



Bulletin

NUMBER

#14-62-01

DATE

July 2, 2014

OF INTEREST TO

County Directors

Social Services Supervisors
and Staff

Nursing Facility Owners

Nursing Facility
Administrators

Nursing Facility Unions

ACTION/DUE DATE

Please read

Some information is time
sensitive

EXPIRATION DATE

July 2, 2016

Nursing Facility Policy Changes in 2014 Legislation

TOPIC

Policy and rate changes enacted during the 2014 Legislative session

PURPOSE

To inform interested parties of changes made to policy and rates that apply to nursing facilities

CONTACT

Nursing Facility Policy Center at (651) 431-2282, or by email at DHS.LTCpolicycenter@state.mn.us

SIGNED

LOREN COLMAN
Assistant Commissioner
Continuing Care

TERMINOLOGY NOTICE

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.

I. Introduction

The purpose of this bulletin is to describe changes to law enacted in the 2014 legislative session that apply to nursing facilities and to provide details on how the Minnesota Department of Human Services (DHS) will implement these changes.

II. Rate Adjustments for Minimum Wage Increases

Laws of Minnesota 2014, chapter 312, article 27, section 59

Minnesota Statutes, section 256B.441, subdivision 64

Nursing facilities are eligible, under Laws of Minnesota, 2014, Chapter 312, for rate increases on October 1st of 2014, 2015, and 2016 to cover the costs resulting from the implementation of the minimum wage phase-in to \$9.50 by 2016. There are two parts to this three year schedule of rate increases:

- Nursing facilities with employees earning less than the phased-in minimum wage for a specific year are eligible to receive a rate increase to cover the costs of complying with that requirement. The cost of complying with this requirement will be referred to as the “primary effect” of the minimum wage law.
- Nursing facilities with employees earning between \$8.00 per hour and \$13.00 per hour are eligible to receive an increase to be distributed over the next three years. Based on 2014 data reported by nursing facilities, this part of the rate increase is for providing wage increases to employees earning less than \$14.00 per hour. The cost of providing these wage increases will be referred to as the “secondary effect” of the minimum wage law. The secondary effect refers to the forces in the labor market resulting from wage compression. It occurs because employers will be under pressure to maintain a wage hierarchy similar to what existed prior to the minimum wage increase.

In Laws of Minnesota, 2014, Chapter 166, the legislature increased the minimum wage. The minimum wage and the associated payment rate increases occur in several phases, with the hourly minimum wage increasing to:

- \$8.00 on August 1, 2014
- \$9.00 on August 1, 2015
- \$9.50 in August 1, 2016, and
- Annually indexed amounts, under certain circumstances, beginning in January 2017.

A. How is the rate adjustment determined?

An amount of money which is to be available for wage increases is determined by estimating the actual cost of the primary and secondary effects. Interested nursing facilities may start by compiling payroll data for a three month period at the beginning of 2014. The data period starts with the first day of the first payroll period beginning in January 2014 and concludes with the end of a payroll period at least three months later. The data set should include the names, ending wage levels and average weekly compensated hours for all employees who are paid wages less than \$14.00 per hour.

Considerations:

- The amount of funding estimated to be available will consider both the primary and secondary effects.
- Estimated costs to be included are for wage increases, the employer's share of associated costs for FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, pensions, and contributions to employee retirement accounts.
- The rate increase will be built into the operating cost portion of the payment rate. Therefore, the data set will need to distinguish between employees who are part of direct care vs. other cost areas.
- Only employees earning less than \$14 per hour.
- Only individuals who are directly employed by the facility during the data period may be included for purposes of calculating the amount of money available.
- A formula is provided which will compute funding for the secondary effect in accordance with values in the statute. This computation will be performed only once, using the 2014 data set. The resulting amount will then be allocated over the three year phase-in of the minimum wage.

The data set is to be compiled in two groups. The first group will be employees whose wages are reported in the direct care cost category on the Annual Statistical and Cost Report. The second group will consist of employees whose wages are reported in the Annual Statistical and Cost Report in areas other than the direct care cost category. For an individual to be included in either of these lists they must be earning less than \$14 per hour and they must be directly employed by the facility during the data period, though not necessarily for the entire data period.

The funding available for the primary effect will be the sum of the average weekly hours of each employee earning less than the minimum wage multiplied by the difference between the minimum wage and their actual wage.

The funding available for the secondary effect will be computed using a formula provided in the statute. This formula will use the data set, and compute the sum of the following eight items for all listed staff earning:

- Between \$8.00 and \$8.49 per hour, compensated hours multiplied by \$0.13
- Between \$8.50 and \$8.99, by \$0.25
- Between \$9.00 and \$9.49, by \$0.38
- Between \$9.50 and \$10.49, by \$0.50
- Between \$10.50 and \$10.99, by \$0.40
- Between \$11.00 and \$11.49, by \$0.30
- Between \$11.50 and \$11.99, by \$0.20
- Between \$12.00 and \$13.00, by \$0.10

The portion of this amount that will be included in the October 1, 2014, rates will be 33.3%; for October 1, 2015, rates will be 44.4%; and for October 1, 2016, rates will be 22.2%.

The amounts computed using this formula for both primary and secondary amounts, for direct care costs, will be annualized; increased to include the employer's share of associated costs for FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, pensions, and contributions to employee retirement accounts; and then divided by standardized resident days. This amount will then be added to the direct care related component of the default rate, also known as the DDF rate. The amount computed for other operating costs will be treated in a similar manner.

B. How must the funding resulting from the rate adjustment be used?

The money made available through the rate increases computed in paragraph A above must be used to increase wages and associated costs, as defined above, of employees with wages less than \$14.00 per hour. While the amount of funding to be used for wage increases and associated costs must at least equal the amount made available in paragraph A, the law does not require that the distribution of available secondary funds be in accordance with the formula that makes the funding

available. Nursing facilities are free to allocate the secondary funds among employees with wages less than \$14.00 per hour, as they see fit, as long as wage increases and associated costs use the full amount during the year beginning October 1, 2014.

C. What process is required in order to receive the rate adjustments?

To receive the October 1, 2014, rate adjustments for minimum wage increases, a nursing facility must submit an application to the commissioner by January 2, 2015, and must, by April 1, 2015, provide any additional documentation requested. DHS has three weeks to respond to applications submitted on a timely basis.

Upon approval of a nursing facility's application, the rate adjustment will be added to the nursing facility's operating payment rates effective October 1, 2014. Nursing facilities are also reminded that thirty days advance notice to private paying residents is required for this rate adjustment.

If there are employees covered by an exclusive bargaining representative, the application can be approved only after the representative sends a signed statement that they agree with the submitted plan.

DHS will provide the "2014 SNF MINIMUM WAGE RATE INCREASE CALCULATOR," an Excel tool to be used to prepare the application. The 2014 SNF MINIMUM WAGE RATE INCREASE CALCULATOR will pre-fill much of the required information, perform needed calculations and expedite review and approval of applications by the department. Nursing home administrators will receive an email notification when the Calculator is available. The Calculator will be found at the [Nursing Facility Rates and Policy \(NFRP\) Division's website](#).

III. Critical Access Nursing Facility Program Restored and Enlarged

Laws of Minnesota 2014, chapter 312, article 27, section 58 and article 30, section 2, subdivision 3, paragraph (d)

Minnesota Statutes, section 256B.441, subdivision 63

In 2012, legislation established the Critical Access Nursing Facility (CANF) Program. CANF selection criteria were established in consultation with stakeholders, applications were solicited, and designations were made. Contracts were in effect for much of 2013 and were cancelled effective November 30, 2013, when the one-time funding was used up.

In 2014, the legislature restored and enlarged the CANF program, providing ongoing funding. Changes to the enabling legislation include seeking, to the extent practicable, to have designated CANF's be evenly distributed across the state and flexibility in the portion of the rate based on the rebasing formula.

Benefits of designation as a CANF include:

- a. Partial rebasing, with operating payment rates being the sum of up to 60 percent of the operating payment rate determined in accordance with the rebasing law, and at least 40 percent (for a sum of 100%) of the operating payment rate that would have been allowed had the facility not been designated. Note that the statute was amended to allow DHS to shift these percentages by up to 20%. For purposes of this solicitation, the percentages will remain as stated above. Value-based reimbursement features under current rebasing law, specifically the use of variable care related limits based on quality scores, will apply to CANFs beginning October 1, 2014.
- b. Enhanced payments for leave days equal to 60 percent of the resident's total payment rate, allowed when the occupancy of the CANF, inclusive of bed hold days is equal to or greater than 90 percent.
- c. Opportunity to apply to the Minnesota Department of Health (MDH) for a waiver for two CANFs, with up to 100 beds, to jointly employ a director of nursing.
- d. A reduced minimum threshold for having a capital project recognized for purposes of rate setting.

A change made in the 2014 legislation allows flexibility under item III.a. above, for designated CANFs to accept a lesser level of rebasing than 60%.

Item a, above, requires that the method of setting spending limits in the rebasing law be based on the facility's quality score. Without item III.a., the limit on care related costs that would be allowed in the rates would be 120% of the median costs. Instead, the limit will be between 105% and 125% of median costs, depending on the quality score of the designated CANF.

Three quality measures are used to determine the quality score, in the same manner as in computing the Quality Add-On that was implemented in September 2013. These are measures that are included in the [Nursing Home Report Card](#) published by the Minnesota Department of Human Services (DHS).

The quality measures are:

1. MINNESOTA QUALITY INDICATORS – clinical process and outcome quality indicators derived from the Minimum Data Set will account for 50 points out of a

possible 100 point score. DHS will use the most recent available data, as reflected on the Nursing Home Report Card as of July 1, 2014.

2. RESIDENT QUALITY OF LIFE AND SATISFACTION – Results from resident interviews will account for 40 points. DHS will use the risk adjusted data from the 2013 Quality of Life interviews.
3. MDH INSPECTION RESULTS – A scoring system based on deficiency findings will account for 10 points. DHS will use the most recent available data, as reflected on the Nursing Home Report Card as of July 1, 2014.

The quality score will be recomputed annually.

Details on these quality measures are provided in the Technical User's Guide, available through a link on the report card. Each facility's total quality score will be used to calculate their care related cost limit by use of a formula under which a score of 100 will result in a limit of 125%, scores between 0 and 40 will result a limit of 105%, and scores between 40 and 100 will have a limit computed using a straight line relationship.

Prior to soliciting applications for CANF designation, DHS will undertake a stakeholder review of the selection criteria. This will be followed by a solicitation, by about June 23, 2014, contract amendments by August 15, 2014 and implementation of CANF benefits on or after October 1, 2014. Contracts will be for up to two years, after which designated CANFs will need to re-apply in order to retain the CANF benefits. Depending on the results of initial CANF designation, additional offers may be made on a somewhat later time frame.

DHS will use the criteria that will be described in the solicitation to calculate a score for each applicant. Applicants will be offered designation in order of the scores assigned. If remaining funding is insufficient to allow designation of a highest scoring remaining applicant, DHS may designate a lower scoring applicant that can be accommodated within available funding.

Nursing home administrators will receive an email notification when the CANF Application is available. The Application will be found at the [Nursing Facility Rates and Policy \(NFRP\) Division's website](#).

Applications should be sent by email to Gary.M.Johnson@state.mn.us, and must be received by 4:30 PM on July 11, 2014, in order to be considered.

IV. Moratorium Exception Project Funding

*Laws of Minnesota 2014, chapter 312, article 27, section 3
Minnesota Statutes, section 144A.073, subdivision 14*

In State Fiscal Year 2015 the commissioner of health may approve moratorium exception funding for projects with an annualized state cost of \$1,000,000. This authority will be combined with carry-over authority resulting from either the cancellation or expiration of projects approved in earlier moratorium exception rounds, for a total authority of approximately \$1,119,560. The Minnesota Department of Health anticipates publishing a request for proposals in July 2014 in the State Register and also will widely disseminate information about the opportunity.

Americans with Disabilities Act (ADA) Advisory

This information is available in accessible formats for people with disabilities by calling (651) 431-2281 (voice) or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.