultation services under this subdivision prior to executing a lease or contract with the prospective resident~~ requirement to contact the Senior LinkAge Line for long-term care options counseling and transitional consultation. The Senior LinkAge Line shall provide a certificate to the prospective resident and also send a copy of the certificate to the housing with services establishment that the prospective resident chooses, verifying that consultation has been provided. The housing with services establishment shall not execute a contract or allow a prospective resident to move in until the establishment has received certification from the Senior LinkAge Line. The housing with services establishment shall maintain copies of contracts and certificates for audit for a period of three years. The purpose of transitional long-term care consultation is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings, and to delay spenddown to eligibility for publicly funded programs by connecting people to alternative services in their homes before transition to housing with services. Regardless of the consultation, prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

(b) Transitional consultation services are provided as determined by the commissioner of human services in partnership with county long-term care consultation units~~, and the Area Agencies on Aging~~ under section 144D.03, subdivision 3, and are a combination of telephone-based and in-person assistance provided under models developed by the commissioner. The consultation shall be performed in a manner that provides objective and complete information. Transitional consultation must be provided within five working days of the request of the prospective resident as follows:

(1) the consultation must be provided by a qualified professional as determined by the commissioner;

(2) the consultation must include a review of the prospective resident's reasons for considering assisted living, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or assisted living settings that may meet the prospective resident's needs; ~~and~~

(3) the prospective resident shall be informed of the availability of long-term care consultation services described in subdivision 3a that are available at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs. The Senior LinkAge Line and long-term care consultation team shall give the highest priority to referrals who are at highest risk of nursing facility placement or as needed for determining eligibility~~.~~; and

(4) a prospective resident does not include a person moving from the community to housing with services during nonworking hours when:

(i) the move is based on a recent precipitating event that precludes the person from living safely in the community, such as sustaining an injury or the caregiver's inability to provide needed care; and

(ii) the Senior LinkAge Line is contacted on the first working day following the nonworking day move to the registered housing with services.

Sec. 14. Minnesota Statutes 2008, section 256B.0915, is amended by adding a subdivision to read:

Subd. 3i. **Rate reduction for customized living and 24-hour customized living services.** (a) The commissioner shall array counties by the number of housing with services beds per 1,000 individuals age 65 and over, calculated based on each individual county and contiguous counties. The commissioner shall then divide counties based upon this measure of housing with services bed concentration into three groups of near equal size: low, medium, and high concentration.

(b) Effective July 1, 2010, the commissioner shall reduce payment rates for customized living services and 24-hour customized living services, from the rates in effect on June 30, 2010, by:

(1) ... percent for facilities located in counties classified as having a low concentration of housing with services beds;

(2) ... percent for facilities located in counties classified as having a medium concentration of housing with services beds; and

(3) ... percent for facilities located in counties classified as having a high concentration of housing with services beds.

(c) Effective January 1, 2011, the commissioner shall reduce capitation rates paid to managed care and county-based purchasing plans under sections 256B.69 and 256B.692 to reflect this reduction. The commissioner shall reduce capitation rates for the period January 1, 2011, through June 30, 2011, to provide savings equivalent to applying the percentage reductions in paragraph (b) for all of fiscal year 2011.

Sec. 15. Minnesota Statutes 2008, section 256B.441, is amended by adding a subdivision to read:

Subd. 24a. **Medicare costs.** For purposes of computing rates under this section for rate years beginning on or after October 1, 2010, "Medicare costs" means 70.4 percent of Medicare part A and part B revenues received during the reporting year.

Sec. 16. Minnesota Statutes 2008, section 256B.441, subdivision 48, is amended to read:

Subd. 48. **Calculation of operating per diems.** The direct care per diem for each facility shall be the facility's direct care costs divided by its standardized days. The other care-related per diem shall be the sum of the facility's activities costs, other direct care costs, raw food costs, therapy costs, and social services costs, divided by the facility's resident days. The other operating per diem shall be the sum of the facility's administrative costs, dietary costs, housekeeping costs, laundry costs, and maintenance and plant operations costs divided by the facility's resident days. For rate years beginning on or after October 1, 2010, the calculations of the direct care per diem, other care-related per diem, and other operating per diem shall:

(1) have allowable costs reduced by Medicare costs as defined in subdivision 24a. The Medicare costs must be allocated between per diems for direct care, other care-related, and other operating based on a ratio of allowable expenses from the cost report; and

(2) have resident days and standardized days computed without using days paid by Medicare.

Sec. 17. Minnesota Statutes 2009 Supplement, section 256B.441, subdivision 55, is amended to read:

Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated under this section shall be phased in by blending the operating rate with the operating payment rate determined under section 256B.434. For purposes of this subdivision, the rate to be used that is determined under section 256B.434 shall not include the portion of

the operating payment rate related to performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d). For the rate year beginning October 1, 2008, the operating payment rate for each facility shall be 13 percent of the operating payment rate from this section, and 87 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2009, the operating payment rate for each facility shall be 14 percent of the operating payment rate from this section, and 86 percent of the operating payment rate from section 256B.434. ~~For rate years beginning October 1, 2010; October 1, 2011; and October 1, 2012, no rate adjustments shall be implemented under this section, but shall be determined under section 256B.434.~~ For the rate year beginning October 1, 2010, the operating payment rate for each facility shall be 14 percent of the operating payment rate from this section, and 86 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2011, the operating payment rate for each facility shall be 31 percent of the operating payment rate from this section, and 69 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2012, the operating payment rate for each facility shall be 48 percent of the operating payment rate from this section, and 52 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2013, the operating payment rate for each facility shall be 65 percent of the operating payment rate from this section, and 35 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2014, the operating payment rate for each facility shall be 82 percent of the operating payment rate from this section, and 18 percent of the operating payment rate from section 256B.434. For the rate year beginning October 1, 2015, the operating payment rate for each facility shall be the operating payment rate determined under this section. The blending of operating payment rates under this section shall be performed separately for each RUG's class.

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

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

(2) The commissioner shall determine a maximum percentage increase that will result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing facilities with a blended October 1, 2008, operating payment rate increase under paragraph (a) greater than the maximum percentage increase determined by the commissioner, when

compared to its operating payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00, shall receive the maximum percentage increase.

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

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

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

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

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

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

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

Sec. 18. Minnesota Statutes 2008, section 256B.441, is amended by adding a subdivision to read:

Subd. 60. **Nursing facility rate reduction.** (a) Effective for the rate year beginning October 1, 2010, the commissioner shall reduce the operating payment rates of nursing facilities reimbursed under this section or section 256B.434 by the following percentages after any blending and rebasing of rates under subdivision 55:

(1) a reduction of three percent for facilities with 50 percent or more of patient days reimbursed through private pay;

(2) a reduction of two percent for facilities with greater than 25 percent but less than 50 percent of patient days reimbursed through private pay; and

(3) a reduction of one percent for facilities with 25 percent or less of patient days reimbursed through private pay.

(b) In determining the percentage of private-pay patient days, the commissioner shall use data from the reporting period ending September 30, 2009.

Sec. 19. Minnesota Statutes 2008, section 256B.48, subdivision 1, is amended to read:

Subdivision 1. **Prohibited practices.** A nursing facility is not eligible to receive medical assistance payments unless it refrains from all of the following:

(a) Charging 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 for special services which are not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services in addition to the daily rate paid by the commissioner~~.~~;

(2) effective July 1, 2010, nursing facilities may charge private paying residents rates up to two percent higher than the allowable payment rate in effect on June 30, 2010, plus an adjustment equal to any other rate increase provided in law, for the RUGs group currently assigned to the resident;

(3) effective October 1, 2011, nursing facilities may charge private paying residents rates up to four percent higher than the allowable payment rate in effect on September 30, 2011, plus an adjustment equal to any other rate increase provided in law, for the RUGs group currently assigned to the resident; and

(4) effective October 1, 2012, nursing facilities may charge private paying residents rates up to six percent higher than the allowable payment rate in effect on September 30, 2012, plus an adjustment equal to any other rate increase provided in law, for the RUGs group currently assigned to the resident.

For purposes of this subdivision, the allowable payment rate under section 256B.434 includes adjustments for enhanced rates during the first 30 days under section 256B.431, subdivision 32, and private room differentials under clause (1), item (i), and Minnesota Rules, part 9549.0060, subpart 11, item C. Nothing in this section precludes a nursing facility from charging a rate allowable under the facility's single room election option under Minnesota Rules, part 9549.0060, subpart 11. 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 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. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' 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 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) Effective October 1, 2013, paragraph (a) 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.

(c)(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, medical assistance payment according to the state plan must be accepted as payment in full for continued stay, except where otherwise provided for under 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)~~ (d) Requiring 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)~~ (e) Providing differential treatment on the basis of status with regard to public assistance.

~~(e)~~ (f) Discriminating 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)~~ (g) Requiring 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's fees or their equivalent.

~~(g)~~ (h) Refusing, 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.

(i) 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 is in violation of this section 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 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.