provided in section 3, subdivision 4, clause (4); section 4, subdivision 1, clauses (3) and (4); and section 4, subdivision 2, clause (b).

Approved June 24, 1985

CHAPTER 3 — S.F.No. 4

An act relating to human services; creating a procedure for reconsideration of a resident's case mix classification; establishing approval procedures and requirements for hospital swing beds; restricting licensure of new nursing home beds; expanding the preadmission screening program; revising statutes relating to nursing home reimbursement; requiring nursing homes participating in the medical assistance program to be medicare certified; creating an appeal process for nursing home appraisals; authorizing the legislative commission on long-term health care to study cost containment strategies and collect data; authorizing bingo in nursing homes and senior citizen housing projects; requiring review by the commissioners of human services and health of proposals for revenue bond financing of health facility projects; appropriating money; amending Minnesota Statutes 1984, sections 144.50, subdivision 2; 144A.01, subdivisions 5, 7, and by adding a subdivision; 144A.04, subdivisions 4 and 6; 144A.071, subdivisions 1, 2, and 3; 144A.08, subdivision 3; 144A.10, subdivision 4, and by adding subdivisions; 144A.11, subdivisions 2 and 3a; 256B.02, subdivision 8; 256B.091, subdivisions 1, 2, 4, 5, and 8; 256B.421, subdivision 5; 256B.431, subdivisions 2b, 3, and 4, and by adding subdivisions; 256B.48, by adding a subdivision; 256B.50; 256B.504, subdivision 1; 349.214, by adding a subdivision; and 474.01, subdivisions 7a and 9; proposing coding for new law in Minnesota Statutes, chapter 144.

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

Section 1. **[144.0722] RESIDENT REIMBURSEMENT CLASSIFICATIONS; PROCEDURES FOR RECONSIDERATION.**

Subdivision 1. **RESIDENT REIMBURSEMENT CLASSIFICATIONS.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under sections 144.072 and 144.0721, or under rules established by the commissioner of human services under sections 256B.41 to 256B.48. The reimbursement classifications established by the commissioner must conform to the rules established by the commissioner of human services.

Subd. 2. **NOTICE OF RESIDENT REIMBURSEMENT CLASSIFICATION.** The commissioner of health shall notify each resident, and the nursing home or boarding care home in which the resident resides, of the reimbursement classification established under subdivision 1. The notice must inform the resident of the classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of

the classification. The notice of resident classification must be sent by first-class mail. The individual resident notices may be sent to the resident's nursing home or boarding care home for distribution to the resident.

Subd. 3. **REQUEST FOR RECONSIDERATION.** The resident or the nursing home or boarding care home may request that the commissioner reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within ten working days of the receipt of the notice of resident classification. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, the requested classification changes, and documentation supporting the requested classification. The documentation accompanying the reconsideration request is limited to documentation establishing that the needs of the resident at the time of the assessment resulting in the disputed classification justify a change of classification.

Subd. 4. **RECONSIDERATION.** The commissioner's reconsideration must be made by individuals not involved in reviewing the assessment that established the disputed classification. The reconsideration must be based upon the initial assessment and upon the information provided to the commissioner under subdivision 3. If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. In its discretion, the commissioner may review the reimbursement classifications assigned to all residents in the facility. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect the needs of the resident at the time of the assessment. The resident and the nursing home or boarding care home shall be notified within five working days after the decision is made. The commissioner's decision under this subdivision is the final administrative decision of the agency.

Sec. 2. Minnesota Statutes 1984, section 144.50, subdivision 2, is amended to read:

Subd. 2. Hospital, sanatorium or other institution for the hospitalization or care of human beings, within the meaning of sections 144.50 to 144.56 shall mean any institution, place, building, or agency, in which any accommodation is maintained, furnished, or offered for: the hospitalization of the sick or injured; the provision of care in a swing bed authorized under section 3; elective outpatient surgery for preexamined, prediagnosed low risk patients; emergency medical services offered 24 hours a day, seven days a week, in an ambulatory or outpatient setting in a facility not a part of a licensed hospital; or the institutional care of human beings. Nothing in sections 144.50 to 144.56 shall apply to a

clinic, a physician's office or to hotels or other similar places that furnish only board and room, or either, to their guests.

Sec. 3. **[144.562] SWING BED APPROVAL; ISSUANCE OF LICENSE CONDITIONS; VIOLATIONS.**

Subdivision 1. **DEFINITION.** For the purposes of this section, "swing bed" means a hospital bed licensed under sections 144.50 to 144.56 that has been granted a license condition under this section and which has been certified to participate in the federal medicare program under United States Code, title 42, section 1395 (tt).

Subd. 2. **ELIGIBILITY FOR LICENSE CONDITION.** A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for medicare reimbursement before May 1, 1985; (2) it is located in a rural area as defined in the federal medicare regulations, Code of Federal Regulations, title 42, section 405.1041; and (3) it agrees to utilize no more than four hospital beds as swing beds at any one time, except that the commissioner may approve the utilization of up to three additional beds at the request of a hospital if no medicare certified skilled nursing facility beds are available within 25 miles of that hospital.

Subd. 3. **APPROVAL OF LICENSE CONDITION.** The commissioner of health shall approve a license condition for swing beds if the hospital meets all of the criteria of this subdivision:

(a) The hospital must meet the eligibility criteria in subdivision 2.

(b) The hospital must be in compliance with the medicare conditions of participation for swing beds under Code of Federal Regulations, title 42, section 405.1041.

(c) The hospital must agree, in writing, to limit the length of stay of a patient receiving services in a swing bed to not more than 40 days, or the duration of medicare eligibility, unless the commissioner of health approves a greater length of stay in an emergency situation. To determine whether an emergency situation exists, the commissioner shall require the hospital to provide documentation that continued services in the swing bed are required by the patient; that no skilled nursing facility beds are available within 25 miles from the patient's home, or in some more remote facility of the resident's choice, that can provide the appropriate level of services required by the patient; and that other alternative services are not available to meet the needs of the patient. If the commissioner approves a greater length of stay, the hospital shall develop a plan providing for the discharge of the patient upon the availability of a nursing home bed or other services that meet the needs of the patient. Permission to

extend a patient's length of stay must be requested by the hospital at least 10 days prior to the end of the maximum length of stay.

(d) The hospital must agree, in writing, to limit admission to a swing bed only to patients who have been hospitalized and not yet discharged from the facility.

(e) The hospital must agree, in writing, to report to the commissioner of health by December 1, 1985, and annually thereafter, in a manner required by the commissioner (1) the number of patients readmitted to a swing bed within 60 days of a patient's discharge from the facility, (2) the hospital's charges for care in a swing bed during the reporting period with a description of the care provided for the rate charged, and (3) the number of beds used by the hospital for transitional care and similar sub-acute inpatient care.

(f) The hospital must agree, in writing, to report statistical data on the utilization of the swing beds on forms supplied by the commissioner. The data must include the number of swing beds, the number of admissions to and discharges from swing beds, medicare reimbursed patient days, total patient days, and other information required by the commissioner to assess the utilization of swing beds.

Subd. 4. **ISSUANCE OF LICENSE CONDITION; RENEWALS.** The commissioner of health shall issue a license condition to a hospital that complies with subdivisions 2 and 3. The license condition must be granted when the license is first issued, when it is renewed, or during the hospital's licensure year. The condition is valid for the hospital's licensure year. The license condition can be renewed at the time of the hospital's license renewal if the hospital complies with subdivisions 2 and 3.

Subd. 5. **INSPECTIONS.** Notwithstanding section 144.55, subdivision 4, the commissioner of health may conduct inspections of a hospital granted a condition under this section to assess compliance with this section.

Subd. 6. **VIOLATIONS.** Notwithstanding section 144.55, subdivision 4, if the hospital fails to comply with subdivision 2 or 3, the commissioner of health shall issue a correction order and penalty assessment under section 144.653 or may suspend, revoke, or refuse to renew the license condition under section 144.55, subdivision 6. The penalty assessment for a violation of subdivision 2 or 3 is $500.

Subd. 7. **EFFECTIVE DATE.** Hospitals participating in the medicare swing bed program on the effective date of this section shall comply with this section by January 1, 1986, or at the time of the renewal of the medicare swing bed approval, whichever is earlier.

Sec. 4. **[144.563] NURSING SERVICES PROVIDED IN A HOSPITAL; PROHIBITED PRACTICES.**

A hospital that has been granted a license condition under section 3 must not provide to patients not reimbursed by medicare or medical assistance the types of services that would be usually and customarily provided and reimbursed under medical assistance or medicare as services of a skilled nursing facility or intermediate care facility for more than 42 days and only for patients who have been hospitalized and no longer require an acute level of care. Permission to extend a patient's length of stay may be granted by the commissioner if requested by the physician at least ten days prior to the end of the maximum length of stay.

Sec. 5. Minnesota Statutes 1984, section 144A.01, subdivision 5, is amended to read:

Subd. 5. "Nursing home" means a facility or that part of a facility which provides nursing care to five or more persons. "Nursing home" does not include a facility or that part of a facility which is a hospital, a hospital with approved swing beds as defined in section 3, clinic, doctor's office, diagnostic or treatment center, or a residential facility licensed pursuant to sections 245.781 to 245.821 or 252.28.

Sec. 6. Minnesota Statutes 1984, section 144A.01, subdivision 7, is amended to read:

Subd. 7. "Uncorrected violation" means ~~(a)~~ a violation of a statute or rule or any other deficiency for which a notice of noncompliance has been issued and fine assessed and allowed to be recovered pursuant to section 144A.10, subdivision ~~6, or (b) the issuance of two or more correction orders, within a 12-month period, for a violation of the same provision of a statute or rule~~ 8.

Sec. 7. Minnesota Statutes 1984, section 144A.01, is amended by adding a subdivision to read:

Subd. 10. "Repeated violation" means the issuance of two or more correction orders, within a 12-month period, for a violation of the same provision of a statute or rule.

Sec. 8. Minnesota Statutes 1984, section 144A.04, subdivision 4, is amended to read:

Subd. 4. The controlling persons of a nursing home may not include any person who was a controlling person of another nursing home during any period of time in the previous two year period:

(a) during which time of control that other nursing home incurred the following number of uncorrected or repeated violations:

(1) two or more uncorrected violations or one or more repeated violations which created an imminent risk to direct resident care or safety; or

(2) ~~five~~ four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the ~~two~~ four highest daily fine categories prescribed in rule; or

(b) who was convicted of a felony or gross misdemeanor punishable by a term of imprisonment of more than 90 days that relates to operation of the nursing home or directly affects resident safety or care, during that period.

The provisions of this subdivision shall not apply to any controlling person who had no legal authority to affect or change decisions related to the operation of the nursing home which incurred the uncorrected violations.

Sec. 9. Minnesota Statutes 1984, section 144A.04, subdivision 6, is amended to read:

Subd. 6. A nursing home may not employ as a managerial employee or as its licensed administrator any person who was a managerial employee or the licensed administrator of another facility during any period of time in the previous two year period:

(a) During which time of employment that other nursing home incurred the following number of uncorrected violations which were in the jurisdiction and control of the managerial employee or the administrator:

(1) two or more uncorrected violations or one or more repeated violations which created an imminent risk to direct resident care or safety; or

(2) ~~five~~ four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the ~~two~~ four highest daily fine categories prescribed in rule; or

(b) who was convicted of a felony or gross misdemeanor punishable by a term of imprisonment of more than 90 days that relates to operation of the nursing home or directly affects resident safety or care, during that period.

Sec. 10. Minnesota Statutes 1984, section 144A.071, subdivision 1, is amended to read:

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~~,~~ and 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~~ is 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 also finds that further increases in the number of licensed nursing home beds, especially in nursing homes not certified for participation in the medical assistance program, is contrary to public policy, because: (1) nursing home residents with limited resources may exhaust their resources more rapidly in these facilities, creating the need for a transfer to a certified nursing home, with the concomitant risk of transfer trauma; (2) a continuing increase in the number of nursing home beds will foster continuing reliance on institutional care to meet the long-term care needs of residents of the state; (3) a further expansion of nursing home beds will diminish incentives to develop more appropriate and cost-effective alternative services and divert community resources that would otherwise be available to fund alternative services; (4) through corporate reorganization resulting in the separation of certified and licensed beds, a nursing home may evade the provisions of section 256B.48, subdivision 1, clause (a); and (5) it is in the best interests of the state to ensure that the long-term care system is designed to protect the private resources of individuals as well as to use state resources most effectively and efficiently.

The legislature declares that a moratorium on the licensure and 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.

Sec. 11. Minnesota Statutes 1984, section 144A.071, subdivision 2, is amended to read:

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 human services, 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 May 23, 1983, 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 human services, 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. The commissioner of health shall deny each request for licensure of nursing home beds except as provided in subdivision 3.

Sec. 12. Minnesota Statutes 1984, section 144A.071, subdivision 3, is amended to read:

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

(a) To replace a bed decertified after May 23, 1983 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 May 23, 1983. 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~~ To license a new nursing home bed in a facility that meets one of the exceptions contained in clauses (a) to (c);

(e) To license nursing home beds in a facility that has submitted either a completed licensure application or a written request for licensure to the commissioner before March 1, 1985, and has either commenced any required construction as defined in clause (b) before May 1, 1985, or has, before May 1, 1985, received from the commissioner approval of plans for phased-in construction and written authorization to begin construction on a phased-in basis. For the purpose of this clause, "construction" means any erection, building, alteration, reconstruction, modernization, or improvement necessary to comply with the nursing home licensure rules; or

(f) To certify or license new beds in a new facility that is to be operated by the commissioner of veterans' affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans' affairs or the United States veterans administration.

Sec. 13. Minnesota Statutes 1984, section 144A.08, subdivision 3, is amended to read:

Subd. 3. **PENALTY.** Any controlling person who establishes, conducts, manages or operates a nursing home which incurs the following number of uncorrected or repeated violations, in any two year period:

(a) two or more uncorrected violations or one or more repeated violations which created an imminent risk ~~of harm~~ to ~~a nursing home~~ direct resident care or safety; or

(b) ~~Five~~ four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the four highest daily fine categories prescribed in rule, is guilty of a misdemeanor.

The provisions of this subdivision shall not apply to any controlling person who had no legal authority to affect or change decisions as to the operation of the nursing home which incurred the uncorrected or repeated violations.

Sec. 14. Minnesota Statutes 1984, 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. If the commissioner finds that the nursing home had uncorrected or repeated violations ~~and that two or more of the uncorrected violations~~ which create a risk to resident care, safety, or rights, the commissioner shall notify the commissioner of human services who shall (1) review reimbursement to the nursing home to determine the extent to which the state has paid for substandard care and, (2) furnish his or her findings and disposition to the commissioner of health within 30 days of notification.

Sec. 15. Minnesota Statutes 1984, section 144A.10, is amended by adding a subdivision to read:

Subd. 4a. **SUSPENSION OF ADMISSIONS.** If the commissioner issues a penalty assessment or if the nursing home has a repeated violation of that portion of Minnesota Rules, part 4655.5600, subdivision 2, establishing minimum nursing personnel requirements, the nursing home shall be prohibited from admitting new residents until correction is verified by a duly authorized representative of the commissioner. A nursing home shall notify the commissioner of health in writing when the violation is corrected. The facility shall be reinspected within three working days after the receipt of the notification.

Sec. 16. Minnesota Statutes 1984, section 144A.10, is amended by adding a subdivision to read:

Subd. 10. **REPORTING TO A MEDICAL EXAMINER OR CORONER.** Whenever a duly authorized representative of the commissioner of health has reasonable cause to believe that a resident has died as a direct or indirect result of abuse or neglect, the representative shall report that information to the appropriate medical examiner or coroner and police department or county sheriff. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff, and to the commissioner of health.

Sec. 17. Minnesota Statutes 1984, section 144A.11, subdivision 2, is amended to read:

Subd. 2. **MANDATORY PROCEEDINGS.** The commissioner of health shall initiate proceedings within 60 days of notification to suspend or revoke a nursing home license or shall refuse to renew a license if within the preceding two years the nursing home has incurred the following number of uncorrected or repeated violations:

(1) two or more uncorrected violations or one or more repeated violations which created an imminent risk to direct resident care or safety~~, violated the patients' bill of rights section 144.651, or violated the vulnerable adults reporting act, section 626.557~~; or

(2) ~~five~~ four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the ~~two~~ four highest daily fine categories prescribed in rule.

Sec. 18. Minnesota Statutes 1984, section 144A.11, subdivision 3a, is amended to read:

Subd. 3a. **MANDATORY REVOCATION.** Notwithstanding the provisions of subdivision 3, the commissioner shall revoke a nursing home license if a controlling person is convicted of a felony or gross misdemeanor punishable by a term of imprisonment of more than 90 days that relates to operation of the nursing home or directly affects resident safety or care. The commissioner shall notify the nursing home 30 days in advance of the date of revocation.

Sec. 19. Minnesota Statutes 1984, section 256B.02, subdivision 8, is amended to read:

Subd. 8. **MEDICAL ASSISTANCE; MEDICAL CARE.** "Medical assistance" or "medical care" means payment of part or all of the cost of the following care and services for eligible individuals whose income and resources are insufficient to meet all of this cost:

(1) Inpatient hospital services. A second medical opinion is required prior to reimbursement for elective surgeries. The commissioner shall publish in the State Register a proposed list of elective surgeries that require a second medical opinion prior to reimbursement. The list is not subject to the requirements of sections 14.01 to 14.70. The commissioner's decision whether a second medical opinion is required, made in accordance with rules governing that decision, is not subject to administrative appeal;

(2) Skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 256B.50, subdivision 1, for mentally retarded individuals residing in intermediate care facilities for the mentally retarded. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 3;

(3) Physicians' services;

(4) Outpatient hospital or nonprofit community health clinic services or physician-directed clinic services. The physician-directed clinic staff shall include at least two physicians, one of whom is on the premises whenever the clinic is open, and all services shall be provided under the direct supervision of the physician who is on the premises. Hospital outpatient departments are subject to the same limitations and reimbursements as other enrolled vendors for all services, except initial triage, emergency services, and services not provided or immediately available in clinics, physicians' offices, or by other enrolled providers. "Emergency services" means those medical services required for the imme-

diate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death or are necessary to alleviate severe pain. Neither the hospital, its employees, nor any physician or dentist, shall be liable in any action arising out of a determination not to render emergency services or care if reasonable care is exercised in determining the condition of the person, or in determining the appropriateness of the facilities, or the qualifications and availability of personnel to render these services consistent with this section;

(5) Community mental health center services, as defined in rules adopted by the commissioner pursuant to section 256B.04, subdivision 2, and provided by a community mental health center as defined in section 245.62, subdivision 2;

(6) Home health care services;

(7) Private duty nursing services;

(8) Physical therapy and related services;

(9) Dental services, excluding cast metal restorations;

(10) Laboratory and xray services;

(11) The following if prescribed by a licensed practitioner: drugs, eyeglasses, dentures, and prosthetic devices. The commissioner shall designate a formulary committee which shall advise the commissioner on the names of drugs for which payment shall be made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The commissioner shall appoint the formulary committee members no later than 30 days following July 1, 1981. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve two year terms and shall serve without compensation. The commissioner may establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the formulary committee shall review and comment on the formulary contents. Prior authorization may be required by the commissioner, with the consent of the drug formulary committee, before certain formulary drugs are eligible for payment. The formulary shall not include: drugs or products for which there is no federal funding; over the counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, prenatal vitamins, and vitamins for children under the age of seven; or any other over the counter drug identified by the commissioner, in consultation with the

appropriate professional consultants under contract with or employed by the state agency, as necessary, appropriate and cost effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14, the Administrative Procedure Act; nutritional products, except for those products needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as requiring a similarly necessary nutritional product; anorectics; and drugs for which medical value has not been established. Separate payment shall not be made for nutritional products for residents of long-term care facilities; payment for dietary requirements is a component of the per diem rate paid to these facilities. Payment to drug vendors shall not be modified before the formulary is established except that the commissioner shall not permit payment for any drugs which may not by law be included in the formulary, and his determination shall not be subject to chapter 14, the Administrative Procedure Act. The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

The basis for determining the amount of payment shall be the actual acquisition costs of the drugs plus a fixed dispensing fee established by the commissioner. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Establishment of this fee shall not be subject to the requirements of the Administrative Procedure Act. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written" on the prescription as required by section 151.21, subdivision 2.

Notwithstanding the above provisions, implementation of any change in the fixed dispensing fee which has not been subject to the Administrative Procedure Act shall be limited to not more than 180 days, unless, during that time, the commissioner shall have initiated rulemaking through the Administrative Procedure Act;

(12) Diagnostic, screening, and preventive services;

(13) Health care pre-payment plan premiums and insurance premiums if paid directly to a vendor and supplementary medical insurance benefits under Title XVIII of the Social Security Act;

(14) Abortion services, but only if one of the following conditions is met:

(a) The abortion is a medical necessity. "Medical necessity" means (1) the signed written statement of two physicians indicating the abortion is medically necessary to prevent the death of the mother, and (2) the patient has given her consent to the abortion in writing unless the patient is physically or legally

incapable of providing informed consent to the procedure, in which case consent will be given as otherwise provided by law;

(b) The pregnancy is the result of criminal sexual conduct as defined in section 609.342, clauses (c), (d), (e)(i), and (f), and the incident is reported within 48 hours after the incident occurs to a valid law enforcement agency for investigation, unless the victim is physically unable to report the criminal sexual conduct, in which case the report shall be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct; or

(c) The pregnancy is the result of incest, but only if the incident and relative are reported to a valid law enforcement agency for investigation prior to the abortion;

(15) Transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by nonambulatory persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. For the purpose of this clause, a person who is incapable of transport by taxicab or bus shall be considered to be nonambulatory;

(16) To the extent authorized by rule of the state agency, costs of bus or taxicab transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care;

(17) Personal care attendant services provided by an individual, not a relative, who is qualified to provide the services, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a registered nurse. Payments to personal care attendants shall be adjusted annually to reflect changes in the cost of living or of providing services by the average annual adjustment granted to vendors such as nursing homes and home health agencies; and

(18) Any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law.

Sec. 20. Minnesota Statutes 1984, 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 180 days of~~ applicants seeking admission to a licensed nursing home or boarding care home participating in the medical assistance 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 human services and health shall seek to maximize

use of available federal and state funds and establish the broadest program possible within the appropriation available.

Sec. 21. Minnesota Statutes 1984, section 256B.091, subdivision 2, is amended to read:

Subd. 2. **SCREENING TEAMS; ESTABLISHMENT.** Each county agency designated by the commissioner of human services 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~~,~~ the health and social needs of all applicants 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 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 a person who has been screened must be reassessed for purposes of assigning a case mix classification because admission to a nursing home occurs later than the time allowed by rule following the initial screening and assessment, the reassessment may be completed by the public health nurse member of the screening team. 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. 22. Minnesota Statutes 1984, 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 180 days of admission to a nursing home or boarding care home~~ applicants, except (1) patients transferred from other nursing homes ~~or~~; (2) patients who, having entered acute care facilities from nursing homes, are returning to nursing home care; (3) persons entering a facility described in section 256B.431, subdivision 4, paragraph (b); or (4) persons entering a facility conducted by and for the adherents of a recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing. ~~Any other interested person may~~ The cost for screening persons who are receiving medical assistance or who would be eligible for medical assistance within 180 days of nursing home or boarding care home admission, must be paid by state, federal, and county money. Other persons shall be assessed by a screening team upon payment of a fee ~~based upon a sliding fee scale~~ approved by the commissioner.

Sec. 23. Minnesota Statutes 1984, section 256B.091, subdivision 5, is amended to read:

Subd. 5. **APPEALS.** Appeals from the screening team's ~~determination~~ recommendation shall be made pursuant to the procedures set forth in section 256.045, subdivisions 2 and 3. An appeal shall be automatic if the individual's physician does not agree with the recommendation of the screening team.

Sec. 24. Minnesota Statutes 1984, 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 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; and (4) who are age 65 or older.

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. 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 ten percent of the costs.

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

Sec. 25. Minnesota Statutes 1984, section 256B.431, subdivision 2b, is amended to read:

Subd. 2b. **OPERATING COSTS, AFTER JULY 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner shall establish procedures for determining per diem reimbursement for operating costs.

(b) The commissioner shall 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.

(c) The commissioner shall analyze and evaluate each nursing home's cost 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.

(d) The commissioner shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs for the reporting year that begins October 1, 1983, taking into consideration relevant factors including resident needs, geographic location, ~~age,~~ size of the nursing home, and the costs that must be incurred for the care of residents in an efficiently and economically operated nursing home. In developing the geographic groups for purposes of reimbursement under this section, the commissioner shall ensure that nursing homes in any county contiguous to the Minneapolis-St. Paul seven-county metropolitan area are included in the same geographic group. The limits established by the commissioner shall not be less, in the aggregate, than the 60th percentile of total 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 limits established under this paragraph remain in effect until the commissioner establishes a new base period. Until the new base period is established, the commissioner shall adjust the limits annually using the appropriate economic change indices established in paragraph (e). In determining allowable historical operating cost per diems for purposes of setting limits and nursing home payment rates, the commissioner shall divide the allowable historical operating costs by the actual number of resident days, except that where a nursing home is occupied at less than 90 percent of licensed capacity days, the commissioner may establish procedures to adjust the computation of the per diem to an imputed occupancy level at or below 90 percent. The commissioner shall establish efficiency incentives as appropriate. The commissioner may establish efficiency incentives for different operating cost categories. The commissioner shall consider establishing efficiency incentives in care related cost categories. The commissioner may combine one or more operating cost categories and may use different methods for calculating payment rates for each operating cost category or combination of operating cost categories. For the rate year beginning on July 1, 1985, the commissioner shall:

(1) allow nursing homes that have an average length of stay of 180 days or less in their skilled nursing level of care, 125 percent of the care related limit and 105 percent of the other operating cost limit established by rule; and

(2) exempt nursing homes licensed on July 1, 1983, by the commissioner to provide residential services for the physically handicapped under Minnesota Rules, parts 9570.2000 to 9570.3600, from the care related limits and allow 105 percent of the other operating cost limit established by rule.

For the purpose of calculating the other operating cost efficiency incentive for nursing homes referred to in clauses (1) or (2), the commissioner shall use the other operating cost limit established by rule before application of the 105 percent.

(e) The commissioner shall establish a composite index or indices by determining the appropriate economic change indicators to be applied to specific operating cost categories or combination of operating cost categories.

(f) Each nursing home shall receive an operating cost payment rate equal to the sum of the nursing home's operating cost payment rates for each operating cost category. The operating cost payment rate for an operating cost category shall be the lesser of the nursing home's historical operating cost in the category increased by the appropriate index established in paragraph (e) for the operating cost category plus an efficiency incentive established pursuant to paragraph (d) or the limit for the operating cost category increased by the same index. 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. In establishing payment rates for one or more operating cost categories, the commissioner may establish separate rates for different classes of residents based on their relative care needs.

(g) 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 (1) shall be divided by actual resident days in order to compute the operating cost payment rate for this operating cost category, (2) shall not be used to compute the 60th percentile or other operating cost limits established by the commissioner, and (3) shall not be increased by the composite index or indices established pursuant to paragraph (e).

Sec. 26. Minnesota Statutes 1984, section 256B.421, subdivision 5, is amended to read:

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, accounting personnel, data processing personnel, and all clerical personnel; board of directors fees; business office functions and supplies; travel, except as necessary for training programs for nursing personnel and dieticians required to

maintain licensure, certification, or professional standards requirements; telephone and telegraph; advertising; 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.~~

Sec. 27. Minnesota Statutes 1984, section 256B.431, is amended by adding a subdivision to read:

Subd. 2g. **REQUIRED CONSULTANTS.** Costs considered general and administrative costs under section 256B.421 must 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. Central, affiliated, or corporate office costs representing services of consultants not required by law in the areas of nursing, quality assurance, medical records, dietary, other care related services, and plant operations may be allocated to the appropriate operating cost category of a nursing home according to paragraphs (a) to (e).

(a) Only the salaries, fringe benefits, and payroll taxes associated with the individual performing the service may be allocated. No other costs may be allocated.

(b) The allocation must be based on direct identification and only to the extent justified in time distribution records that show the actual time spent by the consultant performing the services in the nursing home.

(c) The cost in paragraph (a) for each consultant must not be allocated to more than one operating cost category in the nursing home. If more than one nursing home is served by a consultant, all nursing homes shall allocate the consultant's cost to the same operating category.

(d) Top management personnel must not be considered consultants.

(e) The consultant's full-time responsibilities shall be to provide the services identified in this item.

Sec. 28. Minnesota Statutes 1984, section 256B.431, is amended by adding a subdivision to read:

Subd. 2h. **PHASE-IN.** The commissioner shall allow each nursing home whose actual allowable historical operating cost per diem for the reporting year ending September 30, 1984, and the following two reporting years is five percent or more above the limits established by the commissioner, to be reimbursed for part of the excess costs each year for up to three rate years according to the formula in this subdivision. The commissioner shall reimburse the nursing home:

(1) for the rate year beginning July 1, 1985, 70 percent of the difference between the actual allowable historical operating cost per diem and 105 percent of the limit established by the commissioner;

(2) for the rate year beginning July 1, 1986, 50 percent of the difference between the actual allowable historical operating cost per diem and 105 percent of the limit established by the commissioner; and

(3) for the rate year beginning July 1, 1987, 30 percent of the difference between the actual allowable historical operating cost per diem and 105 percent of the limit established by the commissioner.

Any efficiency incentive amount earned by the nursing home must be subtracted from any of the reimbursement phase-in amounts computed under this section.

Sec. 29. Minnesota Statutes 1984, section 256B.431, subdivision 3, is amended to read:

Subd. 3. **PROPERTY-RELATED COSTS, 1983-1985.** (a) 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.

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

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

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

(3) 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

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

(c) 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 emergency and permanent rules to recapture excess depreciation upon sale of a nursing home.

~~(d)~~ Subd. 3a. **PROPERTY-RELATED COSTS AFTER JULY 1, 1985.** (a) 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 and depreciable equipment. "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.

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

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

(2) minimize discretionary or appealable decisions;

(3) eliminate any incentives to sell nursing homes;

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

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

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

(7) establish an investment per bed limitation;

(8) reward efficient management of capital assets;

(9) provide equitable treatment of facilities;

(10) consider a variable rate; and

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

~~(f)~~ (c) 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.

Sec. 31.* Minnesota Statutes 1984, section 256B.431, subdivision 4, is amended to read:

Subd. 4. **SPECIAL RATES.** (a) For the rate years beginning July 1, 1983, and July 1, 1984, 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 emergency 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. Until procedures determining operating cost payment rates according to mix of resident needs are established, 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.

(b) For the rate years beginning on or after July 1, 1985, 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, operating costs, and real estate taxes and special assessments calculated under rules promulgated by the commissioner.

(c) For rate years beginning on or after July 1, 1983, the commissioner may exclude from a provision of 12 MCAR S 2.050 any facility that is licensed by the commissioner of health only as a boarding care home, ~~is~~ certified by the commissioner of health as an intermediate care facility, is licensed by the

* This section and the following section are both numbered "31".

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

commissioner of human services under 12 MCAR S 2.036, and has less than five percent of its licensed boarding care capacity reimbursed by the medical assistance program. Until a permanent rule to establish the payment rates for facilities meeting these criteria is promulgated, the commissioner shall establish the medical assistance payment rate as follows:

(1) The desk audited payment rate in effect on June 30, 1983, remains in effect until the end of the facility's fiscal year. The commissioner shall not allow any amendments to the cost report on which this desk audited payment rate is based.

(2) For each fiscal year beginning between July 1, 1983, and June 30, 1985, the facility's payment rate shall be established by increasing the desk audited operating cost payment rate determined in clause (1) at an annual rate of five percent.

(3) For fiscal years beginning on or after July 1, 1985, the facility's payment rate shall be established by increasing the facility's payment rate in the facility's prior fiscal year by the increase indicated by the consumer price index for Minneapolis and St. Paul.

(4) For the purpose of establishing payment rates under this paragraph, the facility's rate and reporting years coincide with the facility's fiscal year.

A facility that meets the criteria of this paragraph shall submit annual cost reports on forms prescribed by the commissioner.

For the rate year beginning July 1, 1985, each nursing home total payment rate must be effective two calendar months from the first day of the month after the commissioner issues the rate notice to the nursing home. From July 1, 1985, until the total payment rate becomes effective, the commissioner shall make payments to each nursing home at a temporary rate that is the prior rate year's operating cost payment rate increased by 2.6 percent plus the prior rate year's property-related payment rate and the prior rate year's real estate taxes and special assessments payment rate. The commissioner shall retroactively adjust the property-related payment rate and the real estate taxes and special assessments payment rate to July 1, 1985, but must not retroactively adjust the operating cost payment rate.

Sec. 31.** Minnesota Statutes 1984, section 256B.48, is amended by adding a subdivision to read:

Subd. 6. **MEDICARE CERTIFICATION.** All nursing homes certified as skilled nursing facilities under the medical assistance program shall participate in medicare part A and part B unless, after submitting an application, medicare certification is denied by the federal health care financing administration. Medi-

** This section and the preceding section are both numbered "31".

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

care review shall be conducted at the time of the annual medical assistance review. Charges for medicare-covered services provided to residents who are simultaneously eligible for medical assistance and medicare must be billed to medicare part A or part B before billing medical assistance. Medical assistance may be billed only for charges not reimbursed by medicare.

Until September 30, 1987, the commissioner of health may grant exceptions from this requirement when a nursing home submits a written request for exception and it is determined that there is sufficient participation in the medicare program to meet the needs of medicare beneficiaries in that region of the state. For the purposes of this section, the relevant region is the county in which the nursing home is located together with contiguous Minnesota counties. There is sufficient participation in the medicare program in a particular region when the proportion of skilled resident days paid by the medicare program is at least equal to the national average based on the most recent figure that can be supplied by the federal health care financing administration. A nursing home that is granted an exception under this subdivision must give appropriate notice to all applicants for admission that medicare coverage is not available in the nursing home and publish this fact in all literature and advertisement related to the nursing home.

Sec. 32. Minnesota Statutes 1984, section 256B.50, is amended to read:

256B.50 **APPEALS.**

Subdivision 1. **SCOPE.** A nursing home may appeal a decision arising from the application of standards or methods pursuant to sections 256B.41 and 256B.47 if the appeal, if successful, would result in a change to the nursing home's payment rate, or appraised value. The appeal procedures also apply to appeals of payment rates calculated under 12 MCAR S 2.049 filed with the commissioner on or after May 1, 1984. This section does not apply to a request from a resident or nursing home for reconsideration of the classification of a resident under section 1. To appeal, the nursing home shall notify the commissioner in writing 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.

Except as provided in subdivision 2, the appeal shall be heard by an administrative law judge 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 administrative law judge. 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.421, 256B.431, 256B.47, 256B.48, 256B.50, and 256B.502, a nursing home shall comply with section 14.44.

Subd. 2. **APPRAISED VALUE; APPEALS BOARD.** (a) Appeals concerning the appraised value of a nursing home's real estate must be heard by a three-person appeal board appointed by the commissioner. The real estate as defined in section 256B.431, subdivision 3, must be appraised using the depreciated replacement cost method.

(b) Members of the appeals board shall be appointed by the commissioner from the list of appraisers approved for state contracts by the commissioner of administration. In making the selection, the commissioner of human services shall ensure that each member is experienced in the use of the depreciated replacement cost method and is free of any personal, political, or economic conflict of interest that may impair the member's ability to function in a fair and objective manner.

(c) The appeals board shall appoint one of its members to act as chief representative and shall examine witnesses when it is necessary to make a complete record. Facts to be considered by the board are limited to those in existence at the time of the appraisal being appealed. The board shall issue a written report regarding each appeal to the commissioner within 30 days following the close of the record. The report must contain findings of fact, conclusions, and a recommended disposition based on a majority decision of the board. A copy of the report must be served upon all parties.

(d) The commissioner shall issue an order adopting, rejecting, or modifying the appeal board's recommendation within 30 days of receipt of the report. A copy of the decision must be served upon all parties.

(e) Within 30 days of receipt of the commissioner's order, the appealing party may appeal to the Minnesota court of appeals. The court's decision is limited to a determination of the appraised value of the real estate and must not include costs assessed against either party.

Sec. 33. Minnesota Statutes 1984, section 256B.504, subdivision 1, is amended to read:

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 human services with the ~~goal~~ goals of improving quality of care and controlling health care costs;

(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;

(d) to monitor the delivery of health care in Minnesota, and to study and report on strategies to contain health care costs; and

(e) to study the adequacy of the present system of quality assurance and to recommend changes if the current system is not adequate to ensure a cost-effective, quality care system. The commission shall review the department of health's quality assurance program in order to assure that each individual resident's ability to function is optimized, based upon valid and reliable indicators that focus on individual client outcomes and are not measured solely by the number or amount of services provided.

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.

Sec. 34. Minnesota Statutes 1984, section 349.214, is amended by adding a subdivision to read:

Subd. 1a. **BINGO; CERTAIN ORGANIZATIONS.** Bingo may be conducted within a nursing home or a senior citizen housing project or by a senior citizen organization without compliance with sections 349.11 to 349.213 if the prizes for a single bingo game do not exceed $10, total prizes awarded at a single bingo occasion do not exceed $200, no more than two bingo occasions are held by the organization or at the facility each week, only members of the organization or residents of the nursing home or housing project are allowed to play in a bingo game, no compensation is paid for any persons who conduct the bingo, a manager is appointed to supervise the bingo, and the manager registers with the board. The gross receipts from bingo conducted under the limitations of this subdivision are exempt from taxation under chapter 297A.

Sec. 35. Minnesota Statutes 1984, section 474.01, subdivision 7a, is amended to read:

Subd. 7a. No municipality or redevelopment agency shall undertake any project authorized by sections 474.01 to 474.13, except a project referred to in section 474.02, subdivision 1f, unless its governing body finds that the project furthers the purposes stated in this section, nor until the commissioner of energy and economic development has approved the project, on the basis of preliminary information which the commissioner may require, as tending to further the purposes and policies of sections 474.01 to 474.13. The commissioner may not approve any projects relating to health care facilities except as permitted under

subdivision 9. Approval shall not be deemed to be an approval by the commissioner of energy and economic development or the state of the feasibility of the project or the terms of the revenue agreement to be executed or the bonds to be issued therefor, and the commissioner shall state this in communicating approval.

Sec. 36. Minnesota Statutes 1984, section 474.01, subdivision 9, is amended to read:

Subd. 9. **HEALTH CARE FACILITIES.** The welfare of the state further requires the provision of necessary health care facilities, to the end that adequate health care services be made available to residents of the state at reasonable cost. However, some projects relating to nursing homes may be inconsistent with established state policies and detrimental to the welfare of the state. The commissioner of energy and economic development shall forward to the commissioner of human services and the commissioner of health for review, all applications for projects relating to nursing homes licensed by the commissioner of health under chapter 144A. This review process does not apply to projects approved by the housing finance agency involving residences for the elderly, the costs of which will not be reimbursed under the medical assistance program. The commissioner of human services and the commissioner of health must return the applications to the commissioner of energy and economic development with a recommendation within 30 days of receipt. The commissioner of energy and economic development may not approve an application unless the project has been determined by both the commissioner of human services and the commissioner of health to be consistent with policies of the state as reflected in a statute or rule. The following projects may not be approved:

(1) projects that will result in an increase in the number of nursing home or boarding care beds in the state, unless the increase was approved before May 1, 1985, under section 144A.071, subdivision 3;

(2) projects involving refinancing, unless the refinancing will result in a reduction in debt service charges that will be reflected in charges to patients and third-party payors; and

(3) projects that are inconsistent with the established policies of the state as reflected in a statute or rule.

Sec. 37. **TRANSITIONAL CARE STUDY.**

By February 1, 1986, the commissioner of health shall submit a report to the legislature regarding the provision of transitional care or other sub-acute inpatient services provided in hospitals. The report must contain recommendations for legislative action that address the following: the nature and extent of these services; how these services are reimbursed; the impact of these services on the long-term care system; and the costs, quality, and appropriateness of providing these services in a hospital.

Sec. 38. **APPROPRIATIONS.**

$50,000 is appropriated from the general fund to the commissioner of human services for purposes of section 37. Federal money received during the biennium for purposes of section 37 is appropriated to the commissioner of human services for contracting with the commmissioner of health to study transitional care services provided in hospitals.

Sec. 39. **EFFECTIVE DATES.**

Sections 1 to 5, 10 to 12, 24, and 28 to 33 are effective the day following final enactment. Sections 19 to 23, 25 to 27, 31, and 35 to 37 are effective July 1, 1985.

Approved June 24, 1985

CHAPTER 4 — S.F.No. 8

An act relating to public safety; providing and enhancing penalties upon conviction of certain hit and run violations; subjecting rules relating to drunk driving to certain provisions of the administrative procedure act; providing for the application of certain traffic regulations; eliminating redundant and surplus language; providing for access to drivers license photographic negatives; providing for crime victim services and reparations; creating a crime victim ombudsman and advisory council; amending Minnesota Statutes 1984, sections 14.02, subdivision 4; 169.02, subdivision 1; 169.09, subdivision 14; 169.121, subdivision 1; 169.123, subdivision 2; 169.128; 169.129; 171.07, subdivision 1a; 611A.52; 611A.53, subdivision 2; 611A.54; 611A.55, subdivisions 1 and 2; and 611A.56, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 611A.

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

Section 1. Minnesota Statutes 1984, section 14.02, subdivision 4, is amended to read:

Subd. 4. **RULE.** "Rule" means every agency statement of general applicability and future effect, including amendments, suspensions, and repeals of rules, adopted to implement or make specific the law enforced or administered by it or to govern its organization or procedure. It does not include (a) rules concerning only the internal management of the agency or other agencies, and which do not directly affect the rights of or procedure available to the public; (b) rules of the commissioner of corrections relating to the internal management of institutions under the commissioner's control and those rules governing the inmates thereof prescribed pursuant to section 609.105; (c) rules of the division of game and fish published in accordance with section 97.53; (d) rules relating to weight limitations on the use of highways when the substance of the rules is