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State/Territory Name: Minnesota

State Plan Amendment (SPA) #: MN 26-0005

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

August 11, 2026

Patrick Hultman
Minnesota Department of Human Services
Federal Relations Unit
540 Cedar Street, PO Box 64983
Saint Paul, MN 55164

RE: TN 26-0005

Dear Deputy Medicaid Director Hultman:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Minnesota state plan amendment (SPA) to Attachment 4.19-D MN 26-0005, which was submitted to CMS on January 9, 2026. This plan amendment The amendment eliminates the automatic annual property rate adjustment, extends a previously approved rate increase for specified facilities, modifies the cap on annual rate increases, implements the 25-group Patient Driven Payment Model case mix classification system, increases the rate adjustment for the state's licensing surcharge, and adds a new rate adjustment in recognition of nursing home employment standards.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 1, 2026. We are enclosing the approved CMS-179 and a copy of the new state plan pages. Additionally, a companion letter is included with this approval package. CMS identified issues with the state's base payment methodology for nursing facility providers. The letter clarifies that the SPA contains a previously approved methodology for base payment to out-of-state providers that may differ from base payments made to in-state providers and that CMS is not approving any payment that may violate Circuit opinion in Asante v. Kennedy, No. 23-5055 (D.C. Cir. 2025), petition for cert. filed (U.S. Sept. 17, 2025) (No. 25-361). More details can be found in the attached companion letter.

If you have any additional questions or need further assistance, please contact Tom Caughey at 517-487-8598or via email at tom.caughey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

August 11, 2026

Patrick Hultman
Minnesota Department of Human Services
Federal Relations Unit
540 Cedar Street, PO Box 64983
Saint Paul, MN 55164

RE: TN 26-0005

RE: Minnesota payments for out-of-state nursing facility providers

Dear Deputy Medicaid Director Hultman:

The Centers for Medicare & Medicaid Services (CMS) is providing this letter as a companion to the approval of SPA MN-26-0005 which updates the nursing facility reimbursement rate, effective January 1, 2026.

It appears that some of the previously approved payment methodologies that pay out of state providers differently (noted in "same page" review) may be problematic in light of the D.C. Circuit opinion in *Asante v. Kennedy*, No. 23-5055 (D.C. Cir. 2025), *petition for cert. filed* (U.S. Sept. 17, 2025) (No. 25-361). By approving the corresponding SPA, CMS is expressly not approving any payment methodologies that would violate *Asante*. At this time, CMS will not take enforcement action against the state over such payment methodologies provided that the state does not implement such methodologies in a manner that conflicts with *Asante*. CMS is currently exploring options for how to proceed with this issue, which may include rulemaking.

If you have any additional questions or need further assistance, please contact Tom Caughey at 517-487-8598 or via email at tom.caughey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26 — 0005

2. STATE: MN

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR § 440 and Title XIX of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 3,321,000
b. FFY 2027 $ (18,996,000)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D Pages:
03,18,19,68,72,73,74,75,76,77,133,153,154,177,185,193,194,195,196,200

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

9. SUBJECT OF AMENDMENT

Nursing facility rate changes

10. GOVERNOR'S REVIEW *(Check One)*

(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Patrick Hultman

13. TITLE
Deputy Medicaid Director

14. DATE SUBMITTED
~~February 9, 2026~~ January 9, 2026

15. RETURN TO
Patrick Hultman
Minnesota Department of Human Services
Federal Relations Unit
540 Cedar Street, PO Box 64983
Saint Paul, MN 55164

FOR CMS USE ONLY

16. DATE RECEIVED
1/9/2026

17. DATE APPROVED
08/11/2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2026

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

State provided permission for CMS to perform pen and ink change on Block 14 of the 179 form, on 8/11/26

Other care-related operating costs. "Other care-related operating costs" means the operating costs listed in Section 6.060, and the portion of fringe benefits and payroll taxes allocated to the other care-related cost category, the cost of food, and the dietician consulting fees calculated under Section 8.000.

Other operating costs. "Other operating costs" means the operating costs listed in Sections 6.010-6.040 and 6.070, excluding the cost of food and dietician consulting fees, and the portion of fringe benefits and payroll taxes allocated to each of these operating costs categories under Section 8.000.

Patient driven payment model or PDPM. "Patient driven payment model" or "PDPM" means the case mix reimbursement classification system for residents in nursing facilities based on the resident's condition, diagnosis, and the care the resident received at the time of the MDS assessment with an ARD.

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

Preopening costs. "Preopening costs" means the operating costs incurred prior to the admission of a resident to a newly constructed nursing home.

Private paying resident. "Private paying resident" means a nursing home resident who is not a medical assistance program recipient for the date of service and whose payment rate is not established by another third party, including the Veterans Administration or Medicare.

Productive nursing hours. "Productive nursing hours" means all on-duty hours of nurses, aides, orderlies, and attendants. The on-duty hours of the director of nursing for facilities with more than 60 licensed beds and the on-duty hours of any medical records personnel are not included. Vacation, holidays, sick leave, classroom training, and lunches are not included in productive nursing hours.

Rate year. "Rate year" means the state of Minnesota's fiscal year for which a payment rate is effective, from July 1 through the following June 30. The July 1, 2004 rate year extends through September 30, 2005. As of October 1, 2005, “rate year” means October 1 through the following September 30.

Real estate taxes and special assessments. "Real estate taxes and special assessments" means the real estate tax liability shown on the annual property tax statement of the nursing home for the calendar year during which the rate year begins and the actual special assessments and related interest paid during the reporting year. The term does not include personnel costs or fees for late payment.

Related organization. "Related organization" means a person that furnishes goods or services to a nursing home and that is a close relative of a nursing home, an affiliate of a nursing home, a close relative of an affiliate of a nursing home, or an affiliate of a close relative of an affiliate of a nursing home.

A. An "affiliate" is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with another person.

B. A "person" is an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

C. A "close relative of an affiliate of a nursing home" is an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a nursing home is no more remote than first cousin.

D. "Control" including the terms "controlling," "controlled by," and "under common control with" is 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.

Replacement. "Replacement" means a renovation or substitution of an existing capital asset to improve its function or extend its useful life.

Reporting year. "Reporting year" means the period from October 1 to September 30, immediately preceding the rate year, for which the nursing home submits its cost report, and which is the basis for the determination of the payment rate for the following rate year.

Resident day or actual resident day. "Resident day" or "actual resident day" means a day for which nursing services are rendered and billable, or a day for which a bed is held and billed.

Resident class. "Resident class" means ~~each of~~ the ~~11~~ categories established in Section 1~~3~~4.000.

Resource utilization group or "RUG" means the case mix reimbursement classification system for residents in nursing facilities according to the resident's clinical and functional status as reflected in data supplied by the facility's MDS with an ARD on or before September 30, 2025.

Short length of stay facility. "Short length of stay facility" has the meaning given in Section 20.025.

Standardized resident days. "Standardized resident days" means the sum of the number of resident days in the nursing home in each resident class multiplied by the weight for that resident class.

Top management personnel. "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators and the nursing home

A. To determine the settle-up operating cost payment rate for interim periods or the portion of an interim period occurring after July 1, 1987, subitems (1) to (7) must be applied.

(1) The standardized resident days as determined in Section 9.020 must be used for the interim period.

(2) The Department shall use the standardized resident days in subitem (1) in determining the allowable historical case mix operating cost standardized per diem.

(3) The Department shall use the actual resident days in determining both the allowable historical other care-related operating cost per diem and the allowable historical other operating cost per diem.

(4) The annual adjustment factors determined in Section 10.010 must not be applied to the nursing facility's allowable historical per diems.

(5) The efficiency incentive in Section 11.040, items A or B, must not apply.

B. For the nine-month period following the settle-up reporting period, the total operating cost payment rate must be determined according to item B except that the efficiency incentive as computed in Section 11.040, item A or B, applies.

C. The total operating cost payment rate for the rate year beginning July 1 following the nine-month period in item C must be determined under Sections 6.000 to 16.090.

D. A newly-constructed nursing facility or one with an increase in licensed capacity of 50 percent or more must continue to receive the interim total operating cost payment rate until the settle- up total operating cost payment rate is determined under this subpart.

SECTION 14.000 RESIDENT CLASSES, CLASS WEIGHTS AND RESIDENT ASSESSMENT SCHEDULES.

SECTION 14.010 **Resident classes** A. ~~Effective January 1, 2012,~~ R~~r~~esident classifications are based on the Minimum Data Set (MDS), version 3.0 assessment instrument, or its successor, mandated by the Centers for Medicare & Medicaid Services. The Department of Health establishes resident classes according to the 48-group, Resource Utilization Group, version IV (RUG IV) model. In addition to the 48-group RUG-IV classes, there are penalty and default classes.

The Department of Health establishes resident classes according to the 25-group~~,~~ Patient Driven Payment Model (PDPM). In addition to the 25- group PDPM classes, there are penalty and default classes. Resident classes are established based on the individual items on the MDS and must be completed according to the facility manual for case mix classification issued by the Department of Health.

B. PDPM Case Mix Indices-The Department assigns case mix indices to each resident class according to subitems (1) to (27).

(1) Class ES3, 3.84;

(2) Class ES2, 2.90;

(3) Class ES1, 2.77;

(4) Class HDE2, 2.27;

(5) Class HDE1, 1.88;

(6) Clas HBC2, 2.12;

(7) Class HBC1, 1.76;

(8) Class LDE2, 1.97;

(9) Class LDE1, 1.64;

(10) Class LBC2, 1.63;

(11) Class LBC1, 1.35;

(12) Class CDE2 1.77;

(13) Class CDE1, 1.53;

(14) Class CBC2, 1.47;

(15) Class CA2, 1.03;

(16) Class CBC1, 1.27;

(17) Class CA1, 0.89;

(18) Class BAB2,0.98;

(19) Class BAB1, 0.94;

(20) Class PDE2, 1.48;

(21) Class PDE1, 1.39;

(22) Class PBC2, 1.15;

(23) Class PA2, 0.67;

(24) Class PBC1, 1.07;

(25) Class PA1, 0.62;

(26) Class AAA, 0.62 (penalty);

(27) Class DDF, 1.00 (default).

SECTION 14.030 **Resident assessment schedule.** Nursing facilities must conduct and electronically submit to the Department of Health case mix assessments that conform to the assessment schedule defined in Code of Federal Regulations, title 42, section 483.20, and published by the Centers for Medicare & Medicaid Services in the Long Term Care Assessment Instrument User's Manual, version 3.0, and updates when issued by the Centers for Medicare and Medicaid Services. The Department of Health may substitute successor Centers for Medicare & Medicaid Services' manuals or question and answer documents to replace or supplement the current version of the manual or document.

A. The case mix assessments used for Minnesota's case mix classifications are:

(1) New admission assessments, which must be completed by day 14 following admission;

(2) Annual assessments, which must be completed within 366 days of the last comprehensive assessment;

(3) Significant change assessments, which must be completed within 14 days of the identification of a significant change; and

(4) Quarterly assessments, which must be completed following new admission assessments, annual assessments, and significant change assessments (if significant change assessments have been made). Each quarterly assessment must be completed within 92 days of the previous assessment.

B. (1) A facility must submit to the Department of Health an initial admission assessment for all residents who stay in the facility less than 14 days.

(2) Notwithstanding subitem (1), in lieu of submitting an initial admission assessment, a facility may elect to accept a default rate with a case mix index of 1.0 for all facility residents who stay less than 14 days. Residents with a stay of less than 14 days who are admitted to a nursing facility that makes this election for all stays of less than 14 days will be assigned a ~~RUG~~ PDPM case mix classification code of DDF.

(3) Nursing facilities must elect one of the options in subitems (1) and (2) with the Department of Health on an annual basis. The election will be effective on the following July 1.

C. Residents who are admitted and readmitted and leave the facility on a frequent basis and for whom readmission is expected may be discharged on an extended leave status. This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred since the last assessment. The case mix classification for these residents is determined by the facility election made in item B.

D. (1) A facility that fails to complete or submit an assessment for a ~~RUG-IV~~ PDPM classification within seven days of the time requirements according to the schedule in item A is subject to a reduced rate for that resident. The resident for whom the facility failed to complete or submit an assessment within the time required will be assigned a ~~RUG~~ PDPM case mix classification code AAA. The reduced rate is the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission of the resident's assessment.

(2) If loss of revenue due to penalties incurred by a facility for any period of 92 days are equal to or greater than 1.0 percent of the total operating costs on the facility's most recent annual statistical and cost report, a facility may apply to the Commissioner of Human Services for a reduction in the total penalty amount. Effective August 1, 2017, a facility may apply to the Commissioner for a reduction in the penalty amount if loss of revenue is equal to or greater than .1 percent of total operating costs. The Commissioner of Human Services, in consultation with the Commissioner of Health, may, at the sole discretion of the Commissioner of Human Services, limit the penalty for residents covered by medical assistance to 15 days. Effective August 1, 2017, the Commissioner may limit the penalty to 10 days.

E. Resident reimbursement classifications will be effective:

(1) The day of admission for new admission assessments.

(2) The assessment reference date, which is the last day of the MDS observation period, for significant change assessments.

(3) The first day of the month following the assessment reference date for annual and quarterly assessments.

SECTION 14.040 **~~Rate determination upon~~ Patient Driven Payment Model (PDPM) payment rates transition ~~to RUG-IV~~**

~~A. Effective January 1, 2012, the Department determines payment rates using the RUGS-IV based payment model in a facility-specific, budget-neutral manner. To transition from the current calculation methodology to the RUG-IV based methodology nursing facilities reported to the Department the private pay and Medicaid resident days classified under both RUG-III and~~

~~RUG-IV for the six-month reporting period ending June 30, 2011. This report was submitted to the Department, in a form prescribed by the Department, by August 15, 2011. The Department used this data to compute the standardized days for the RUG-III and RUG-IV classification systems.~~

~~A. The Department determines the case-mix adjusted component for the rate for services on or after January 1, 2012, as follows:~~

~~(1) using the September 30, 2010, cost report, determine the case mix portion of the operating cost for each facility;~~

~~(2) multiply the 36 operating payment rates in effect on December 31, 2011, by the number of private pay and Medicaid resident days assigned to each group for the reporting period ending June 30, 2011, and compute the total;~~

~~(3) compute the product of the amounts in clauses (1) and (2);~~

~~(4) determine the private pay and Medicaid RUG standardized days for the reporting period ending June 30, 2011, using the new indices calculated under section 14.020, item A.;~~

~~(5) divide the amount determined in clause (3) by the amount in clause (4), which shall be the default rate (DDF) unadjusted case mix component of the rate under the RUG-IV method; and~~

~~(6) determine the case mix adjusted component of each operating rate by multiplying the default rate (DDF) unadjusted case mix component by the case mix weight in section 14.020, item A. for each RUG-IV group.~~

~~B. The noncase mix components were allocated to each RUG group as a constant amount to determine the operating payment rate.~~

A. Effective January 1, 2026, through December 31, 2028, for each facility, the commissioner must determine an adjustment to its total payment rate as determined under Section 18.010 and Section 16.140.L to phase in the transition from the RUG-IV case mix classification system to the patient driven payment model (PDPM) case mix classification system.

B. "Medical assistance facility average case mix index" means the facility average case mix index for the subset of a facility's residents that includes only medical assistance recipients.

C. A facility's PDPM phase-in rate adjustment to its total payment rate is equal to the blended medical assistance case mix adjusted direct care payment rate determined in Item H; minus the PDPM medical assistance case mix adjusted direct care payment rate determined in Section 23.150. Direct care costs are defined in sections 6.050 and 23.050.

D. Effective January 1,2026, through December 31, 2027, for each facility, the commissioner must determine the RUG-IV standardized days and RUG-IV medical assistance facility average case mix index.

E. For the rate year beginning January 1, 2028, only: (1) for each facility, the commissioner must determine both the RUG-IV facility average case mix index and the RUG-IV medical assistance facility average case mix index using resident days by the case mix classification on the facility's September 30, 2025, Minnesota Statistical and Cost Report; and (2) for each facility, the commissioner must determine the RUG-IV standardized days by multiplying the facility's resident days on the facility's September 30, 2026, Statistical and Cost Report by the facility's RUG-IV facility average case mix index determined under clause (1).

F. The commissioner must determine a facility's RUG-IV medical assistance case mix adjusted direct care payment rate as the product of: (1) the facility's RUG-IV direct care payment rate determined in Section 23.080, using the RUG-IV standardized days determined in Section 9.020; and: (2) the corresponding RUG-IV medical assistance facility average case mix index determined in Section 14.000.

G. The commissioner must determine a facility's PDPM case mix adjusted direct care payment rate as the product of: (1) the facility's direct care payment rate determined in Section 23.150; and (2) the corresponding medical assistance facility average case mix index.

H. The commissioner must determine a facility's blended medical assistance case mix adjusted direct care payment rate as the sum of:

(1) the RUG-IV medical assistance case mix adjusted direct care payment rate determined in item F multiplied by the following percentages:

(i) October 1, 2025, through December 31, 2026, 75 percent;

(ii) January 1, 2027, through December 31, 2027, 50 percent; and

(iii) January 1, 2028, through December 31, 2028, 25 percent; and

(2) the PDPM medical assistance case mix adjusted direct care payment rate determined in Item G multiplied by the following percentages:

(i) October 1, 2025, through December 31, 2026, 25 percent;

(ii) January 1, 2027, through December 31, 2027, 50 percent; and

(iii) January 1, 2028, through December 31, 2028, 75 percent.

SECTION 20.020 **Negotiated rates for services for ventilator-dependent persons.** A nursing facility may receive a negotiated payment rate to provide services to a ventilator-dependent person if:

A. Nursing facility care has been recommended for the person by a long-term care consultation team.

B. The person has been hospitalized and no longer requires inpatient acute care hospital services.

C. Necessary services for the person cannot be provided under existing nursing facility rates.

A negotiated adjustment to the operating cost payment rate for a nursing facility must reflect only the additional cost of meeting the specialized care needs of a ventilator-dependent person based on documentation of supplies used and time spent on caring for the resident, up to the maximum rate described below. For persons who are initially admitted to a nursing facility before July 1, 2001, and have their payment rate negotiated after July 1, 2001, the negotiated payment rate must not exceed 200 percent of the highest ~~RUGs~~ PDPM rate. For persons initially admitted to a facility on or after July 1, 2001, the negotiated payment rate must not exceed 300 percent of the highest ~~RUGs~~ PDPM rate. The adjustment may be negotiated with a resident who is ventilator-dependent, for that resident.

~~Effective July 1, 2007, or upon opening a unit of at least ten beds dedicated to care of ventilator-dependent persons, whichever is later, the operating payment rates for residents meeting the ventilator-dependent criteria above in A-C, in a nursing facility in Waseca county that on February 1, 2007, was licensed for 70 beds and reimbursed under Sections 1.000 to 22.000 or pursuant to Section 22.000, shall be 300 percent of the facility's highest RUG rate.~~

SECTION 20.025 **Special payment rates for short-stay nursing facilities.** For the rate year beginning on or after July 1, 1993, a nursing facility whose average length of stay for the preceding reporting years is (1) less than 180 days; or (2) less than 225 days in a nursing facility with more than 315 licensed beds must be reimbursed for allowable costs up to 125 percent of the total care-related limit and 105 percent of the other-operating-cost limit for hospital-attached nursing facilities. A nursing facility that received the benefit of this limit during the rate year beginning July 1, 1992, continues to receive this rate during the rate year beginning July 1, 1993 even if the nursing facility's length of stay is more than 180 days in the rate years subsequent to the rate year beginning July 1, 1991. For purposes of this section a nursing facility shall compute its average length of stay by dividing the nursing facility's actual resident days for the reporting year by the nursing facility's total resident discharges for that reporting year.

SECTION 20.026 Interim closure payments for nursing facilities designated for closure

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and rules is eligible to respond to a request for proposal. A facility's compliance history is not the sole determining factor in situations where the facility has been sold and the new owners have submitted a proposal;

(1) Whether the facility has a record of excessive licensure fines or sanctions or fraudulent cost reports;

(2) The facility's financial history and solvency; and

(3) Other factors identified by the Department that it deems relevant to a determination that a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

B. If the Department rejects the proposal of a nursing facility, it will provide written notice to the facility of the reason for the rejection, including the factors and evidence upon which the rejection was based.

SECTION 22.050 **Duration and termination of contracts.**

A. ~~Contracts with nursing facilities may be executed beginning November 1, 1995.~~

B. All contracts entered into under this section are for a term not to exceed four years.

C. Either party may terminate a contract at any time without cause by providing 90 calendar days advance written notice to the other party. The decision to terminate a contract is not appealable.

D. The contract will be renegotiated for additional terms of up to four years, unless either party provides written notice of termination. The provisions of the contract will be renegotiated at a minimum of every four years by the parties before the expiration date of the contract.

E. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

F. If a nursing facility fails to comply with the terms of a contract, the Department will provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance.

G. If the facility fails to come into compliance or to remain in compliance, the Department may terminate the contract. Termination is a last resort after documenting issues and providing opportunity to correct issues. The Department assesses the severity and duration of noncompliance, the risk to patients, the risk of public funds, the provider's responsiveness, and the legal and financial implications of termination. The review is guided by legal, regulatory, and contractual obligations. If the issues are not resolved, the Department will terminate the contract with appropriate notice.

SECTION 22.060 Alternate rates for nursing facilities.

For nursing facilities that have their payment rates determined pursuant to this section rather than pursuant to Sections 1.000 to 21.000, a rate must be established under this section as follows:

A. The nursing facility must enter into a written contract with the Department;

B. A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the same payment rate as established for the facility under Sections 1.000 to 21.000;

C. A nursing facility's property payment rate for the second and subsequent years of a facility's contract under this section ~~are~~ is the previous rate year's property payment rate ~~plus an inflation adjustment as provided in items D and E~~

D. ~~The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) as forecasted by the Department in the fourth quarter of the calendar year preceding the rate year.~~

E. ~~The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined~~.

SECTION 22.061 Construction project rate adjustments.

A. Effective October 1, 2006, facilities paid under this section may receive a property rate adjustment for construction projects that exceed the threshold for additions and replacements described in section 16.1373, but are below the threshold described in section 16.1374, item F.

(1) For these projects, capital assets purchased shall be counted as construction project costs for a rate adjustment request made by a facility if they are purchased within 24 months of the completion of the construction project, purchased after the completion date of any prior construction project, and are not purchased prior to July 14, 2005.

(2) Except as otherwise provided in this section, the definitions, rate calculation methods, and principles in Section 16.000 shall be used to calculate rate adjustments for

~~Seventy-five percent of the money resulting from the rate adjustment must be used to provide the Medicaid portion of quarterly bonus payments and to pay for associated employer costs and other benefits as specified in Section 22.0763 for all employees directly employed by the facility on December 31, 2008, March 31, 2009, June 30, 2009, and September 30, 2009, except:~~

~~i. the administrator;~~
~~ii. central office staff of a corporation that has an ownership interest in the facility or exercises control over the facility; or~~
~~iii. persons paid by the facility under a management contract.~~

~~Two-thirds of the money available as described above in this section must be used for the Medicaid portion of an equal hourly percentage wage bonus wage increase for all eligible employees.~~

~~Facilities may apply for the portion of the rate adjustment described above in this section which shall be acted on by the commissioner as described in section 22.0763, item (6). The portion of the rate adjustment that is not part of the seventy-five percent described above in this section shall be provided to facilities effective October 1, 2008.~~

~~Effective July 1, 2023, each facility receives a temporary payment rate add-on of $12.35 per resident day. This rate add-on expires on December 31, 2024.~~

SECTION 22.0765 Payment for post-PERA pension benefit costs

Nursing facilities that convert or converted after September 30, 2006, from public to private ownership shall have a portion of their post-PERA pension costs treated as a component of the historic operating rate. Effective for the rate years beginning on or after October 1, 2009, and prior to October 1, 2016, the commissioner shall determine the pension costs to be included in the facility's base for determining rates under this section by using the following formula: post-privatization pension benefit costs as a percent of salary shall be determined from either the cost report for the first full reporting year after privatization or the most recent report year available, whichever is later. This percentage shall be applied to the salary costs of the alternative payment system base rate year to determine the allowable amount of pension costs. The adjustments provided for in sections 1.000 to 23.000 shall be applied to the allowable amount. The adjusted allowable amount shall be added to the operating rate effective the first rate year PERA ceases to remain as a pass-through component of the rate.

SECTION 22.0766 Special diet adjustment

For rate years beginning on or after August 1, 2010, in calculating a facility's operating cost per diem for the purposes of comparing to an array, a median, or other statistical measure of facility payment rates to be used to determine future rate adjustments, the Department will exclude adjustments for

Commissioner. "Commissioner" means the commissioner of human services unless specified otherwise.

Cost to limit ratio. "Cost to limit ratio" means a facility's total care-related cost per day divided by its total care-related payment rate limit.

CPI-U inflation. "CPI-U inflation" means the percentage change in the Consumer Price Index-All Items (United States City average) (CPI-U) provided by the Reports and Forecasts Division of the Department of Human Services in the fourth quarter of the calendar year preceding the rate year based on the 12-month period ending with the midpoint of the reporting period for which CPI-U inflation is being applied to determine the rates and beginning with the midpoint of the previous reporting period.

Desk audit. "Desk audit" means the establishment of the payment rate based on the commissioner's review and analysis of required reports, supporting documentation, and work sheets submitted by the nursing facility.

Dietary costs. "Dietary costs" means the costs for the salaries and wages of the dietary supervisor, dietitians, chefs, cooks, dishwashers, and other employees assigned to the kitchen and dining room, and associated fringe benefits and payroll taxes. Dietary costs also include the salaries or fees of dietary consultants, dietary supplies, and food preparation and serving.

Direct care costs. "Direct care costs" means costs for the wages of nursing administration, direct care registered nurses, licensed practical nurses, certified nursing assistants, trained medication aides, employees conducting training on resident care topics, and associated fringe benefits and payroll taxes; services from a supplemental nursing services agency; supplies that are stocked at nursing stations or on the floor and distributed or used individually, including, but not limited to: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, clinical reagents or similar diagnostic agents, drugs that are not paid on a separate fee schedule by the medical assistance program or any other payer, and technology related to the provision of nursing care to residents, such as electronic charting systems. Effective August 1, 2009, direct care costs also means wages of employees conducting training in resident care topics, costs of materials used for resident care training and training course outside of the facility attended by direct care staff on resident care topics. Effective October 1, 2017, direct care costs also means costs for nurse consultants, pharmacy consultants, and medical directors.

Employer health insurance costs. "Employer health insurance costs" means premium expenses for group coverage, actual expenses incurred for self-insured plans, including reinsurance; and employer contributions to employee health reimbursement and health savings accounts. Premium and expense costs and contributions are allowable for employees, and the spouse and dependents of those employees who are employed on average at least 30 hours per week. Employer costs for health insurance for spouse and dependents of part-time employees shall not be an allowable cost.

(b) Changes in the total payment rate which result from desk or field audit adjustments to statistical and cost reports for reporting years earlier than the four most recent annual cost reports must be made to the four most recent annual statistical and cost reports, the current statistical and cost report, and future statistical and cost reports to the extent that those adjustments affect the total payment rate established by those reporting years.

(c) The commissioner shall extend the period for retention of records under section 23.050 for purposes of performing field audits as necessary, ~~to enforce Minnesota Statutes, 256B.48~~ with written notice to the facility postmarked no later than 90 days prior to the expiration of the record retention requirement.

Section 23.080. **Calculation of care-related per diems**.
The direct care per diem for each facility shall be the lessor of (1) the facility's direct care costs divided by its standardized days, (2) the facility's direct care costs per standardized day divided by its cost to limit ratio, (3) the previous year's direct care payment rate times one plus CPI-U inflation, or (4) 104 percent of the previous year's direct care payment rate. The other care-related per diem shall be the lessor of (1) the sum of the facility's activities costs, other direct care costs, raw food costs, therapy costs, and social services costs, divided by the facility's resident days (2) the facility's other care-related cost per resident day divided by its cost to limit ratio, (3) the previous year's other care-related rate times one plus CPI-U inflation, or (4) 104 percent of the previous year's other care-related rate. Direct care costs are defined in sections 6.050 and 23.50. Other care-related costs are defined in sections 6.060 and 23.50.

Section 23.090. **Determination of total care-related per diem**. The total care-related per diem for each facility shall be the sum of the direct care per diem as determined under section 23.080 and the other care-related per diem as determined under section 23.080.

Section 23.100. **Determination of total care-related limit.** (a) The median total care-related per diem shall be determined according to definition of median total-care related per diem in 23.050.

(b) A facility's total care-related limit shall be a variable amount based on each facility's quality score, as determined under section 22.076, item (A):

(1) the quality score determined in section 22.076 shall be multiplied by 0.5625;
(2) add 89.375 to the amount determined in clause (1), and divide the total by 100; and
(3) multiply amount determined in clause (2) by the median total care-related the per diem determined in section 23.050.

(c) A RUG's weight of 1.00 shall be used in the calculation of the median total care-related per diem, and in comparisons of facility-specific direct care costs to the median.

(d) A facility that is above its total care-related limit as determined according to paragraph (b) shall have its total care-related per diem reduced to its limit. If a reduction of the total care-related per

diem is necessary due to this limit, the reduction shall be made proportionally to both the direct care per diem and the other care-related per diem.

Section 23.110. **Reserved**

Section 23.120. **Determination of other operating price**. The price for other operating costs shall be determined as the lesser of (1) 105 percent of the median other operating per diem described in section 23.050, (2) the previous year's other operating payment rate times one plus CPI-U inflation, or (3) 104 percent of the previous year's other operating payment rate.

Section 23.130. **Exception for specialized care facilities.**

(a) For rate years beginning on or after January 1, 2016, the care-related limit for specialized care facilities shall be increased by 50 percent.

(b) "Specialized care facilities" are facilities with specialized treatment programs for residents with physical disabilities, or is a facility with 96 beds on January 1, 2015, located in Robbinsdale that specializes in the treatment of Huntington's Disease.

Section 23.131. **Nursing facility in Golden Valley.** Effective for the rate year beginning January 1, 2016, and all subsequent rate years, the operating payment rate for a facility located in the city of Golden Valley with 44 licensed rehabilitation beds as of January 7, 2015, must be calculated without the application of the rate limit in section 23.100 and shall not be limited to the price determined in section 23.120.

Effective July 1, 2023, and expiring on June 30, 2025, the other operating payment rate, for a facility located at 1412 West 4th Street in the city of Red Wing, is the sum of its direct care costs per standardized day, its other care-related costs per resident day, and its other operating costs per day without the application of the rate limit in section 23.100 or the price determined in section 23.120.

Section 23.132. **Special dietary needs.** The Commissioner shall adjust the rates of a nursing facility that meets the criteria for the special dietary needs of its residents, including the requirements for kosher and halal products. The adjustment for raw food cost shall be the difference between the nursing facility's most recently reported allowable raw food cost per diem and 115 percent of the median allowable raw food cost per diem. For rate years beginning on or after January 1, 2016, this amount shall be removed from allowable raw food per diem costs under operating costs and included in the external fixed per diem rate under section 23.140.

Section 23.133.**Nursing facilities in border cities.** Effective for the rate year beginning January 1, 2016, and annually thereafter, operating payment rates of a non-profit nursing facility that exists on January 1, 2015, is located anywhere within the boundaries of the city of Breckenridge, and is reimbursed under this section, shall be adjusted to be equal to the median RUG's rates, including comparable rate components as determined by the Commissioner, for the equivalent RUG's weight of the nonprofit nursing facility or facilities located in an adjacent city in another state and in cities

contiguous to the adjacent city. The Minnesota facility's operating payment rate with a weight of 1.0 shall be computed by dividing the adjacent city's nursing facilities median operating payment rate with a weight of 1.02 by 1.02. If the adjustments under this subdivision result in a rate that exceeds the limits in section 23.120 in a given rate year, the facility's rate shall not be subject to those limits for that rate year. This section shall apply only if it results in a higher operating payment rate than would otherwise be determined under this section.

Effective for the rate year beginning on or after January 1, 2021, each eligible nonprofit facility located within the boundaries of the city of Breckenridge or Moorhead will receive a rate add-on to their external fixed rate if they apply via the application process and by the statutory deadline. The add-on to the external fixed costs payment rate is the difference on January 1 of the median total payment rate for case mix classification PA1 of the nonprofit facilities located in an adjacent city in another state and in cities contiguous to the adjacent city minus the eligible nursing facility's total payment rate for case mix classification PA1.

Section 23.140. **Calculation of payment rate for external fixed costs**. The commissioner shall calculate a payment rate for external fixed costs. The state will pay the Medicaid portion of the following calculated rate:

(a) For a facility licensed as a nursing home, the portion related to the nursing home surcharge ~~Minnesota Statutes, §256.9657~~, shall be equal to $8.86, except for the period between January 1, 2026 and September 30, 2026, when the portion shall be $19.02. For a facility licensed as both a nursing home and a boarding care home, the portion related to the nursing home surcharge ~~Minnesota Statutes, §256.9657~~, shall be equal to $8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds, except for the period between January 1, 2026 and September 30, 2026, when the portion shall be $19.02.

(b) The portion related to the Minnesota Department of Health licensure fee shall be the amount of the fee divided by actual resident days.

(c) The portion related to scholarships shall be determined under Section 20.060.

(d) The portion related to development and education of resident and family advisory councils shall be $5 divided by 365.

(e) The portion related to planned closure rate adjustments shall be as determined under Section 20.027.

(f) The portions related to real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

(g) The portion related to the Public Employees Retirement Association shall be ~~actual~~ allowable costs divided by resident days.

(h) The single bed room incentives shall be as determined under Section 11.056B and Section 22.073B.

(i) The portion related to employer health insurance costs shall be the allowable costs divided by resident days.

(j) The portion related to special dietary needs shall be the per diem amount determined under section 23.132.

(k) The portion related to quality improvement shall be the allowable amount determined under section 22.076, item (B).

(l) The portion related to the performance incentive shall be the amount determined under section 22.0761.

(m) The portion related to consolidation rate adjustments shall be the amount determined under section 20.115.

(n) The payment rate for external fixed costs shall be the sum of paragraphs (a) through ~~(q)~~(r).

(o) Costs for pre-approved property assessed clean energy project.

(p) For rate years effective on or after January 1, 2021, the rate adjustments for border city facilities under section 23.133.

(q) The portion related to the rate adjustment for the critical access nursing facilities under section 23.211.

(r) The portion related to the rate adjustment for the Nursing Home Employment Standards under section 23.214.

Section 23.150. Determination of total payment rates. The total payment rate for a ~~RUG's~~ PDPM weight of 1.00 shall be the sum of the total care-related payment rate, other operating payment rate, external fixed cost rate, and the property rate determined under section 22.060. To determine the care-related payment rate for each ~~RUG's~~ PDPM level, multiply each ~~RUG's~~ PDPM weight by the direct care portion of the care-related per diem.

23.160. **Reserved**

Section 23.170. Hold harmless. (a) For the rate years beginning on or after January 1, 2016, no nursing facility shall receive a cost payment rate, including the property insurance portion of operating costs plus health insurance component of external fixed, less than its cost payment rate under the prior system, which included operating costs inclusive of health insurance costs plus the

per hour. The applications must be submitted within three months of the effective date of any operating payment rate adjustment under this section. Within three weeks of receiving a complete application, the commissioner will request any additional information needed to determine the rate adjustment. The nursing facility must provide any additional information requested by the commissioner within six months of the effective date of any operating payment rate adjustment under this section. The commissioner may waive the deadlines in this section under extraordinary circumstances.

(b) For nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the applications described in paragraph (d) only upon receipt of a letter, or letters, of acceptance of the spending plans in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 31, 2014. Upon receipt of the letter, or letters, of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

Section 23.213 ~~**Temporary p**~~**Property rate adjustment**

~~(a)~~ Effective January 1, 2026, a 225-bed facility in Ramsey County will receive a ~~temporary~~ property-rate increase of $10.65 per day. ~~This increase will expire upon the effective date this facility transitions to the FRV property rate system or May 31, 2026, whichever is earlier.~~

~~(b)~~ Effective January 1, 2026, an 88-bed facility in St. Louis County will receive a ~~temporary~~ property-rate increase of $20.81 per day. ~~This increase will expire upon the effective date this facility transitions to the FRV property rate system or May 31, 2026, whichever is earlier.~~

~~(c)~~ Effective January 1, 2026, a 78-bed facility in Fillmore County will receive a ~~temporary~~ property-rate increase of $21.35 per day. ~~This increase will expire upon the effective date this facility transitions to the FRV property rate system or May 31, 2026, whichever is earlier.~~

~~(d) Effective January 1, 2025, through June 30, 2025, a 105-bed facility in Ottertail County will receive a temporary property-rate increase of $38.56 per day.~~

Section 23.214 **Nursing Home Employment Standards rate adjustment**

Effective January 1, 2026, through December 31, 2027, nursing facilities with an approved rate adjustment application will receive an external fixed rate adjustment to pay for the costs of meeting those standards. The adjustment is equal to the total of 1) the annualized compensated hours of nursing home workers with an hourly wage less than the new minimum wage standard, multiplied by the difference between the current wage and the new mandated wage, plus 2) the associated increases in payroll taxes and benefits, divided by the total resident days from the most recently available cost report. The adjustment remains in effect for two years from the initial determination and is facility specific based on approved costs.