DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
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CMS
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Financial Management Group

DEC 15 2015

Marie Zimmerman
State Medicaid Director
Minnesota Department of Human Services 540 Cedar Street
P.O. Box 64983
St. Paul, MN 55164-0983

RE: Minnesota State Plan Amendment (SPA) 13-023

Dear Ms. Zimmerman:

We have reviewed the proposed amendment to Attachment 4.19-B and Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 13-023. Effective for services on or after July 1, 2013 this amendment revises methodologies and standards for determining payment rates by increasing payments for family planning and dental services and intermediate care facilities for persons with developmental disabilities (ICF/DD) using a prospective rate setting methodology.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act. We hereby inform you that Medicaid State plan amendment 13-023 is approved effective July 1, 2013. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosure

6.d. Other practitioners' services. (continued)

Payment ~~The rates~~ for public health nurse assessments for personal care services is the lower of the submitted charge or the rate from the chart below. ~~are as follows:~~

Service	10/1/06	10/1/07	7/1/08	10/1/08	7/1/09	7/1/13	4/1/14	7/1/14
Initial Public Health Nursing Assessment Visit for Personal Care Services (in-person)	$257.42 /visit	$262.57 /visit	$262.57 /visit	$267.82 /visit	$260.91 /visit	$258.29 /visit	$260.87 /visit	$273.91 /visit
Public Health Nursing Reassessment Visit for Personal Care Services submitted prior to the end date of current PCA service authorization	$257.42	$262.57	$262.57	$267.82	$260.91 /visit	$258.29 /visit	$260.87 /visit	$273.91 /visit
Public Health Nursing Service Update submitted prior to the end date of current PCA service authorization	$128.72	$131.29	$131.29	$133.92	$130.46 /visit	$129.14 /visit	$130.43 /visit	$136.95 /visit
~~Public Health Nursing Reassessment Visit for PCA Services submitted after the end date of current PCA service authorization.~~			~~$196.93~~	~~$200.86~~	~~$195.68~~			
~~Public Health Nursing Service Update submitted after the end date of current PCA service authorization.~~			~~$98.47~~	~~$100.44~~	~~$97.84~~			

7.a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

~~Payment is the lower of:~~

~~1) submitted charge; or~~

~~2) Medicare cost-per-visit limits based on Medicare cost reports submitted by free-standing home health agencies in the Minneapolis and St. Paul area in the calendar year specified in state legislation governing maximum payment rates.~~

~~Effective July 1, 1994, this payment rate is increased by three percent.~~

Payment for skilled nurse visits is the lower of the submitted charge or the rate from the chart below.

Service provided on or after	07/01/2009	09/01/2011	07/01/2013	04/01/2014	07/01/2014
Skilled nurse visit	$70.75	$69.69	$70.04	$70.74	$74.28

Immunizations and other injectables are paid using the same methodology as Item 2.a., Outpatient hospital services.

Home health agencies that administer pediatric vaccines in item 2.a., Outpatient hospital services, available through the Minnesota Vaccines for Children Program pursuant to §1928 of the Act, are paid using the same methodology in item 2.a. for these vaccines.

7.b. Home health aide services provided by a home health agency.

~~Payment is the lower of:~~

~~1) submitted charge; or~~

~~2) Medicare cost-per-visit limits based on Medicare cost reports submitted by free-standing home health agencies in the Minneapolis and St. Paul area in the calendar year specified in state legislation governing maximum payment rates.~~

~~Effective July 1,1994, this payment rate is increased by three percent.~~

Payment for home health aide visits is the lower of the submitted charge or the rate from the chart below.

Service provided on or after	07/01/2009	09/01/2011	07/01/2013	04/01/2014	07/01/2014
Home Health Aide Visit	$54.29	$ 53.48	$53.75	$54.29	$57.00

7.d. Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health or medical rehabilitation agency.

~~Physical therapist, occupational therapist, speech pathologist and audiologist services provided by a **home health agency** are paid the lower of:~~

~~1) submitted charge; or~~

2) ~~Medicare cost-per-visit limits based on Medicare cost reports submitted by free-standing home health agencies in the Minneapolis and St. Paul area in calendar year 1982.~~

Payment for therapy visits is the lower of the submitted charge or the rate from the chart below.

Service provided on or after	07/01/2009	09/01/2011	07/01/2013	04/01/2014	07/01/2014
Physical Therapy Visit (PT)	$66.38	$ 65.38	$65.71	$66.37	$69.69
Physical Therapy Visit (Ass't)	$43.15	$ 42.50	$42.71	$43.14	$45.30
Speech Therapy Visit	$67.39	$ 66.38	$66.71	$67.38	$70.75
Occupational Therapy Vist (OT)	$67.74	$ 66.72	$67.05	$67.72	$71.11
Occupational Therapy Visit (Ass't)	$44.03	$ 43.37	$43.59	$44.03	$46.22
Respiratory Therapy Visit	$46.91	$ 46.21	$46.44	$46.90	$49.25

Physical therapy assistant and occupational therapy assistant services provided by a **home health agency** are paid using the same methodology as items 11a., Physical therapy and 11b., Occupational therapy.

8. Private duty nursing services.

Payment for private duty nursing services is the lower of the submitted charge~~;~~ or the rate from the chart below. ~~following:~~

Service provided on or after	07/01/2009	09/01/2011	07/01/2013	04/01/2014	07/01/2014
Private Duty Nursing L.P.N. Unit	$6.30	$ 6.21	$6.24	$6.30	$6.62
Private Duty R.N. Unit	$8.21	$ 8.09	$8.13	$8.21	$8.62
Private Duty L.P.N. (complex)	$7.39	$ 7.28	$7.32	$7.39	$7.76
Private Duty R.N. (complex)	$9.85	$ 9.70	$9.75	$9.85	$10.34

NOTE: 1 unit = 15 minutes

10. Dental services (continued):

X-ray services are paid according to the dental services methodology listed above. Effective January 1, 2002, payment for x-ray services provided to recipients under age 21 are paid the lower of:

1) the submitted charge; or
2) 85% of the median charges submitted in 1999.

Diagnostic examinations are paid according to the dental services methodology listed above. Effective January 1, 2002, payment for diagnostic examinations provided to recipients under age 21 are paid the lower of:

1) the submitted charge; or
2) 85% of the median charges submitted in 1999.

Effective for services provided on or after October 1, 1999, t**ooth sealants** and **fluoride treatments** are paid at the lower of:

1) submitted charge; or
2) 80% of the median charges submitted in 1997.

Effective January 1, 2000, the rate is increased by three percent.

Medical and surgical services (as defined by the Department) furnished by dentists are paid using the same methodology as item 5.a., Physicians' services.

Community health worker services educating patients to promote good oral health and self-management of dental conditions when supervised by a dentist are paid using the same methodology that applies to community health workers in item 5.a., Physicians' services.

The base rates as described in this item are adjusted by the following clauses of Supplement 2 of this Attachment:

X. Dental Services rate decrease 2011 (does not apply to state operated dental clinics)

cc. Supplemental payment for medical education
dd. Dental Services rate increase 2014

26. Personal care services.

Payment is the lower of the submitted charge~~,~~ or the rate from the chart below.~~ state agency established rate:~~

Service provided on or after	07/01/2009	09/01/2011	07/01/2013	04/01/2014	07/01/2014
Personal Care 1:1 unit	$3.96	$3.90	$3.92	$3.96	$4.16
Personal Care 1:2 unit	$2.97	$2.93	$2.94	$2.97	$3.12
Personal Care 1:3 unit	$2.61	$2.57	$2.58	$2.61	$2.74
Supervision of Personal Care unit	$6.96	$6.86	$6.89	$6.96	$7.31

[**NOTE**: 1 unit = 15 minutes]

Shared care: For two recipients sharing services, payment is one and one-half times the payment for serving one recipient. For three recipients sharing services, payment must not exceed two times the payment for serving one recipient. This paragraph applies only to situations in which all recipients were present and received shared services on the date for which the service is billed.

PCA Choice option: Payment is the same as that paid for personal care assistant services.

and specialized maintenance physical therapy, occupational therapy, and speech, language and hearing therapy services, and respiratory therapy services (Item 13.d)
- services for individuals age 65 or older in institutions for mental diseases (Item 14)
- inpatient psychiatric facility services for individuals under 22 years of age (Item 16)
- nurse midwife services (Item 17)
- pregnancy-related and postpartum services for 60 days after the pregnancy ends (Item 20.a)
- services for any other medical condition that may complicate pregnancy (Item 20.b)
- certified pediatric or family nurse practitioner services (Item 23)
- licensed ambulance services, excluding volunteer ambulance services (Item 24.a)
- emergency hospital services (Item 24.e)

E. **Modifiers**

22 modifier: unusual procedural services = additional reimbursement based on line description or claim attachment. This modifier specifies a ratio for twin delivery and VBAC delivery. All other services are priced according to the service rendered. (Item 5.a)

99 modifier: multiple modifier = may be an increase or a decrease to the reference file allowable depending on the modifiers represented within the 99. (Item 5.a)

F. **Family Planning**

Effective for services provided on or after July 1, 2007, **family planning services** provided by family planning clinics, public health clinics and community health clinics are paid 25% over the rate in effect on June 30, 2007. (Item 5.a.)

Effective for services provided on or after January 1, 2011, **family planning services** provided by family planning clinics, public health clinics and community health clinics are paid 25% over the rate in effect on January 1, 2011. (Item 5.a.)

Effective for services provided on or after July 1, 2013, **family planning services** provided by family planning clinics, public health clinics and community health clinics are paid 20% over the rate in effect on June 30, 2013. (Item 5.a.)

G. **Community and Public Health Clinic**

Effective July 1, 1989, rates for services provided by **community and public health** clinics are increased by 20%, except for laboratory services.

cc. Supplemental payment for medical education (cont'd)
Qualifying Provider. "Qualifying provider" means a Medical Assistance enrolled hospital, medical center, clinic, practitioner, or other organization that provides accredited clinical training of: physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advance practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants, and effective July 1, 2015, dental therapists, advanced dental therapists, psychologists, clinical social workers, community paramedics, and community health workers; and that has successfully applied for this payment, in accordance with Minnesota Statutes § 62J.692.

dd. Dental Services rate increase 2014
Effective for services provided on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, Indian Health Service, and tribal 638 facilities.

METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR SERVICES PROVIDED BY INTERMEDIATE CARE FACILITIES FOR PERSONS WITH ~~MENTAL RETARDATION~~ DEVELOPMENTAL DISABILITIES (ICFs/~~MR~~DD) THAT ARE NOT PAID ON A COST BASIS

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METHODS AND STANDARDS FOR DETERMINING PAYMENT RATES FOR SERVICES PROVIDED BY INTERMEDIATE CARE FACILITIES FOR PERSONS WITH ~~MENTAL RETARDATION~~ DEVELOPMENTAL DISABILITIES (ICFs/~~MR~~DD) THAT ARE NOT PAID ON A COST BASIS

SECTION 1.000 INTRODUCTION.

Section 1.010 **General purpose.** The purpose of Minnesota's methods and standards for determining medical assistance payment rates for ICFs/MR that are not paid on a cost basis is to provide for rates in conformity with applicable state and federal laws, regulations and quality and safety standards. Minnesota has in place a public process that complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act. In determining the rates, the Department of Human Services takes into account the provider's historical costs, the size of the facility, and other factors.

Facilities participating in the Minnesota Medical Assistance Program are paid by a prospective rate-setting methodology, based upon a contracting system. This methodology, established in Minnesota statutes, is described in this attachment.

Facilities contract with the Department in order to receive payment. Contracts include descriptions of payments that may be modified when significant changes occur in residents' needs, the establishment and use of a quality improvement plan, appropriate and necessary statistical information required by the Department, annual aggregate facility financial information, and additional requirements for facilities not meeting the standards set forth in each contract.

Section 1.020 **Rate methodology.** The total payment rate for ICFs/MR in existence as of October 1, 2000, is the sum of the operating payment rate and the property payment rate.

Section 1.030 **Definitions.** For the purposes of Sections 2.000 to 9.060, the following terms have the meanings given them in this section.

Capacity days. "Capacity days" means the total number of licensed beds in the facility multiplied by the number of days in the reporting year.

Capital assets. "Capital assets" means a facility's land, physical plant, land improvements, depreciable equipment, leasehold improvements, capitalized improvements and repairs, and all additions to or replacement of those assets.

Capital debt. "Capital debt" means a debt incurred by the facility for the purpose of purchasing a capital asset, to the extent that the proceeds of the debt were actually applied to purchase the capital asset including points, financing charges, and bond premiums or discounts. Capital debt includes debt incurred for the purpose of refinancing a capital debt.

Class A beds. "Class A beds" means beds licensed for ambulatory and mobile persons who are capable of taking appropriate action for self-preservation under emergency conditions as determined by state and federal licensing law.

Class B beds. "Class B beds" means beds for ambulatory, nonambulatory, mobile, or nonmobile persons who are not mentally or physically capable of taking appropriate action for self-preservation under emergency conditions as determined by state and federal licensing law.

Commissioner. "Commissioner" means the commissioner of the Minnesota Department of Human Services.

Day services. "Day services" means services or supports provided to a resident that enables the resident to be fully integrated into the community. Day services may include supported work, support during community activities, day training and habilitation, community volunteer activity, adult day care, recreational activities, and other individualized integrated supports.

Department. "Department" means the Minnesota Department of Human Services.

Depreciable equipment. "Depreciable equipment" means the standard moveable resident care equipment and support service equipment generally used in an ICF/~~MR~~DD. Depreciable equipment includes the equipment specified in the major moveable equipment table of the depreciation guidelines.

Depreciation guidelines. "Depreciation guidelines" means The Estimated Useful Lives of Depreciable Hospital Assets, issued by the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois (Chicago: 1983). The depreciation guidelines are incorporated by reference and are available for reference at the Minnesota State Law Library, Minnesota Judicial Center, 25 Constitution Avenue, Saint Paul, Minnesota, 55155. Only the 1983 publication will be used and will not change.

Desk audit. "Desk audit" means the Department's review and analysis of required reports, supporting documentation, and work sheets submitted by the provider.

Direct cost. "Direct cost" means a cost that can be identified within a general cost category without the use of allocation methods.

Facility. "Facility" or "ICF/~~MR~~DD" means a program licensed to serve persons with ~~metal retardation~~ developmental disabilities or related conditions under state laws, and a physical plant licensed as a supervised living facility under state laws, which together are certified by the Minnesota Department of Health as an intermediate care facility for the developmentally disabled ~~mentally retarded~~.

Fringe benefits. "Fringe benefits" means workers' compensation insurance (including self-insurance plans), group health insurance, disability insurance, dental insurance, group life insurance, and retirement benefits or plans.

Leasehold improvement. "Leasehold improvement" means an improvement to property leased by the provider for the use of the facility that reverts to the owner of the property upon termination of the lease.

Medical assistance program. "Medical assistance program" means the program that reimburses the cost of health care provided to eligible residents pursuant to state and federal law.

Modified property payment rate. "Modified property payment rate" means the actual property payment rate exclusive of the effect of gains or losses on disposal of capital assets or adjustments for excess depreciation claims.

Necessary service. "Necessary service" means a function pertinent to the facility's operation that if not performed by the assigned individual would have required the provider to employ or assign another individual to perform it.

Occupancy report. "Occupancy report" means the report submitted monthly by a facility indicating bed use data by client for the preceding month.

Payroll taxes. "Payroll taxes" means the employer's share of social security withholding taxes, and state and federal unemployment compensation taxes or costs.

Physical plant. "Physical plant" means the building or buildings in which a program licensed to provide services to persons with developmental disabilities ~~mental retardation~~ or related conditions under state law is located, and all equipment affixed to the building and not easily subject to transfer as specified in the building and fixed equipment tables of the depreciation guidelines, and auxiliary buildings in the nature of sheds, garages, and storage buildings located on the same site if related to resident care, and the allocated portion of office space if the office is located in that facility. Physical plant does not include buildings or portions of buildings used by central**,** affiliate, or corporate offices if those offices are not located in that facility**.**

Private paying resident. "Private paying resident" means a facility resident whose care is not paid for by the medical assistance program, cost of care program, or the Community Social Services Block Grant for the date of service.

Program. "Program" means those functions and activities of the facility that contribute to the care, supervision, developmental growth, and skill acquisition of the residents under state and federal laws.

Provider. "Provider" means the corporation, governmental unit, partnership, person, or persons

licensed to operate the facility, which controls the facility's operation, incurs the costs reported, and claims reimbursement under Sections 1.010 to 9.060 or the care provided in the facility.

Provider group. "Provider group" means a parent corporation, any subsidiary corporations, partnerships, management organizations, and groups of facilities operated under common ownership or control that incurred the costs shown on the income and expense report that are claimed for reimbursement under Sections 1.010 to 9.060.

Quality improvement plan. "Quality improvement plan" means the document submitted by a facility to the Department describing the facility's quality improvement process.

Rate adjustment. "Rate adjustment" means a rate change granted by the Department. The amount available for rate adjustments is set by legislative appropriation.

Rate year. For the initial year, "rate year" means the period for which the total payment rate is effective, from October 1, 2000 through December 31, 2001. Thereafter, "rate year" means a calendar year.

Related organization. "Related organization" means a person that furnishes goods or services to a facility and that is a close relative of a provider or a provider group, an affiliate of a provider or provider group, or an affiliate of a close relative of an affiliate of a provider or provider group. For the purposes of this definition, the following terms have the meanings given them.

A. "Affiliate" means a person that directly, or indirectly though one or more intermediaries, controls, or is controlled by, or is under common control with another person.

B. "Person" means an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

C. "Close relative of an affiliate of a provider or provider group" means an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a provider or provider group is no more remote than first cousin.

D. "Control" including the terms "controlling", "controlled by", and "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management, operations, or policies of a person, whether through the ownership of voting securities, by contract or otherwise.

Repair. "Repair" means the cost of labor and materials needed to restore an existing capital asset to sound condition after damage or malfunction or to maintain an existing capital asset in a usable condition.

Reporting year. "Reporting year" means the period from January 1 to December 31 immediately preceding the rate year, for which the provider submits its income and expense

report.

Resident day. "Resident day" means a day on which services provided to residents are rendered and billable, or a day for which a bed is held and billed.

Statewide advisory committee. "Statewide advisory committee" means the committee charged with reviewing county and provider proposals and making recommendations to the Department regarding facility payment rate adjustments. The committee uses established criteria for ranking proposals in order to make recommendations.

Total payment rate. "Total payment rate" means the amount established by the commissioner to reimburse the provider for service provided to each resident. The total payment rate is calculated by adding the operating payment and the property payment rate.

Variable rate. A rate approved by the Department, upon the recommendation of the county of financial responsibility, when there is a documented increase in the needs of a resident. A documented increase is a demonstrated medical or behavioral need that significantly impacts the type or amount of services needed by a resident.

SECTION 2.000 GENERAL REPORTING REQUIREMENTS.

Section 2.010 **Required income and expense reports.** By April 30 of each year, the provider must submit an annual income and expense report on the form prescribed by the Department in order to receive medical assistance payments. The reports must cover the reporting year ending the previous December 31.

Section 2.020 **Required information.** A complete income and expense report contains the following items:

A. Salaries and related expenses, including salaries to program, administrative, and support staff, payroll taxes and fringe benefits, and training.

B. General operating expenses, including supplies, repairs, purchased services and consultants, utilities, food, licenses and fees, real estate taxes, insurance, and working capital interest.

C. Property-related expenses, including real estate taxes, depreciation, capital debt interest, rent and leases, and property insurance.

D. Facility income, including receipt of all income from accounts receivable related to facility operations.

E. Annual resident days.

Section 2.030 **Occupancy reports.**

A. A facility must maintain and submit monthly bed use data. The total payments made to a facility may be adjusted based on concurrent changes in the needs of recipients that are covered by a variable rate adjustment. Any adjustment for multiple resident changes does not result in a decrease to the facility base rate.

B. Bed use data will also indicate leave days and vacancies.

Section 2.040 **Deadlines, extensions, and rejections.**

A. A facility that terminates participation in the Medical Assistance Program during a reporting year must submit the required annual income and expense report covering the period from January 1 of that reporting year to the date of termination. The income and expense report must be submitted within four months after termination.

B. The Department may reject any annual income and expense report filed by a facility that is incomplete or inaccurate, or for which supplemental information is required. In these cases, the Department will inform the facility what additional information is required. The facility will be given a reasonable amount of time to supply the information.

Failure to file the required income and expense report and other required information constitutes a material breach of the contract, allowing the Department to pursue termination of the contract.

Section 2.050 **False reports.** If a provider knowingly supplies inaccurate or false information on an income and expense report, the Department will exercise its options under the breach of terms provisions in its contract with the facility.

Section 2.060 **Adequate documentation.** A facility must keep adequate documentation.

A. In order to be considered adequate, documentation must:

(1) be maintained in orderly, well-organized files;

(2) not include documentation of more than one facility in one set of files unless transactions may be traced by the Department to the facility's annual income and expense report;

(3) include a paid invoice or copy of a paid invoice with date of purchase, vendor name and address, purchaser name and delivery address, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a

breakdown of any allocation of costs between accounts or facilities. If any of the information to be listed on the invoice is not available, the providers must document their good faith attempt to obtain the information;

(4) include copies of all written agreements and debt instruments to which the facility is a party and any related mortgages, financing statements, and amortization schedules to explain the facility's costs and revenues;

(5) if a cost or revenue item is not documented under subitem (3) or (4), the facility must document the amount, source, and purpose of the item in its books and ledgers following generally accepted accounting principles and in a manner providing an audit trail; and

(6) be retained by the facility to support the five most recent annual income and expense reports submitted to the Department. The Department may extend the period of retention if the desk audit was postponed because of inadequate record keeping or accounting practice, or if the records are necessary to resolve a pending appeal.

B. Providers must document all consultant, professional, or purchased service contracts. They must maintain copies of all contracts and invoices relating to consultant, professional, or purchased services. These documents must include the name and address of the vendor or contractor, the name of the person who actually performed the services, the dates of service, a description of the services provided, the unit cost, and the total cost of the service.

C. Payroll records must be maintained by a facility and must show the amount of compensation paid to each employee and the days and hours worked. Complete and orderly cost allocation records must be maintained for cost allocations made among cost categories or facilities.

SECTION 3.000 QUALITY IMPROVEMENT PLAN.

A. Except for the initial rate year, by the March following the end of each rate year, facilities must submit reports regarding the previous year’s quality improvement plans to the Department. For the initial rate year, facility quality improvement plans must be submitted by December 31, 2000.

B. Each quality improvement plan must identify a minimum of one performance measure on which to focus during the contract period.

C. Elements of a quality improvement plan:

(1) a facility-specific quality improvement team;

(2) area(s) of need (and why), including the strategies used to identify the causes;

(3) definition of the quality improvement goal or benchmark;

(4) identified data sources;

(5) plan of action and strategies to address the problem;

(6) summarized and interpreted data; and

(7) evaluation of the results, including how the quality improvement plan is communicated to residents, staff, and residents' families, and how the process is monitored and changed as needed.

SECTION 4.000 DETERMINATION OF TOTAL PAYMENT RATE.

Section 4.010 **Total payment rate.** The total payment rate is the sum of the operating payment rate and the property payment rate.

A. Operating payment rate.

(1) The operating payment rate is the facility's total payment rate in effect on September 30, 2000, minus the property rate. It includes the efficiency incentive in effect as of September 30, 2000.

(2) Within the limits of appropriations for this purpose, the operating payment rate is increased for each rate year by the annual percentage change in the Employment Cost Index for Private Industry Workers–Total Compensation in the second quarter of the **calendar year** preceding the start of the rate year. For the initial rate year, the percentage change is based on the percentage change in the Employment Cost Index for Private Industry Workers–Total Compensation for the 15-month period from October 1, 2000 through December 31, 2001, as forecast by Data Resources, Inc.

(3) The operating payment rate is adjusted to reflect an occupancy rate equal to 100 percent of a facility's capacity days as of September 30, 2000, except that effective July 1, 2009, through June 30, 2013, no occupancy rate adjustment will be applied.

(4) For the initial rate year, the Department will make an adjustment to the operating payment rate for a facility that submits a plan, approved by the Department, in

accordance with unit (b). Operating costs will be separated into compensation-related costs and all other costs. Compensation-related costs means allowable program operating cost category employee training expenses and allowable salaries, payroll taxes, and fringe benefits for all employees except the administrator and central office staff.

(a) Facilities that have rates governed by closure agreements, receivership agreements, or interim rates are not eligible for these adjustments.

(b) The payment rate is increased by:

1) 6.6 percent of compensation-related costs, 45 percent of which must be used to increase the per-hour pay rate of all employees except administrative and central office employees by an equal dollar amount and to pay associated costs for FICA, the Medicare tax, workers' compensation premiums, and federal and state unemployment insurance provided that this portion of the compensation-related increase must be used only for wage increases implemented on or after October 1, 2000, and must not be used for wage increases implemented before that date;

2) and 2.0 percent of all other operating costs.

A facility's most recent cost report submitted for desk audit will be used to calculate the adjustment.

(c) To receive the operating payment rate adjustment, a facility must apply to the Department. The application must contain a plan by which the facility will distribute the compensation-related portion of the payment rate adjustment to employees of the nursing facility. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan only if the agreement is finalized after May 16, 2000.

1) The Department will review the plan to ensure that the payment rate adjustment is used as provided in unit (b).

2) To be eligible, a facility must submit its plan for the payment rate adjustment by December 31, 2000. If a facility's plan for the payment rate adjustment is effective for its employees after October 1 of the year that the funds are available, the payment rate adjustment shall be effective the same date as its plan.

(d) The Department will determine the payment rate adjustment using the categories listed above multiplied by the rate increases in unit (b), divided by the facility's actual resident days.

(5) Effective July 1, 2001, the Department will make an adjustment to the operating payment rate of 3.5 percent for a facility that submits a plan, approved by the Department. Of this adjustment, two-thirds must be used in accordance with unit (a) and one-third must be used for operating costs.

(a) Two-thirds of the adjustment must be used to increase the wages and benefits and pay associated costs of all employees except administrative and central office employees, provided that this increase is used only for wage and benefit increases implemented on or after July 1, 2001.

(b) For each facility, the Department will make available an adjustment by multiplying 3.5 percent by the total payment rate in effect on June 30, 2001, excluding the property-related payment rate.

(c) The application for the rate adjustment must contain a plan by which the facility will distribute the adjustment in unit (a) to employees of the facility. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan only if the agreement is finalized after June 30, 2001.

1) The Department will review the plan to ensure that the payment rate adjustment per diem is used as provided in this subitem.

2) To be eligible, a facility must submit its plan for the rate adjustment by March 31, 2002. If a facility's plan for the payment rate adjustment is effective for its employees after July 1, 2001, the payment rate adjustment is effective the same date as its plan.

(d) A facility that has payment rate governed by closure agreements or receivership agreements cannot receive an adjustment.

(6) Effective July 1, 2002, the Department will make an adjustment to the operating payment rate of 3.5 percent for a facility that submits a plan, approved by the Department. Of this adjustment, two-thirds must be used in accordance with unit (a) and one-third must be used for operating costs.

(a) Two-thirds of the adjustment must be used to increase the wages and benefits and pay associated costs of all employees except administrative and central office employees, provided that this increase is used only for wage and benefit increases implemented on or after July 1, 2002.

(b) For each facility, the Department will make available an adjustment by multiplying 3.5 percent by the total payment rate in effect on June 30, 2002, excluding the

property-related payment rate.

(c) The application for the rate adjustment must contain a plan by which the facility will distribute the adjustment in unit (a) to employees of the facility. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan only if the agreement is finalized after June 30, 2002.

1) The Department will review the plan to ensure that the payment rate adjustment per diem is used as provided in this subitem.

2) To be eligible, a facility must submit its plan for the rate adjustment by March 31, 2003. If a facility's plan for the payment rate adjustment is effective for its employees after July 1, 2002, the payment rate adjustment is effective the same date as its plan.

(d) A facility that has payment rate governed by closure agreements or receivership agreements cannot receive an adjustment.

(7) Effective April 1, 2002, the operating payment rate is adjusted for increases in licensing fees paid by facilities.

(8) Effective July 1, 2003, the operating payment rate in effect on June 30, 2002 is reduced by one percent. Facilities with payment rates governed by a receivership agreement in Sections 7.000 or 8.000, or by a closure agreement in Section 9.010, are not subject to this item.

(9) Effective October 1, 2005, the operating payment rate is increased by 2.2553 percent for a facility that submits a plan, approved by the Department. Of this increase, two-thirds must be used in accordance with unit (a).

(a) Two-thirds of the increase must be used to increase the MA portion of wages and benefits and pay associated MA costs of all employees except administrative and central office employees, provided that this increase is used only for wage, benefit, and staff increases implemented on or after October 1, 2005.

(b) For each facility, the Department will make available an increase by multiplying 2.2553 percent by the total payment rate in effect on September 30, 2005, excluding the property-related payment rate.

(c) The application for the rate increase must contain a plan by which the facility will distribute the increase in unit (a) to employees of the facility. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes

the plan only if the agreement is finalized after July 15, 2005.

(1) The Department will review the plan to ensure that the payment rate increase per diem is used in accordance with unit (a).

(2) To be eligible, a facility must submit its plan by March 31, 2006. If a facility's plan for the payment rate increase is effective for its employees after October 1, 2005, the increase is effective the same date as its plan.

(d) Facilities that have rates governed by closure agreements, receivership agreements, or interim rates are not eligible for these increases.

(10) Effective October 1, 2006, the operating payment rate is increased by 2.2553 percent for a facility that submits a plan, approved by the Department. Of this increase, two-thirds must be used in accordance with unit (a).

(a) Two-thirds of the increase must be used to increase the MA portion of wages and benefits and pay associated MA costs of employees except administrative and central office employees, provided that this increase is used only for wage, benefit, and staff increases implemented on or after October 1, 2006.

(b) For each facility, the Department will make available an increase based on occupied beds.

(c) The application for the increase must contain a plan by which the facility will distribute the increase in unit (a) to employees of the facility. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan only if the agreement is finalized after July 15, 2006.

(1) The Department will review the plan to ensure that the payment rate increase per diem is used in accordance with unit (a).

(2) To be eligible, a facility must submit its plan by December 31, 2006. If a facility's plan for the payment rate increase is effective for its employees after October 1, 2006, the payment rate increase is effective the same date as its plan.

(d) Facilities that have rates governed by closure agreements, receivership agreements, or interim rates are not eligible for these increases.

(11) Effective October 1, 2007, the operating payment rate is increased by 2 percent for a facility that submits a plan, approved by the Department. Of this increase, three-fourths must be used in accordance with unit (a).

(a) The rate increase must be used to increase the MA portion of wages and benefits and pay associated MA costs of employees directly employed by the facility except administrative, or central office, employees or persons paid under a management contract, provided that this increase is used only for wage, benefit, and staff increases implemented on or after October 1, 2007.

(b) Two-thirds of the increase described in unit (a) must be paid as an equal hourly percentage wage increase to the MA portion of wages for employees directly employed by the facility effective on the same date for all eligible employees. This provision does not apply to employees represented by an exclusive bargaining representative.

(c) For the purposes of units (a) and (b) compensation related costs include:

(1) wages and salaries;

(2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided, subject to the approval of the Department.

(d) For each facility, the Department will make available an increase not subject to units (a) and (b), based on occupied beds and effective October 1, 2007

(e) Increases subject to units (a) and (b) will be based on the lesser of the amount distributed as wage increases in accordance with units (a) and (b) or the amount of the percentage rate increase based on occupied beds.

(f) The application for the increase must contain a plan by which the facility will distribute the increase in units (a) and (b) to employees of the facility. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan effective the later of July 15, 2007 or Departmental receipt of a letter of acceptance of the wage distribution plan by the exclusive bargaining representative.

(g) The Department shall ensure that cost increases in distribution plans under unit (f)(2)(ii), that may be included in approved applications, comply with the following requirements:

(1) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2006, and prior to the first day of the facility's payroll period that includes October 1, 2007, shall be allowed if they were not used in the prior year's application;

(2) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the Department shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(3) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2007, and prior to April 1, 2008.

(h) Facilities that have rates governed by closure agreements, receivership agreements, or interim rates are not eligible for these increases.

(12) Effective October 1, 2008, the operating payment rate is increased by 2 percent for a facility that submits a plan, approved by the Department. Of this increase, three-fourths must be used in accordance with unit (a).

(a) The rate increase must be used to increase the MA portion of wages and benefits and pay associated MA costs of employees directly employed by the facility except administrative, or central office, employees or persons paid under a management contract, provided that this increase is used only for wage, benefit, and staff increases implemented on or after October 1, 2008.

(b) Two-thirds of the increase described in unit (a) must be paid as an equal hourly percentage wage increase to the MA portion of wages for employees directly employed by the facility effective on the same date for all eligible employees. This provision does not apply to employees represented by an exclusive bargaining representative.

(c) For the purposes of units (a) and (b) compensation related costs include:

(1) wages and salaries;

(2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided, subject to the approval of the Department.

(d) For each facility, the Department will make available an increase not subject to units (a) and (b), based on occupied beds and effective October 1, 2008

(e) Increases subject to units (a) and (b) will be based on the lesser of the amount distributed as wage increases in accordance with units (a) and (b) or the amount of the percentage rate increase based on occupied beds.

(f) The application for the increase must contain a plan by which the facility will distribute the increase in units (a) and (b) to employees of the facility. For a facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan effective the later of July 15, 2007 or Departmental receipt of a letter of acceptance of the wage distribution plan by the exclusive bargaining representative.

(g) The Department shall ensure that cost increases in distribution plans under unit (f)(2)(ii), that may be included in approved applications, comply with the following requirements:

(1) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2007, and prior to the first day of the facility's payroll period that includes October 1, 2008, shall be allowed if they were not used in the prior year's application;

(2) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the Department shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(3) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2008, and prior to April 1, 2009.

(h) Facilities that have rates governed by closure agreements, receivership agreements, or interim rates are not eligible for these increases.

(13) Effective July 1, 2009 the operating payment rate is decreased by 2.58 percent and the provisions in sub-items 12(a) through 12(g) no longer apply.

(14) Effective for July 1, 2014, the operating payment rate is increased by 5 percent for a facility that submits a plan, approved by the Department. Of this increase, 80 percent must be used in accordance with unit (a).

(a) The rate increase must be used to increase the MA portion of compensation costs of employees directly employed by the facility except central office employees or persons paid under a management contract.

(b) For the purpose of unit (a), compensation related costs include:
(1) wages and salaries;
(2) the employer's share of FICA taxes, Medicare taxes, state and federal

unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other benefits provided and workforce needs, subject to the approval of the Department.

(c) For each facility, the Department will make available an adjustment by multiplying 5 percent by the total payment rate in effect on June 30, 2014, excluding the property-related payment rate.

(d) To receive the operating payment rate adjustment, a facility must apply to the Department. The application must contain a plan by which the facility will distribute the compensation-related portion of the payment rate adjustment to employees of the nursing facility.

For public employees under a collective bargaining agreement, the increase for wages and benefits is available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. Money received by a facility for pay increases for public employees must be used only for pay increases implemented between July 1, 2014, and August 1, 2014.

For a facility that has employees that are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan, in regard to the members of the bargaining unit, signed by the exclusive bargaining agent.

(e) Effective January 1, 2015, the Department shall decrease by 1 percent the payment rate of any facility that fails to submit the plan described in paragraph (d).

B. Property payment rate.

(1) The property payment rate is based on the facility's modified property payment rate in effect on September 30, 2000. The modified property payment rate is the actual property payment rate exclusive of the effect of gains or losses on disposal of capital assets or adjustments for excess depreciation claims.

(2) Effective October 1, 2000, a minimum property payment rate of $8.13 is applied to all existing facilities. Effective October 1, 2000, facilities with modified property payment rates effective September 30, 2000 below the minimum property payment rate receive an increase equal to the difference between the minimum property payment rate and the modified

property payment rate in effect on September 30, 2000. Effective October 1, 2000, facilities with modified property payment rates effective September 30, 2000 at or above the minimum property payment rate receive the modified property payment rate.

(3) Within the limits of appropriations for this purpose, effective January 1, 2002, facility property payment rates are increased annually for inflation. The increase is based on each facility's property payment rate in effect on September 30, 2000.

(4) Modified property payment rates effective September 30, 2000 are arrayed from the highest to lowest before applying the minimum property payment rate in subitem (2).

(a) For modified property payment rates at the 90th percentile or above, the annual inflation increase is zero.

(b) For modified property payment rates below the 90th percentile but at least at the 75th percentile, the annual inflation increase is one percent.

(c) For modified property payment rates below the 75th percentile, the annual inflation increase is 2 percent.

Section 4.020 **Increase in payment rate beginning June 6, 2003.**

Each facility receives an increase in its payment rate of $3.00, which is added following the determination of the payment rate for each facility. This increase is not subject to any annual percentage increase.

Section 4.030 **Limitations to total payment rate.** The total payment rate must not exceed the rate paid by private paying residents for similar services for the same period.

Section 4.040 **Increase in payment rate beginning March 1, 2006.** Effective March 1, 2006 and ending September 30, 2007, payment for ICF/~~MR~~DD services is increased by .2% for those providers who applied and met the competitive requirements for a medical assistance payment rate increase for the purpose of employee scholarships, except that the increase is .3% effective on or after September 1, 2006, for those providers who agree to accept the higher rate on a contract entered into on or after March 1, 2006 or whose new contract was entered into on or after September 1, 2006.

Section 4.050 **Payment rates for new facilities in Hennepin County.** Upon completion of relocation, the two six-bed level B facilities licensed to replace a 15 bed level A facility that is inaccessible to persons with disabilities will receive a payment rate of $200.47 per day plus any rate adjustments effective on or after July 1, 2007.

Section 4.060 **Payment rates for new facilities in Chisholm and Hibbing**. Effective for admissions on or after October 1, 2009 the newly licensed six-bed, level B facility in Chisholm will receive a payment rate of $274.50 per day and the newly licensed six-bed level B facility in Hibbing will receive a payment rate of $250.84 per day plus any rate adjustments effective on or after October 1, 2009.

Section 4.070 **Payment rates for certain facilities in Clearwater County**. Effective for admissions on or after July 1, 2010 through June 30, 2011, the per diem rate for a Class A facility with 15 beds in Clearwater County is increased from $112.73 to $138.23.

Section 4.080 **Payment rates for certain facilities in Kandiyohi County**. Effective for admissions on or after July 1, 2010 through June 30, 2011, the per diem rate for a six bed Class A facility is increased by $43.04.

Section 4.090 **Payment rates for certain facilities in Clearwater County.** Effective for admissions on or after September 1, 2011, the per diem rate for a Class A facility with 15 beds in Clearwater County is increased from $112.73 to 138.23.

Section 4.100 **Decrease in payment rate.** On September 1, 2011, each facility, except for a Class A facility located in Clearwater County with 15 beds, shall receive a decrease of .095 percent to the operating payment rate and all variable rates in effect on August 31, 2011.

Section 4.110 **Decrease in payment rate.** On September 1, 2011, each facility shall receive a decrease of 1.5 percent to the operating payment rate and all variable rates in effect on August 31, 2011.

Section 4.120 **Payment rates for certain facilities in Cottonwood County.** Effective for admissions on or after July 1, 2013, the per diem rate for a facility with 18 beds in Cottonwood County shall adjust to $282.62.

Section 4.130 **Increase in payment rate beginning July 1, 2013.** Effective for admissions on or after July 1, 2013, each facility shall receive an increase in its payment rate of $7.81, which is added following the determination of the payment rate for each facility. This increase is not subject to any annual percentage increase.

Section 4.140 **Increase in payment rate beginning July 1, 2013.** Effective for admissions on or after July 1, 2013, each facility shall receive an increase of .5 percent to the operating payment rate and all variable rates in effect on June 30, 2013.

Section 4.150 **Increase in payment rates beginning April 1, 2014.** Effective for admissions on or after April 1, 2014, each facility shall receive an increase of 1 percent to the operating payment rate and all variable rates in effect on March 31, 2014.

SECTION 5.000 DAY SERVICES CHARGES.

A. Charges incurred by the ICF/~~MR~~DD for day services provided by an entity licensed as a day training and habilitation provider are paid as a pass-through payment. The pass-through payment is paid separately and is not included in the computation of the total payment rate._Effective March 1, 2006 and ending September 30, 2007, payment for day services is increased by .2% for those providers who applied and met the competitive bidding requirements for a medical assistance payment rate increase for the purpose of employee scholarships, except that the increase is .3% on or after September 1, 2006, for those providers who agree to accept the higher rate on a contract entered into on or after March 1, 2006 or whose new contract was entered into on or after September 1, 2006. Effective October 1, 2007 payment for day services is increased by 2%. Providers receiving this rate increase must comply with the requirement of unit (1). Effective October 1, 2008 payment for day services is increased by 2%. Providers receiving this rate increase must comply with the requirements of unit (1). Effective July 1, 2009 payment for day services is reduced by 2.58 percent.

(1) Seventy-five percent of the rate increases effective October 1, 2007 and July 1, 2008 must be used to increase the MA portion of wages and benefits and pay associated MA costs of employees directly employed by the facility except administrative, or central office, employees or persons paid under a management contract, provided that this increase is used only for wage, benefit, and staff increases implemented on or after October 1, 2008.

(2) Two-thirds of the increase must be paid as an equal hourly percentage wage increase to the MA portion of wages for employees directly employed by the facility effective on the same date for all eligible employees. This provision does not apply to employees represented by an exclusive bargaining representative.

(3) For the purposes of units (1) and (2) compensation related costs include:

(a) wages and salaries;

(b) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation; and

(c) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions.

(4) For public employees, the increase for wages and benefits for certain staff is available and pay rates must be increased only to the extent that they comply with laws governing public employees collective bargaining.

(5) Providers receiving the rate increase shall provide to the Department within six months of the rate increase, a letter that provides assurances that the provider has developed and implemented a compensation plan and complied with units (1) and (2).

B. By January 1, 2004, charges incurred by the ICF/~~MR~~DD for day services

provided by a licensed entity that is not licensed as a day training and habilitation provider will be paid separately and will not be included in the computation of the total payment rate. Rates for day services will not exceed 75 percent of a resident's day services costs prior to leaving a day training and habilitation program. Effective March 1, 2006 and ending September 30, 2007, payment for day services is increased by .2% for those providers who applied and met the competitive requirements for a medical assistance payment rate increase for the purpose of employee scholarships, except that the increase is .3% effective on or after September 1, 2006, for those providers who agree to accept the higher rate on a contract entered into on or after March 1, 2006 or whose new contract was entered into on or after September 1, 2006.

SECTION 6.000 APPEAL PROCEDURES.

Section 6.010 **Scope of appeals.**

A provider may appeal from a determination of a payment rate established pursuant to this Attachment if the appeal, if successful, would result in a change to the provider's payment rate. Appeals must be filed in accordance with procedures in this section.

Section 6.020 **Filing of appeals.**

To appeal, the provider files with the Department a written notice of appeal; the appeal must be postmarked or received by the Commissioner within 60 days of the date the determination of the payment rate was mailed or personally received by a provider, whichever is earlier. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the Commissioner.

Section 6.030 **Contested case procedures appeals review process.**

A. Effective for desk audit appeals on or after October 1, 2000, the Commissioner must review appeals and issue a written appeal determination on each appeals item within one year of the due date of the appeal. Upon mutual agreement, the Commissioner and the provider may extend the time for issuing a determination for a specified period. The Commissioner must notify the provider by first class mail of the appeal determination. The appeal determination takes effect 30 days following the date of issuance specified in the determination.

B. In reviewing the appeal, the Commissioner may request additional written or oral information from the provider. The provider has the right to present information by telephone, in

writing, or in person concerning the appeal to the Commissioner prior to the issuance of the appeal determination within six months of the date the appeal was received by the Commissioner. Written requests for conferences must be submitted separately from the appeal letter. Statements made during the review process are not admissible in a contested case hearing absent an express stipulation by the parties to the contested case.

C. For an appeal item with which the provider disagrees with the appeal determination, the provider may file with the Commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the Commissioner within 30 days of the date of issuance specified in the determination. A contested case demand for an appeal item nullifies the written appeal determination issued by the Commissioner for that appeal item. The Commissioner must refer any contested case demand to the office of the Attorney General.

D. A contested case hearing must be heard by an administrative law judge. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the determination of a payment rate is incorrect.

E. Regardless of any rate appeal, the rate established must be the rate paid and must remain in effect until final resolution of the appeal or subsequent desk audit adjustment.

F. The Commissioner has discretion to issue to the provider a proposed resolution for specified appeal items upon a request from the provider filed separately from the notice of appeal. The proposed resolution is final upon written acceptance by the provider within 30 days of the date the proposed resolution was mailed to or personally received by the provider, whichever is earlier.

Section 6.040 **Attorney's fees and costs.**

A. For an issue appealed under Section 6.010, the prevailing party in a contested case proceeding or, if appealed, in subsequent judicial review, must be awarded reasonable attorney's fees and costs incurred in litigating the appeal, if the prevailing party shows that the position of the opposing party was not substantially justified. The procedures for awarding fees and costs set forth in state law regarding procedures for award of fees in contested cases must be followed in determining the prevailing party's fees and costs except as otherwise provided in this section. For purposes of this section, "costs" means subpoena fees and mileage, transcript costs, court reporter fees, witness fees, postage and delivery costs, photocopying and printing costs, amounts charged the Commissioner by the office of administrative hearings, and direct administrative costs of the Department; and "substantially justified" means that a position had a reasonable basis in law and fact, based on the totality of the circumstances prior to and during the contested case proceeding and subsequent review.

B. When an award is made to the Department under this section, attorney fees must be

calculated at the cost to the Department. When an award is made to a provider under this section, attorney fees must be calculated at the rate charged to the provider except that attorney fees awarded must be the lesser of the attorney's normal hourly fee or $100 per hour.

C. In contested case proceedings involving more than one issue, the administrative law judge must determine what portion of each party's attorney fees and costs is related to the issue or issues on which it prevailed and for which it is entitled to an award. In making that determination, the administrative law judge must consider the amount of time spent on each issue, the precedential value of the issue, the complexity, of the issue, and other factors deemed appropriate by the administrative law judge.

D. When the Department prevails on an issue involving more than one provider, the administrative law judge must allocate the total amount of any award for attorney fees and costs among the providers. In determining the allocation, the administrative law judge must consider each provider's monetary interest in the issue and other factors deemed appropriate by the administrative law judge.

E. Attorney fees and costs awarded to the Department for proceedings under this section must not be reported or treated as allowable costs on the provider's income and expense report.

F. Fees and costs awarded to a provider for proceedings under this section must be reimbursed to them within 120 days of the final decision on the award of attorney fees and costs.

G. If the provider fails to pay the awarded attorney fees and costs within 120 days of the final decision on the award of attorney fees and costs, the Department may collect the amount due through any method available to it for the collection of medical assistance overpayments to providers. Interest charges must be assessed on balances outstanding after 120 days of the final decision on the award of attorney fees and costs. The annual interest rate charged must be the rate charged by the Commissioner of revenue for late payment of taxes that is in effect on the 121st day after the final decision on the award of attorney fees and costs.

H. Amounts collected by the Commissioner pursuant to this section must be deemed to be recoveries.

Section 6.050 **Legal and related expenses.** Legal and related expenses for unresolved challenges to decisions by governmental agencies must be separately identified and explained on the provider's income and expense report for each year in which the expenses are incurred. When the challenge is resolved in favor of the governmental agency, the provider must notify the Department of the extent to which its challenge was unsuccessful on the income and expense report filed for the reporting year in which the challenge was resolved. In addition, the provider must inform the Department of the years in which it claimed legal and related expenses and the amount of the expenses claimed in each year relating to the unsuccessful challenge. The Department must reduce the provider's medical assistance rate in the subsequent rate year by the

total amount claimed by the provider for legal and related expenses incurred in an unsuccessful challenge to a decision by a governmental agency.

SECTION 7.000 VOLUNTARY RECEIVERSHIP.

Section 7.010 **Receivership agreement.** A majority of controlling individuals of a residential program may at any time ask the Department to assume operation of the residential program through appointment of a receiver. On receiving the request, the Department may enter into an agreement with a majority of controlling individuals and become the receiver and operate the program under conditions acceptable to both the Department and the majority of controlling individuals. The agreement will specify the terms and conditions of the receivership and preserve the rights of the persons being served by the program. A receivership set up under this section terminates at the time specified by the parties to the agreement.

Section 7.020 **Management agreement.** When the Department agrees to become the receiver of a program, the Department may enter into a management agreement with another entity or group to act as the managing agent during the receivership period. The managing agent will be responsible for the day-to-day operations of the residential program subject at all times to the review and approval of the Department. A reasonable fee may be paid to the managing agent for the performance of these services**.**

Section 7.030 **Rate adjustment.** The sections on rate recommendations and adjustments to the rate found in Section 8.000 also apply to voluntary receiverships.

Section 7.040 **Controlling individuals; restrictions on licensure.** No controlling individual of a residential program placed into receivership under Section 7.000 must apply for or receive a license to operate a program for five years from the commencement of the receivership period. Section 7.000 does not apply to programs that are owned or operated by controlling individuals, that were in existence prior to the date of the receivership agreement, and that have not been placed into receivership.

Section 7.050 **Liability.** The controlling individuals of a residential program placed into receivership remain liable for any claims made against the residential program that arose from incidents or events that occurred prior to the commencement of the receivership period. Neither the Department nor the managing agent of the Department assumes this liability.

Section 7.060 **Liability for financial obligations.** Neither the Department nor the managing agent will be liable for payment of any financial obligations of the residential program or of its controlling individuals incurred prior to the commencement of the receivership period unless such liability is expressly assumed in the receivership agreement. Those financial obligations remain the liability of the residential program and its controlling individuals. Financial

obligations of the residential program incurred after the commencement of the receivership period are the responsibility of the Department or the managing agent to the extent such obligations are expressly assumed by each in the receivership or management agreements. The controlling individuals of the residential program remain liable for any financial obligations incurred after the commencement of the receivership period to the extent these obligations are not reimburse in the rate paid to the residential program and are reasonable and necessary to the operation of the residential program. These financial obligations, or any other financial obligations incurred by the residential program prior to the commencement of the receivership period that are necessary to the continued operation of the residential program, may be deducted from any rental payments owed to the controlling receivership agreement.

Section 7.070 **Physical plant of the residential program.** Occupation of the physical plant after commencement of the receivership period will be controlled by items A and B.

A. If the physical plant of a residential program placed in receivership is owned by a controlling individual or related party, the physical plant may be used by the Department or the managing agent for purposes of the receivership as long as the receivership period continues. A fair monthly rental will be paid by the Department or the managing agent to the owner of the physical plant. This fair monthly rental will be determined by considering all relevant factors necessary to meet required arms-length obligations of controlling individuals. This rental will not include any allowance for profit or be based on any formula that includes an allowance for profit.

B. If the owner of the physical plant is not a related party, the controlling individual shall continue as the lessee of the property. However, during the receivership period, rental payments shall be made to the owner of the physical plant by the Department or the managing agent on behalf of the controlling individual. Neither the Department nor the managing agent assumes the obligations of the lease unless expressly stated in the agreement. Should the lease expire during the receivership, the Department or the managing agent may negotiate a new lease for the term of the receivership period.

Section 7.080 Receivership costs. The Department may use the accounts and funds that would have been available for the room and board, services, and program costs of persons in the residential program for costs, cash flow, and accounting purposes related to the receivership.

SECTION 8.000 INVOLUNTARY RECEIVERSHIP.

Section 8.010 **Application.** In addition to any other remedy provided by law, the Department may petition the district court in the county where the program is located for an order directing the controlling individuals of the program to show cause why the Department should not be appointed receiver to operate the program. The petition must contain proof by affidavit: (1) that the Department has either begun license suspension or revocation proceedings, suspended or

revoked a license, or has decided to deny an application for licensure of the program; or (2) it appears to the Department that the health, safety, or rights of the residents may be in jeopardy because of the manner in which the program may close, the program's financial condition, or violations committed by the program of federal or state laws or rules. If the license holder, applicant, or controlling individual operates more than one program, the Department's petition will specify and be limited to the residential program for which it seeks receivership. The affidavit submitted must set forth alternatives to receivership that have been considered, including rate adjustments. The order to show cause is returnable not less than five days after service is completed and must provide for personal service of a copy to the program administrator and to the persons designated as agents by the controlling individuals to accept service on their behalf.

Section 8.020 **Appointment of receiver.** If the court finds that involuntary receivership is necessary as a means of protecting the health, safety, or rights of persons being served by the program, the court will appoint the Department as receiver to operate the program. The Department may contract with another entity or group to act as the managing agent during the receivership period. The managing agent will be responsible for the day-to-day operations of the program subject at all times to the review and approval of the Department.

Section 8.030 **Powers and duties of the receiver.** Within 36 months after the receivership order, the receiver will provide for the orderly transfer of the persons served by the program to other residential programs or make other provisions to protect their health, safety, and rights. The receiver or managing agent will correct or eliminate deficiencies in the program that the Department determines endanger the health, safety, or welfare of the persons being served by the residential program unless the correction or elimination of deficiencies involves major alteration in the structure of the physical plant. If the correction or elimination of the deficiencies requires major alterations in the structure of the physical plant, the receiver will take actions designed to result in the immediate transfer of persons served by the program. During the period of the receivership, the receiver and the managing agent will operate the program in a manner designed to preserve the health, safety, rights, adequate care, and supervision of the persons served by the program. The receiver or the managing agent may make contracts and incur lawful expenses. The receiver or the managing agent shall collect incoming payments from all sources and apply them to the cost incurred in the performance of the functions of the receivership. No security interest in any real or personal property comprising the residential program or contained within it, or in any fixture of the physical plant, shall be impaired or diminished in priority by the receiver or the managing agent.

Section 8.040 **Liability and liability for financial obligations.** These are the same as those for voluntary receivership that are found in Section 7.000.

Section 8.050 **Physical plant of the residential program.** Occupation of the physical plant is governed by the following:

A. The physical plant owned by a controlling individual of the residential program or related party must be made available for the use of the program throughout the receivership period. The court will determine a fair monthly rental for the plant, taking into account all relevant factors necessary to meet required arms-length obligations of controlling individuals. The rental fee must be paid by the receiver to the appropriate controlling individuals or related parties for each month that the receivership remains in effect. No payment made to a controlling individual or related party by the receiver or the managing agent or any state agency during a period of the receivership shall include any allowance for profit or be based on any formula that includes an allowance for profit.

B. If the owner of the physical plant of a program is not a related party, the court will order the controlling individual to continue as the lessee of the property during the receivership period. Rental payments during the receivership period shall be made to the owner of the physical plant by the Department or the managing agent on behalf of the controlling individual.

Section 8.060 **Fee.** A receiver or the managing agent is entitled to a reasonable fee as determined by the court.

Section 8.070 **Termination.** An involuntary receivership terminates 36 months after the date on which it was ordered or at any other time designated by the court or when any of the following occurs:

A. The Department determines that the program's license application should be granted or should not be suspended or revoked.

B. A new license is granted to the program.

C. The Department determines that all persons residing in the program have been provided with alternative residential programs.

D. The residential program closes.

Section 8.080 **Emergency procedure**. If it appears from the petition filed or from the affidavit filed with the petition or from testimony of witnesses under oath, that there is probable cause to believe that an emergency exists in a program, the court must issue a temporary order for appointment of a receiver within five days after receipt of the petition. Notice of the petition must be served on the residential program administrator and on the persons designated as agents by the controlling individuals to accept service on their behalf. A hearing on the petition must be held within five days after notice is served unless the administrator or designated agent consents to a later date. After the hearing, the court may continue, modify, or terminate the temporary order.

Section 8.090 **Rate recommendation.** The Department may review rates of a program

participating in the Medical Assistance Program that is in receivership and that has needs or deficiencies documented by the Department of Health or the Department of Human Services. If the Department determines that a review of the rate established is needed, the Department will:

A. Review the order or determination that cites the deficiencies or needs.

B. Determine the need for additional staff, additional annual hours by type of employee, and additional consultants, services, supplies, equipment, repairs, or capital assets necessary to satisfy the needs or deficiencies.

Section 8.100 **Adjustment to the rate.** Upon review of rates the Department may adjust the program's payment rate. The Department will review the circumstances, together with the most recent residential program income and expense report, to determine whether or not the deficiencies or needs can be corrected or met by reallocating residential program staff, costs, revenues, or any other resources including investments. If the Department determines that any deficiency cannot be corrected or the need cannot be met with the payment rate currently being paid, the Department must determine the payment rate adjustment by dividing the additional annual costs established during the Department's review by the residential program's actual resident days from the most recent income and expense report or the estimated resident days in the projected receivership period. The payment rate adjustment remains in effect during period of the receivership or until another date set by the Department. Upon the subsequent sale, closure or transfer of the program, the Department may recover amounts that were paid as payment rate adjustments under this section. This recovery is determined through a review of actual costs and resident days in the receivership period. The costs the Department finds to be allowable are divided by the actual resident days for the receivership period. This rate is compared to the rate paid throughout the receivership period, with the difference multiplied by resident days, being the amount to be repaid to the Department. Allowable costs are determined by the Department as those ordinary, necessary, and related to resident care by prudent and cost-conscious management. The buyer or transferee shall repay this amount to the Department within 60 days after the Department notifies the buyer or transferee of the obligation to repay.

Section 8.110 **Receivership costs.** The Department may use the accounts and funds that would have been available for the room and board, services, and program costs of persons in the residential program for costs, cash flow, and accounting purposes related to the receivership.

SECTION 9.000 SPECIAL SITUATIONS.

Section 9.010 **Closure.** In order to facilitate an orderly transition of residents from community ICFs/MR to services provided under the home and community-based services waiver programs, upon closure of a facility, the facility’s contract is null and void.

Section 9.020 **Variable rate adjustments.** The following items apply for the payment rate

adjustment.

A. A resident's county of financial responsibility requests a variable rate adjustment. The request must be for an amount not otherwise paid for through a facility's per diem.

The Department grants variable rate adjustments after considering:

(1) changes in a resident's condition(s);

(2) the typical cost to treat the condition(s), based on the community standard; and

(3) the facility's staffing levels.

B. Variable rate adjustments will not exceed $274.00 per day, per occurrence.

C. With one exception, variable rate adjustments may be granted for up to one year.

Variable rate adjustments may exceed one year when there is a documented increase in the needs of a resident due to the resident's full or partial permanent retirement from participation in a day training and habilitation program. The resident must:

(1) be at least age 65 or have a change in health condition that makes it difficult for the resident to participate in a day training and habilitation program over an extended period of time; and

(2) express a desire for change through the developmental disability ~~mental retardation~~ and related conditions screening process.

D. Effective July 1, 2003, facilities with base rates above the 50th percentile of the statewide average payment rate for Class A or Class B facilities are not eligible for a variable rate adjustment. Effective July 1, 2009 through June 30, 2010 variable rate adjustments in effect on June 30, 2009 are frozen and no new variable rate adjustments will be approved.

Section 9.030 **Relocation.**

A. For the initial rate year, property rates for facilities relocated after December 31, 1997, and up to and including October 1, 2000, have the full annual costs of relocation included in the initial rate year property rate. The property rate for the relocated facility is subject to the costs that were allowable in the State plan in effect on September 30, 2000 and the investment per bed limitation for newly constructed or newly established class B facilities.

B. As of January 1, 2002, property rates for facilities relocated after October 1, 2000

may be adjusted.

(1) Relocated facilities are subject to the investment per bed limit for newly constructed or newly established class B facilities. The limits are adjusted on January 1 of each year by the percentage increase in the construction index published by the Bureau of Economic Analysis of the United States Department of Commerce in the Survey of Current Business Statistics in October of the previous two years. Facilities that are relocated within the investment per bed limit may be approved by the statewide advisory committee.

(2) Rate adjustments for facilities that relocate within the investment per bed limit are reviewed by the statewide advisory committee.

C. Costs for relocation exceeding the investment per bed limit are absorbed by the facility.

Section 9.040 **Disasters.**

A. Notwithstanding a provision to the contrary, effective June 6, 2003, a facility may receive payments for expenses specifically incurred due to a disaster. Payments will be based on actual documented costs for the period during which the costs were incurred, and will be paid as an add-on to the facility's payment rate, or as a lump sum payment. The actual costs paid will be reported on the next annual income and expense cost report as non-allowable costs, in order to avoid duplicate payment. Costs submitted for payments will be subject to review and approval by the Department. The Department's decision is final and not subject to appeal.

B. For transfers, the rates continue to apply for evacuated facilities, and residents are not counted as admissions to facilities that admit them.

Section 9.050 **Temporary adjustments for short-term admissions for crisis or specialized medical care.**

A. Effective July 1, 2003, the Department may designate up to 25 beds in facilities statewide for short-term admissions due to crisis care needs or care for medically fragile individuals. The Department may designate short-term beds based on the short-term care needs of a region or a county.

B. The Department will adjust the monthly facility rate to provide payment for vacancies in designated short-term beds by an amount equal to the rate for each recipient residing in a designated bed for up to 15 days per bed per month.