CHAPTER 199 — S.F.No. 695

An act relating to public welfare; requiring new procedures for determining nursing home payment rates; requiring a moratorium on certification or welfare licensure of new beds with certain exceptions; providing for an interagency board for quality assurance; appropriating money; amending Minnesota Statutes 1982, sections 144A.10, subdivisions 4, 6, and by adding a subdivision; 256B.091, subdivisions 1, 2, 4, and 8; 256B.41; 256B.47; and 256B.48; proposing new law coded in Minnesota Statutes 1982, chapters 144A and 256B; repealing Minnesota Statutes 1982, sections 256B.42; 256B.43; 256B.44; 256B.45; and 256B.46; and 12 MCAR 2.049.

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

Section 1. **[144A.071] MORATORIUM ON CERTIFICATION OF NURSING HOME BEDS.**

Subdivision 1. **FINDINGS.** The legislature finds that medical assistance expenditures are increasing at a much faster rate than the state's ability to pay them; that reimbursement for nursing home care and ancillary services comprises over half of medical assistance costs, and, therefore, controlling expenditures for nursing home care is essential to prudent management of the state's budget; that construction of new nursing homes, the addition of more nursing home beds to the state's long-term care resources, and increased conversion of beds to skilled nursing facility bed status inhibits the ability to control expenditures; that Minnesota already leads the nation in nursing home expenditures per capita, has the fifth highest number of beds per capita elderly, and that private paying individuals and medical assistance recipients have equivalent access to nursing home care; and that in the absence of a moratorium the increased numbers of nursing homes and nursing home beds will consume resources that would otherwise be available to develop a comprehensive long-term care system that includes a continuum of care. Unless action is taken, this expansion of bed capacity and changes of beds to a higher classification of care are likely to accelerate with the repeal of the certificate of need program effective March 15, 1984. The legislature also finds that Minnesota's dependence on institutional care for elderly persons is due in part to the dearth of alternative services in the home and community.

The legislature declares that a moratorium on medical assistance certification of new nursing home beds and on changes in certification to a higher level of care is necessary to control nursing home expenditure growth and enable the state to meet the needs of its elderly by providing high quality services in the most appropriate manner along a continuum of care.

Subd. 2. **MORATORIUM.** Notwithstanding the provisions of the Certificate of Need Act, sections 145.832 to 145.845, or any other law to the contrary, the commissioner of health, in coordination with the commissioner of public welfare, shall deny each request by a nursing home or boarding care home,

except an intermediate care facility for the mentally retarded, for addition of new certified beds or for a change or changes in the certification status of existing beds except as provided in subdivision 3. The total number of certified beds in the state in the skilled level and in the intermediate levels of care shall remain at or decrease from the number of beds certified at each level of care on the effective date of this section, except as allowed under subdivision 3. "Certified bed" means a nursing home bed or a boarding care bed certified by the commissioner of health for the purposes of the medical assistance program, under United States Code, title 42, sections 1396 et seq.

The commissioner of public welfare, in coordination with the commissioner of health, shall deny any request to issue a license under sections 245.781 to 245.812 and 252.28 to a nursing home or boarding care home, if that license would result in an increase in the medical assistance reimbursement amount.

Subd. 3. **EXCEPTIONS.** The commissioner of health, in coordination with the commissioner of welfare, may approve the addition of a new certified bed or change in the certification status of an existing bed under the following conditions:

(a) To replace a bed decertified after the effective date of this section or to address an extreme hardship situation, in a particular county that, together with all contiguous Minnesota counties, has fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than the national average of nursing home beds per 1,000 elderly individuals. For the purposes of this section, the national average of nursing home beds shall be the most recent figure that can be supplied by the federal health care financing administration and the number of elderly in the county or the nation shall be determined by the most recent federal census or the most recent estimate of the state demographer as of July 1, of each year of persons age 65 and older, whichever is the most recent at the time of the request for replacement. In allowing replacement of a decertified bed, the commissioners shall ensure that the number of added or recertified beds does not exceed the total number of decertified beds in the state in that level of care. An extreme hardship situation can only be found after the county documents the existence of unmet medical needs that cannot be addressed by any other alternatives;

(b) To certify a new bed in a facility that commenced construction before the effective date of this section. For the purposes of this section, "commenced construction" means that all of the following conditions were met: the final working drawings and specifications were approved by the commissioner of health; the construction contracts were let; a timely construction schedule was developed, stipulating dates for beginning, achieving various stages, and completing construction; and all zoning and building permits were secured;

(c) To certify beds in a new nursing home that is needed in order to meet the special dietary needs of its residents, if: the nursing home proves to the

commissioner's satisfaction that the needs of its residents cannot otherwise be met; elements of the special diet are not available through most food distributors; and proper preparation of the special diet requires incurring various operating expenses, including extra food preparation or serving items, not incurred to a similar extent by most nursing homes; or

(d) When the change in certification status results in a decrease in the reimbursement amount.

Subd. 4. **MONITORING.** The commissioner of health, in coordination with the commissioner of public welfare, shall implement mechanisms to monitor and analyze the effect of the moratorium in the different geographic areas of the state. The commissioner of health shall submit to the legislature, no later than January 15, 1984, and annually thereafter, an assessment of the impact of the moratorium by geographic area, with particular attention to service deficits or problems and a corrective action plan.

Subd. 5. **REPORT.** The commissioner of energy, planning, and development, in consultation with the commissioners of health and public welfare, shall report to the senate health and human services committee and the house health and welfare committee by January 15, 1986 and biennially thereafter regarding:

projections on the number of elderly Minnesota residents including medical assistance recipients;

the number of residents most at risk for nursing home placement;

the needs for long-term care and alternative home and noninstitutional services;

availability of and access to alternative services by geographic region; and

the necessity or desirability of continuing, modifying, or repealing the moratorium in relation to the availability and development of the continuum of long-term care services.

Sec. 2. Minnesota Statutes 1982, section 144A.10, subdivision 4, is amended to read:

Subd. 4. **CORRECTION ORDERS.** Whenever a duly authorized representative of the commissioner of health finds upon inspection of a nursing home, that the facility or a controlling person or an employee of the facility is not in compliance with sections 144.651, 144A.01 to 144A.17, or 626.557 or the rules promulgated thereunder, a correction order shall be issued to the facility. The correction order shall state the deficiency, cite the specific rule or statute violated, state the suggested method of correction, and specify the time allowed for correction. ~~The commissioner of health by rule shall establish a schedule of allowable time periods for correction of nursing home deficiencies.~~ If the commissioner finds that the nursing home had uncorrected violations and that

two or more of the uncorrected violations create a risk to resident care, safety, or rights, the commissioner shall notify the commissioner of public welfare who shall review reimbursement to the nursing home to determine the extent to which the state has paid for substandard care.

Sec. 3. Minnesota Statutes 1982, section 144A.10, subdivision 6, is amended to read:

Subd. 6. **FINES.** A nursing home which is issued a notice of noncompliance with a correction order shall be assessed a civil fine in accordance with a schedule of fines ~~promulgated by rule of~~ established by the commissioner of health before December 1, 1983. In establishing the schedule of fines, the commissioner shall consider the potential for harm presented to any resident as a result of noncompliance with each statute or rule. The fine shall be assessed for each day the facility remains in noncompliance and until a notice of correction is received by the commissioner of health in accordance with subdivision 7. No fine for a specific violation may exceed ~~$250~~ $500 per day of noncompliance.

Sec. 4. Minnesota Statutes 1982, section 144A.10, is amended by adding a subdivision to read:

Subd. 6a. **SCHEDULE OF FINES.** The commissioner of health shall propose for adoption the schedule of fines by publishing it in the State Register and allowing a period of 60 days from the publication date for interested persons to submit written comments on the schedule. Within 60 days after the close of the comment period, and after considering any comments received, the commissioner shall adopt the schedule in final form.

The schedule of fines is exempt from the definition of "rule" in section 14.02, subdivision 4, and has the force and effect of law upon compliance with section 14.38, subdivision 7. The effective date of the schedule of fines is five days after publication, as provided in section 14.38, subdivision 8. The provisions of any rule establishing a schedule of fines for noncompliance with correction orders issued to nursing homes remain effective with respect to nursing homes until repealed, modified, or superseded by the schedule established in accordance with this subdivision.

Sec. 5. **[144A.31] INTERAGENCY BOARD FOR QUALITY ASSURANCE.**

Subdivision 1. **INTERAGENCY BOARD.** The commissioners of health and public welfare shall establish, by July 1, 1983, an interagency board of employees of their respective departments who are knowledgeable and employed in the areas of long-term care, geriatric care, long-term care facility inspection, or quality of care assurance. The number of interagency board members shall not exceed seven; three members each to represent the commissioners of health and public welfare and one member to represent the commissioner of public safety in the enforcement of fire and safety standards in nursing homes. The commission-

er of public welfare or a designee shall chair and convene the board. The board may utilize the expertise and time of other individuals employed by either department as needed. The board may recommend that the commissioners contract for services as needed. The board shall meet as often as necessary to accomplish its duties, but at least monthly. The board shall establish procedures, including public hearings, for allowing regular opportunities for input from residents, nursing homes, and other interested persons.

Subd. 2. **INSPECTIONS.** No later than January 1, 1984, the board shall develop and recommend implementation and enforcement of an effective system to ensure quality of care in each nursing home in the state. Quality of care includes evaluating, using the resident's care plan, whether the resident's ability to function is optimized and should not be measured solely by the number or amount of services provided.

The board shall assist the commissioner of health in ensuring that inspections and reinspections of nursing homes are conducted with a frequency and in a manner calculated to most effectively and appropriately fulfill its quality assurance responsibilities and achieve the greatest benefit to nursing home residents. The commissioner of health shall require a higher frequency and extent of inspections with respect to those nursing homes that present the most serious concerns with respect to resident health, treatment, comfort, safety, and well-being. These concerns include but are not limited to: complaints about care, safety, or rights; situations where previous inspections or reinspections have resulted in correction orders related to care, safety, or rights; instances of frequent change in administration in excess of normal turnover rates; and situations where persons involved in ownership or administration of the nursing home have been convicted of engaging in criminal activity. A nursing home that presents none of these concerns or any other concern or condition established by the board that poses a risk to resident care, safety, or rights shall be inspected once every two years for compliance with key requirements as determined by the board.

The board shall develop and recommend to the commissioners mechanisms beyond the inspection process to protect resident care, safety, and rights, including but not limited to coordination with the office of health facility complaints and the nursing home ombudsman program.

Subd. 3. **METHODS FOR DETERMINING RESIDENT CARE NEEDS.** The board shall develop and recommend to the commissioners definitions for levels of care and methods for determining resident care needs for implementation on July 1, 1985 in order to adjust payments for resident care based on the mix of resident needs in a nursing home. The methods for determining resident care needs shall include assessments of ability to perform activities of daily living and assessments of medical and therapeutic needs.

Subd. 4. **ENFORCEMENT.** The board shall develop and recommend for implementation effective methods of enforcing quality of care standards. When it deems necessary, and when all other methods of enforcement are not appropriate, the board shall recommend to the commissioner of health closure of all or part of a nursing home and revocation of the license. The board shall develop, and the commissioner of public welfare shall implement, a resident relocation plan that instructs the county in which the nursing home is located of procedures to ensure that the needs of residents in nursing homes about to be closed are met. The county shall ensure placement in swing beds in hospitals, placement in unoccupied beds in other nursing homes, utilization of home health care on a temporary basis, foster care placement, or other appropriate alternative care. In preparing for relocation, the board shall ensure that residents and their families or guardians are involved in planning the relocation.

Subd. 5. **REPORTS.** The board shall prepare a report and the commissioners of health and public welfare shall deliver this report to the legislature no later than January 15, 1984, on the board's proposals and progress on implementation of the methods required under subdivisions 2, 3, and 4. The commissioners shall recommend changes in or additions to legislation necessary or desirable to fulfill their responsibilities. The board shall prepare an annual report and the commissioners shall deliver this report annually to the legislature, beginning in January, 1985, on the implementation and enforcement of the provisions of this section.

Subd. 6. **DATA.** The interagency board may have access to data from the commissioners of health, public welfare, and public safety for carrying out its duties under this section. The commissioner of health and the commissioner of public welfare may each have access to data on persons, including data on vendors of services, from the other to carry out the purposes of this section. If the interagency board, the commissioner of health, or the commissioner of public welfare receives data on persons, including data on vendors of services, that is collected, maintained, used or disseminated in an investigation, authorized by statute and relating to enforcement of rules or law, the board or the commissioner shall not disclose that information except:

(a) pursuant to section 13.05;

(b) pursuant to statute or valid court order; or

(c) to a party named in a civil or criminal proceeding, administrative or judicial, for preparation of defense.

Data described in this subdivision is classified as public data upon its submission to a hearing examiner or court in an administrative or judicial proceeding.

Sec. 6. Minnesota Statutes 1982, section 256B.091, subdivision 1, is amended to read:

Subdivision 1. **PURPOSE.** It is the purpose of this section to prevent inappropriate nursing home or boarding care home placement by establishing a program of preadmission screening teams for all medical assistance recipients and any individual who would become eligible for medical assistance within ~~90~~ 180 days of admission to a licensed nursing home or boarding care home participating in the program. Further, it is the purpose of this section and the program to gain further information about how to contain costs associated with inappropriate nursing home or boarding care home admissions. The commissioners of public welfare and health shall seek to maximize use of available federal and state funds and establish the broadest program possible within the appropriation available. ~~The commissioner of public welfare shall promulgate temporary rules in order to implement this section by September 1, 1980.~~

Sec. 7. Minnesota Statutes 1982, section 256B.091, subdivision 2, is amended to read:

Subd. 2. **SCREENING TEAMS; ESTABLISHMENT.** Each county agency designated by the commissioner of public welfare to participate in the program shall contract with the local board of health organized under section 145.911 to 145.922 or other public or nonprofit agency to establish a screening team to assess, prior to admission to a nursing home or a boarding care home licensed under section 144A.02 or sections 144.50 to 144.56, that is certified for medical assistance as a skilled nursing facility, intermediate care facility level I, or intermediate care facility level II, the health and social needs of medical assistance recipients and individuals who would become eligible for medical assistance within ~~90~~ 180 days of nursing home or boarding care home admission. Each local screening team shall be composed of a public health nurse from the local public health nursing service and a social worker from the local community welfare agency. Each screening team shall have a physician available for consultation and shall utilize individuals' attending physicians' physical assessment forms, if any, in assessing needs. The individual's physician shall be included on the screening team if the physician chooses to participate. If the individual is being discharged from an acute care facility, a discharge planner from that facility may be present, at the facility's request, during the screening team's assessment of the individual and may participate in discussions but not in making the screening team's recommendations under subdivision 3, clause (e). If the assessment procedure or screening team recommendation results in a delay of the individual's discharge from the acute care facility, the facility shall not be denied medical assistance reimbursement or incur any other financial or regulatory penalty of the medical assistance program that would otherwise be caused by the individual's extended length of stay; 50 percent of the cost of this reimbursement or financial or regulatory penalty shall be paid by the state and 50 percent shall be paid by the county. Other personnel as deemed appropriate by the county agency may be included on the team. The county agency may contract with an acute care facility to have the facility's discharge planners perform the functions of a screening team with regard to individuals discharged from the

facility and in those cases the discharge planners may participate in making recommendations under subdivision 3, clause (e). No member of a screening team shall have a direct or indirect financial or self-serving interest in a nursing home or noninstitutional referral such that it would not be possible for the member to consider each case objectively.

Sec. 8. Minnesota Statutes 1982, section 256B.091, subdivision 4, is amended to read:

Subd. 4. **SCREENING OF PERSONS.** Prior to nursing home or boarding care home admission, screening teams shall assess the needs of all persons receiving medical assistance and of all persons who would be eligible for medical assistance within ~~90~~ 180 days of admission to a nursing home or boarding care home, except patients transferred from other nursing homes or patients who, having entered acute care facilities from nursing homes, are returning to nursing home care. Any other interested person may be assessed by a screening team upon payment of a fee based upon a sliding fee scale.

Sec. 9. Minnesota Statutes 1982, section 256B.091, subdivision 8, is amended to read:

Subd. 8. **ALTERNATIVE CARE GRANTS.** The commissioner shall provide grants to counties participating in the program to pay costs of providing alternative care to individuals screened under subdivision 4. Payment is available under this subdivision only for individuals (1) for whom the screening team would recommend nursing home admission if alternative care were not available; (2) who are receiving medical assistance or who would be eligible for medical assistance within ~~90~~ 180 days of admission to a nursing home; and (3) who need services that are not available at that time in the county through other public assistance.

Grants may be used for payment of costs of providing services such as, but not limited to, foster care for elderly persons, day care whether or not offered through a nursing home, nutritional counseling, or medical social services, which services are provided by a licensed health care provider, a home health service eligible for reimbursement under Titles XVIII and XIX of the federal Social Security Act, or by persons employed by or contracted with by the county board or the local welfare agency. The county agency shall ensure that a plan of care is established for each individual in accordance with subdivision 3, clause (e)(2). The plan shall include any services prescribed by the individual's attending physician as necessary and follow up services as necessary. The county agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program and shall provide documentation in each individual's plan of care that the most cost effective alternatives available have been offered to the individual. Grants to counties under this subdivision are subject to audit by the commissioner for fiscal and utilization control.

The commissioner shall establish a sliding fee schedule for requiring payment for the cost of providing services under this subdivision to persons who are eligible for the services but who are not yet eligible for medical assistance. The sliding fee schedule is not subject to chapter 14 but the commissioner shall publish the schedule and any later changes in the State Register and allow a period of 20 working days from the publication date for interested persons to comment before adopting the sliding fee schedule in final forms.

The commissioner shall apply for a waiver for federal financial participation to expand the availability of services under this subdivision. The commissioner shall provide grants to counties from the nonfederal share, unless the commissioner obtains a federal waiver for medical assistance payments, of medical assistance appropriations. ~~The state expenditures for this section shall not exceed $1,800,000 for the biennium ending June 30, 1983.~~ A county agency may use grant money to supplement but not supplant services available through other public assistance or service programs and shall not use grant money to establish new programs for which public money is available through sources other than grants provided under this subdivision. A county agency shall not use grant money to provide care under this subdivision to an individual if the anticipated cost of providing this care would exceed the average payment, as determined by the commissioner, for the level of nursing home care that the recipient would receive if placed in a nursing home. The nonfederal share may be used to pay up to 90 percent of the start-up and service delivery costs of providing care under this subdivision. Each county agency that receives a grant shall pay 10 percent of the costs.

The commissioner shall promulgate temporary rules in accordance with sections 14.29 to 14.36, to establish required documentation and reporting of care delivered.

Sec. 10. Minnesota Statutes 1982, section 256B.41, is amended to read:

256B.41 **INTENT.**

Subdivision 1. **AUTHORITY.** The ~~state agency~~ commissioner shall ~~by rule~~ establish ~~a formula,~~ by rule, procedures for ~~establishing payment~~ determining rates for care of residents of nursing homes which qualify as vendors of medical assistance, and for implementing the provisions of sections 256B.41, 256B.47, 256B.48, and sections 11, 12, 15, and 16. The procedures shall be based on methods and standards that the commissioner finds are adequate to provide for the costs that must be incurred for the care of residents in efficiently and economically operated nursing homes and shall specify the costs that are allowable for establishing payment rates through medical assistance.

Subd. 2. **FEDERAL REQUIREMENTS.** ~~It is the intent of the legislature to establish certain limitations on the state agency in setting standards for nursing home rate setting for the care of recipients of medical assistance pursuant~~

~~to this chapter. It is not the intent of the legislature to repeal or change any existing or future rule promulgated by the state agency relating to the setting of rates for nursing homes unless the rule is clearly in conflict with sections 256B.41 to 256B.48.~~ If any provision of sections 256B.41 ~~to~~, 256B.47, and 256B.48 and sections 11, 12, 15, and 16, is determined by the United States government to be in conflict with existing or future requirements of the United States government with respect to federal participation in medical assistance, the federal requirements shall prevail.

Sec. 11. **[256B.421] DEFINITIONS.**

Subdivision 1. **SCOPE.** For the purposes of sections 256B.41, 256B.47, 256B.48, and sections 11, 12, 15, and 16, the following terms and phrases shall have the meaning given to them.

Subd. 2. **ACTUAL ALLOWABLE HISTORICAL OPERATING COST PER DIEM.** "Actual allowable historical operating cost per diem" means the per diem payment for actual costs, including operating costs, allowed by the commissioner for the most recent reporting year.

Subd. 3. **COMMISSIONER.** "Commissioner" means the commissioner of public welfare.

Subd. 4. **FINAL RATE.** "Final rate" means the rate established after any adjustment by the commissioner, including but not limited to adjustments resulting from cost report reviews and field audits.

Subd. 5. **GENERAL AND ADMINISTRATIVE COSTS.** "General and administrative costs" means all allowable costs for administering the facility, including but not limited to: salaries of administrators, assistant administrators, medical directors, accounting personnel, data processing personnel, and all clerical personnel; board of directors fees; business office functions and supplies; travel; telephone and telegraph; advertising; licenses and permits; membership dues and subscriptions; postage; insurance, except as included as a fringe benefit under subdivision 14; professional services such as legal, accounting and data processing services; central or home office costs; management fees; management consultants; employee training, for any top management personnel and for other than direct resident care related personnel; and business meetings and seminars. These costs shall be included in general and administrative costs in total, without direct or indirect allocation to other cost categories.

In a nursing home of 60 or fewer beds, part of an administrator's salary may be allocated to other cost categories to the extent justified in records kept by the nursing home. Central or home office costs representing services of required consultants in areas including, but not limited to, dietary, pharmacy, social services, or activities may be allocated to the appropriate department, but only if those costs are directly identified by the nursing home.

Subd. 6. **HISTORICAL OPERATING COSTS.** "Historical operating costs" means the allowable operating costs incurred by the facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective, after the commissioner has reviewed those costs and determined them to be allowable costs under the medical assistance program, and after the commissioner has applied appropriate limitations such as the limit on administrative costs.

Subd. 7. **NURSING HOME.** "Nursing home" means a facility licensed under chapter 144A or a boarding care facility licensed under sections 144.50 to 144.56.

Subd. 8. **OPERATING COSTS.** "Operating costs" means the day-to-day costs of operating the facility in compliance with licensure and certification standards. Operating cost categories are: nursing, including nurses and nursing assistants training; dietary; laundry and linen; housekeeping; plant operation and maintenance; other care-related services; general and administration; payroll taxes; real estate taxes and actual special assessments paid; and fringe benefits, including clerical training.

Subd. 9. **PAYMENT RATE.** "Payment rate" means the rate determined under section 12.

Subd. 10. **PRIVATE PAYING RESIDENT.** "Private paying resident" means a nursing home resident who is not a medical assistance recipient and whose payment rate is not established by another third party, including the veterans administration or medicare.

Subd. 11. **RATE YEAR.** "Rate year" means the fiscal year for which a payment rate determined under section 12 is effective, from July 1 to the next June 30.

Subd. 12. **REPORTING YEAR.** "Reporting year" means the period from October 1 to September 30, immediately preceding the rate year, for which the nursing home submits reports required under section 256B.48, subdivision 2.

Subd. 13. **ACTUAL RESIDENT DAY.** "Actual resident day" means a billable, countable day as defined by the commissioner.

Subd. 14. **FRINGE BENEFITS.** "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, and uniform allowances.

Subd. 15. **PAYROLL TAXES.** "Payroll taxes" means the employer's share of FICA taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.

Sec. 12. **[256B.431] RATE DETERMINATION.**

Subdivision 1. **IN GENERAL.** The commissioner shall determine prospective payment rates for resident care costs. In determining the rates, the commissioner shall group nursing homes according to different levels of care and geographic location until July 1, 1985, and after that date, mix of resident needs, and geographic location, as defined by the commissioner. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. Until groups are established according to mix of resident needs, the commissioner shall group all convalescent and nursing care units attached to hospitals into one group for purposes of determining reimbursement for operating costs. On or before June 15, 1983, the commissioner shall mail notices to each nursing home of the rates to be effective from July 1 of that year to June 30 of the following year. In subsequent years, the commissioner shall provide notice to each nursing home on or before May 1 of the rates effective for the following rate year. If a statute enacted after May 1 affects the rates, the commissioner shall provide a revised notice to each nursing home as soon as possible.

The commissioner shall establish, by rule, limitations on compensation recognized in the historical base for top management personnel. The commissioner shall also establish, by rule, limitations on allowable nursing hours for each level of care for the rate years beginning July 1, 1983 and July 1, 1984.

Subd. 2. **OPERATING COSTS.** (a) The commissioner shall establish, by rule, procedures for determining per diem reimbursement for operating costs based on actual resident days. The commissioner shall disallow any portion of the general and administration cost category, exclusive of fringe benefits and payroll taxes, that exceeds

10 percent for nursing homes with more than 100 certified beds in total,

12 percent for nursing homes with fewer than 101 but more than 40 certified beds in total,

14 percent for nursing homes with 40 or fewer certified beds in total, and

15 percent for convalescent and nursing care units attached to hospitals for the rate year beginning July 1, 1983,

of the expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administration.

(b) For the rate year beginning July 1, 1983, and ending June 30, 1984, the prospective operating cost payment rate for each nursing home shall be determined by the commissioner based on the allowed historical operating costs as reported in the most recent cost report received by December 31, 1982 and audited by March 1, 1983, and may be subsequently adjusted to reflect the costs allowed. To determine the allowed historical operating cost, the commissioner shall update the historical per diem shown in those cost reports to June 30, 1983,

using a nine percent annual rate of increase after applying the general and administrative cost limitation described in paragraph (a). The commissioner shall calculate the 60th percentile of actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1.

(1) Within each group, each nursing home whose actual allowable historical operating cost per diem as determined under this paragraph (b) is above the 60th percentile shall receive the 60th percentile increased by six percent plus 80 percent of the difference between its actual allowable operating cost per diem and the 60th percentile.

(2) Within each group, each nursing home whose actual allowable historical operating cost per diem is at or below the 60th percentile shall receive that actual allowable historical operating cost per diem increased by six percent.

For the rate year beginning July 1, 1984, and ending June 30, 1985, the prospective operating cost payment rate for each nursing home shall be determined by the commissioner based on actual allowable historical operating costs incurred during the reporting year preceding the rate year. The commissioner shall analyze and evaluate each nursing home's report of allowable operating costs incurred by the nursing home during the reporting year immediately preceding the rate year. The actual allowable historical operating costs, after the commissioner's analysis and evaluation, shall be added together and divided by the number of actual resident days to compute the actual allowable historical operating cost per diem. The commissioner shall calculate the 60th percentile of actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1.

(3) Within each group, each nursing home whose actual allowable historical operating cost per diem is above the 60th percentile of payment rates shall receive the 60th percentile increased at an annual rate of six percent plus 75 percent of the difference between its actual allowable historical operating cost per diem and the 60th percentile.

(4) Within each group, each nursing home whose actual allowable historical operating cost per diem is at or below the 60th percentile shall receive that actual allowable historical operating cost per diem increased at an annual rate of six percent.

(c) For subsequent years, the commissioner shall:

(1) Contract with an econometric firm with recognized expertise in and access to national economic change indices that can be applied to the appropriate cost categories when determining the operating cost payment rate;

(2) Establish the 60th percentile of actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year.

The commissioner shall analyze and evaluate each nursing home's report of allowable operating costs incurred by the nursing home during the reporting year immediately preceding the rate year for which the payment rate becomes effective. The allowable historical operating costs, after the commissioner's analysis and evaluation, shall be added together and divided by the actual number of resident days in order to compute the actual allowable historical operating cost per diem;

(3) Establish a composite index for each group by determining the weighted average of all economic change indicators applied to the operating cost categories in that group.

(4) Within each group, each nursing home shall receive the 60th percentile increased by the composite index calculated in paragraph (c)(3). The historical base for determining the prospective payment rate shall not exceed the operating cost payment rates during that reporting year.

The commissioner shall include the reported actual real estate tax liability of each proprietary nursing home as an operating cost of that nursing home. The commissioner shall include a reported actual special assessment for each nursing home as an operating cost of that nursing home. Total real estate tax liability and actual special assessments paid for each nursing home (i) shall be divided by actual resident days in order to compute the operating cost payment rate for this operating cost category, but (ii) shall not be used to compute the 60th percentile.

(d) The commissioner shall allow the nursing home to keep, as an efficiency incentive, the difference between the nursing home's operating cost payment rate established for that rate year and the actual historical operating costs incurred for that rate year, if the latter amount is smaller. If a nursing home's actual historic operating costs are greater than the prospective payment rate for that rate year, there shall be no retroactive cost settle-up. If an annual cost report or field audit indicates that the expenditures for direct resident care have been reduced in amounts large enough to indicate a possible detrimental effect on the quality of care, the commissioner shall notify the commissioner of health and the interagency board for quality assurance. If a field audit reveals that unallowable expenditures have been included in the nursing home's historical operating costs, the commissioner shall disallow the expenditures and recover the entire overpayment. The commissioner shall establish, by rule, procedures for assessing an interest charge at the rate determined for unpaid taxes or penalties under section 270.75 on any outstanding balance resulting from an overpayment or underpayment.

(e) The commissioner may negotiate, with a nursing home that is eligible to receive medical assistance payments, a payment rate of up to 125 percent of the allowed payment rate to be paid for a period of up to three months for individuals who have been hospitalized for more than 100 days, who have

extensive care needs based on nursing hours actually provided or mental or physical disability, or need for respite care for a specified and limited time period, and based on an assessment of the nursing home's resident mix as determined by the commissioner of health. The payment rate negotiated and paid pursuant to this paragraph is specifically exempt from the definition of "rule" and the rule-making procedures required by chapter 14 and section 16.

(f) Until groups are established according to mix of resident care needs, nursing homes licensed on June 1, 1983 by the commissioner to provide residential services for the physically handicapped and nursing homes that have an average length of stay of less than 180 days shall not be included in the calculation of the 60th percentile of any group. For rate year beginning July 1, 1983 and July 1, 1984, each of these nursing homes shall receive their actual allowed historical operating cost per diem increased by six percent. The commissioner shall also apply to these nursing homes the percentage limitation on the general and administrative cost category as provided in subdivision 2, paragraph (a).

Subd. 3. **PROPERTY-RELATED COSTS.** For rate years beginning July 1, 1983 and July 1, 1984, property-related costs shall be reimbursed to each nursing home at the level recognized in the most recent cost report received by December 31, 1982 and audited by March 1, 1983, and may be subsequently adjusted to reflect the costs recognized in the final rate for that cost report, adjusted for rate limitations in effect before the effective date of this section. Property-related costs include: depreciation, interest, earnings or investment allowance, lease, or rental payments. No adjustments shall be made as a result of sales or reorganizations of provider entities.

Adjustments for the cost of repairs, replacements, renewals, betterments, or improvements to existing buildings, and building service equipment shall be allowed if:

(i) The cost incurred is reasonable, necessary, and ordinary;

(ii) The net cost is greater than $5,000. "Net cost" means the actual cost, minus proceeds from insurance, salvage, or disposal;

(iii) The nursing home's property-related costs per diem is equal to or less than the average property-related costs per diem within its group; and

(iv) The adjustment is shown in depreciation schedules submitted to and approved by the commissioner.

Annual per diem shall be computed by dividing total property-related costs by 96 percent of the nursing home's licensed capacity days for nursing homes with more than 60 beds and 94 percent of the nursing home's licensed capacity days for nursing homes with 60 or fewer beds. For a nursing home whose residents' average length of stay is 180 days or less, the commissioner may

waive the 96 or 94 percent factor and divide the nursing home's property-related costs by the actual resident days to compute the nursing home's annual property-related per diem. The commissioner shall promulgate temporary and permanent rules to recapture excess depreciation upon sale of a nursing home.

For rate years beginning on or after July 1, 1985, the commissioner, by permanent rule, shall reimburse nursing home providers that are vendors in the medical assistance program for the rental use of their property. The "rent" is the amount of periodic payment which a renter might expect to pay for the right to the agreed use of the real estate and the depreciable equipment as it exists. "Real estate" means land improvements, buildings, and attached fixtures used directly for resident care. "Depreciable equipment" means the standard moveable resident care equipment and support service equipment generally used in long-term care facilities.

In developing the method for determining payment rates for the rental use of nursing homes, the commissioner shall consider factors designed to:

(i) simplify the administrative procedures for determining payment rates for property-related costs;

(ii) minimize discretionary or appealable decisions;

(iii) eliminate any incentives to sell nursing homes;

(iv) recognize legitimate costs of preserving and replacing property;

(v) recognize the existing costs of outstanding indebtedness allowable under the statutes and rules in effect on May 1, 1983;

(vi) address the current value of, if used directly for patient care, land improvements, buildings, attached fixtures, and equipment;

(vii) establish an investment per bed limitation;

(viii) reward efficient management of capital assets;

(ix) provide equitable treatment of facilities;

(x) consider a variable rate; and

(xi) phase in implementation of the rental reimbursement method.

No later than January 1, 1984, the commissioner shall report to the legislature on any further action necessary or desirable in order to implement the purposes and provisions of this subdivision.

Subd. 4. **SPECIAL RATES.** A newly constructed nursing home or one with a capacity increase of 50 percent or more may, upon written application to the commissioner, receive an interim payment rate for reimbursement for property-related costs calculated pursuant to the statutes and rules in effect on May 1,

1983 and for operating costs negotiated by the commissioner based upon the 60th percentile established for the appropriate group under subdivision 2, paragraph (b) to be effective from the first day a medical assistance recipient resides in the home or for the added beds. For newly constructed nursing homes which are not included in the calculation of the 60th percentile for any group, subdivision 2(f), the commissioner shall establish by rule procedures for determining interim operating cost payment rates and interim property-related cost payment rates. The interim payment rate shall not be in effect for more than 17 months. The commissioner shall establish, by temporary and permanent rules, procedures for determining the interim rate and for making a retroactive cost settle-up after the first year of operation; the cost settled operating cost per diem shall not exceed 110 percent of the 60th percentile established for the appropriate group. The commissioner shall establish by rule procedures for determining payment rates for nursing homes which provide care under a lesser care level than the level for which the nursing home is certified.

Subd. 5. **ADJUSTMENTS.** When resolution of appeals or on-site field audits of the records of nursing homes within a group result in adjustments to the 60th percentile of the payment rates within the group in any reporting year, the 60th percentile established for the following rate year for that group shall be increased or decreased by the adjustment amount.

Sec. 13. Minnesota Statutes 1982, section 256B.47, is amended to read:

256B.47 **~~RATE LIMITS~~ NONALLOWABLE COSTS; NOTICE OF INCREASES TO PRIVATE PAYING RESIDENTS.**

Subdivision 1. **NONALLOWABLE COSTS.** ~~The state agency shall by rule establish separate overall limitations on the costs for items which directly relate to the provision of patient care to residents of nursing homes and those which do not directly relate to the provision of care. The state agency may also by rule, establish limitations for specific cost categories which do not directly relate to the provision of patient care. The state agency shall reimburse nursing homes for the costs of nursing care in excess of any state agency limits on hours of nursing care if the commissioner of health issues a correction order pursuant to section 144A.10, subdivision 4, directing the nursing home to provide the additional nursing care. All costs determined otherwise allowable shall be subject to these limitations.~~

~~Subd. 2.~~ The following costs shall not be recognized as allowable ~~to the extent that these costs cannot be demonstrated by the nursing home to the state agency to be directly related to the provision of patient care~~: (1) political contributions; (2) salaries or expenses of a lobbyist, as defined in section 10A.01, subdivision 11, for lobbying activities; (3) advertising designed to encourage potential residents to select a particular nursing home; (4) assessments levied by the ~~health department~~ commissioner of health for uncorrected violations; (5) legal and related ~~fees~~ expenses for unsuccessful challenges to decisions by ~~state~~

Changes or additions are indicated by underline, deletions by ~~strikeout~~.

governmental agencies; (6) memberships in sports, health or similar social clubs or organizations; and (7) costs incurred for activities directly related to influencing employees with respect to unionization ~~and (6) dues paid to a nursing home or hospital association. The state agency shall promulgate rules establishing standards which shall distinguish between any patient care related components and nonpatient care related components of these costs, where applicable. For purposes of these rules, the state agency shall exercise emergency powers and establish emergency rules pursuant to section 15.0412, subdivision 5, before September 1, 1977~~. The ~~state agency~~ commissioner shall by rule exclude the costs of any other items ~~which it determines are~~ not directly related to the provision of ~~patient~~ resident care.

~~Subd. 3. On or before January 1, 1977 the state agency shall by rule establish a procedure affording notice of the approved rate for medical assistance recipients to nursing homes within 120 days after the close of the fiscal year of the nursing home.~~

Subd. ~~4.~~ 2. **NOTICE TO RESIDENTS.** No increase in nursing home rates for private paying residents shall be effective unless the nursing home notifies the resident or person responsible for payment of the increase in writing 30 days before the increase takes effect.

A nursing home may adjust its rates without giving the notice required by this subdivision when the purpose of the rate adjustment is to: ~~(a)~~ reflect a necessary change in the level of care provided to a resident; ~~or (b) retroactively or prospectively equalize private pay rates with rates charged to medical assistance recipients as required by section 256B.48, subdivision 1, clause (a) and applicable federal law.~~

~~Subd. 5. The commissioner shall promulgate rules no later than August 1, 1980, to amend the current rules governing nursing home reimbursement, in accordance with sections 14.01 to 14.70, to allow providers to allocate their resources in order to provide as many nursing hours as necessary within the total cost limitations of the per diem already granted.~~ If the state fails to set rates as required by section 12, the time required for giving notice is decreased by the number of days by which the state was late in setting the rates.

Sec. 14. Minnesota Statutes 1982, section 256B.48, is amended to read:

256B.48 **CONDITIONS FOR PARTICIPATION.**

Subdivision 1. **PROHIBITED PRACTICES.** ~~No~~ A nursing home ~~shall be~~ is not eligible to receive medical assistance payments unless it ~~agrees in writing that it will refrain~~ refrains from:

(a) ~~Charging nonmedical assistance residents rates for similar services which exceed by more than ten percent those rates which are approved by the state agency for medical assistance recipients. For nursing homes charging~~

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~~nonmedical assistance residents rates less than ten percent more than those rates which are approved by the state agency for medical assistance recipients, the maximum differential in rates between nonmedical assistance residents and medical assistance recipients shall not exceed that differential which was in effect on April 13, 1976. If a nursing home has exceeded this differential since April 13, 1976, it shall return the amount collected in excess of the allowable differential stated by this subdivision to the nonmedical assistance resident, or that person's representative, by July 1, 1977. Effective July 1, 1978, no nursing home shall be eligible for medical assistance if it charges nonmedical assistance recipients~~ Charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients~~; provided, however, that~~ as determined by the prospective desk audit rate, except under the following circumstances: the nursing home may (1) charge ~~nonmedical assistance~~ private paying residents a higher rate for a private room, and (2) charge for special services which are not included in the daily rate if medical assistance ~~patients~~ residents are charged separately at the same rate for the same services in addition to the daily rate paid by the ~~state agency~~ commissioner. A nursing home that charges a private paying resident a rate in violation of this clause is subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing home that charges the resident rates in violation of this clause. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing home may request a hearing to determine the allowed rate or rates at issue in the cause of action. Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of a hearing examiner under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The hearing examiner shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this clause shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance;

(b) Requiring an applicant for admission to the home, or the guardian or conservator of the applicant, as a condition of admission, to pay ~~an admission fee~~ any fee or deposit in excess of $100, loan any money to the nursing home, or promise to leave all or part of the applicant's estate to the home; ~~and~~

(c) Requiring any resident of the nursing home to utilize a vendor of health care services who is a licensed physician or pharmacist chosen by the nursing home;

(d) Requiring any applicant to the nursing home, or the applicant's guardian or conservator, as a condition of admission, to assure that the applicant is neither eligible for nor will seek public assistance for payment of nursing home care costs;

(e) Requiring any vendor of medical care as defined by section 256B.02, subdivision 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any portion of his fee to the nursing home except as payment for renting or leasing space or equipment of the nursing home or purchasing support services, if those agreements are disclosed to the commissioner; and

(f) Refusing, for more than 24 hours, to accept a resident returning to his same bed or a bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.

The prohibitions set forth in clause (b) shall not apply to a retirement home with more than 325 beds including at least 150 licensed nursing home beds and which:

(1) is owned and operated by an organization tax-exempt under section 290.05, subdivision 1, clause (i); and

(2) ~~at the time of admission places~~ accounts for all of the applicant's assets which are required to be assigned to the home ~~in a trust account from which~~ so that only expenses for the cost of care of the applicant may be ~~deducted~~ charged against the account; and

(3) agrees in writing at the time of admission to the home to permit the applicant, or his guardian, or conservator, to examine the records relating to the ~~individual's trust~~ applicant's account upon request, and to receive an audited statement of the expenditures ~~from~~ charged against his individual account upon request; and

(4) agrees in writing at the time of admission to the home to permit the applicant to withdraw from the home at any time and to receive, upon withdrawal, ~~all of the unexpended funds remaining in~~ the balance of his individual ~~trust~~ account; ~~and~~

~~(5) was in compliance with provisions (1) to (4) as of June 30, 1976.~~

Subd. 2. **REPORTING REQUIREMENTS.** ~~Effective July 1, 1976, no nursing home shall be eligible to receive medical assistance payments unless it agrees in writing to:~~

~~(a) provide the state agency with its most recent (1) balance sheet and statement of revenues and expenses as audited by a certified public accountant licensed by this state or by a public accountant as defined in section 412.222; (2) statement of ownership for the nursing home; and (3) a separate audited balance sheet and statement of revenues and expenses for each nursing home if more than~~

~~one nursing home or other business operation is owned by the same owner; a governmentally owned nursing home may comply with the auditing requirements of this clause by submitting an audit report prepared by the state auditor's office;~~

~~(b) Provide the state agency with copies of leases, purchase agreements and other related documents related to the lease or purchase of the nursing home; and~~

~~(c) Provide to the state agency upon request copies of leases, purchase agreements, or similar documents for the purchase or acquisition of equipment, goods and services which are claimed as allowable costs.~~

No later than December 31 of each year, a skilled nursing facility or intermediate care facility, including boarding care facilities, which receives medical assistance payments or other reimbursements from the state agency shall:

(a) Provide the state agency with a copy of its audited financial statements. The audited financial statements must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statements of changes in financial position (cash and working capital methods), notes to the financial statements, applicable supplemental information, and the certified public accountant's or licensed public accountant's opinion. The examination by the certified public accountant or licensed public accountant shall be conducted in accordance with generally accepted auditing standards as promulgated and adopted by the American Institute of Certified Public Accountants;

(b) Provide the state agency with a statement of ownership for the facility;

(c) Provide the state agency with separate, audited financial statements as specified in clause (a) for every other facility owned in whole or part by an individual or entity which has an ownership interest in the facility;

(d) Upon request, provide the state agency with separate, audited financial statements as specified in clause (a) for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

(e) Provide the state agency with copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility;

(f) Upon request, provide the state agency with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs; and

(g) Permit access by the state agency to the certified public accountant's and licensed public accountant's audit workpapers which support the audited financial statements required in clauses (a), (c), and (d).

Changes or additions are indicated by underline, deletions by ~~strikeout~~.

Documents or information provided to the state agency pursuant to this subdivision shall be public. If the requirements of clauses (a) to (g) are not met, the reimbursement rate may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting year, and the reduction shall continue until the requirements are met.

Subd. 3. **INCOMPLETE OR INACCURATE REPORTS.** The ~~state agency~~ commissioner may reject any annual cost report filed by a nursing home pursuant to this chapter if ~~it~~ the commissioner determines that the report or the information required in subdivision 2, clause (a) has been filed in a form that is incomplete or inaccurate. In the event that a report is rejected pursuant to this subdivision, the ~~state agency may make payments~~ commissioner shall reduce the reimbursement rate to a nursing home ~~at the~~ to 80 percent of its most recently established rate ~~determined for its prior fiscal year, or at an interim rate established by the state agency,~~ until the information is completely and accurately filed.

Subd. 4. **EXTENSIONS.** The commissioner may grant a 15-day extension of the reporting deadline to a nursing home for good cause. To receive such an extension, a nursing home shall submit a written request by December 1. The commissioner will notify the nursing home of the decision by December 15.

Subd. 5. **FALSE REPORTS.** If a nursing home knowingly supplies inaccurate or false information in a required report that results in an overpayment, the commissioner shall:

(a) immediately adjust the nursing home's payment rate to recover the entire overpayment within the rate year; or

(b) terminate the commissioner's agreement with the nursing home; or

(c) prosecute under applicable state or federal law; or

(d) use any combination of the foregoing actions.

Sec. 15. **[256B.50] APPEALS.**

A nursing home may appeal a decision arising from the application of standards or methods pursuant to sections 10 and 256B.47 if the appeal, if successful, would result in a change to the nursing home's payment rate. To appeal, the nursing home shall notify the commissioner of its intent to appeal within 30 days and submit a written appeal request within 60 days of receiving notice of the payment rate determination or decision. The appeal request shall specify each disputed item, the reason for the dispute, an estimate of the dollar amount involved for each disputed item, the computation that the nursing home believes is correct, the authority in statute or rule upon which the nursing home 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. The appeal shall be heard by a hearing examiner

according to sections 14.48 to 14.56, or upon agreement by both parties according to a modified appeals procedure established by the commissioner and the hearing examiner. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect. Regardless of any rate appeal, the rate established shall be the rate paid and shall remain in effect until final resolution of the appeal or subsequent desk or field audit adjustment, notwithstanding any provision of law or rule to the contrary. To challenge the validity of rules established by the commissioner pursuant to sections 256B.41, 256B.47, 256B.48, and sections 11, 12, 15, and 16, a nursing home shall comply with section 14.44.

Sec. 16. **[256B.502] TEMPORARY RULES.**

The commissioners of health and public welfare shall promulgate temporary and permanent rules necessary to implement sections 1 to 15 except as otherwise indicated in accordance with sections 14.01 to 14.38. Temporary rules promulgated by August 15, 1983 to implement the rate determination provisions of section 12 are retroactive to and effective as of July 1, 1983. Notwithstanding the provisions of section 14.35, temporary rules promulgated to implement sections 1 to 15 shall be effective for up to 360 days after July 1, 1983, and may be continued in effect for two additional periods of 180 days each if the commissioner gives notice of continuation of each additional period by publishing notice in the State Register and mailing the same notice to all persons registered with the commissioner to receive notice of rulemaking proceedings in connection with sections 1 to 15. The temporary rules promulgated in accordance with this section shall not be effective 720 days after their effective date without following the procedures in sections 14.13 to 14.20. The commissioner shall report to the legislature by January 1, 1985, on likely groups and shall establish groups of nursing homes based on the mix of resident care needs, and on geographic area, by July 1, 1985.

Sec. 17. **LEGISLATIVE COMMISSION ON LONG-TERM HEALTH CARE.**

Subdivision 1. A legislative study commission is created

(a) to monitor the inspection and regulation activities, including rule developments, of the departments of health and public welfare with the goal of improving quality of care;

(b) to study and report on alternative long-term care services, including respite care services, day care services, and hospice services; and

(c) to study and report on alternatives to medical assistance funding for providing long term health care services to the citizens of Minnesota.

The study commission shall consider the use of such alternatives as private insurance, private annuities, health maintenance organizations, preferred provider

organizations, medicare, and such other alternatives as the commission may deem worthy of study.

Subd. 2. The commission shall consist of six members of the house of representatives appointed by the speaker and six members of the senate appointed by the subcommittee on committees.

Subd. 3. The commission shall report its findings and recommendations to the governor and the legislature not later than January 1, 1985.

Subd. 4. The commission shall hold meetings and hearings at the times and places it designates to accomplish the purposes set forth in this section. It shall select a chairperson and other officers from its membership as it deems necessary.

Subd. 5. The commission shall make use of existing legislative facilities and staff of the house and senate research department and senate counsel, but it may also request the legislative coordinating commission to supply it with additional necessary staff, office space, and administrative services. All additional personnel shall be hired and supervised by the directors of the house and senate research departments and senate counsel. The commission shall have full authority to contract for expert services and opinions relevant to the purposes of this section. The commission, by a two-thirds vote of its members, may request the issuance of subpoenas, including subpoenas duces tecum, requiring the appearance of persons, production of relevant records, and giving of relevant testimony.

Sec. 18. **[256B.433] ANCILLARY SERVICES.**

The commissioner shall promulgate rules pursuant to the Administrative Procedures Act to set the amount and method of payment for ancillary materials and services provided to recipients residing in long-term care facilities. Payment for materials and services may be made to either the nursing home in the operating cost per diem, to the vendor of ancillary services pursuant to 12 MCAR 2.047 or to a nursing home pursuant to 12 MCAR 2.047. Payment for the same or similar service to a recipient shall not be made to both the nursing home and the vendor. The commissioner shall ensure that charges for ancillary materials and services are as would be incurred by a prudent buyer.

Sec. 19. **REPEALER.**

Minnesota Statutes 1982, sections 256B.42; 256B.43; 256B.44; 256B.45; and 256B.46 are repealed effective July 1, 1983. 12 MCAR, section 2.049 is superseded effective on the effective date of the first temporary rule promulgated to implement section 12, retroactive to July 1, 1983.

Sec. 20. **APPROPRIATION.**

The approved complement of the department of health increased by one-half position for the interagency board. $1,043,520 for fiscal year 1984 and $603,680 for fiscal year 1985 are appropriated from the general fund to the commissioner of public welfare for the state's costs of implementing sections 1 to 19 for the biennium ending June 30, 1985. $4,376,560 for fiscal year 1984 and $6,176,462 for fiscal year 1985 is appropriated from the general fund for the state's costs for preadmission screening and alternative care grants. Remaining amounts necessary to fund these areas shall be obtained from federal and county sources and shall be appropriated for implementing sections 1 to 18. The approved complement of the department of public welfare is increased by five and one-half full-time positions; the one-half full-time position is for the interagency board.

Sec. 21. **EFFECTIVE DATE.**

Sections 1 to 20 are effective the day following enactment, for the moratorium and for establishing procedures for determining payment rates to become effective for the biennium beginning July 1, 1983, and thereafter. The amendments to section 256B.48, subdivision 1, apply to causes of action arising from charges made on or after the effective date of section 14.

Approved May 22, 1983

CHAPTER 200 — S.F.No. 598

An act relating to insurance premium finance companies; authorizing finance charges based on the federal discount rate; amending Minnesota Statutes 1982, sections 59A.09, subdivisions 3, 4 and 6; and 59A.12, subdivisions 1 and 4.

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

Section 1. Minnesota Statutes 1982, section 59A.09, subdivision 3, is amended to read:

Subd. 3. The finance charge ~~shall be a maximum of $8 per $100 per year for amounts financed of $300 or less and $6 per $100 per year on that amount financed over $300 plus~~ must not exceed five percent in excess of the discount rate on 90-day commercial paper in effect at the federal reserve bank located in the Ninth Federal Reserve District when an insurance premium finance agreement is made or when an additional or subsequent premium is added under an open end agreement. For expenses incurred in servicing the loan including any filing fees, application fee for the examination or investigation of the character of the borrower, comaker or security, and drawing any necessary papers in making the loan, an insurance premium finance company may contract for a flat rate