CHAPTER 9500
DEPARTMENT OF HUMAN SERVICES
ASSISTANCE PAYMENTS PROGRAMS

AID TO FAMILIES WITH DEPENDENT CHILDREN

9500.0010 SCOPE AND STATUTORY AUTHORITY FOR AFDC PROGRAM.

Parts 9500.0010 to 9500.0370 shall govern administration of the Aid to Families with Dependent Children (AFDC) program in Minnesota. The provisions of these parts are to be read in conjunction with title IV-A of the federal Social Security Act, Code of Federal Regulations, title 45, Minnesota Statutes, chapter 256; and other rules of the Department of Human Services pertaining to public assistance and the administration of Minnesota's state and local welfare departments. Local welfare department or "agency" includes the county welfare department of those multi-county welfare agencies established under Minnesota Statutes, section 393.01 or chapter 402.

Statutory Authority: *MS s 256.01 subd 4*

History: *L 1984 c 654 art 5 s 58*

9500.0020 INSTRUCTIONS, BULLETINS, AND MANUALS.

The commissioner of human services may issue instructions, bulletins, and manuals to the local welfare agencies to clarify the provisions of parts 9500.0010 to 9500.0370 (part 9500.0010 takes precedence over such documents) and may prescribe forms and procedures to be used in administration of this program. In order to assist others in interpretation of parts 9500.0010 to 9500.0370, the Department of Human Services has issued, informally, an AFDC policy manual. The material in the manual is not an official rule and does not have the force and effect of law.

Statutory Authority: *MS s 256.01 subd 4*

History: *L 1984 c 654 art 5 s 58*

9500.0030 STATE COOPERATION WITH FEDERAL GOVERNMENT.

The commissioner shall cooperate with the federal government and its public welfare agencies in any reasonable matter that will be necessary to qualify for AFDC. Notwithstanding any provisions of parts 9500.0010 to 9500.0370, administration of the AFDC program shall be subject to changes in federal or state law. The commissioner shall notify the local welfare agencies of such changes as they occur.

Statutory Authority: *MS s 256.01 subd 4*

9500.0040 PROGRAM ADMINISTRATION IN GENERAL.

The AFDC program shall be administered to provide qualifying needy families with the resources necessary to sustain a reasonable subsistence compatible with decency and health, according to parts 9500.0010 to 9500.0370. The AFDC program shall not be administered to deny applicants and recipients their individual and civil rights, nor to obtain or disclose information regarding them except as provided by Department of Human Services rules.

The commissioner shall supervise the AFDC program on a statewide basis in accordance with equitable standards for assistance and administration which shall be mandatory upon all political subdivisions.

Statutory Authority: *MS s 256.01 subd 4*

History: *L 1984 c 654 art 5 s 58*

9500.0050 APPLICATIONS FOR ASSISTANCE.

Subpart 1. **Right to apply and application procedure.** Any person may apply for AFDC to the local welfare agency in the county in which he/she resides, and the local agency shall promptly advise him/her of the program's eligibility requirements. The local agency shall provide an application form immediately upon receipt of a written or oral request for assistance. The local agency shall require a written application signed under a penalty of perjury, on a

form prescribed by the state agency, by applicant himself/herself or his authorized representative, whom he/she has specified in writing, or, where the applicant is incompetent or incapacitated, by someone acting responsibly for him/her. If the application is for AFDC-Foster Care (FC), it shall be signed in accordance with this part, except that the agency, or its designee, may also sign in lieu of the applicant, his/her authorized representative or someone acting responsibly for him/her. (See parts 9500.0340 and 9500.0350)

Subp. 2. **Timing for determination of eligibility.** As soon as possible, but not later than 45 days from the date of request for assistance, the local agency shall determine the applicant's eligibility for assistance. All eligibility conditions must be met within this 45-day limit. Assistance may be issued before the eligibility process is completed, but if the applicant is found ineligible, no federal or state financial participation may be claimed for this assistance.

Subp. 3. **Written notification.** The applicant must be notified in writing that his/her application has been approved or denied, unless the applicant dies or cannot be located. If the application is denied, the recipient must be notified in writing of the reasons for denial and of his/her right to appeal.

Subp. 4. **Reapplication.** Any person has the right to reapply for assistance. New applications must be taken whenever a previous application has been denied or withdrawn, or whenever a grant has been canceled, or whenever the payee has been changed. An approved application shall be addended for the purpose of adding additional eligible persons or when the payee has changed his/her name.

An application for AFDC received by a county must be processed as such, formally acted upon, and written notification of the disposition of the application must be provided the applicant regardless of the length of time that the applicant intends to remain a resident of that county. Until the applicant is notified in writing of the disposition of his/her application, any additional AFDC applications signed by this applicant in the same or in a different county are null and void. An applicant may voluntarily withdraw his/her application at any time.

Subp. 5. **Semiannual redetermination.** Eligibility shall be redetermined at least semiannually. When the local income maintenance unit receives information about a change in case facts, eligibility shall be reviewed within 30 days. The recipient shall furnish such correct information and reports as required by the agency to assure eligibility and payments.

Subp. 6. **Information verification.** The local agency shall verify the information contained in the application from the applicant or other persons or agencies only with the applicant's signed permission; blanket consents may be used only for groups of related agencies (such as banks, insurance agencies, etc.). If the applicant refuses to cooperate with the county agency in verifying the needed information, the application must be denied.

The following information shall be verified:

A. Social Security numbers of caretakers applying for or receiving assistance;

B. incapacity of a parent or unemployment of a father if such is the basis of eligibility; and

C. the applicant's income and acknowledged property.

Any other factor of eligibility may be verified depending on circumstances of the case.

Subp. 7. **Referrals to social service unit.** The income maintenance unit shall make immediate referral to the social service unit when there is reason to suspect that the home in which the relative and child requesting/receiving aid reside is unsuitable because of neglect, or sexual or physical abuse as defined in state statute.

Subp. 8. **Right to an advocate.** Because of the complexity of the welfare system in Minnesota applicants and recipients may have someone act as an advocate to ensure that their legal, civil, and human rights are upheld or have someone assist them in the application, redetermination, or fair hearing processes or in any other contacts with the agency. The applicant or recipient may be represented by an individual (who need not be a lawyer) of his/her choice whom he/she has specified in writing. Each local agency employee is to ensure the rights and benefits of all applicants and recipients.

Subp. 9. **Client's duty to notify concerning change of circumstances.** The client shall be responsible for informing the agency within ten days of receipt or by the fifth of the following month, whichever is earlier, of changes in circumstances and/or income. Such reports shall include new sources or amounts of income. The local agency shall use this report to determine continued eligibility or the amount of assistance for the next subsequent month unless income averaging is used.

Subp. 10. **Information about services available.** The local agency shall inform applicants and recipients of the availability of all programs, the benefits and limitations of each, the areas of client choice among and within programs and the results of such choices, the items concerning eligibility or payment which must be reported if they change, the time within which such reports must be made, and any other policies or actions which have a direct effect on recipients.

Statutory Authority: *MS s 256.01 subd 4*

9500.0060 FINANCIAL RESPONSIBILITY AND RESIDENCE.

Subpart 1. **Definitions.** "Residence" or "abode" means where a person lives and intends to remain; the "county of financial responsibility" or "county of settlement" means the county which is liable for a person's public assistance.

Subp. 2. **Residency requirement.** Minnesota residence shall be an eligibility requirement for AFDC, but no length of residence is required. A person loses Minnesota residence when he/she leaves the state with the intent to establish a home elsewhere; evidence of intent under parts 9500.0010 to 9500.0370 is not simply the person's stated intentions, but includes consideration of objective criteria associated with the move (e.g., movement of possessions, rent payments, changes in voter or driver's license registrations).

Subp. 3. **County of responsibility.** The county of financial responsibility for an AFDC grant shall be the county wherein the dependent child is residing as of the date the application is signed. The county of financial responsibility for an AFDC-Unborn (UB) grant shall be the county where the mother is residing at the time the application is signed. (See part 9500.0070.) The county of residence, if different from county of responsibility, shall be fiscally responsible for any erroneous payments, including payments to ineligible individuals and families which result from its decisions, failures to act, agency-caused errors to overdue eligibility redeterminations.

If more than one county is financially responsible for the children in one AFDC grant, the caretaker's needs shall be assigned to the county having the responsibility for the most children, or the county responsible for the oldest child if each county is responsible for the same number of children.

Subp. 4. **Transfers of county of responsibility.** If a child moves from one county to another and continues to receive AFDC, the county of financial responsibility shall transfer to his/her county of residence when he/she has resided in that county for two calendar months, provided the child and/or his/her caretaker were not placed in such other county pursuant to a plan of treatment for health, rehabilitation, foster care, child care, or training, nor as a result of a placement in any correctional plan.

If the original county or court or related agencies developed a treatment plan requiring the child's and/or family's move to another county, and even if

the original county did not take an application prior to the move, then the original county is still responsible for initiating and accepting applications and retains financial responsibility for the AFDC grants until the goals of the plan have been reached.

If thereafter the family or child continues to reside in the second county, the latter shall not assume financial responsibility until two calendar months have elapsed subsequent to completion of the plan. Such delay in transfer of financial responsibility shall relate only to such treatment placement plans which are arranged by a local agency, court order, or other governmental unit such as the Division of Vocational Rehabilitation or Probation and which became effective after July 31, 1977. The delay shall not apply to child care arrangements made by the family themselves and independent of local agency or court order. The delay will apply where the local agency, etc., arranged for plans of a parent to participate in a training plan for himself/herself only and he/she takes his/her children with him/her to reside near the training facility in another county. However, the county of the child's residence shall be the county which services his/her AFDC grant, whether or not it is the county of financial responsibility; moreover, whenever the county of financial responsibility and county of residence have policies which conflict, the latter shall take precedence.

The county of residence must furnish the county of financial responsibility with reports of interviews and budgetary recommendations.

The county of financial responsibility must establish grants in accordance with recommendations of the county of residence after review for conformity to the statutes and the rules of the state agency.

If the county of financial responsibility's action is not the one recommended by the county of residence, the county of financial responsibility shall notify the county of residence of the action taken and the reason.

Client eligibility shall not be affected by a change in county of residence of and by itself.

Once the client has notified the current county of residence of a planned move, the current county shall immediately forward to the new county all current and permanent case record information. Within 30 calendar days the new county of residence shall interview the client and respond to any changed circumstances which affect eligibility for AFDC payment.

The county shall not take a formal reapplication for the client or apply any eligibility criteria which governs only initial applications. This includes, but is not limited to, the quarters of work in unemployed fathers (see part 9500.0080, subpart 1, item H, subitem (1)) and the application of the $30 and one-third disregard (see part 9500.0110, subpart 8, item B.)

In all situations in which a grant is being continued, as a result of a pending appeal or as an order resulting from an appeal, the county of financial responsibility shall be determined according to this subpart.

Subp. 5. **Solution to disagreement over county of responsibility.** If counties disagree as to which is the county of financial responsibility, the following procedures shall apply:

A. the county of residence shall grant AFDC to the applicant, if eligible, while it refers the case to the alleged county of financial responsibility;

B. the alleged county of financial responsibility shall promptly decide if the applicant is eligible for AFDC and if it is the county of financial responsibility;

C. if the alleged county of financial responsibility denies eligibility or financial responsibility for the applicant, the county of residence may accept financial responsibility or may refer the matter to the commissioner of human services;

D. the commissioner of human services shall review the matter and provide both counties with the opportunity to state their position, by formal hearing or otherwise, and decide which county is financially responsible; the commissioner's determination shall be binding on both counties unless it is appealed to and reversed by the courts according to law; and

E. the county determined to be financially responsible shall reimburse any other county for any costs the county previously paid on the grant; if eligibility is denied, the county of residence shall be responsible for costs previously paid.

Statutory Authority: *MS s 256.01 subd 4*

History: *L 1984 c 654 art 5 s 58*

9500.0070 ELIGIBILITY FACTOR: CHILD STATUS.

Subpart 1. **Age.** Children under the age of 18 are eligible for AFDC; children age 18 to 19 are eligible if they are full-time students attending a high school, college, university, or vocational or technical training institute.

Unborn are eligible for AFDC during the last three months of the mother's pregnancy as medically certified. AFDC grants for unborn are referred to as "AFDC-UB."

Subp. 2. **Eligible relatives.** Parents (natural or adoptive), grandparents, brothers, sisters, uncles, aunts, great-grandparents, great-uncles, great-aunts, nephews, nieces, and first cousins, whether of whole or half-blood and stepparents, stepbrothers, and stepsisters, and spouses of these persons even after the marriage is terminated by death or divorce, are eligible to be the caretaker of a child receiving AFDC.

The caretaker must meet all eligibility requirements to be included in the child's AFDC grant.

Subp. 3. **Child's physical presence in the home.** A child must reside in the same home with an eligible caretaker to be eligible for AFDC unless he/she has special educational needs which cannot be met by local public school district which require that he/she reside away from home. "Educational needs" for this provision is defined as a curriculum directed toward achieving a special vocational or academic goal.

If an emergency exists that deprives the child of the care of the relative through whom he has been receiving aid, temporary absences of the caretaker or the child from the home shall not defeat AFDC eligibility for a temporary period necessary to make and carry out plans for the child's continuing care and support. No absence may exceed six months and all absences of more than three months shall be referred to the commissioner for a determination of continued eligibility. If the caretaker no longer, thereafter, can provide direct care for the child(ren), conditions for continued assistance do not exist. Alternative arrangements for care of the child(ren) shall be made.

Subp. 4. **Guardianship.** Guardianship of a child shall not affect AFDC eligibility, but if the child does not reside with an eligible caretaker, he/she must meet the requirements of AFDC-FC (see parts 9500.0340 and 9500.0350).

Subp. 5. **Death of child.** If a child dies, or if an unborn is stillborn, the AFDC grant shall be paid for the entire month in which death occurs.

Subp. 6. **Deprivation of parent.** To be eligible for AFDC a child must be deprived of parental support or care due to the death, incapacity, or continued absence of a parent from the home, or due to the unemployment of the father. This rule shall apply to natural and adoptive parents; the term "parental support or care" means financial maintenance, training, supervision, housekeeping, and feeding normally given to children by their parents.

Subp. 7. **Death of parent.** Death of a parent must be verified by official records (death certificates, military records, etc.).

Subp. 8. **Incapacitated parents.** A parent is incapacitated if he/she has a physical or mental defect, illness, or impairment which makes him/her unable to care for the child or substantially reduces or eliminates the ability to support the child. The incapacity must be expected to last at least 30 days from its onset. Budget deficiency alone shall not establish need in incapacity cases; the physical or mental handicap must cause the budget deficiency.

The incapacitated parent, and the caretaker relative, shall be included in the AFDC grant if need exists.

The incapacitated parent who is exempt from WIN registration (see part 9500.0320) must be referred to the Vocational Rehabilitation Division, Department of Economic Security.

Subp. 9. **Continued absence of parent.** A parent is continually absent from the home if he/she is physically absent from the home and if this absence interrupts or makes uncertain his/her ongoing parental support or care; there is no minimum time period used to establish continued absence. The agency shall obtain, and the applicant shall provide, all available facts serving to establish a continued absence.

Upon an absent parent's return to the home, AFDC shall continue, if need exists, for one month following the month of his/her return.

Where continued absence exists:

A. The applicant/recipient shall assign to the state his/her rights to any support from any other person. The assigned rights shall include support owed to the applicant/recipient on his/her own behalf and support owed on behalf of any other family member whose needs are included in the AFDC grant. The assignment shall not give to the state the right to agree to a reduction in the support being assigned or to a lump sum compromise or settlement of support due in the future. The maximum amount of the assigned support that shall be retained by the state shall be an amount equal to the total assistance expenditures.

B. The applicant/recipient must be referred to the child support unit.

C. The applicant/recipient must cooperate in establishing paternity or obtaining support. The child support unit shall not attempt to establish paternity in cases involving incest or forcible rape, or in any case in which legal proceedings for adoption are pending if, in the opinion of the income maintenance unit, it would not be in the best interest of the child.

D. If an applicant or recipient fails to assign rights to support or to cooperate in establishing paternity or obtaining support, an AFDC grant shall be provided only for the child/children through protective or vendor payments. The needs of the caretaker shall not be deleted, nor protective or vendor payments instituted, if the caretaker demonstrates good cause that establishing paternity or obtaining support is not in the best interest of the child. The conditions of good cause as stated in federal regulations shall be applied.

Statutory Authority: *MS s 256.01 subd 4*

9500.0080 ELIGIBILITY FACTOR: UNEMPLOYED FATHER (AFDC-UF).

Subpart 1. **Definition.** An "unemployed father" is a father:

A. whose family is in need;

B. who is not unemployed due to a labor dispute;

C. who works less than 100 hours per month;

D. who has not been fully employed for 30 days prior to the receipt of AFDC-UF;

E. who has not refused or quit employment except for good cause, within 30 days prior to the receipt of AFDC-UF;

F. who has not been fired from his job within 30 days prior to the receipt of AFDC-UF;

G. who is currently registered with the local job service office of the Department of Economic Security and is available for training and/or employment; and

H. who has:

(1) worked at least six quarters during any 13 calendar quarters ending within one year prior to the date of application; at least $50 per quarter must have been earned during this period or the father must have been in an approved work-and-training program; or

(2) received or could have qualified for unemployment compensation during the year prior to application for AFDC-UF.

Subp. 2. **Good cause.** "To refuse or quit employment or training except for good cause" means that an individual refused or quit employment or training, or the offer of employment or training, which he was physically and technically able to perform, which was not excessively hazardous, for which transportation was available, and which paid the prevailing wage in the community for that type of work, but not less than the minimum wage.

Subp. 3. **Assistance and unemployment insurance.** An unemployed father and family shall be eligible to receive AFDC-UF and unemployment insurance concurrently, provided that the unemployed father applies for and accepts any unemployment insurance to which he is entitled. All unemployment insurance benefits received by the unemployed father must be subtracted from the amount of aid otherwise payable to the AFDC assistance unit. Ineligibility for AFDC for the whole family shall exist for any week for which the child's father qualifies for unemployment insurance, but refuses to apply for or accept these benefits.

Subp. 4. **Non-WIN counties and AFDC-UF eligibility.** To continue AFDC-UF eligibility in non-WIN counties, the father must reregister with the local job service office of the Department of Economic Security every 30 days, and actively seek employment or enroll in a work training program or the entire family is ineligible. In WIN counties he must register for WIN (see part 9500.0320).

If the father quits or refuses an offer of employment or training without good cause he shall no longer be considered registered in a non-WIN county and the entire family shall become ineligible to receive AFDC payments for so long as the father refuses a bona fide offer of employment or training. See part 9500.0320 for sanctions in WIN counties.

Statutory Authority: *MS s 256.01 subd 4*

9500.0090 STEPPARENT.

A stepparent is a potential resource for the support of his/her stepchildren, but cannot be required to support them. If a stepparent chooses to support a stepchild, that stepchild's needs must be removed from the grant.

A stepparent shall be legally responsible for the support of his/her spouse; if the stepparent is unable to support the spouse and can document that fact, the spouse's needs may be included in his/her children's AFDC grant, assuming other eligibility conditions are met. To determine if the stepparent is unable to support his/her spouse, the amount of the stepparent's income, determined in the same way that an AFDC recipient's income is determined under part 9500.0110, shall be compared with the SSI payment level for one person; if the stepparent's income does not exceed this level, the spouse may be included in the AFDC grant, but any excess income shall be considered available for the support of the spouse.

Statutory Authority: *MS s 256.01 subd 4*

9500.0100 PROPERTY.

Subpart 1. **Types of ownership.** The owner of property in joint tenancy shall be considered as owning one-half of the value of such property, but the county or the joint tenant may establish legal interest of a greater or lesser amount. An owner of property as a tenant-in-common owns his/her pro rata share of the property's value. All other types of ownership shall be evaluated according to the law.

Subp. 2. **Transfers of property.** The transfer of real or personal property to establish or continue AFDC eligibility is contrary to public policy. Under this provision:

A. Each AFDC applicant shall be required to disclose whether he/she has transferred any property within the last year worth more than $500 for which a reasonable consideration was not received; this disclosure requirement shall apply to all AFDC recipients upon a redetermination of their eligibility.

B. Any property so transferred is a potential resource for the applicant or recipient, and the transferor must disclose the property's description and value, the names of the transferees, and the circumstances of the transfer.

C. The applicant or recipient must cooperate with the local agency in reasonable efforts to reacquire the property or its value; failure to cooperate in reasonable efforts to do so shall constitute grounds for termination or denial of assistance.

D. If the property cannot be reacquired, the matter must be referred to the county attorney for possible civil and criminal prosecution; the fact of transfer in itself shall not defeat AFDC eligibility.

Subp. 3. **Real estate.** The following limitations apply:

A. No AFDC recipient may own net equity in real estate used as a home which exceeds $15,000, unless the local welfare board waives such excess equity. The amount of net equity is the difference between the recipient's share of the property's market value and encumbrances on the property.

B. No AFDC recipient may own real property not used as a home (including properties being sold for contract for deed) unless the local welfare agency determines that the property produces net income applicable to the family's needs or which the family is making a continuous effort to sell at a fair and reasonable price. To determine net income from such property, taxes and maintenance expenses (but not principal payments of costs of improvement) shall be deducted from the gross income of the property.

C. In deciding if the property limits of item A should be waived, the local board shall determine if such real estate is available for the support of the family or if the sale of such property would cause undue hardship. If so, then the excess shall be waived.

D. The total real property (except for that used as a home and that which is income-producing) plus all excluded and nonexcluded personal property (except the earnings of a child being saved for educational needs) shall not exceed the limits established in federal regulations.

Subp. 4. **Personal property.** The following limitations apply:

A. No AFDC recipient may own personal property the value of which is more than $300 if one child is included in the grant, or $500 if more than one child is included in the grant.

B. The provisions of item A shall not apply to household goods, furniture, clothing, burial lots, mobile homes used as a home, or personal items; the limits of item A may be exceeded where the excess is:

(1) derived from a child's earnings and is designated for specific educational needs of the child, and is in an amount reasonable for that need, and is held in a separate account; and/or

(2) is designated for a specific purpose (such as real estate taxes or other large expenses), will be eliminated yearly, and does not exceed $500; and/or

(3) is legislatively disregarded payment (such as some Indian tribal payments); and/or

(4) is due to an income tax refund received within the preceding three months.

C. A recipient may build his/her personal property to limits set forth in item A as long as all his/her nonexempt income has been reported and counted in determining the amount of his/her grant.

D. Income producing personal property shall be exempt from limits of item A. This includes tools, implements (trucks, tractors), and domestic animals.

E. One automobile, the market trade-in value of which does not exceed $1,650, shall be excluded in determining the personal property resources of all applicants/recipients. Market value shall be its current National Automobile Dealers Association (NADA) trade-in value. If client disagrees with NADA value, local agency evaluation shall be used. If the market trade-in value exceeds $1,650 the automobile shall be excluded if client is employed, in training for employment, actively seeking employment, temporarily unemployed due to illness or injury and has a definite plan to work, or the automobile is needed to obtain necessary medical care. "Medical care" shall mean the person or a member of such individual's immediate family has a medically diagnosed mental or physical condition which requires continued inevitable or unavoidable medical attention.

If the market trade-in value exceeds $1,650 and none of the exceptions are applicable, the automobile's equity (when added to the value of nonexempt personal property owned by the recipient) must be within the personal property limits for the family. Equity shall be NADA trade-in value minus encumbrances.

Subp. 5. **Life insurance and trust funds.** A recipient unit may retain life insurance policies with total cash surrender values of not more than $500 without defeating AFDC eligibility.

A trust fund whose beneficiary is a dependent child shall be subject to the property limits of this rule unless it can be demonstrated that the fund cannot be made available for the child's support.

Subp. 6. **Prepaid burials.** An AFDC recipient may have a prepaid burial contract which does not exceed $750 for each family member plus $200 in accrued interest. The funeral director must be the trustee of any such burial contract and a recipient must be the beneficiary, or a trust account specifically designated for funeral costs may be established by the funeral director and recipient jointly.

Subp. 7. **Report of property appreciation.** Personal property which has increased in value beyond the limits of this part must be reported to the agency. Such property will not defeat AFDC eligibility if the applicant/recipient within 15 days of notice by the county agency:

A. converts the excess to an excluded type of property;

B. uses the excess to repay the county for assistance already received;

C. uses the excess to reduce his/her grant for one month; or

D. uses the excess to meet all his/her needs for up to three months, thereby suspending his/her grant for those months.

Subp. 8. **Property limits for other programs.** The resources of an SSI recipient shall be exempt in determining AFDC eligibility. In any family situation in which some members are eligible for AFDC and any other members are eligible for Minnesota supplemental aid (MSA) or general assistance (GA), the property limitations in the program involved that has the least restrictive

eligibility maxima will apply to the extent allowed by law.

Statutory Authority: *MS s 256.01 subd 4*

9500.0110 INCOME.

Subpart 1. **Definition.** Generally, "income" is any benefit received by and available to an AFDC recipient as earnings or otherwise. Income may be earned or unearned. In family groups living together, the income of a spouse shall be considered available to his/her children under age 21. All income, except noncash items provided free of cost and other items specifically disregarded in this part, must be evaluated in determining the need of AFDC recipients. Real or personal property which has been converted to cash shall be treated within the property standards stated in part 9500.0100, subpart 4, not as newly received income.

Subp. 2. **Exclusions.** The following income is not considered a resource for AFDC purposes:

A. inconsequential income (amounts up to $30 per month providing such amount is less than the grant);

B. reimbursement for the maintenance costs incurred in providing foster care;

C. WIN work and training allowances;

D. non-WIN training allowances received as a social service expense;

E. food stamp bonuses;

F. Comprehensive Employment and Training Act incentive payments;

G. home-produced foods used in the home;

H. reimbursement for out-of-pocket expense incurred for volunteer work;

I. corrective payments from the local agency;

J. assistance under the Uniform Relocation Act of 1970;

K. Indian tribal payments specifically exempted by Congress;

L. loans and grants, such as scholarships, obtained and used under conditions that preclude their use for current living costs;

M. any grant or loan to any undergraduate student for educational purposes made or insured under any programs administered by the United States commissioner of education;

N. Vietnam veteran's bonuses authorized by law;

O. benefits under titles VI or VII of the Older Americans Act of 1965;

P. federal and state income tax refunds, (annual tax refunds shall not be considered available income; availability of income shall be determined at the time income is earned; determination of currently available income shall require assessment and disregard of the amount of tax obligation incurred at a given level of current monthly income; the amount withheld from wages, for various reasons, may exceed the amount of tax obligation; when the excessive amount withheld is returned in the form of a tax refund, the amount of the tax refund shall be disregarded; the availability of that income has been previously assessed);

Q. federal payments for presidentially declared disaster areas when specifically identified in federal law;

R. volunteer payments under titles II and III of the Domestic Service Act of 1973;

S. assistance through the National School Lunch and Child Nutrition Act amendments of 1973;

T. allowances and expenses paid by vocational rehabilitation;

U. other income disregards as mandated by federal or state law;

V. earnings received by any youth under title III, part C, Youth Employment Demonstration Program of the Comprehensive Employment and Training Act of 1973 (Public Law Number 93-203) is to be disregarded; and

W. Minnesota property tax credits or refunds received by a recipient who does not receive a housing allowance pursuant to part 9500.0220 shall be excluded.

Subp. 3. **Allocation of income.** The following limitations apply:

A. Before applying income to need, income may be allocated from spouse to spouse and from parents to children under age 21 if such person resides with the AFDC recipient and is in need.

B. The income and resources of an SSI recipient shall not be counted in determining the AFDC recipient's income.

C. Trust funds for a particular person or purpose shall not be allocated to the family until that person's needs or the particular purpose are met; only legally restricted trust funds shall be excluded.

D. Retirement, survivors, and disability insurance (RSDI) payments are considered family income unless they are paid on behalf of a child who is excluded from the grant.

E. Income from jointly held property shall be allocated according to the share of ownership and availability to AFDC recipients.

Subp. 4. **Allocation prohibition.** Income cannot be allocated to meet past obligations. See 12 MCAR S 2.053.

Subp. 5. **Income determination during period of eligibility.** During the period of eligibility, the county may determine income and work expenses monthly or average them over a three-month period.

Subp. 6. **Unexcluded income minus deductions.** All unexcluded unearned income and earned income minus allowable deductions must be applied against the AFDC standard.

Subp. 7. **Averaging income.** Income averaging shall involve use of three months of income to establish assistance for three months; actual income variations shall be ignored when income averaging is used unless a significant change requires a stop in the averaging cycle. Significant changes are: a decrease in total income (disregard, available income, and grant) to less than the need standard; an increase in net income which would result in ineligibility; termination of employment; a change in net income totaling more than a $50 difference from the average in a given month, except when the difference is due to calendar fluctuations causing receipt of an extra paycheck, and except when the agency reconciles the budget at the end of the averaging period. When income is averaged or budgeted monthly, monthly equivalent income shall be established by one of the following methods: by multiplying weekly income by 4.3, biweekly income by 2.16, and semimonthly income by 2, or by using any method resulting in an accurate reflection of total monthly income.

Subp. 8. **Earned income.** The following limitations apply:

A. Generally, earned income shall include any compensation from employment or self-employment (wages, salary, tips, commissions, profits, etc.), plus training incentive payments and work allowances under the Equal Opportunity Act and title I of the Elementary and Secondary Education Act.

B. Thirty dollars plus one-third of the remainder of the family's total earned income shall be disregarded unless a family member has terminated or refused employment, or reduced earned income without good cause within the preceding 30 days (in which case the disregard shall not be applied for one month to the earnings of that individual); this disregard shall not apply to income from WIN public service employment.

C. The earned income of a child under age 14 shall be excluded.

D. The earned income of a child over age 14 who is a full- or part-time student (but not employed full time) in a high school, college, university, vocational or technical courses shall be excluded; the earnings of the student shall be considered in determining initial eligibility and afterward, excluded.

E. In new applications, the $30 and one-third earned income disregard shall not be applied to earned income unless the applicant's needs were met, in whole or in part, by AFDC in any of the four months preceding the month of application.

Subp. 9. **Employment expense deductions.** The following employment expenses shall be deducted in determining net earned income:

A. Federal and state income tax obligation. The expense of employment at a given level of income is the tax obligation incurred. In determining net income which is currently available, the amount of the tax obligation incurred at current monthly income is used. The amount of monthly tax obligation is displayed on tables developed and published by the Department of Human Services. At client's request, a reconciliation shall be performed to determine whether client's tax obligation for a past tax year has been understated. Any understatement discovered shall be corrected by a supplementary payment to the client.

B. FICA and SMI payments.

C. Child care costs, unless these are paid as a social service, or paid to a relative included in the AFDC grant, or paid to a relative who is financially responsible for the family and able to contribute to it. Child care costs paid to a parent may not be deducted in determining net income.

D. Business expenses, except depreciation.

E. Personal expenses in the manner described in parts 9500.0110 to 9500.0130.

Subp. 10. **Personal expenses of employment.** Personal expenses of employment shall be recognized by deducting ten percent of gross income up to a maximum of $60. If the client requests that actual expenses be recognized in lieu of the standard deductions, the following expenses shall be deducted, if incurred, necessary, and reasonable:

A. mandatory retirement fund deductions;

B. transportation costs to and from work based on the actual cost of public transportation or car pool payments, or 13 cents per mile for the actual number of miles driven, not to exceed 100 miles per day of employment; no-fault insurance is included in the 13 cents per mile;

C. cost of work uniforms;

D. union dues;

E. professional association dues required for employment;

F. health insurance premiums;

G. cost of tools and equipment used on the job;

H. one dollar per day for the cost of meals eaten during employment;

I. public liability insurance required by the employer when an automobile is used in employment and the cost is not compensated for by the employer.

Subp. 11. **Income from small businesses.** Income from small businesses is the difference between gross receipts and business costs. Capital expenditures and depreciation are not a business cost. Those expenses which are allowable as personal expenses of employment under subpart 10, items A to I shall not be allowed as business expenses.

Subp. 12. **Farm income.** Farm income is the difference between gross receipt (sales, rents, soil conservation payments) and operating expenses. Home-produced foods for sale are included. Capital expenditures are not included as an operating expense.

Subp. 13. **Income from child care.** Income from child care in the home shall be 40 percent of gross receipts. The client may rebut this presumption by documenting actual business expenses in conformance with IRS schedule C and the limitations in subpart 11, in which case income shall be gross receipts minus actual business expenses.

Subp. 14. **Income from roomers and boarders.** Income from roomers and boarders is computed by allowing $58 per month for each border, $48 per month for each roomer, or $105 per month for each roomer and boarder, as the expenses of producing this income.

Subp. 15. **Miscellaneous income.** Unearned income is not the direct result of labor performed by the recipient as an employee. Receipt of SSI shall be a bar to receipt of AFDC. Serviceperson's income shall be counted after deducting the amount needed for the serviceperson's clothing, personal needs, and transportation, but cannot be greater than the amount actually received by the family.

Subp. 16. **Rental income.** Rental income is unearned income unless there is labor expended in obtaining the income from rental property. Sixty-nine dollars shall be deducted per year or two percent of market value (whichever is less) for upkeep and repairs, and taxes, insurance, utilities, and interest on principal payments shall be deducted. Where the recipient lives on the property, these expenses shall be allocated according to the number of rooms.

Subp. 17. **Lump sums and windfalls.** Unless otherwise excepted, lump sum payments and windfalls shall be unearned income in the month received and shall be considered property thereafter.

Statutory Authority: *MS s 256.01 subd 4*

NOTE: 12 MCAR section 2.053 has been repealed.

History: *L 1984 c 654 art 5 s 58*

9500.0120 CITIZENSHIP STATUS OF RECIPIENTS.

An AFDC recipient must be a U.S. citizen, an alien lawfully admitted for permanent residence, or a continuous U.S. resident since July 1948.

Statutory Authority: *MS s 256.01 subd 4*

9500.0130 SOCIAL SECURITY NUMBERS REQUIRED.

Social Security numbers of all caretakers included in the grant must be provided to the county agency as a condition of eligibility, but assistance shall not be denied where a number has been requested from the Social Security Administration, but not received. Failure to cooperate shall result in deletion of the caretaker's needs and protective/vendor payments shall be issued for the children.

Statutory Authority: *MS s 256.01 subd 4*

9500.0140 STANDARDS OF NEED.

The need standards set forth in parts 9500.0140 to 9500.0240 shall be used to determine the grant for every AFDC family in Minnesota, except AFDC-FC.

Statutory Authority: *MS s 256.01 subd 4*

9500.0150 DEFINITIONS OF STANDARDS.

Subpart 1. **Eligible person.** An "eligible person" is one who is eligible for and receives AFDC; in most circumstances it means one caretaker relative and the dependent children he/she cares for. More than one caretaker may be included when eligibility is based on parental incapacity or unemployment of the father. All "eligible persons" receiving one AFDC grant constitute one "recipient unit."

Subp. 2. **Children standard.** The "children" standard shall apply to all members of a recipient unit except the caretaker or other adult.

Subp. 3. **First adult standard.** The "first adult" standard shall apply to the caretaker relative.

Subp. 4. **Second adult standard.** The "second adult" standard shall apply to an adult member of the recipient unit who is in addition to the caretaker.

Statutory Authority: *MS s 256.01 subd 4*

9500.0160 GRANT AMOUNT DETERMINATION.

To determine the grant amount for an eligible family, the appropriate amount for the children from the standard shall be added to the amount for an adult(s) from the standard, if applicable, to arrive at the grant amount.

Statutory Authority: *MS s 256.01 subd 4*

9500.0170 RECIPIENT UNIT.

A family composed of individuals with varying bases of eligibility but living together as a unit shall constitute one recipient unit. This does not apply when two eligible adults share shelter without a marital bond.

Statutory Authority: *MS s 256.01 subd 4*

9500.0180 MINOR CHOOSES MANNER OF DETERMINATION.

In family groups in which there is an adult caretaker(s), a minor, and a child of the minor, the minor shall have the choice as to which way the grant shall be determined:

A. the minor and her child may be included in the adult caretaker's grant;

B. the minor and her child may receive a separate grant; or

C. the minor may continue in the adult caretaker's grant and the child of the minor shall receive a separate grant.

Statutory Authority: *MS s 256.01 subd 4*

9500.0190 FAMILY ALLOWANCES.

Eligible Persons	Children Standard	
1	171	
2	235	
3	295	
4	348	First Adult standard: 129
5	399	
6	451	
7	495	Second Adult standard: 51
8	540	
9	578	
10	614	
Each person		

above 10 add	37

Statutory Authority: *MS s 256.01 subd 4*

9500.0200 AMOUNT OF GRANT.

The amount of the AFDC grant for a recipient unit is the difference between the standard of need as determined by the table in part 9500.0190 and the recipient's nonexempt, nondisregarded income (see parts 9500.0110 to 9500.0130).

Statutory Authority: *MS s 256.01 subd 4*

9500.0210 SPECIAL NEED ITEMS.

Subpart 1. **In general.** The local agency shall provide funds for certain special needs of AFDC recipients as specified below. Allowances for these items shall receive prior authorization from the local agency. The payment shall be issued directly to the recipient, unless he/she elects to sign a request to have payment issued directly to the vendor.

Subp. 2. **Major home repairs.** The local agency shall provide payment for costs of major home repairs if the home is owned and lived in by the recipient; if the need for repair is documented to the local agency's satisfaction; if such expenditures are within reasonable limits in relation to overall condition of dwelling and available alternative housing. Major home repairs allowed as special need items shall include repairs to the home's roof, foundation, wiring, heating system, chimney, and plumbing. The recipient shall provide the local agency with a vendor's written estimate for repairs and the agency may require up to two additional estimates when it deems the first estimate excessive. There shall be no maximum allowance established for major home repairs.

Subp. 3. **Replacement or repair of essential major appliances and household furnishings.** Costs up to agency maximums for replacement or repair of essential major appliances and household furnishings shall be authorized if the need for such replacement or repair is established to the local agency's satisfaction and any existing rental agreement does not establish that such item, in good repair, is to be provided by landlord/lessor. The local agency shall inform the recipient of the maximum agency allowance for the item and the recipient's free choice to apply such allowance to either repair or replacement of the item. If the recipient elects to repair a major appliance, he/she shall provide the local agency with a vendor's written estimate for repairs. The local agency may require up to two additional estimates when it deems the first estimate excessive. The recipient may supplement the agency's maximum allowance if he/she so chooses.

A. Major household appliances repair/replacement. Major household appliances covered and agency maximum allowances shall be as follows:

(1) cooking stove or range, $55;

(2) refrigerator, $64;

(3) washing machine, $64;

(4) dryer, $64; and

(5) water heater, $128.

B. Household furnishings repair/replacement. Essential household furnishings covered and agency maximum allowances shall be as follows:

(1) kitchen table, $17;

(2) kitchen chair, $7;

(3) couch, $51;

(4) living room chair, $7;

(5) lamp, $9;

(6) chest of drawers, $18;

(7) crib and mattress, $34;

(8) high chair, $11;

(9) living room table, $7;

(10) bed, full size complete, $81; mattress or box spring only, $34; frame only, $13;

(11) bed, twin size complete, $51; mattress or box spring only, $19; frame only, $13; and

(12) bedding (includes blanket, pillow and case, sheets), $14.

Subp. 4. **Medically prescribed diets.** Costs for medically prescribed diets shall be authorized if they are prescribed by a physician and add expense to a normal diet. The following diets shall not be authorized: diets which are paid for by the medical assistance program, reducing or low caloric diets (1,800 calories or less), sodium restricted diets (1,000 mg sodium), diabetic diets (1,800 calories or less), fat-controlled diets (55 mg fat or less) and bladder, ulcer, low residue or low fiber diets which prescribe only soft food or prescribe special food preparation.

Subp. 5. **State appropriation.** Each quarter the state appropriation for special needs shall be allocated among the local agencies on the basis of caseloads. Unused funds shall be reallocated at the end of the fiscal year.

Statutory Authority: *MS s 256.01 subd 4*

9500.0220 HOUSING ALLOWANCE.

An AFDC allowance for a portion of housing costs attributable to the local property tax will be provided to individuals who have not received such payment under the Minnesota Property Tax Refund Act. The amount of the allowance shall be the same as that paid under the Property Tax Refund Act.

Statutory Authority: *MS s 256.01 subd 4*

9500.0230 FUNERALS.

The local agency shall pay the funeral expenses of AFDC recipients (not exceeding $370) and actual cemetery charges, unless the deceased's estate or surviving spouse and children are able to pay. The local agency's payment shall not be limited by additional payments for or donation of a cemetery lot, interment, religious service, and transportation of the body to or from the community of the deceased's residence.

The state shall reimburse the county for 50 percent of the funeral expenses not exceeding $370, under this provision, and the county shall have a prior claim against the deceased's estate for the amount of the payments made hereunder.

Statutory Authority: *MS s 256.01 subd 4*

9500.0240 PAYMENT METHODS.

Subpart 1. **Money payments.** In usual circumstances, AFDC payments shall be made by monthly check to the AFDC recipient. The initial grant shall be retroactive to the first day of the month of application when all eligibility factors were met in that month. The county shall impose no restrictions on the use of the grant. A money payment for one time only may be made to someone acting on behalf of the caretaker in an emergency situation. Recipients may elect to have their monthly food stamp purchase requirement withheld from the assistance check.

Payment shall be made only to the address at which the recipient resides, unless another address has been approved in advance by the local agency. Box numbers shall not be sufficient as addresses unless:

A. prior agency approval has been received for their use; or

B. box numbers are used in the community as the usual means of mail delivery.

Failure to comply with this provision shall be a sufficient ground for termination of the grant.

The issuance of duplicate checks shall be in accordance with the provisions of Minnesota Statutes, section 471.415.

Subp. 2. **Protective and vendor payments.** A protective payment is one made to someone other than the recipient; a vendor payment is one made to a provider of goods and services.

Protective and vendor payments shall be made only in the following cases:

A. when a recipient fails to participate in WIN or during the 60-day counseling period (see part 9500.0320);

B. when the caretaker fails to assign support, furnish or obtain Social Security numbers for himself/herself, or cooperate in establishing paternity or obtaining support; or

C. when the caretaker's continued mismanagement of funds causes hardship for the children. If this situation persists for more than two years, the agency shall take steps to establish a guardianship or other arrangements for the children.

Protective and vendor payments because of money mismanagement shall not continue for more than two years and are subject to a fair hearing appeal by the recipient. Not more than ten percent of the total state AFDC recipients may be paid through protective and vendor payments under this provision.

When protective and vendor payments because of money mismanagement are required, the local welfare board shall approve the payment method selected before it is implemented, and shall review it at least quarterly.

Protective payments cannot be made to the local welfare director or welfare board members, or to landlords, grocers, or other vendors (who can receive vendor payments); a local agency staff member can be the protective payee for cases other than those in his/her own caseload if no other suitable payee can be found.

As a WIN sanction, protective and vendor payments shall be made according to the above requirements for selection of payees. There shall be quarterly review of the payee's performance by the local agency; the recipient has the right to appeal the use of protective or vendor payments and the payee selected.

For cases subject to protective or vendor payments because of failure to obtain support or cooperate in establishing paternity, the requirements for the selection of protective payees and vendors and quarterly reviews by the local agency of the way in which the protective payee's duties are carried out must be met. The entire amount of assistance must be made as a protective or vendor payment.

Statutory Authority: *MS s 256.01 subd 4*

9500.0250 GRANT TERMINATION, SUSPENSION, AND REDUCTION.

Subpart 1. **Appealable actions.** AFDC applicants and recipients have the right to a fair hearing if they are aggrieved by action or inaction of the local agency. The following issues shall be appealable:

A. denial of application for assistance;

B. failure to act upon application within the prescribed time limits;

C. suspension of assistance;

D. reduction of assistance;

E. termination of assistance;

F. use of protective/vendor payments; and

G. referral by local agency to WIN for appraisal interview.

The foregoing items are meant to serve as examples only. An appeal shall also be authorized relative to any matter which is appealable based on state law

or federal law and regulation as they currently exist or as they may exist based on subsequent amendment.

Subp. 2. **Notice requirements.** The local agency must give the recipient timely, advance notice of a grant suspension, termination, or reduction. This notice must be in writing, mailed to the recipient at least ten days before the effective date of the action, and must clearly state what action the agency intends to take, the reasons for the action, the right to appeal the action, the conditions under which assistance can be continued, and any collateral consequences of the action (e.g., loss of food stamp or medical assistance eligibility). Five days shall be sufficient for timely notice where the agency has verified and documented that the case facts require grant action and the action is based upon probable fraud by the recipient.

The local agency must give the recipient adequate written notice, no later than the effective date of the action, when there is:

A. confirmation of the death of the recipient or payee;

B. a written statement by the recipient that assistance is no longer desired;

C. written information from the recipient that requires grant reduction or termination and the recipient understands that the change will occur; or when:

D. the recipient has been admitted to an institution; placed in skilled nursing or intermediate care or long term hospitalization;

E. the recipient has been accepted for assistance by another county;

F. the recipient has been placed in foster care; or

G. the recipient's whereabouts are unknown.

Subp. 4. **Effect of agency's action.** If the recipient appeals the agency's action before it is effected, the action shall not be effected until the appeal is decided by the local or state hearings process.

Statutory Authority: *MS s 256.01 subd 4*

9500.0260 INCORRECT PAYMENTS.

Subpart 1. **Underpayments.** Underpayments shall be adjusted through an additional or a supplemental payment to the grant; the agency need not correct underpayments made more than 12 months prior to the date of discovery of error.

Subp. 2. **Overpayments.** Overpayments caused by client or agency error shall be corrected through the process of recoupment or by the recipient's voluntary reimbursement. Voluntary reimbursements must be documented by the recipient's signed agreement and shall not be fulfilled through reduction of the grant. Overpayments caused by client error shall not be recouped unless the process is begun within a year after the agency learns of the overpayment. The process begins with the sending of the notice. Overpayments more than 12 months old when the agency learns of the error may not be recouped. Overpayment due solely to agency error shall be recoupable for the three months prior to the discovery if the client is notified in writing.

Subp. 3. **Recoupment.** Recoupment shall be made by deducting an amount up to one-half of the recipient's disregarded earnings from the AFDC grant until the overpayment has been corrected. Recoupment shall be made only from recipients who have disregarded earnings. If recoupment has been interrupted by termination of employment or assistance, the recoupment shall be resumed when the individual resumes AFDC and employment.

Subp. 4. **Scope of rule.** The provisions of this part regarding incorrect payments shall be applicable to cases involving recipient fraud or abuse.

Statutory Authority: *MS s 256.01 subd 4*

9500.0270 WRONGFULLY OBTAINED ASSISTANCE.

Subpart 1. **Statutory authority.** The legal basis for prosecution of fraud in the AFDC program is Minnesota Statutes, section 256.98.

Subp. 2. **Agency action.** The local agency director shall be responsible for securing appropriate action relative to any fraud allegation received. Appropriate action shall include:

A. issuing timely notice and taking grant action where warranted;

B. referring cases of suspected fraud to the agency investigative unit for necessary investigations; and

C. ensuring the referral of substantiated fraud to the county attorney for necessary legal action.

Subp. 3. **Continuation of grant.** If eligibility otherwise exists, a grant shall be continued at the established level when fraud is suspected or the case is under investigation for fraud.

Subp. 4. **Recovery.** Recovery in fraud cases may be based on client agreement, recoupment, or court order. A client's basic grant shall not, however, be reduced to meet the recovery obligation. Recoupment shall be applicable only in cases involving disregarded earnings and shall follow the procedures outlined above dealing with incorrect payments.

Subp. 5. **Statistics.** The local agency director shall be responsible for securing and reporting such statistical data on agency fraud prevention activities as the commissioner may require.

Statutory Authority: *MS s 256.01 subd 4*

9500.0280 RELATIVE RESPONSIBILITY.

Subpart 1. **Persons responsible.** Parents, grandparents, brothers, and sisters shall be responsible for the support of children on AFDC; spouses shall be responsible for the support of their spouses whose needs are included in an AFDC grant.

Subp. 2. **Effect of nonsupport.** Failure of responsible relatives to furnish support shall not render an individual ineligible for AFDC; the local agency shall take the steps outlined in these parts to seek support from responsible relatives whom it believes are able to contribute toward the needs of AFDC recipients.

If the responsible relative fails to contribute support after the local agency notifies him/her of his/her obligation to do so, the agency shall notify the county attorney or the commissioner of human services to take legal action against the relative.

Subp. 3. **Amount of support recoverable.** The amount of support recoverable from a responsible relative, other than the parent of a child under 18, shall not exceed the amount of AFDC assistance granted after the relative is notified of his/her obligation to support. Recovery shall apply only to the period following issuance of notice to contribute. However, the court can order a continuing contribution while the recipient continues to receive public assistance.

Statutory Authority: *MS s 256.01 subd 4*

History: *L 1984 c 654 art 5 s 58*

9500.0290 PARENTAL SUPPORT.

Subpart 1. **Amount of support.** The amount of support due from the absent parent of a child or the parents of a child in AFDC-FC shall be established by the court or through voluntary agreement by the absent parent and the local child support unit.

Subp. 2. **Availability of parental income.** Parental income shall be totally available for the needs of children under 18 and residing in the parental home. The ability of parent to support a minor, including one who is eligible for AFDC as a caretaker relative, shall be based upon a determination of parental income according to the procedures used in establishing AFDC eligibility for new applicants. All income in excess of the appropriate AFDC standard is available for the support of the minor.

Subp. 3. **Support from other responsible relatives.** The financial contribution of other responsible relatives, and the parents of caretakers under 18 and residing outside the parental home, shall be computed according to the relative responsibility scale.

Statutory Authority: *MS s 256.01 subd 4*

9500.0300 RELATIVE RESPONSIBILITY SCALE.

Size of Family	Annual Cost of Living (ACL)	Monthly Cost of Living
1	$ 5,304	$ 442
2	8,196	683
3	11,784	982
4	14,088	1,174
5	16,200	1,350

Twenty percent of the ACL for a family of five shall be added for each additional family member.

A. The gross income of the responsible relative shall be assessed against the above scale; taxes or employment expenses shall not be deducted.

B. "Size of family" means all persons who are in fact supported by the responsible relative (whether or not he/she is legally responsible for their support).

C. Other justified expenses (such as medical and educational bills, or housing costs exceeding 30 percent of the family's gross income) shall be deducted from the gross income.

D. If a minus balance remains, no contribution shall be expected. If a plus balance remains, one-third of the amount shall be the expected contribution.

Statutory Authority: *MS s 256.01 subd 4*

9500.0310 CHILD SUPPORT AND PATERNITY.

Every AFDC applicant and recipient shall be required to furnish information (including court testimony) needed by the local agency to obtain child support payments, locate absent parents, establish paternity, and obtain support from responsible relatives.

If a caretaker relative fails to cooperate with the above requirements, his/her needs shall be deleted from the grant and the eligible children shall be furnished assistance through protective or vendor payments.

If a court orders child support paid by an absent parent, the local agency shall petition the court for an order directing that all such payments be made to the local welfare board until AFDC assistance stops.

The regulations and procedures of title IV-D of the federal Social Security Act shall be applied in the collection of support and establishment of paternity.

Statutory Authority: *MS s 256.01 subd 4*

9500.0320 WORK INCENTIVE PROGRAM (WIN).

Subpart 1. **Registration requirements.** All AFDC applicants and recipients residing in WIN counties (who are not exempted below) must register for WIN as a condition of eligibility.

Subp. 2. **Exemptions.** The following persons shall be exempted from WIN registration:

A. Children under age 16.

B. Children age 16 through 18 attending school full time.

C. Persons who are ill.

D. Persons who are incapacitated; if WIN exemption is based on incapacity a referral to the Division of Vocational Rehabilitation is mandatory. Note: the local agency may require a physical examination to confirm illness or incapacity.

E. Over age 65.

F. Persons who live so far away from a WIN project that more than a ten-hour day (employment plus commuting time) would be required to participate.

G. Persons whose presence in the home is needed because of the illness or incapacity of other persons.

H. A caretaker of a child under age six. Only one such exemption is allowed per family. In AFDC-UF cases, either parent may elect to claim this exemption.

I. The spouse of a WIN registrant.

Subp. 3. **Refusal to register.** If a required WIN registrant refuses to register, his/her needs shall be deleted from the AFDC grant; if the only dependent child over age 16 and not in school in a family refuses to register, the entire AFDC grant for the family will be denied or terminated. If the father in an AFDC-UF case refuses to register, or if he refuses a bona fide offer of employment or training without good cause, the entire family is ineligible for AFDC-UF.

Subp. 4. **Right to contest registration requirement.** An AFDC applicant or recipient may contest the requirement that he/she register for WIN through the fair hearing procedure.

Subp. 5. **Definition: Failure to participate in WIN.** "Failure to participate in WIN" means:

A. failure to attend the WIN appraisal interview;

B. failure to accept child care plans for the WIN program;

C. failure to participate in job service office of the Department of Economic Security activities;

D. failure to accept employment or training; or

E. failure to remain in employment.

If a WIN registrant fails to participate in WIN, WIN job service office of the Department of Economic Security shall provide him/her an opportunity to contest whether or not this failure was for good cause; the decision of this hearing shall not be appealable to the commissioner of human services and the result shall be binding on the local welfare agency. If the hearing opportunity is not taken, or if the failure to participate is found to be without good cause, WIN will provide the individual with a 60-day counseling period to correct the situation.

Subp. 6. **Sanctions.** If an individual is found to have failed to participate in WIN, the following sanctions shall apply:

A. If the individual is the only dependent child in an AFDC family, assistance for the entire family shall be terminated; if the individual is one of several dependent children in an AFDC family, his/her needs shall be deleted from the AFDC grant. In AFDC-UF, if the father refuses to accept a bona fide

offer of employment or training without good cause, he shall be considered deregistered and the entire family shall be ineligible unless the individual is undergoing the 60-day counseling period which is described in item B.

B. If the individual is the caretaker of AFDC children, his/her needs shall be excluded from the grant and assistance to other family members will be provided through protective or vendor payments. If the individual is undergoing the 60-day counseling period his/her needs will not be removed from the grant; however, assistance to the family shall be provided in the form of protective or vendor payments. These sanctions shall not apply to persons who are voluntary WIN registrants.

Subp. 7. **Reregistration for WIN.** An individual who has been found to have failed to participate in WIN without good cause must wait 90 days after his/her AFDC benefits are terminated to reregister for WIN; if an individual has twice failed to participate in WIN without good cause, he/she must wait six months to reregister. WIN may reaccept any such reregistrant whose prior failure to participate was the result of criminal or other activities which presented a hazard to WIN staff or other WIN participants.

Subp. 8. **WIN exclusions from income.** A WIN participant's monthly $40 training allowance and $30 incentive payment shall be disregarded as income in computing the AFDC grant.

Subp. 9. **Public service employment.** Public service employment (WIN/PSE) shall not be subject to the $30 plus one-third disregard.

Subp. 10. **On-the-job training.** On-the-job training (WIN/OJT) shall be subject to the $30 plus one-third disregard plus employment expenses. If the recipient is on AFDC-UF, the 100-hour rule shall apply.

Statutory Authority: *MS s 256.01 subd 4*

History: *L 1984 c 654 art 5 s 58*

9500.0330 EMERGENCY ASSISTANCE FOR FAMILIES WITH CHILDREN UNDER AGE 21 (AFDC-EA).

Subpart 1. **Definition.** Emergency assistance is immediate financial aid for AFDC families and other families in situations that place a child and any other member(s) of the family in jeopardy and cannot be resolved with the family's current resources. Examples of emergencies are natural and civil disorders, illness, accident, death, threat of eviction, etc.

Subp. 2. **Eligibility.** Emergency assistance shall be granted only to a family which includes a child under age 21 who is, or within six months prior to application has been, living with a relative eligible as an AFDC caretaker, and which is completely without resources to solve the emergency. It shall not be available to persons or on behalf of children over age 16 and not in school who have refused employment or training without good cause.

Subp. 3. **Allowable need items.** Emergency assistance shall cover payment for food, shelter, clothing, fuel and utilities, medical care, and child care. It may also cover moving expense, major home repairs and major furniture and appliance replacement, replacement of furnace, roof, plumbing, or electrical systems, if authorized by the local agency before the expense is incurred.

Emergency assistance shall be available when the proceeds of cashed AFDC checks are lost or stolen; the theft must be reported to the police and the local welfare agency in the form of an affidavit. It shall not be available when uncashed AFDC checks are lost or stolen; in such cases, the lost or stolen AFDC funds shall be replaced in accordance with the provisions of part 9500.0240.

Subp. 4. **Emergency assistance payments.** The amount of emergency assistance shall be based on the AFDC standard and the state standard for special need items; if this sum is insufficient to meet need, the AFDC-EA

allowance shall be based on cost. Payments may be made as money, vendor payments, payments in kind, or in the form of interest free loans up to $100 for employment expenses.

AFDC-EA shall be granted only for one consecutive 30-day period in one consecutive 12-month period; needs which accrue prior to the 30-day period may be met only when necessary to resolve the current emergency situation (e.g., back rent or utility payments). Assistance may be extended for up to 30 days beyond the 30-day base period, if authorized during the base period.

Each local agency shall designate at least one staff member to authorize immediate AFDC-EA grants.

Statutory Authority: *MS s 256.01 subd 4*

9500.0340 AFDC-FOSTER CARE (AFDC-FC).

Subpart 1. **Eligibility.** AFDC-FC shall be available for children placed by judicial action in foster homes or private nonprofit child caring institutions. All such institutions, homes, and agencies must be licensed for child caring. Payments for foster or institutional services may be made to cooperating public or private agencies for care given in foster homes or nonprofit private child care institutions.

AFDC-FC shall not be available when the child lives with a relative who is legally liable for support. AFDC-FC shall be paid to nonlegally responsible relatives who are licensed or approved as foster care providers.

AFDC-FC shall be available only for children eligible for ordinary AFDC during the month in which judicial proceedings are started, or who would have been eligible during the prior six months and if they had lived with an eligible relative.

Subp. 2. **Petition for parental contribution.** AFDC-FC shall be available whether or not parental support is available; the local agency shall petition the juvenile court for an order requiring the parents to contribute to the child's support.

Subp. 3. **Payments made to provider.** AFDC-FC will be paid to the foster home parent or institutional care representative, as the provider of care, not as the payee.

Statutory Authority: *MS s 256.01 subd 4*

9500.0350 AFDC FOSTER CARE RATES (AFDC-FC).

Subpart 1. **Application of rates.** The rates for AFDC-FC shall be applicable to foster and group homes and child care institutions. In no circumstances can rates paid to institutions include overhead costs.

Subp. 2. **Mandatory statewide rates (basic).**

Age	Basic Rate		Initial Clothing
	Monthly	Per Diem	
0-3	$123	$ 4.10	$ 56
4-8	156	5.20	83
9-11	172	5.73	110
12-14	206	6.87	193
15-18	225	7.50	221

The initial clothing allowance shall be available at the time of the initial application and each reapplication. The care rate includes food, clothing, shelter, physical attendance, and supervision, and transportation. Additional payments may be made for specific social services provided by the foster home or child care institutions. Additional payments shall not be made to supplement maintenance costs.

Subp. 3. **Additional maintenance needs.** In addition to the basic rate, monthly payment for additional maintenance needs, as determined by the local agency, may be made. The additional care rates shall be determined by adding the points assigned to each level and type of care required by the child. No more than 175 points may be designated for each child.

Subp. 4. **Difficulty of care schedule and rates.**

	A	B	C	D	E
Emotional	5	15	30	60	175
Physical	5	15	30	60	175
Auxiliary	5	10	15	60	

Points	Monthly	Daily
5	$ 34	$ 1.13
10	45	1.50
15	57	1.90
20	68	2.27
25	80	2.67
30	91	3.03
35	103	3.43
40	114	3.80
45	126	4.20
50	138	4.60
55	149	4.97
60	161	5.37
65	172	5.73
70	184	6.13
75	195	6.50
80	207	6.90
85	218	7.27
90	230	7.67
95	242	8.07
100	253	8.43
105	265	8.83
110	276	9.20
115	288	9.60
120	299	9.97
125	311	10.37
130	322	10.73
135	334	11.13
140	345	11.50
145	357	11.90
150	369	12.30
155	380	12.67
160	392	13.07
165	403	13.43
170	415	13.83
175	426	14.20

A. Emotional.

Level A: These are children who periodically exhibit excessive dependency, passivity, lack of responsiveness, and the inability to relate.

Level B: Children at this level require abnormal amounts of attention and affection, and have need for a regimental program, such as behavior modification. Such children often have school problems, difficulty with peers, moodiness, and frequent enuresis. Foster parents often have to provide an

abnormal amount of structure (e.g., constant repetition and follow through on instructions).

Level C: These children exhibit extreme attention-seeking behavior, stealing, drug use, encopresis, destructive behavior, extreme hyperactivity, sexual acting-out, running away, withdrawal, etc.

Level D: These children show extreme bizarre behavior, and may be self-destructive and require exceptional care.

Level E: Children at this level show severely disturbed behavior, such as frequent running away, depression, attempted suicide, fantasizing, or inappropriate behavior. They may be dangerous to themselves or others, and cannot be maintained in a normal family setting.

B. Physical.

Level A: These children need some help with putting on braces or prosthetic devices, some help with buttons, laces, etc., but are basically self-caring.

Level B: These children need help with dressing, bathing, and general toilet needs, as well as some help in ambulation. They exhibit feeding problems such as excessive intake, or are extremely slow and/or messy requiring help and/or supervision due to retardation or emotional or physical handicap. They may need tube or gavage feeding. They may need physical therapy, under one hour per day.

Level C: These children need appliances for drainage or ileal conduit, or a colostomy. They may need aspiration, suctioning, mist tent, etc. They are nonambulatory, needing constant attendance, and/or prescribed physical therapy, 1-2 hours per day, by foster parent.

Level D: These children require custodial care, and physical therapy 2-3 hours per day. They may have uncontrollable seizures.

Level E: Due to the severity of their physical handicap, these children are unable to tolerate a normal family setting and require ongoing care. Such children possibly need 24-hour supervision.

C. Auxiliary.

Level A: These children require special diets or supplements that require extra expense and are not covered under any other program. Regular but infrequent (less than monthly) trips must be made to a physician, psychiatrist, therapist, etc.

Level B: These children require special equipment or a regular and consistent tutoring program at home. There is unusual wear and tear on the home, and need for occasional periods of relief by an adult. Therapeutic appointments must be met every two to four weeks.

Level C: There is extreme wear and tear on the home, frequent hospitalizations, and/or therapeutic visits every two weeks or oftener.

Level D: These children exhibit either emotional or physical problems of such severity that the foster parents must make extraordinary adjustments in their family life style to accommodate the foster child. Such adjustments may include, but not be limited to, ongoing regular attendance at supportive group meetings, physical changes in the home (such as building ramps, installing lifts, etc.), ongoing consultation with child care professionals. These children require foster parents who have shown skill in adapting family life to the needs of each child.

Statutory Authority: *MS s 256.01 subd 4*

9500.0360 RELATIONSHIP OF AFDC TO OTHER PROGRAMS.

Subpart 1. **Automatic eligibility.** AFDC recipients are automatically eligible for:

A. medical assistance upon signing a benefit assignment form 1933 for health care coverage in which he/she is a policyholder;

B. food stamps; and

C. social services.

Subp. 2. **No simultaneous eligibility.** AFDC recipients may not be simultaneously eligible for:

A. general assistance unless served by the battered women program;

B. poor relief; and

C. supplemental security income.

Subp. 3. **Referrals for social service.** The income maintenance unit shall refer all cases involving minor caretakers to the social service unit for evaluation of service needs. Such referrals shall not be a factor in determining eligibility and shall be made after such eligibility is determined.

Subp. 4. **Other sources of income.** The following programs are not a bar to AFDC eligibility but may furnish the AFDC family with another source of support which may remove the need for AFDC:

A. retirement, survivors, and disability insurance;

B. school lunch program;

C. services and payments to veterans and armed forces personnel;

D. services and payments for immigrants and refugees; and

E. servicemen's quarters allowances.

The local agency shall help the AFDC recipient explore the resources offered by these programs.

Statutory Authority: *MS s 256.01 subd 4*

9500.0361 NOTICE TO AFDC APPLICANTS AND RECIPIENTS.

Subpart 1. **Authority.** Minnesota Statutes, section 268.74, subdivision 5 authorizes the commissioner to adopt rules to inform applicants for, and recipients of, aid to families with dependent children, of the availability of the Minnesota Emergency Employment Development Act (MEED), Minnesota Statutes, sections 268.60 to 268.77 and to refer persons required to register for the work incentive program to the MEED program.

Subp. 2. **Coordination of MEED with WIN.** Part 9500.0361 establishes the responsibility of the Department of Human Services to notify recipients of aid to families with dependent children of the benefits of the MEED program and the responsibility of the Department of Economic Security to coordinate MEED program services with the work incentive program.

Subp. 3. **Requirement.** Until such time as the MEED program ends, the local agency shall notify each adult applicant for or recipient of aid to families with dependent children of the availability of the MEED program and shall also provide a description of the program. Persons required to register for the work incentive program or with job services shall be referred by the local agency to the Department of Economic Security, which shall:

A. include information about MEED in its orientation;

B. use its appraisals for referrals to MEED jobs; and

C. include MEED jobs in its job search activities.

Statutory Authority: *MS s 256D.01 subd 1; 256D.03; 256D.04; 256D.09; 256D.111; 256D.112*

History: *9 SR 593; L 1984 c 654 art 5 s 58*

9500.0370 SEVERABILITY.

The provisions of parts 9500.0010 to 9500.0370 shall be severable and if any phrase, clause, sentence, or provision is declared illegal or of no effect, the validity of the remainder of this rule and the applicability, thereof, to any agency, person, or circumstances shall not be affected thereby.

Statutory Authority: *MS s 256.01 subd 4*

9500.0500 STATUTORY AUTHORITY FOR GENERAL ASSISTANCE PROGRAM.

Parts 9500.0500 to 9500.0610 governs the administration of the general assistance program as enacted by Laws of Minnesota 1973, chapter 650, article XXI.

Statutory Authority: *MS s 256D.01; 256D.04*

9500.0510 PURPOSE OF GENERAL ASSISTANCE PROGRAM.

The purposes of the general assistance program are:

A. to provide financial assistance and services to persons unable to provide for themselves, who have not refused suitable employment, and who are not otherwise provided for by law;

B. to strengthen and preserve the family unit;

C. to aid those persons who can be helped to become self-supporting or to attain self-care; and

D. to provide property tax relief by providing state financing for some welfare costs historically financed by county property tax levies.

Statutory Authority: *MS s 256D.01; 256D.21*

9500.0520 DEFINITIONS.

Subpart 1. **Scope.** The terms defined in this part shall have the meanings given them unless otherwise provided or indicated by the context.

Subp. 2. **Child.** "Child" means an individual who is under the age of 18.

Subp. 3. **Childless couple.** "Childless couple" means two individuals who are related by marriage and who are living in a place of residence by them as their own home.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of human services or his designee.

Subp. 5. **Department.** "Department" means the Department of Human Services.

Subp. 6. **Earned income.** "Earned income" means remuneration for services performed as an employee, and net earnings from self-employment.

Subp. 7. **Family.** "Family" means two or more individuals who are related by blood, marriage, or adoption who are living in a place or residence maintained by one or more of them as his or their own home and at least one of whom is a child who is not married to another of such individuals and is in the care of or dependent upon another of such individuals.

Subp. 8. **General assistance.** "General assistance" means cash payments to persons who are unable to provide themselves with a reasonable subsistence compatible with decency and health and who are not otherwise provided for under the laws of this state or the United States. It shall include cash payments for goods, shelter, fuel, food, clothing, lights, necessary household supplies, and personal needs items. General assistance shall not include payments for foster care, child welfare services, medical care, dental care, hospitalization, nursing care, drugs, or medical supplies. It is the intent of Laws of Minnesota 1973, chapter 650, article XXI, that these items be provided by local agencies in accordance with programs in effect at the time of the passage of Laws of Minnesota 1973, chapter 650, article XXI. Vendor payments may be made only

as provided for in Laws of Minnesota 1973, chapter 650, article XXI, sections 9 and 11 (Minnesota Statutes 1974, sections 245A.09 and 245A.11).

Subp. 9. **Income.** "Income" means earned and unearned income reduced by amounts paid or withheld for federal and state personal income taxes and federal social security taxes. General assistance shall be administered according to law and rules promulgated by the commissioner pursuant to the provisions of Laws of Minnesota 1973, chapter 650, article XXI.

Subp. 10. **Local agency.** "Local agency" means the county welfare boards in the several counties of the state except that it may also include any multi-county welfare boards or departments where those have been established in accordance with law.

Subp. 11. **State aid.** "State aid" means state aid to local agencies for general assistance expenditures as provided for in Laws of Minnesota 1973, chapter 650, article XXI.

Subp. 12. **Unearned income.** "Unearned income" means all other income including any payments received as an annuity, retirement, or disability benefit, including veteran's compensation; old age, survivors, and disability insurance; railroad retirement benefits; unemployment benefits; and benefits under any federally aided categorical assistance program, supplementary security income, or family assistance program; rents, dividends, interest, and royalties; and support and alimony payments except that such payment may not be considered as available to meet the needs of any person other than the person for whose benefit they are received, unless that person is under a legal duty to support another family member.

Statutory Authority: *MS s 256D.01; 256D.21*

History: *L 1984 c 654 art 5 s 58*

9500.0530 ELIGIBILITY REQUIREMENTS.

General assistance shall be granted to an assistance unit that meets all of the following qualifications:

A. The assistance unit shall not include a person who is eligible for or receiving one of the following federally aided assistance programs: Aid to Families with Dependent Children (AFDC), AFDC-Emergency Assistance, or a successor to these programs.

B. Except as provided in part 9500.0531, the assistance unit does not possess net equity in real and personal property that exceeds the maximum standards established in the AFDC program.

C. The assistance unit has countable income less than the general assistance standard or the average of its seasonal income for any three-month period is less than the general assistance standard.

D. The assistance unit contains a member who, if apparently eligible for participation in the federally sponsored Supplemental Security Income (SSI) program, has executed an authorization form (DPW 1795) permitting the secretary of health, education, and welfare, in accordance with Public Law Number 93-368, to make his initial SSI payment to the county welfare agency which provides him general assistance during the interim period while he awaits his first SSI check. If the person fails to complete the authorized form, the person shall be determined ineligible for general assistance and the assistance standard used shall be based on the number of remaining eligible members of the assistance unit.

E. The assistance unit shall contain only members who are exempt from or who are in compliance with the registration and work requirements of parts 9555.3400 to 9555.3410.

Statutory Authority: *MS s 256D.01; 256D.08 subds 1,2; 256D.21*

History: *9 SR 593*

9500.0531 EXCLUSION OF EXCESS PROPERTY.

Subpart 1. **Property excluded.** In determining eligibility for general assistance, the local agency shall exclude real and personal property more than the limits in part 9500.0530, item B, when the local agency finds that:

A. the property is essential to the assistance unit's self-support or self-care or that the property is needed to obtain or retain suitable employment;

B. a reasonable expectation exists that the assistance unit will use the property as a source of self-support either within six months of the date when the applicant or recipient is determined to have property more than the limit in part 9500.0530, item B or, if the property produces income on a seasonal basis, during the income producing season immediately following the determination;

C. the property produces net income that is being used for the support of the assistance unit;

D. the applicant has not received general assistance within the last 60 days and the circumstances of the applicant indicate that the need for general assistance will not exceed 30 days;

E. a grant of general assistance for an emergency need is required and the excess property cannot be liquidated in time to meet that need; or

F. an undue hardship would be imposed upon the applicant or recipient by the forced disposal of the property.

Subp. 2. **Undue hardship.** An undue hardship exists when general assistance eligibility is prevented because the assistance unit owns property more than the limit in part 9500.0530, item B and one of the following conditions is met:

A. the property is for sale at a reasonable price but has not been sold;

B. the property is not legally available for liquidation by the applicant or recipient; or

C. the property is essential to the assistance unit for other reasons as determined by the local agency.

Statutory Authority: *MS s 256D.08 subds 1,2*

History: *9 SR 593*

9500.0532 INFORMING APPLICANTS OR RECIPIENTS OF EXCLUSION CONDITIONS.

Upon determining that an assistance unit is not eligible for general assistance or emergency assistance under the general assistance program due to owning property more than the limit in part 9500.0530, item B, the local agency shall inform in writing the applicant or recipient of the conditions under which excess property may be excluded.

Statutory Authority: *MS s 256D.08 subds 1,2*

History: *9 SR 593*

9500.0540 DETERMINATION OF NEED.

Local agencies shall determine need in individual cases up to the standards promulgated by the department.

Statutory Authority: *MS s 256D.01; 256D.21*

9500.0550 GRANT AMOUNT.

Except as provided in part 9500.0560, the total amount of general assistance payment shall be the difference between the amount of recipients' needs as determined pursuant to part 9500.0540 minus available, nonexempt income. The local agency may average seasonal income over a three-month period.

Statutory Authority: *MS s 256D.01; 256D.21*

9500.0560 GRANTS ABOVE STANDARD AMOUNTS; EMERGENCY ASSISTANCE.

Any local agency may issue grants in amounts above those described in parts 9500.0540 and 9500.0550 provided that it deletes the additional costs thus incurred from its claim for state aid reimbursement, except the state aid may be available for payments made in excess of general assistance standards in emergent situations wherein the request was for a period of less than 30 days. As used herein, an "emergency situation" refers to a circumstance that:

A. places in jeopardy one or more persons in an eligible family unit;

B. cannot be resolved by the applicant with his or her current resources; and

C. in the absence of other resources, requires immediate financial assistance.

Statutory Authority: *MS s 256D.01; 256D.21*

9500.0570 COUNTY WARRANTS.

Grants of general assistance shall be issued by the local agencies to the recipient in the form of county warrants immediately redeemable in cash. Such payments shall cover his unmet needs and may be issued in monthly, semimonthly, weekly, or daily installments as the local agency deems to be appropriate in individual situations.

Statutory Authority: *MS s 256D.01; 256D.21*

9500.0580 VENDOR PAYMENTS.

Vendor payments shall be made in the following situations:

A. When the county determines that the recipient has not used his resources in the best interest of his needs and that of his dependents. Evidence of the recipient's inability to manage his resources must be documented in the case record.

B. When an individual has remained uncooperative about registering for employment services or in seeking and/or accepting suitable employment, vendor payments shall be made for the maintenance needs of his dependents. "Suitable employment" is defined in Minnesota Statutes,. section 268.09, subdivision 1, clause (4).

C. Issuance of general assistance by vendor payment is permissible in emergency situations when a cash payment cannot be processed on weekends or holidays to resolve the current crisis.

Statutory Authority: *MS s 256D.01; 256D.21*

9500.0590 STATE REIMBURSEMENT TO LOCAL AGENCIES.

The state will reimburse local agencies on a monthly basis for actual general assistance payments made pursuant to part 9500.0550 subject to the following limitations:

A. 50 percent of the actual grant paid to the recipient; or

B. 50 percent of the appropriate standard in part 9500.0540, whichever is less.

Statutory Authority: *MS s 256D.01; 256D.21*

9500.0600 STATE PAYMENTS FOR EMERGENCY ASSISTANCE.

The state will participate in actual emergency payments made pursuant to part 9500.0560, up to 50 percent of each such grant.

Statutory Authority: *MS s 256D.01; 256D.21*

9500.0610 DETERMINATION OF COUNTY OF FINANCIAL RESPONSIBILITY.

Subpart 1. **Definitions.** In all matters involving legal settlement of the poor, "county of financial responsibility" means:

A. The county in which an individual resides.

B. An individual shall be held to reside in a particular county if he has established a home there and has not established a home elsewhere.

C. If, at the time of making application, the applicant is a patient in a hospital, nursing home, or boarding care home, as defined in Minnesota Statutes, section 144.50, or is placed in a county as a result of a correctional program or a treatment plan for health, rehabilitation, foster care, child care, or training, and immediately prior thereto he had resided in another county in an established abode that was not such a like care facility, it is in the former county.

D. The above provisions notwithstanding, if an individual is a recipient of medical assistance, the county from which he is receiving medical assistance.

E. The above provisions notwithstanding, the county of financial responsibility shall not change as a result of successive placements in one or more counties pursuant to a plan of treatment for health, rehabilitation, foster care, child care or training; nor as a result of placement in any correctional program.

Subp. 2. **Procedures.** If, upon investigation of an application for general assistance, the local agency finds that the applicant is otherwise eligible for assistance but that his county of financial responsibility is some other county, it shall within 15 days, while providing assistance in the meanwhile, transmit a copy of the application together with a record of its investigation to the local agency of the other county. If, within 15 days, the local agency of such other county concludes that it is not the county of financial responsibility for the applicant, it shall forward concurrently copies of the application and the investigation reports of both counties to the state agency and to the county of origin. The state agency shall thereupon promptly decide the question of which county is the county of financial responsibility and issue an order referring the application to the proper county and include therein directives as necessary for any reimbursement of general assistance advanced to the recipient in the meanwhile. The order of the state agency shall be binding on the local agency so named and shall be complied with until such state agency decision is changed upon appeal to the district court.

Statutory Authority: *MS s 256D.01; 256D.21*

MINNESOTA SUPPLEMENTAL AID

9500.0650 STATUTORY AUTHORITY FOR MINNESOTA SUPPLEMENTAL AID PROGRAM.

Parts 9500.0650 to 9500.0710 governs the administration of the Minnesota supplemental aid program as enacted by Laws of Minnesota 1974, chapter 487.

Statutory Authority: *MS s 256D.41*

9500.0660 PURPOSE OF MINNESOTA SUPPLEMENTAL AID PROGRAM.

The purpose of the Minnesota supplemental aid program is to provide financial assistance to recipients of supplemental security income for the aged, blind, disabled (SSI), or to persons who, but for excess income or resources, would be receiving SSI, and who are found to have maintenance needs as determined by the application of the state standards in effect for the adult categories in December 1973, which exceed their income from SSI and other sources, and who would otherwise have qualified for the benefits under the

programs of OAA, AB, or AD as such former programs were then in effect.

Statutory Authority: *MS s 256D.41*

9500.0670 DEFINITIONS.

Subpart 1. **Scope.** The terms defined in this part shall have the meanings given them unless otherwise provided as indicated by the context.

Subp. 2. **Applicant for supplemental security income.** "Applicant for supplemental security income" means an individual who has applied for supplemental security income and who, but for excess income or resources, would be a recipient of supplemental security income.

Subp. 3. **Commissioner.** "Commissioner" means the commissioner of human services or his designee.

Subp. 4. **Department.** "Department" means the Department of Human Services.

Subp. 5. **Income.** "Income" means earned and unearned income from any source whatsoever, reduced by amounts paid for federal and state personal income taxes and federal social security taxes.

Subp. 6. **Local agency.** "Local agency" means the county welfare boards in the several counties of the state except that it may also include any multi-county welfare boards or departments where those have been established in accordance with law.

Subp. 7. **Supplemental security income.** "Supplemental security income" means benefits paid under the federal program of supplemental security income for the aged, blind, and disabled, title XVI of the Social Security Act, as enacted by section 301 of the Social Security Amendments of 1972.

Subp. 8. **Supplemental aid.** "Supplemental aid" means state and county payments to eligible applicants for or recipients of supplemental security income, in accordance with the provisions of this act and rules promulgated by the commissioner of welfare.

Statutory Authority: *MS s 256D.41*

History: *L 1984 c 654 art 5 s 58*

9500.0680 ELIGIBILITY REQUIREMENTS.

Minnesota supplemental aid shall be granted to any person:

A. who has attained the age of 65 years or who has met SSI criteria for blindness or disability; and

B. whose net equity in real property:

(1) if aged or disabled, does not exceed $10,000, which maximum will be increased to $12,000, effective July 1, 1974, and to $15,000 effective January 1, 1975; or

(2) if blind, does not exceed $15,000; and

C. whose net equity in personal property:

(1) if aged or disabled, convertible into cash does not exceed $300 if single or if married does not exceed $450;

(2) if aged, does not have in excess of $1,000 in cash surrender value of life insurance; or

(3) if disabled, does not have in excess of $500 in cash surrender value of life insurance; or

(4) if aged, blind, or disabled, does not have in excess of $750 in prepaid funeral contract plus accrual of interest therein not exceeding $200;

(5) if blind and single, does not have in excess of $2,000 in undifferentiated liquid assets, or if blind and married, together with his spouse does not have in excess of $4,000 in undifferentiated liquid assets, including therein up to $750 per person for a prepaid funeral contract plus an accrual of interest not over $200 per person; and

MEDICAL ASSISTANCE

9500.0750 INTRODUCTION.

Subpart 1. **Scope.** Parts 9500.0750 to 9500.1080 govern administration of the Medical Assistance (MA) program in Minnesota. The provisions of these parts are to be read in conjunction with title XIX of the federal Social Security Act, Title 45 of the Code of Federal Regulations, Minnesota Statutes, chapter 256B, and other rules of the Minnesota Department of Human Services (hereinafter, the state agency) which is responsible for the administration of the title XIX program in Minnesota.

Subp. 2. **Purpose.** The MA program shall be administered to provide eligible needy persons whose financial resources are not adequate to meet the cost of medical care and services with such care and services according to the provisions of these parts.

Subp. 3. **Civil rights.** The MA program shall not be administered to deny applicants and recipients their individual and civil rights, nor to disclose information regarding them except as provided under applicable state law and/or official departmental rules.

Subp. 4. **Jurisdiction.** These parts are binding on all county welfare boards (hereinafter referred to as local welfare agencies) in the State of Minnesota administering the MA program (title XIX), on all providers of service participating in the MA program, on all applicants/recipients under the MA program, and on the state agency.

Subp. 5. **Official state plan.** The official state plan is the submitted and approved federal document which indicates those options covered by Minnesota Statutes.

Subp. 6. **References.** These parts specifically include by reference any federal laws or regulations or state laws pertaining to the Minnesota Medical Assistance program, and any provision of these parts which is inconsistent with those laws and rules is superseded thereby.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.0760 DEFINITIONS.

Subpart 1. **Applicant.** "Applicant" means a person who has directly, or through his authorized representative (or where incompetent or incapacitated, through someone acting responsibly for him), made application for medical assistance with his local welfare agency.

Subp. 2. **Application.** "Application" means the action by which an individual indicates in writing to the agency administering public assistance his desire to receive medical assistance. An application is distinguished from an "inquiry," which is simply a request for information about eligibility requirements for medical assistance.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0770 APPLYING FOR MEDICAL ASSISTANCE.

Subpart 1. **Right to apply.** Any person has the right to apply for medical assistance to the local welfare agency in the county in which he resides and has established an abode, regardless of whether or not it appears he will be found eligible for participation in the MA program. In such cases, the local agency shall promptly advise the applicant of the MA program's eligibility requirements.

Subp. 2. **Signature.** Each application form shall be signed by the applicant or the applicant's responsible relative, legal guardian, or authorized representative (or where incompetent or incapacitated, by someone acting responsibly for him).

Subp. 3. **Time limits; personal interview.** As soon as possible, but no later than 45 days from the date of application for medical assistance in the case of families, the aged, and the blind, or no later than 60 days in the case of the

disabled, the local welfare agency shall conduct a personal interview with the applicant and determine his eligibility for medical assistance. All eligibility conditions shall be met within these time limits. Where a delay is necessary because necessary information cannot be obtained within the time limits, the applicant shall be notified in writing of the delay and shall be advised of his right to appeal such delay.

Subp. 4. **Written notice to applicant.** Each applicant shall be notified in writing that his application has been approved or denied, unless the applicant dies or cannot be located. If the application is denied, the individual shall be notified in writing of the reasons for denial and of his right to appeal.

Subp. 5. **Reapplication.** Any person has the right to re-apply for medical assistance. New applications must be taken whenever a previous application has been denied or withdrawn, or when the county of financial responsibility has been changed. An approved application shall be appended by an addendum thereto for the purpose of adding additional eligible persons or when the payee has changed his/her name.

Subp. 6. **Federal regulations.** Medical assistance eligibility shall be redetermined in accordance with the provisions of applicable federal regulations. In those cases where the local welfare agency receives information about a change in case facts, eligibility shall be reviewed within 30 days of receipt of that information.

Subp. 7. **Application information.** The local welfare agency shall verify information cited in this subpart and contained in the application received from the applicant or other persons or agencies only with the applicant's written permission. If the applicant refuses to cooperate with the local welfare agency in verifying the needed information, his application shall be automatically denied. The following information shall be verified:

A. Social Security numbers as provided under subpart 8 of all individuals applying for or receiving medical assistance and the parents of dependent children;

B. the applicant's income and property holdings;

C. any other information affecting eligibility as deemed necessary under the circumstances of each particular case.

Subp. 8. **Social Security numbers.** For assistance under title XIX of the Social Security Act, the local welfare agency shall request each applicant to supply the Social Security number (SSN) for each individual (including children) for whom assistance is requested. Furnishing or applying for a SSN is not an eligibility factor for medical assistance and benefits cannot be denied because an individual will not furnish or apply for a SSN or consent to use of a SSN.

The local, state, and federal agencies are prohibited from using an individual's SSN without the written consent of the individual, unless required by law to use that number.

The local welfare agency shall request in writing and obtain written consent to use the individual's SSN to validate information contained in the application.

Subp. 9. **Public information.** Local welfare agencies shall give a copy of the state agency's informational pamphlet on medical assistance to every person who inquires about, indicates a need for, and/or applies for any of the categorical aid programs. Local welfare agencies shall inform all applicants that their medical records may, only with their signed consent, be released to the state agency, the local welfare agency, the Minnesota Department of Health, the U.S. Department of Health, Education and Welfare, and the PSRO. No records will be released to any person or agency absent the specific consent of the recipient. No person shall be eligible for medical assistance unless he has authorized in writing the commissioner of human services to examine all personal medical records developed while receiving medical assistance for the sole purpose of investigating whether or not a vendor has submitted a claim for reimbursement,

cost report or rate application which the vendor knows to be false in whole or in part.

Subp. 10. **Concurrent eligibility.** Individuals found eligible for Aid to Families with Dependent Children (AFDC) shall be eligible for medical assistance without a separate application. Aged, blind, or disabled individuals found eligible for Minnesota Supplemental Aid (MSA) shall be eligible for medical assistance without a separate application. Aged, blind, or disabled Supplemental Security Income (SSI) recipients are required to file a separate application for medical assistance. Cases converted from state administered payments under OAA, AB, and AD programs which are terminated by SSI require a separate application and determination of eligibility. All other individuals not specified herein shall file a separate medical assistance application.

Subp. 11. **Termination of categorical assistance.** Medical assistance eligibility for a recipient of categorical assistance ends when there is no longer eligibility for that assistance. At that point, the individual shall file a separate medical assistance application and the MA program eligibility criteria must be applied.

Subp. 12. **County of residence.** The county in which the applicant resides at the time of application for medical assistance is the county of financial responsibility. Continuous receipt of assistance will continue financial responsibility in that county.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1985 c 654 art 5 s 58*

ELIGIBILITY FACTORS

9500.0780 AGE REQUIREMENTS.

Subpart 1. **In general.** Individuals eligible for medical assistance by reason of receiving a categorical form of public assistance, or who would be eligible under a category except for residence or amounts of income or resources, must meet the specific age requirements of the appropriate category.

Subp. 2. **Minors, seniors.** Medical assistance is available on behalf of otherwise eligible individuals who were, for any portion of the month in which they received medical care or services, under 21 years of age (or under 22 years of age and receiving inpatient psychiatric hospital services), or 65 years of age or older.

Subp. 3. **Unborn.** The unborn are eligible for medical assistance during the last three months of the mother's pregnancy (as medically certified), so long as other factors of AFDC eligibility exist.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0790 RESIDENCE.

Subpart 1. **Definition: residence, abode.** "Residence" or "abode" is where a person lives and intends to remain.

Subp. 2. **Length and intent.** Minnesota residence is an eligibility requirement for medical assistance but no specific length of residence is required. A person loses Minnesota residence when he leaves the state with the intent to establish a home elsewhere. Evidence of intent under this rule is not simply the person's stated intentions but includes consideration of objective criteria associated with the move (e.g., movement of possessions, rent payments, changes in voter or driver's license registrations).

Subp. 3. **Definition: resident.** A "resident" of Minnesota is a person who is living in the state voluntarily with the intention of making Minnesota his permanent home. A child is a resident of Minnesota if he is living in the state on other than a temporary basis. Residence may not depend upon the reason

for which the individual entered the state, except insofar as it may bear upon whether he is there voluntarily or for a temporary purpose. An agricultural migrant who meets all other eligibility requirements and who has an abode in another state shall be eligible for medical assistance. Residence is deemed retained until abandoned. Temporary absence from Minnesota, with subsequent return to the state or intent to return when the purpose of the absence has been accomplished, does not interrupt continuity of residence.

Subp. 4. **Absent residents.** Under the following circumstances, medical assistance will be furnished to eligible individuals who are residents of Minnesota but who are absent from the state, to the same extent that such assistance is furnished under the MA program to meet the cost of medical care and services rendered to eligible individuals within the state:

A. where an emergency arises from accident or illness;

B. where the health of the individual would be endangered if the care and services are postponed until he returns to Minnesota; or

C. where his health would be endangered if he attempted to return to Minnesota in order to receive medical care.

Subp. 5. **Medical care and services provided outside state.** Medical care and services will be provided outside Minnesota to eligible residents of this state in the following situations:

A. when it is general practice for residents of Minnesota to use medical resources beyond the borders of this state; or

B. when the availability of necessary medical care, services, or supplementary resources make it desirable for the individual to use medical facilities outside the state, for short or long periods of time and in accordance with plans developed jointly by the local welfare agency and the individual, based upon sound medical advice.

Subp. 6. **Residents of other states.** The state agency shall assist in meeting the medical needs of residents of other states who are eligible for medical assistance in that state while they are within Minnesota.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0800 CITIZENSHIP AND ALIENAGE.

Medical Assistance payments may be made on behalf of any otherwise eligible individual who is a resident of the United States, but only if he is either a citizen of the United States, or an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0810 INCOME.

Subpart 1. **Limits; determinations.** Medical assistance may be paid for any person who anticipates receiving annual net income up to the amounts specified under state law. Individuals or families with income in excess of these maxima and who in the month of application or during the three preceding months incur expenses for medical care that total more than one-half of the annual excess income, may also be eligible for participation in the MA program.

In the determination of eligibility for MA-only (over 65 years of age), and MA-categorically related, "income" is the total net income the applicant and relatives responsible under statutes expect to receive from all sources during the year.

In determining eligibility for medical assistance for children under 18 years of age, the local welfare agency must consider all income of the applicants, and their relatives responsible under Minnesota Statutes, sections 256B.06 and 256B.14. Eligibility of individuals between 18 and 21 years of age shall be determined separately.

Subp. 2. **Definitions.** The following definitions apply:

A. "Income" means any benefit received by or available to a medical assistance applicant/recipient as earnings or otherwise. Income may be earned or unearned. In family groups living together, the income of a spouse is considered available to his/her spouse and the income of a parent is considered available to his/her children under 18 years of age. All income, including non-cash items provided free of cost, is considered a resource to be evaluated in determining the need of medical assistance applicants/recipients.

B. "Net income" means the amount left after deducting allowable expenses and income disregards.

C. "Earned income" means income received in the form of wages, salary, commissions, or profits from activities in which the applicant/recipient is engaged as an employee or as a self-employed person.

D. "Unearned income" means income which is not the direct result of labor or services performed by the individual as an employee or as a self-employed person.

Subp. 3. **Employment expense deductions.** The following employment expenses are to be deducted in determining net earned income:

A. mandatory retirement fund deductions;

B. transportation costs to and from work based on the actual cost of public transportation or car-pool payments, or 13 cents per mile for the actual number of miles driven, not to exceed 100 miles per day of employment (unless the recipient can establish actual higher transportation costs);

C. cost of work uniforms;

D. FICA and SMI payments;

E. federal and state income taxes withheld;

F. union dues;

G. professional association dues required for employment;

H. health insurance premiums;

I. cost of tools and equipment used on the job;

J. $1 per day for the cost of meals eaten during employment hours (unless the recipient can establish actual higher work-related meal expenses that are necessary and reasonable);

K. public liability insurance required by the employer when an automobile is used in employment and the cost is not compensated by the employer.

Subp. 4. **Rental income.** Rental income is considered unearned income.

Subp. 5. **Lump sums and windfalls.** Lump sum payments and windfalls (e.g., Social Security retroactive benefits, inheritances, income tax refunds, gifts) are considered a resource which will necessitate a redetermination of medical assistance eligibility, except when specifically exempted by federal law.

Subp. 6. **Application to maintenance needs.** Income of a medical assistance recipient, as in any other public assistance program, shall first be applied to the maintenance needs of the recipient or his legal dependents up to the statutory standards.

Subp. 7. **Income under legal maxima.** Income that is within the legal maxima of the MA program is not to be considered in determining the amount of payments made for medical services, except in long term care facility, convalescent care unit, state veterans' facility, and state hospital cases. In such cases, if the applicant/recipient has legal dependents (spouse and/or minor dependent children), the family's total net income, within the medical assistance legal maxima, is to be applied to the maintenance needs of the patient and those legal dependents. In such a situation the only income to be considered allocable to the maintenance needs of the long term care facility patient is the allowance for personal needs and clothing. Retarded or handicapped persons living in

skilled nursing facilities, intermediate care facilities, or intermediate care facilities/mentally retarded who are employed under a plan of rehabilitation are eligible for a special personal allowance from earned income as specified in state statutes. The remainder of the income within the legal maxima for the family is to be attributed to the maintenance needs of the legal dependents with any income over the medical assistance maxima to be applied to the institutional charges. If the patient has no legal dependents, any income in excess of the allowance for his personal needs and clothing is to be applied to the costs of long term care facility services.

Subp. 8. **SSI income.** Income from an SSI grant is to be disregarded in determining the medical assistance eligibility of an SSI recipient. However, to be eligible under the MA program, other sources of income must comply with MA program standards.

Subp. 9. **Automatic eligibility.** Persons receiving a maintenance grant under the AFDC or MSA programs shall be automatically eligible for medical assistance.

Subp. 10. **Spend-down.** Persons who have income in excess of the medical assistance income maxima and who do not qualify for categorical assistance because their income is in excess of the limits of those programs, may qualify for medical assistance through the spend-down provision of the MA program.

"Spend-down" means to reduce available or anticipated income which exceeds the amount protected by state law for maintenance needs. Such reduction must be for current medical obligations.

"Current" means medical obligations during the period of time the applicant is requesting assistance and which are allowable under state and federal law or federal regulations.

"Medical obligations" are amounts owed any eligible provider for medical care, services or supplies which are covered under the MA program.

Spend-down applies only to income.

Spend-down is computed by the local welfare agency and is a condition of eligibility. Spend-down is computed by first determining the current and anticipated annual income of the applicant and his responsible relatives under state law. The amount protected under state law is subtracted to determine the amount of anticipated annual income available to meet medical obligations. This amount is reduced by one-half to indicate the anticipated income available during the next six months.

The spend-down requirement cannot be assumed by any third-party; such third-party resource shall be applied against medical obligations prior to determining the applicant/recipient's unmet medical obligation. For the purpose of spend-down only, "third-party" means anyone other than the applicant/recipient or his responsible relatives.

The amount of spend-down shall be paid or incurred prior to establishing eligibility for medical assistance, except in those instances where a continuing spend-down exists. "Continuing spend-down" means the spend-down requirement is met on a monthly basis rather than on a six-month basis. Continuing spend-down is limited to institutionalized individuals and those special situations individually approved by the state agency.

When medical assistance eligibility is established through the spend-down provision, eligibility shall be limited to a period of six months beginning with the first of the month in which medical obligations are first incurred. This six month period may include retroactive coverage of up to three months prior to the first of the month in which the application was made.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0820 RESOURCES.

Subpart 1. **Real property.** Medical assistance may be available to any individual who, either alone or together with his/her spouse, does not have equity in real property exceeding that permitted under state law. "Equity" shall be the assessed tax value minus any encumbrance against the property.

In situations where the appropriate local welfare board determines that an applicant/recipient's excess equity in real estate cannot be converted into cash to meet his current maintenance needs, or that liquidation of the property would result in an undue hardship, the board may waive the equity limitation. It is not intended that this waiver provision be applied universally to achieve medical assistance eligibility for applicants or recipients. Instead, the following considerations shall act to restrict waiver of the real property equity limitation:

A. No maximum limit on the value of equity in real property to be waived shall be adopted by a local welfare board or local welfare agency as a matter of practice or general policy.

B. The circumstances and conditions under which the excess equity in real property was waived shall be examined periodically (at least annually) for changes in current market value, opportunity for sale or mortgage, or other pertinent factors.

Subp. 2. **Personal property.** Medical assistance may be available to any individual whose cash or liquid assets do not exceed the limits established by state law.

Under the MA program, the following items are exempted in determining the value of personal property owned by the applicant/recipient:

A. household goods and furniture presently used in the applicant's/recipient's residence;

B. wearing apparel;

C. life insurance policies with combined cash surrender values not exceeding $1,000 per insured person (individual applicant and each legal dependent or legally responsible member of his family);

D. burial plots; and

E. prepaid burial contracts not exceeding $750 for the applicant/recipient and each legally dependent member of his family, plus $200 in accrued interest under each such contract. In order to be covered by this exemption, either the funeral director must be the "trustee" and the applicant/recipient (or a member of his family for whom he is legally responsible) the "beneficiary" under the terms of such burial contract, or a trust account must be created restricting use of its funds to payment of funeral and burial costs.

Equity in personal property exceeding the applicable program maxima may be waived when the appropriate local welfare board determines that liquidation of the property would result in undue hardship.

If personal property increases in value beyond the limits allowed under applicable state law, it will not defeat medical assistance eligibility if the applicant/recipient, within 15-calendar days from the date he received notice from the local welfare agency, either transfers the excess to an excluded type of property, or uses the excess to repay the local welfare agency and/or state agency for medical assistance already received.

A trust fund is subject to the personal property limitations mandated under applicable state law unless it can be affirmatively demonstrated that such fund cannot be made available to meet the individual's medical needs.

Subp. 3. **List of personal property.** At the time of filing application for medical assistance, each applicant shall submit a complete and accurate list and description of all real and nonexempt personal property in which he has an equitable interest. Such list of property shall include not only the property

currently owned, but all property in which he had an equitable interest during the three years prior to applying for medical assistance.

Subp. 4. **Transfers of property.** The establishment of initial or continuing eligibility for medical assistance by disposing of resources which otherwise would be available for the applicant/recipient's support is contrary to public policy. In some instances, such dispositions may constitute a criminal offense on the part of the donor and/or donee of the property. If a person tenders any amount of money as a deposit to a long term care facility within three years immediately preceding his application for medical assistance, or while receiving such assistance, all such deposits shall be considered a resource in determining such person's eligibility for medical assistance.

The following provisions shall govern property transfers as they affect potential eligibility under the MA program:

A. Each applicant for and recipient of medical assistance shall be required to reveal whether he has transferred within the preceding three years real or personal property with a total fair market value in excess of $750 without receiving adequate consideration for such property. Any property so transferred shall be viewed as an available resource for the medical needs of the applicant/recipient.

B. The applicant or recipient who has transferred property as described in this subpart shall be required to provide to the local welfare agency a description, including value, of the property transferred; the name or names of all persons who received such property; and the specific circumstances under which the property was transferred.

C. The applicant or recipient who has transferred property as described herein shall be required to make a reasonable effort in cooperation with the local welfare agency to reacquire the property transferred.

D. The information required by item B and the efforts made to reacquire the property mandated by item C shall be entered in the applicant/recipient's case record with the appropriate eligibility determination.

E. If return of the property or adequate consideration for the property cannot be arranged by the local welfare agency, the matter of the property transfer shall be reported with full documentation to the county attorney for possible criminal prosecution or civil action.

F. Transfer of property in violation of this part shall not, in itself, constitute automatic ineligibility for medical assistance since such property may be deemed, in fact, to be unavailable to meet the applicant/recipient's medical needs.

Subp. 5. **Types of property ownership.** The owner of property in joint tenancy shall be considered as owning his pro-rata share of the value of such property, but the county or the joint tenant may establish ownership of a greater or lesser amount. An owner of property as a tenant-in-common owns his pro-rata share of the property's value. All other types of ownership shall be evaluated according to the law.

Subp. 6. **Assignment of benefits.** Each applicant or recipient shall, as a condition of eligibility:

A. notify his county of service of any health care coverage available to him or his dependents and agree to apply all proceeds received or potentially receivable by him or his spouse from private health care coverage to the costs of medical care for himself, his spouse, and children; and

B. assign any rights accruing under private health care coverage to the state agency, to be applied against the cost of medical care paid for by the MA program.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0830 RELATIVE RESPONSIBILITY.

Subpart 1. **In general.** Within the limitations provided by state law and parts 9500.0750 to 9500.1080, the spouse of an applicant and the parent of an applicant under 18 years of age shall be financially responsible for the cost of medical services.

Subp. 2. **Income and resources of responsible relatives.** In determining an applicant's eligibility for medical assistance, the income and resources of a responsible relative shall be considered in the following manner:

A. Income and resources of spouses living together in the same household are to be considered available one to the other without proof of actual contribution. Income and resources of a parent are to be considered available to a child under 18 years of age.

B. If an applicant for or recipient of medical assistance does not reside in the same household as a spouse, only the income and resources actually contributed by the spouse may be considered in determining medical assistance eligibility for the applicant or recipient.

Subp. 3. **Determination of liability.** In determining the liability of a financially responsible relative, the local welfare agency shall proceed in the following manner:

A. When the local welfare agency determines that a responsible relative is able to contribute without undue hardship to himself or his immediate family but refuses to contribute, the local welfare agency shall exhaust all administrative procedures to obtain that relative's contribution. When such procedures fail, the local welfare agency shall consult its county attorney regarding possible legal action.

B. In all cases when spouses are separated due to one spouse's need for care in a nursing home or state hospital, the following schedule of contribution shall be applied to determine the responsibility of the noninstitutionalized spouse for support, out of his/her own income (earned or unearned). The local welfare agency may vary the contribution schedule for a specific case on a showing of undue hardship.

Monthly Income	Contribution/Month
$400 to $449	$ 15
$450 to $499	$ 30
$500 to $549	$ 50
$550 to $599	$ 70
$600 to $649	$ 90
$650 to $699	$120
Over $700	$150 plus 100 percent of the excess over $700

C. If the responsible relative fails to contribute support, after the local welfare agency notifies him of his obligation to do so, the local welfare agency shall notify the county attorney in an effort to commence legal action against that relative.

D. The amount of support recoverable from a responsible relative (other than an absent parent) shall not exceed the amount of assistance paid on behalf of the recipient.

E. The local welfare agency shall not withhold, delay, or deny medical assistance because a responsible relative deemed able to contribute fails or refuses to accept financial responsibility.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0840 MARRIAGE OR REMARRIAGE OF PARENT.

In the event that a parent with dependent children under 18 years of age marries or remarries and applies for medical assistance on behalf of those dependent minor children residing with him or her, the following provisions shall apply in determining available income with relation to eligibility for medical assistance:

A. All income and resources of natural or adoptive parents who reside in the home are to be considered available to meet the medical needs of the children.

B. All income and resources of the children themselves must be considered available to meet the medical needs of the children so long as such income and resources are under the control of the parents.

C. All other income and resources available to the MA applicants/recipients received in the form of gifts, income-in-kind, support payments, whether from responsible relatives or other family members, must be considered as a resource available to the children in determining their eligibility for medical assistance.

D. All income-in-kind received by the natural or adoptive parent must also be considered as an income or resource in determining medical assistance eligibility for the children.

E. Proof of actual contribution by relatives or other persons may be obtained by reference to previous income tax returns on which these children may have been declared as dependent by the parent or adult family member. Such proof of support or contribution may also be obtained by direct inquiry of the adult family members residing in the home.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0850 INSTITUTIONAL STATUS.

Subpart 1. **In general.** An individual who is an inmate of a public institution, except as a patient in a medical institution or as a resident of an intermediate care facility, is not eligible for medical assistance. Individuals over age 65 and under age 21 who are patients in institutions for mental diseases or tuberculosis are eligible for medical assistance if all conditions of eligibility are satisfied.

Subp. 2. **Definitions.** The following definitions apply:

A. "Inmate" means a person who is being involuntarily retained and who is living in the institution.

B. "Institution" means an establishment which furnishes (in single or multiple facilities) food and shelter to four or more individuals unrelated to the proprietor and, in addition, provides treatment services which meet some needs of the individuals beyond the basic provision of food and shelter.

C. "Patient" means an individual who is in need of and receiving professional services directed by a licensed practitioner of the healing arts towards the maintenance, improvement, or protection of health, or the alleviation of illness, disability, or pain.

D. "Public institution" means a facility that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

E. "Resident" means an individual receiving room, board, and a planned program of care and supervision on a continuous 24-hour-a-day basis as determined necessary by a licensed physician or, if appropriate, a mental retardation team.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0860 TERMINATION OF MEDICAL ASSISTANCE.

Subpart 1. **Right to hearing.** Medical assistance applicants and recipients have the right to a fair hearing when aggrieved by action or inaction of the local and/or state welfare agencies. Such hearings shall be conducted in accordance with contested case and/or appeal procedures established by and consistent with applicable state law and federal regulations. The aggrieved applicant/recipient shall submit a written request for a hearing to the state or local welfare agency, whichever is appropriate. A local welfare referee shall conduct a hearing on the matter and shall issue a ruling affirming, reversing or modifying the action or decision of the local agency. The ruling of the local welfare referee shall be binding upon the local agency and the aggrieved party unless appeal is taken to the state agency. If appeal is taken directly to the state agency, a state welfare referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. In appeals to the state agency from rulings of local welfare referees, the hearing may be limited, upon stipulation of the parties, to a review of the record of the local welfare referee. The commissioner of human services shall issue an order on the matter to the local agency and applicant/recipient. Any order so issued shall be conclusive upon the parties unless appeal is taken to district court. Termination of medical assistance may be effected only at the end of the month, except in the case of the death of the recipient.

An applicant/recipient for medical assistance is entitled to a hearing when the local welfare agency fails to act on his application within the time limits imposed by applicable federal regulations, or when his medical assistance coverage is to be denied or terminated. See part 9500.0770, subpart 3.

Subp. 2. **Notice of intent to deny or terminate assistance.** The local welfare agency board shall give the applicant/recipient timely advance notice of its intention to deny or terminate medical assistance. This notice shall be in writing and mailed to the applicant/recipient at least ten calendar days prior to the effective date of such proposed action and shall clearly state what action the local welfare agency intends to take, the reasons for such proposed action and the right to appeal such proposed action.

Subp. 3. **Appeals.** If the applicant/recipient appeals the proposed action before it is effected, the action shall not be taken until the appeal is heard and decided in accordance with applicable state law and federal regulations.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

GENERAL ADMINISTRATION

9500.0900 FREE CHOICE OF PROVIDER.

Subject to the following limitations, the MA program shall provide eligible recipients with free choice of participating local medical providers. The term "local" as used herein means that geographic area surrounding the recipient's residence which is viewed by the local welfare agency as reasonable for obtaining any given medical service. Free choice is limited by the choice available to the local population. Eligible recipients may exercise free choice by enrolling in participating Health Maintenance Organizations (HMO). While enrolled in an HMO, the recipient is limited to free choice within that HMO. No long term care facility shall be eligible to receive medical assistance payments unless it agrees in writing that it will refrain from requiring any resident of the facility to utilize a vendor of health care services who is a licensed physician or pharmacist chosen by the facility.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0910 COUNTY MEDICAL ASSISTANCE PLAN.

Counties shall administer the MA program according to the rules, procedural regulations, and policies of the state agency, Minnesota Department of Human Services. Each local welfare agency shall develop methods and procedures for keeping adequate records to:

A. verify current individual eligibility for the MA program;

B. justify that payment for long term care facility services was correctly made; and

C. record individual eligibility for levels of care or other federal regulatory requirements as prescribed by the state agency.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.0920 ACCURATE FILE.

The county of service (physical residence of eligible recipient) is responsible for submitting necessary information to the Department of Human Services to insure compilation of an accurate recipient eligibility file. The county of service is solely and fully responsible for any payments made on behalf of ineligible recipients as a result of:

A. late or inaccurate redeterminations of eligibility;

B. noncompliance with utilization review and control requirements (see part 9500.0990);

C. inaccurate or incomplete record-keeping or failure to satisfy other written requirements (see part 9500.0930, subpart 3);

D. failure to submit accurate information on recipient eligibility to the Department of Human Services.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.0930 RECORDS.

Subpart 1. **In general.** The state and local welfare agencies and all medical providers shall maintain separate medical and/or fiscal records.

Subp. 2. **State agency records.** The state agency shall:

A. keep records necessary for a centralized disbursement system which maximizes federal financial participation (FFP);

B. maintain a recipient eligibility file based on information supplied by the county of service;

C. maintain records on all eligibile providers; and

D. maintain an information retrieval system for necessary statistical reports and/or audits of payment.

Subp. 3. **Local agency records.** Local welfare agencies shall:

A. maintain eligibility records to include at a minimum the recipient's application and redetermination forms, as necessary or advisable for efficient administration of the MA program; and

B. maintain records containing a physician's certification of recipient's need for inpatient care to be used by the Department of Human Services's utilization review and control system.

Subp. 4. **Provider records.** Medical providers participating in the MA program shall:

A. maintain for at least five years, in the manner prescribed by the Department of Human Services in accordance with applicable federal regulations, medical and financial records fully disclosing the extent of service provided, the medical necessity for such service and payment claimed under the MA program;

B. on request, and upon being provided a copy of the recipient's written consent, make their records available to the Department of Human Services, the state legislative auditor and the Department of Health, Education and Welfare (or representatives of those agencies) in order to justify all payments made to such provider and the propriety of all services rendered by such provider under the MA program;

C. not be subject to any civil or criminal liability for providing access to medical records to the commissioner of human services pursuant to Minnesota Statutes, chapter 256B.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.0940 THIRD-PARTY LIABILITY.

Subpart 1. **In general.** The term "third-party" as used herein includes, but is not limited to, insurance companies, (including HMOs); other governmental programs such as medicare; worker's compensation; and potential defendants in legal actions arising out of any type of accident or intentional tort. Insurance companies are liable for full payment of policy benefits on behalf of beneficiaries and any overage will be forwarded to the provider of service. Any recovery through court action shall be considered as a resource to the recipient in determining eligibility for medical assistance. A trust fund is a resource of first recourse.

Subp. 2. **Duties of local agency.** The local welfare agency shall:

A. determine and identify any third-party which has a potential legal liability to pay for medical care provided eligible medical assistance recipients prior to establishing or continuing recipient eligibility; and

B. as provided under state law, file its verified lien statements within one year from the date the last item of medical care was furnished.

Subp. 3. **Duties of state agency.** The state agency shall:

A. seek recovery of all third-party liability benefits;

B. distinguish between third-party liability which is a current resource and one which is not current, based on the following considerations:

(1) Current liability consists of but is not limited to, known amounts of participation or coverage payable by liable third parties; the amount of actual claims, payments or settlements received.

(2) Liability which is not current includes potential resources such as legal actions or disputable claims whose results are speculative and uncertain. In such cases, the state agency shall either perfect a lien or refer the matter to the county attorney in the county of financial responsibility for the purpose of perfecting a lien.

C. file its verfied lien statement within one year from the date the last item of medical care was furnished; and

D. refrain from withholding payment on behalf of an otherwise eligible recipient when third-party liability cannot be readily determined or collected.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0950 IDENTIFICATION CARD.

The state agency or the local welfare agency as directed by the state agency shall periodically issue medical assistance identification (ID) cards to eligible recipients, or if the recipient is legally incompetent to his guardian. Recipients shall show each provider a valid ID card establishing identity and current eligibility before obtaining medical care. Nothing in this rule shall be construed as requiring a provider to provide services to a recipient who fails to present a currently valid ID card. A provider may contact the local welfare agency for

verification of current eligibility if the recipient fails to present a currently valid ID card. The state agency may restrict the use of ID cards to particular providers of specified services when necessary to prevent duplication or documented abuse of services, to prevent violation of prior authorization requirements, or to assure continuity of care. Such restrictions on the use of ID cards shall be subject to the fair hearing requirements of applicable state law and federal regulations (see part 9500.0860, subpart 1). The state agency will periodically issue ID cards until instructed by the county of service that medical assistance eligibility no longer exists. The state agency shall automatically cease to issue cards when a spend-down period ends, when eligibility redeterminations are more than 90 days overdue, or when the special four month AFDC extended medical periods terminate in accordance with applicable federal regulations. Local welfare agencies shall notify the recipient during the first five days of the last month of eligibility prior to the automatic discontinuance to issue ID cards. The state agency shall be fully responsible for payments made on behalf of ineligible individuals due to state processing error.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0960 AGREEMENTS WITH PROVIDERS.

An eligible provider is a vendor of medical care, services, or supplies which meets federal and state standards for participation in the MA program, complies with all requirements of parts 9500.0750 to 9500.1080, and executes a provider agreement. Providers shall complete and sign an appropriate provider agreement in the form stipulated by the Department of Human Services. Failure by the provider to comply with federal and state statutes, rules, and regulations pertinent to the MA program shall result in termination of the provider agreement, ineligibility to receive MA program reimbursement and, where appropriate, action to recover medical assistance funds. In order to be eligible for reimbursement under the Minnesota MA program, out-of-state providers must complete and sign an appropriate provider agreement and comply with all licensing and certification requirements of the state or Canadian province in which they are located.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.0970 QUALIFICATION OF ELIGIBLE PROVIDERS.

The state agency shall determine the eligibility of each provider of medical care, services, and supplies. Any medical vendor who, on request, and upon being provided a copy of the recipient's written consent, refuses to allow a proper survey and/or reimbursement agency access to its records, shall become an ineligible provider upon written notification from the Department of Human Services. The commissioner may terminate payments under Minnesota Statutes, chapter 256B to any person or facility providing medical assistance which under applicable federal law or regulation, has been determined to be ineligible for payments under Title XIX of the Social Security Act. Any vendor of medical care who submits to the state agency a claim for reimbursement, a cost report, or a rate application which he knows to be false in whole or in part shall be declared ineligible for further payments of medical assistance funds by the commissioner of human services. The commissioner shall determine the time period of ineligibility and any conditions for reinstatement of eligibility. No vendor of medical care shall be declared ineligible without prior notice and an opportunity for a hearing, pursuant to Minnesota Statutes, chapter 14, on the commissioner's proposed action.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.0980 PRIOR AUTHORIZATION.

Services and items of care which must receive prior authorization are so indicated in part 9500.1070, subparts 1 to 23. The state agency shall provide vendors of medical care with designated forms to be used in making prior authorization requests. The vendor shall submit the contemplated charge and sufficient information to allow a reasonable evaluation of the request. The state agency shall send a form to the provider indicating whether the requested authorization has been approved or denied. The state agency shall use the following criteria in evaluating prior authorization requests in order to:

A. safeguard against the unnecessary or inappropriate utilization of care and services;

B. safeguard against excess payments;

C. assess the quality and timeliness of such services;

D. determine if less expensive medical care, services, or supplies are useable;

E. promote the most effective and appropriate use of available services and facilities; and

F. attempt to rectify misutilization practices of providers, recipients and institutions.

Emergency services may be covered under the MA program even if the required prior authorization was not obtained. In order to be covered, the provider shall attach to the invoice an explanation of the circumstances under which the services were provided and why such services should be classified as emergency care. The state agency shall reimburse only those services usually requiring prior authorization for which emergency status is established.

The state agency may delegate the responsibility for prior authorization of specific items and services to the local welfare agency which shall be responsible for implementing the methods and procedures prescribed.

Statutory Authority: *MS s 256B.04 subd 2*

9500.0990 UTILIZATION CONTROL.

Subpart 1. **Statewide program.** A statewide surveillance and utilization control program is established subject to applicable federal law and regulations. Such program shall include:

A. an ongoing evaluation of the necessity for the quality and timeliness of the services provided to eligible individuals under the MA program in order to promote the most effective and appropriate use of available services and facilities;

B. a post-payment review process which allows for the development and review of recipient utilization profiles, provider service profiles, exception criteria, and one which identifies exceptions in order to rectify misutilization practices of recipients, providers, and institutions.

Subp. 2. **Inpatient hospital services and services provided in skilled and intermediate care facilities.** Under this surveillance and utilization control program, all inpatient facilities shall:

A. have in effect a written utilization review plan which meets the requirements of applicable state law and federal regulations;

B. provide that the committee performing the utilization review activities will review each eligible individual's discharge plan to be developed in accordance with applicable state law and federal regulations;

C. obtain physician certification prior to or at the time of admission that such inpatient services are medically necessary or, in the case of an individual who applies for medical assistance while in an institution, obtain physician certification prior to authorization of payment;

D. obtain physician recertification at least every 60 days thereafter that such services continue to be medically necessary;

E. develop written plans of care in accordance with applicable state law and federal regulations; and

F. cooperate in a quality assurance and review program established by the Minnesota Department of Health in cooperation with the Department of Human Services and in accordance with the provisions of applicable state law and federal regulations.

Subp. 3. **Long-term care facility requirements.** In accordance with the surveillance and utilization control program, all long-term care facilities (i.e., skilled nursing facilities, intermediate care facilities, mental hospitals) shall provide for:

A. A periodic review and evaluation of the necessity for admission and continued stay of each eligible individual receiving inpatient long-term care facility services. Such review and evaluation shall be performed by medical and other appropriate professional staff who are not themselves directly responsible for the care of eligible individuals, nor financially interested in any such institution nor (except in the case of mental hospitals) employed by such institution. Such reviews and evaluations shall be carried out in accordance with the requirements specified in applicable federal regulations.

B. Review by the state agency (or its designee) of the recommendations for admission, in accordance with applicable federal regulations.

Subp. 4. **Medical and independent professional review.** Under the surveillance and utilization control program, the state agency shall establish and implement a program of medical review (including medical evaluation and on-site inspection) of the care provided patients in mental hospitals and skilled nursing facilities, and a program of independent professional review (including medical evaluation and on-site inspection) of the care provided residents in intermediate care facilities both of which shall satisfy the requirements of applicable federal regulations.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.1000 TRANSPORTATION.

The MA program shall pay for transportation through the centralized payment system only in accordance with part 9500.1070, subpart 22, item A. However, local welfare agencies may approve and pay for transportation when furnished by someone other than an enrolled medical provider. Such service must receive prior authorization and shall be reimbursable from the local welfare agency's medical assistance administrative account.

Statutory Authority: *MS s 256B.04 subd 2*

SERVICES UNDER THE MEDICAL ASSISTANCE PROGRAM

9500.1060 SERVICES NOT COVERED BY MEDICAL ASSISTANCE.

The following services are not covered under the MA program:

A. medical services or supplies paid for directly by the recipient;

B. medications dispensed by a physician that could reasonably be obtained from a licensed pharmacy (see part 9500.1070, subpart 18);

C. medical services or supplies where the requisite prior authorization was not submitted or was denied;

D. autopsies;

E. missed appointments;

F. telephone calls or other non face-to-face communication between the provider and the recipient;

G. routine reports (e.g., Social Security, insurance) unless requested by the state agency;

H. investigational surgery or procedures (e.g., research efforts not clearly essential to the patient's health);

I. illegal operations and other procedures prohibited by law;

J. artificial insemination;

K. transsexual surgery;

L. aversion therapy (including cash payments from recipients) unless provided in accordance with DPW 39 (12 MCAR section 2.039);

M. cosmetic surgery aimed at beautification only;

N. weight reduction programs unless the program treats a medical condition causing obesity, or obesity interferes with the health, well-being, or employability of the recipient;

O. billing charges;

P. mileage charged by eligible providers;

Q. reversal of voluntary sterilization procedures;

R. medical care or services for an individual who is an inmate of a public institution, except as a patient in a medical institution or as a resident of an intermediate care facility (i.e., an individual who is under the care or control of a correctional authority);

S. duplication of services by more than one provider without appropriate medical referrals; and

T. abortion services unless specifically provided in part 9500.1070, subpart 24.

Statutory Authority: *MS s 256B.04 subd 2*

NOTE: 12 MCAR section 2.039 (DPW 39) has been repealed.

9500.1070 SERVICES COVERED BY MEDICAL ASSISTANCE.

Subpart 1. **In general.** The following services are covered under the MA program.

Subp. 2. **Inpatient hospital services.** "Inpatient hospital services" are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients; and which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases; and which is licensed or formally approved as a hospital by the Minnesota Department of Health; and which is qualified to participate under title XVIII of the Social Security Act or is determined currently to meet the requirements for such participation; and which has in effect a utilization review plan applicable to all patients who receive medical assistance under title XIX of the Social Security Act which meets applicable federal requirements, unless a waiver has been granted by the secretary of the Department of Health, Education, and Welfare. All inpatient hospitals certified for participation under medicare (title XVIII) are eligible to participate in the MA program upon completion of a provider agreement.

The following inpatient hospitalization services must receive prior authorization: medical care of marginal medical necessity.

The following limitations apply to inpatient hospital services:

A. A private room must be certified by a licensed physician as medically necessary, unless the private room rate does not exceed the semiprivate room rate in that hospital.

B. The hospital must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment by the Department of Human Services.

The following inpatient hospital services are not covered under the MA program: leave days, leaves-of-absence, and reserved beds as defined under federal regulations.

Subp. 3. **Long term care facility services.** "Long term care facility services" are those services provided in facilities (or distinct parts thereof) licensed by the Minnesota Department of Health and certified as eligible providers of skilled nursing facility services, intermediate care facility services, tuberculosis or mental hospital services, or those facilities similarly licensed in another state or a Canadian province. The term "long term care facilities" (LTC) as used herein includes skilled nursing facilities (SNF), intermediate care facilities (ICF), and tuberculosis or mental hospitals.

A. "Skilled nursing facility services" (other than services in an institution for tuberculosis or mental disease) are those services provided in a SNF. A SNF is a facility certified by MDH as meeting the requirements of Title XVIII of the Social Security Act, except that the exclusion contained therein with respect to institutions which are primarily for the care of tuberculosis or mental disease shall not apply; and which meets the requirements of applicable federal regulations.

B. "Intermediate care facility services" (other than services in an institution for tuberculosis or mental disease) are those services provided for individuals who are determined, in accordance with Title XIX of the Social Security Act, to be in need of the care provided in an ICF. An ICF is an institution which:

(1) is licensed under state law to provide on a regular basis health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities;

(2) satisfies the standards prescribed by the secretary of health, education and welfare as necessary for the proper provision of such care as enumerated in applicable federal regulations; and

(3) meets such standards of safety and sanitation as mandated by federal regulations.

The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements described above. With respect to services furnished to individuals under age 65, the term intermediate care facility does not include any public institution for mental diseases or mental defects except it may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

"Intermediate care facility, services/nursing home" means services provided in an ICF-NH. An "ICF-NH" is an institution licensed as a nursing home and which meets each of the conditions described above. "Intermediate care facility services/boarding care home" means services provided in an ICF-BCH or which could be provided in an ICF-BCH. An "ICF-BCH" is an institution licensed at least as a boarding-care home and which meets each of the conditions described above.

"Intermediate care facility services/mentally retarded" means services provided in an ICF/MR. An "ICF/MR" is an institution licensed by the Minnesota Department of Health, licensed in accordance with parts 9525.0230 to 9525.0430 and which meets each of the conditions described above.

"Intermediate care facility services/chemically dependent" means services provided in an ICF/CD. An "ICF/CD" is a facility licensed by the Minnesota Department of Health, licensed under parts 9530.2600 to 9530.4000 and which meets each of the conditions described above.

C. "Inpatient psychiatric hospital services for individuals under age 21" are those services provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals. Such services include only inpatient services which, in the case of an individual:

(1) involve active treatment which meets the standards prescribed by the secretary of health, education and welfare;

(2) are provided by a team (consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and treatment thereof) and determined to be necessary on an inpatient basis and which can reasonably be expected to improve the condition giving rise to the need for such services, to the extent that eventually such services will no longer be necessary; and

(3) are provided prior to the date such individual attains age 21, or if the individual was receiving such services during the period immediately preceding his 21st birthday, such services may be continued up to the date the individual no longer requires such services or the date the individual attains age 22, whichever date comes first.

D. Inpatient hospital, SNF, and ICF services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.

(1) "Inpatient hospital services in an institution for mental diseases" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a psychiatric hospital which meets the requirements of title XVIII of the Social Security Act.

(2) "Inpatient hospital services in an institution for tuberculosis" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a tuberculosis hospital which meets the requirements of title XVIII of the Social Security Act.

(3) "Skilled nursing facility services" are those items and services furnished by a skilled nursing facility as defined by applicable federal regulations.

(4) "Intermediate care facility services" are those items and services furnished by an intermediate care facility, as defined by applicable federal regulations, to residents who have been determined in accordance with such federal regulations to be in need of such care.

(5) An "institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services.

(6) An "institution for tuberculosis" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with tuberculosis including medical attention, nursing care, and related services.

E. Levels of care. Reserved for future use.

F. General limitations. Payment will be made only to facilities that have in effect an approved utilization review plan and which meet all other requirements of the surveillance and utilization control program prescribed by applicable federal regulations. Medical assistance is not available on behalf of any individual who is an inmate of a public institution (except where a patient is in a medical institution (see Minnesota Statutes, chapter 256B) or is a resident of an intermediate care facility) or any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases. An individual on provisional discharge or convalescent leave from an institution for mental diseases is not considered to be a patient in such institution. An institution for the mentally retarded or an institution for the chemically dependent is not considered an institution for mental diseases. Payments to

institutions for the mentally retarded or persons with related conditions shall not include reimbursement for vocational and educational activities. Payment will be made to facilities only in accordance with applicable federal reimbursement formula regulations.

G. Health care facility report. Every facility required by state law to be licensed by the Minnesota Department of Health shall provide such annual reports to the commissioner of human services as may hereafter be required. Each health care facility participating under the MA program shall provide the commissioner of human services with a full and complete financial report of the facility's operations, including:

(1) an annual statement of income and expenditures;

(2) a complete statement of fees and charges;

(3) the names of all individuals, partnerships, and corporations (other than mortgage companies) owning any interest of ten percent or more of the facility; and

(4) the names of all owners of interest in the facility as defined in subitem (3), or the children, parents, or spouses of such owners who own an interest in any other health care facility or organization doing business with the MA program or who are otherwise enrolled as providers.

A chapter 9510 cost report shall satisfy this requirement. The financial records, reports, and supporting data of each participating facility shall be accessible for inspection and audit by the commissioner of human services or designees.

Subp. 4. **Physician services.** Physician services are those services provided by or under the personal supervision of a licensed physician or osteopath within the scope of his profession as defined by state law. All physicians currently licensed to practice medicine under Minnesota law are eligible to participate in the MA program. Out-of-state physicians who are licensed in the state of service are also eligible for participation in Minnesota's MA program. The MA program shall pay for all emergency and medically-necessary health care.

A. The following physician services must receive prior authorization:

(1) all medical, surgical, or behavioral modification services aimed specifically at weight reduction;

(2) surgery and other procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to interfere with the individual's personal and social adjustment or employability;

(3) removal of tattoo;

(4) payment for physicians' services exceeding 30 days of inpatient psychiatric treatment per calendar year;

(5) individual hourly sessions with a psychiatrist licensed to practice medicine in the United States or Canada in excess of ten per calendar year.

B. The following are limitations to physicians' services:

(1) The MA program will pay for up to ten hourly sessions with a psychiatrist licensed to practice medicine in the United States or Canada per calendar year for any eligible recipient.

(2) The MA program will pay for up to 26 additional hourly sessions with a psychiatrist licensed to practice medicine in the United States or Canada per calendar year when all of the following conditions exist:

(a) three or more members of one family unit are all seen together at every session;

(b) the 26 hourly sessions extend over a period of time greater than six consecutive months; and

(c) at least one of the family members is under age 18.

(3) The MA program will pay for ongoing chemotherapy management on a once-a-week average basis, provided that both of the following conditions apply: the medication required is an anti-psychotic or anti-depressant, and no more than 52 sessions take place within a 12-month period.

(4) The MA program will pay for family psychotherapy of two family members (conjoint psychotherapy with continuing medical diagnostic evaluation and drug management) as needed for up to two hours per week for a 20-week period. (When more than two family members are involved. See item B, subitem (2)).

(5) The MA program will pay for multiple family group-psychotherapy or group-psychotherapy for up to two hours per week for a ten-week period.

Subp. 5. **Health maintenance organization (HMO).** Health maintenance organizations are organizations licensed by the state which provide comprehensive health care to a voluntarily enrolled population in a specified geographic area. The MA program shall reimburse participating HMOs through a pre-negotiated and fixed per capita payment determined in accordance with applicable federal regulations made on behalf of enrolled recipients. HMOs shall provide, either directly or through arrangements with other medical providers, for all medical services and supplies covered under the offical medical assistance state plan. HMO services shall be provided in accordance with the HMO contract and shall not be subject to service limitations, prior authorization requirements, and billing and recovery procedures under parts 9500.0750 to 9500.1080.

Subp. 6. **Other licensed practitioners.** The MA program shall pay for medical and remedial care or services, other than physicians' services, provided by a practitioner currently licensed under Minnesota law and performed within the scope of his practice as defined by state law. Out-of-state practitioners who are licensed in the state of service are also eligible to participate in Minnesota's MA program. This category is limited to services provided by licensed chiropractors, podiatrists, vision care providers, psychologists, nurse-midwives, osteopaths not licensed to practice medicine and surgery, and by public health nurses. Limitations on the number of treatments pertain to each eligible recipient per calendar year.

A. Chiropractors. Chiropractors must be licensed and conform to the uniform minimum standards promulgated by the secretary of health, education and welfare under title XVIII of the Social Security Act, as amended. The MA program limits payment for services provided by chiropractors as follows:

(1) The request for chiropractic services must originate with the recipient, his family or caseworker and may proceed only with the recipient's full knowledge and consent.

(2) Payment is limited to manual manipulation of the spine for a diagnosis of subluxation of the spine. No other chiropractic service is covered under the MA program.

(3) Payment is limited to six treatments per month and 24 treatments per calendar year for each eligible recipient. Treatment in excess of these maxima must receive prior authorization.

(4) The MA program shall not cover Xrays nor any other diagnostic or laboratory procedure provided by a chiropractor.

B. Podiatrists. The MA program limits payment for podiatry services as follows:

(1) The request for podiatry services must originate with the recipient, his family, his caseworker or, where applicable, the staff of the long term care facility wherein he resides, and may proceed only with the patient's full knowledge and consent.

(2) A limit of three vists per month and 12 visits per year is placed on the following: total office and outpatient visits, total home or long term care facility visits, and hospital visits.

(3) Treatment in excess of these maxima must receive prior authorization.

(4) The following podiatry services are not covered under the MA program for long term care facility patients: ordinary foot hygiene, use of skin creams to maintain skin tone, and normal trimming of nails and other services that can reasonably and safely be performed by LTC facility personnel.

C. Vision care. "Optometric services" are those services provided by or under the personal supervision of a licensed optometrist within the scope of his profession as defined by state law. "Eyeglasses" are lenses (including frames when necessary) and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select, to aid or improve vision. Eligible providers include optometrists currently licensed by the Board of Optometry, ophthalmologists currently licensed by the state, opticians who are normally associated with the fabrication and/or dispensing of materials, and out-of-state providers in one of the above classifications licensed by the state of service.

(1) The following vision care services must receive prior authorization:

(a) Contact lenses: supplemental contact lens evaluation; contact lens check-up; spherical lens fitting (single vision); cylindrical, lenticular, aphakic, or prism ballast lenses; keratoconus lenses; cosmetic lenses (disfigurement only); fitting previous contact lens wearer; soft contact lens fitting; fitting monocular patient;

(b) Custom-fit prosthetic eye;

(c) Amblyopia therapy: "Amblyopia" includes all test procedures necessary for classification and determination of expecteds.

(d) Strabismus therapy: "Strabismus" includes all test procedures necessary for classification, degree of squint, and determination of expecteds.

(e) Vision therapy-supplemental evaluation and report.

(f) More than one pair of eyeglasses in any single 12-month period.

(g) Photochromatic lenses: must be accompanied by a statement of medical necessity.

(h) Sunglasses: must be accompanied by statement of medical necessity.

(i) Lens coating-surface or edge.

(2) The following vision care services are not covered under the MA program:

(a) services provided principally for cosmetic reasons, including contact lenses prescribed for reasons other than aphakia, keratoconus, aniseikonia, or marked acuity improvement over spectacle correction; and replacement of lenses or frames due to a recipient's personal preference for a change of style or color;

(b) technical services related to the provision of noncovered services.

D. Psychologists. Eligible providers are individuals currently licensed by the Minnesota Board of Examiners of Psychologists to practice as licensed psychologists or licensed consulting psychologists in the appropriate service areas.

(1) The following psychological services must receive prior authorization: services in excess of the limitation on the number of visits (see below).

(2) The MA program limits payment for services provided by psychologists as follows:

The MA program will pay for up to ten hourly sessions with a licensed psychologist per calendar year for any eligible recipient.

The MA program will pay for up to 26 additional hourly sessions with a licensed psychologist per calendar year when all of the following conditions exist: three or more members of one family unit are all seen together at every session, the 26 hourly sessions extend over a period of time greater than six consecutive months, and at least one of the family members is under age 18.

The MA program will pay for family psychotherapy of two family members as needed for up to two hours per week for a 20-week period. When more than two family members are involved, see subitem (2).

The MA program will pay for multiple family group-psychotherapy or group-psychotherapy for up to two hours per week for a ten-week period.

(3) The following psychological services are not covered under the MA program: medical supplies and equipment.

E. Public health nurses. A "public health nurse" is a registered nurse who is licensed as a professional nurse and certified by the State Board of Health as a public health nurse. The MA program limits payment for public health nurses to the following services:

(1) health assessment and screening;

(2) health promotion and preventive counseling;

(3) EPSDT screening if approved by the Minnesota Department of Health; and

(4) Health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided.

Subp. 7. **Outpatient hospital services.** "Outpatient hospital services" are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a licensed physician or dentist to an outpatient in an outpatient facility which is licensed as a hospital by the state and which is qualified to participate under title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation. All outpatient hospitals certified to participate under Medicare (title XVIII) are eligible to participate in the MA program upon completion of a provider agreement.

A. The following outpatient hospital services must receive prior authorization:

(1) kidney dialysis not covered by Medicare;

(2) oral surgery (except in emergencies);

(3) hemodialysis back-up service;

(4) supplemental and tube feedings for patients who have special nutritional needs; and

(5) all physician services which must receive prior authorization (see subpart 4, item A).

B. The following is a limitation to services provided by outpatient hospitals:

Each hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply will result in denial of payment under the MA program.

C. The following outpatient hospital services are not covered under the MA program: hypoallergenic foods, baby foods; diapers; charges for services of house staff, interns, residents, administrative or supervisory staff (including physician-owners) who are paid by the hospital or by other sources.

Subp. 8. **Clinic services.** "Clinic services" are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an an outpatient by or under the direction of a licensed physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients. Family planning agencies or centers are considered "clinics" under this definition.

"Family planning agencies" are agencies or clinics which primarily offer family planning related services and have executed either a contract or provider agreement with the state agency. Family planning agencies provide services concerned with the voluntary planning of the conception and bearing of children. Such services include both fertility and infertility programs.

The following are limitations to services provided by family planning agencies: the request for such services must originate with the recipient and proceed with his full knowledge and consent. The agency or clinic must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment under the MA program.

Subp. 9. **Home health care services.** "Home health care services" are any of the following items and services when they are prescribed by a licensed physician to a patient in his place of residence, but exluding residence in a hospital, SNF, or ICF:

A. intermittent or part-time nursing services furnished by a home health agency;

B. intermittent or part-time nursing services of a professional registered nurse or licensed practical nurse under the direction of the patient's physician, when no home health agency services are available;

C. medical supplies, equipment, and appliances prescribed by a physician as necessary for the care of the patient and suitable for use in the home;

D. services of a home health aide under the supervision of a professional nurse assigned by a home health agency.

A "home health agency" is a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act or is determined by the Department of Health to currently meet the requirements of applicable federal regulations. The following home health care services are not covered under the MA program: homemaker services and social services provided by a home health agency.

Subp. 10. **Medical supplies.** The term "medical supplies" as used herein includes the most cost effective nondurable medical supplies, durable medical equipment, prostheses, orthoses, and oxygen. Medical supplies must be prescribed by a physician or other licensed medical practitioner within the scope of his profession as defined by state law. Medical supplies must be necessary and reasonable for the treatment or diagnosis of an illness or injury or to improve the functioning of a malformed body member.

A. "Nondurable medical supplies" means those items which have a limited life expectancy (e.g., atomizers, nebulizers, fountain syringes, and incontinence pads).

B. "Durable medical equipment" means equipment which can withstand repeated use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home (e.g., wheel chairs, hospital beds, and side rails).

C. "Prostheses" and "orthoses" mean replacement, corrective, or supportive devices for the purpose of artificially replacing a missing portion of the body or to prevent or correct physical deformity or malfunction or to support a weak or deformed portion of the body.

D. The MA program pays for oxygen and any equipment necessary for administration of oxygen (or other than nasal catheters and positive pressure breathing apparatus) when prescribed by a licensed physician so long as prior authorization is obtained.

Payment for equipment repair will be allowed only when that equipment is medically necessary. Routine periodic servicing such as testing, cleaning, regulating, and checking of a recipient's equipment will not be covered. Extensive, complex maintenance may be covered as a necessary repair. Payment on equipment will not continue after the recipient's need for that equipment ceases to exist. The MA program will pay for supplies essential to the effective use of medically necessary durable equipment.

Eligible providers include those individuals or agencies who supply and/or service medical supplies. Medical supply and hearing aid dealers must complete a "Performance Agreement" to be eligible to participate in the MA program. Performance agreement as used herein means a written agreement between a provider of service and the state agency, as required by federal regulations.

E. The following medical supplies must receive prior authorization:

(1) nondurable medical supplies, when the cost exceeds the performance agreement limitations;

(2) durable medical equipment, when the purchase, projected cumulative rental, repair, or maintenance cost exceeds the performance agreement limitation;

(3) prostheses and orthoses, when:

(a) the purchase, projected cumulative rental, or repair cost exceeds the performance agreement limitations;

(b) the order is for an indwelling catheter (which requires a diagnosis of permanent urinary incontinence); or

(c) the order is for a hearing aid, repairs to hearing aids when the costs of parts and labor exceeds the performance agreement limitations, repairs under the limitations, if performed by a hearing aid dealer more than once a year, or visits by a hearing aid dealer/servicer to the recipient's home in excess of one visit per year;

(4) Oxygen and any equipment necessary for the administration of oxygen, except in documented emergencies;

(5) Medical supplies for recipients who are residents of long term care facilities may be authorized under the following conditions:

(a) the cost of a specific item cannot be covered in the per diem rate;

(b) the item is necessary for the continuous care and exclusive use of this recipient to meet an unusual medical need; and

(c) the need is identified and documented in the recipient's plan of care.

F. The following items are not covered under the MA program:

(1) Equipment primarily and customarily used for nonmedical purposes, i.e.: air conditioners, food blenders, exercycles, orthopedic mattresses, dehumidifiers, humidifiers, air filters, auto modifications, books, TV sets, bicycles, household items, safety bars, and training equipment;

(2) comfort or convenience items (i.e., electric beds, elevators, waterbeds, cushion lift chairs);

(3) stock orthopedic shoes unless attached to a leg brace;

(4) medical equipment and supplies for recipients who are residents of long term care facilities, except as provided in item E, subitem (5);

(5) the three follow-up visits per year at the hearing aid dealer's office or service center specified in the hearing aid performance agreement; and

(6) reimbursement to long term care facilities for any medical equipment or supplies other than allowed under chapter 9510.

Subp. 11. **Private duty nursing services.** "Private duty nursing services" are nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician to the patient in his own home or in a hospital or SNF, when the patient requires individual and continual care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or SNF. Eligible providers include registered nurses and licensed practical nurses in independent practice who provide services separate and apart from any employment or contract with any agency, organization, or facility.

The MA program pays for private duty nursing services only:

A. when ordered in writing by the patient's primary physician or consulting physician;

B. in hospitals having no intensive care unit capable of meeting the patient's needs;

C. in the family residence when there is no available home health care agency to provide the required level of nursing care which meets the requirements for participation under title XVIII of the Social Security Act; or

D. if the private duty nurse is not a member of the patient's family.

Subp. 12. **Rehabilitative and therapeutic services.** "Rehabilitative and therapeutic services" are provided for the purpose of increasing or maintaining the maximum level of functional independence of patients. These services are defined as follows and include the use of such supplies and equipment as necessary, when pursuant to physician orders and when purchased by a facility, agency, or independent practitioner.

Subp. 13. **Rehabilitative and therapeutic services in long-term care facilities.** Such services must be provided in accordance with applicable federal regulations, state law, and the Department of Human Services rules.

A. "Physical therapy" means those services prescribed by a physician and provided to a patient by a qualified physical therapist. In addition, other qualified rehabilitative personnel, including physical therapy assistants, physical therapy aides, and physical therapy orderlies may assist the physical therapist in performing physical therapy services and in the performance of duties that do not require a qualified physical therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified physical therapist. A "qualified physical therapist" is a graduate of a school of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, and who has a valid Minnesota certificate of registration (as soon as such certificate is available from the Minnesota Department of Health).

B. "Occupational therapy" means those services prescribed by a physician and provided to a patient by a qualified occupational therapist. In addition, other qualified rehabilitative personnel, including occupational therapy assistants, occupational therapy aides, and occupational therapy orderlies may assist the occupational therapist in performing occupational therapy services and in the performance of duties that do not require a qualified occupational therapist's knowledge and skill. The full responsibility for the patient's instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct, on-site observation and supervision by the qualified occupational therapist. A "qualified occupational therapist" is a graduate of a school of occupational therapy approved by the Council on

Medical Education of the American Medical Association and the American Occupational Therapy Association, and/or who is registered by the American Occupational Therapy Association.

C. "Services for individuals with speech, hearing, and language disorders" means those diagnostic, screening, preventive, or corrective services prescribed by a physician and provided by a qualified speech pathologist or a qualified audiologist in the practice of his profession. A "qualified speech pathologist" or "qualified audiologist" shall have a certificate of clinical competence from the American Speech and Hearing Association, or shall have completed the equivalent educational requirements and work experience necessary for obtaining such a certificate, or shall have completed the academic program and be in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

D. Specialized rehabilitative service requirements, inpatient and outpatient are:

(1) Restorative therapy. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonably and generally predictable period of time. This expectation shall be based on an assessment made by the attending physician of the patient's restorative potential after consultation with qualified rehabilitative personnel.

(2) Specialized maintenance therapy. Physician orders must relate the necessity for specialized maintenance therapy to the patient's particular disabilities. Such therapy must be necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's condition. Specialized maintenance therapy shall be provided only by qualified rehabilitative personnel and only to those patients who cannot be adequately and appropriately treated solely within the facility's nursing program.

E. Billing and reimbursement. The long term care facility in which the recipient resides shall bill on behalf of the rehabilitative personnel, agency or hospital for services provided. In cases where a patient residing in a facility is provided specialized rehabilitative services in a setting other than his residential facility, the residential facility shall bill for services provided pursuant to agreement with the agency, hospital, or other institution where the service is provided.

Reimbursement to qualified rehabilitative personnel (including rehabilitative assistants and aides) under contract with a facility: Each facility shall bill the MA program on behalf of qualified rehabilitative personnel providing services under contract to it.

Reimbursement to qualified rehabilitative personnel (including supervised rehabilitative assistants and aides) salaried by the facility. Each facility shall bill on behalf of salaried, qualified rehabilitative personnel for the services provided. At the end of each fiscal year, the facility shall:

(1) Determine the total number of treatment sessions provided by each salaried, qualified rehabilitative employee during the fiscal year. A "treatment session" is defined as one or more treatment procedures and/or modalities provided to one patient during one session.

(2) Determine, for each qualified rehabilitative employee, the total number of treatment sessions (as defined herein) provided to eligible recipients and indicate this number as a percentage of the total number of treatment sessions provided by the employee.

(3) Multiply the resulting percentage by the salary of the employee. "Salary" means all direct costs related to employment. If medical assistance reimbursement exceeds the percentage of salary related to treatment sessions provided to medical assistance recipients, the excess amount shall be applied to and, therefore, reduce the "general and administration" expenses on the health facility cost report submitted by the respective facility.

F. The following rehabilitative and therapeutic services are not reimbursable as a separate charge under the MA program when furnished in a long term care facility:

(1) Services authorized by a physician but not documented in the patient's medical record.

(2) Services provided by unsupervised assistants, aides and/or other supportive personnel. Salaries and costs related to these personnel are to be included as part of the facility's rate determination in accordance with the health facility cost report.

(3) Rehabilitative services provided by nursing personnel.

(4) Services for personal comfort.

(5) Services of qualified rehabilitative personnel related to training or consultation of facility staff.

(6) Activities programs.

(7) Services of a rehabilitative nature provided by living unit personnel, qualified mental retardation professionals, direct care staff, and training or habilitational personnel.

(8) Screening procedures not ordered by a physician.

(9) Services not reasonable and necessary to the treatment of the patient's condition.

(10) Services provided without written orders of the patient's attending physician.

(11) Services provided without physician review of the patient's progress and plan of care at least once every 30 days, with written certification and recertification by the physician.

(12) Services of a preventive or maintenance nature when physician orders do not relate such services to the patient's disabilities.

(13) Physical therapy services not authorized after the initial 90-day service period by an independent medical consultant or the facility's utilization review committee, or through the local welfare agency's approved review plan only if authorization by an independent medical consultant or the utilization committee is not possible.

(14) Outpatient services provided by a facility not certified as an outpatient provider.

(15) Outpatient services provided off the facility's premises.

(16) Services billed for by any source other than the skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

Subp. 14. **Speech pathology, audiology, and physical therapy provided by independent practitioners.** Such services are of a diagnostic, screening, preventive, or corrective nature and provided to individuals with speech, hearing and language disorders, or physical impairments. Such services must be provided in accordance with the applicable federal regulations, state law, and the Department of Human Services rules.

A. "Speech pathology" means those services prescribed by a licensed physician and provided to a patient by a qualified speech pathologist in independent practice. A "qualified speech pathologist in independent practice" shall have received a certificate of clinical competence from the American Speech and Hearing Association (ASHA) or shall have submitted to the MA program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

B. "Audiology" means those services prescribed by a licensed physician and provided to a patient by a qualified audiologist in independent practice. A "qualified audiologist in independent practice" shall have received the certificate of clinical competence from ASHA or shall have submitted to the

MA program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

C. "Physical therapy" means those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist in independent practice. A "qualified physical therapist in independent practice" is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, has a valid Minnesota Certificate of Registration (as soon as such certificate is available from the Minnesota Department of Health), and has been certified as an independent practitioner by the Minnesota Department of Health.

D. The following services are not covered as independent practitioner services under the MA program:

(1) services provided by an independent practitioner speech pathologist, audiologist, or physical therapist not maintaining at his own expense an office or office space and the necessary equipment to provide an adequate treatment program;

(2) services which are not physician prescribed;

(3) any service authorized by a physician but not documented in the clinical record of the patient;

(4) training or consultation provided by a speech pathologist, audiologist, or physical therapist to an agency, facility, or other institution;

(5) screening procedures not physician authorized;

(6) services provided under a written treatment plan which is not reviewed at least once every 30 days with certification and recertification by the ordering physician.

E. The following services of independent practitioners must be billed through the contracting or employing facility, agency, or person and will not be reimbursed directly to the practitioner:

(1) Services provided in settings other than the independent practitioner speech pathologist's, audiologist's, or physical therapist's own office or the recipient's place of residence. "Place of residence" excludes skilled nursing facilities, intermediate care facilities, hospitals, rehabilitation agencies, home health agencies, public health agencies, clinics, and day activity centers.

(2) Services of a speech pathologist, audiologist, or physical therapist employed and salaried by physicians.

Subp. 15. **Rehabilitation agencies.** A "rehabilitation agency" is an agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, a rehabilitation agency must provide physical therapy or speech pathology services, and a rehabilitation program which in addition to physical therapy or speech pathology services, includes social or vocational adjustment services. Eligible providers include all rehabilitation agencies participating in the medicare program (title XVIII) who have signed and returned to the state agency a provider agreement within 60 days after receipt thereof. "Rehabilitation agency services" are those services provided by certified rehabilitation agencies in accordance with applicable federal regulations, state law, and the Department of Human Services rules and defined as follows:

A. "Medical services" are those services provided to a patient within the scope and practice of medicine as defined by Minnesota law and performed by a currently licensed physician.

B. "Psychological services" are those services provided to a patient by a psychologist licensed to practice in the appropriate service areas, when medically necessary.

C. "Psychosocial services" are those services provided to a patient by a social worker for whom a licensed physician assumes total professional and administrative responsibility as if the services were provided by the physician himself. To receive reimbursement under the MA program all psychosocial services shall be ordered by a licensed physician.

D. "Physical therapy" means those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist. Other personnel may assist physical therapists in performing physical therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified physical therapist.

E. "Occupational therapy" are those services prescribed by a licensed physician and provided to a patient by a qualified occupational therapist. Other personnel may assist occupational therapists in performing occupational therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified occupational therapist.

F. "Speech pathology or audiology services for individuals with speech, hearing, and language disorders" are those diagnostic, screening, preventive, or corrective services provided by a qualified speech pathologist or audiologist in the practice of his profession for which a patient is referred by a licensed physician.

G. "Special services" are physician-ordered and monitored evaluations, classes, clinics, or programs provided to patients generally by a rehabilitation team.

H. The MA program will reimburse for services provided only by the following qualified personnel:

(1) Physicians. A qualified physician who is currently licensed in the state of Minnesota to practice medicine or, if an out-of-state physician, who is licensed in the state of service.

(2) Psychologists. A qualified psychologist who is currently licensed by the Minnesota State Board of Examiners of Psychologists as a licensed consulting psychologist or a licensed psychologist.

(3) Social workers. A qualified social worker is an individual with a master's degree from a school of social work accredited by the Council on Social Work Education.

(4) Physical therapists. A qualified physical therapist is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, and has a valid Minnesota certificate of registration.

(5) Occupational therapists. A qualified occupational therapist is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and/or who is registered by the American Occupational Therapy Association.

(6) Speech pathologists and audiologists. A qualified speech pathologist or audiologist is an individual with a certificate of clinical competence from the American Speech and Hearing Association or an individual who has completed the equivalent educational requirements and work experience necessary for obtaining such a certificate, or, who has completed the academic

program and is in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

I. Rehabilitation agencies, noncovered services include:

(1) services provided without physician orders (excluding psychological services);

(2) psychosocial services provided by a social worker when a licensed physician does not assume professional and administrative responsibility for such services;

(3) services authorized by a physician but not documented in the patient's clinical record; and

(4) services provided in day activity centers which are subsidiaries of rehabilitation agencies.

Subp. 16. **Dental services.** "Dental services" are diagnostic, preventive, or corrective procedures administered by or under the supervision of a licensed dentist. The MA program pays for all emergency care and basic medically necessary oral health needs. "Dentures" are artificial structures prescribed by a dentist to replace a full or partial set of teeth and made by or according to the directions of a licensed dentist. Eligible providers are dentists licensed to practice dentistry in Minnesota, another state, or a Canadian province.

A. The following dental services and procedures must receive prior authorization:

(1) pedodontics (only when the secondary tooth has completed two-thirds of its development);

(2) hospitalization for dental treatment;

(3) periodontics;

(4) root canal therapy (molars only and only if more than one needs treatment);

(5) gold restorations and/or inlays (including cast nonprecious and semi-precious metals);

(6) fixed prosthodontics;

(7) orthodontics;

(8) surgical services except emergencies and alveolectomies;

(9) removal of impacted teeth.

B. The following are limitations on the MA dental program:

(1) Oral hygiene instruction: one time only.

(2) Dentures (any type): one per five-year period, except under special circumstances and only then if prior authorization is received. Dentures that are lost and/or destroyed by recipient negligence will not be replaced during such five-year period.

(3) Relines or rebase: one every three years, except under special circumstances and only then if prior authorization is received.

(4) Patients in hospitals or long term care facilities: three visits by the dentist to the hospital or LTC facility per diagnosis. (As used here, "diagnosis" means evaluation, determination of medical condition, and plan of treatment. This limitation applies to inpatient hospital facilities only if the recipient has been hospitalized in order to treat a dental condition. This does not limit the number of visits a recipient can make to the dentist's office.)

C. The following services are not covered under the MA dental program:

(1) additional clasps for partial dentures;

(2) bases;

(3) sealants;

(4) local anesthetics when billed as a separate procedure;

(5) toothbrushes and/or other hygiene aids;

(6) services provided to a recipient in his home.

Subp. 17. **Other laboratory and X-ray services.** "Other laboratory and X-ray services" include professional and technical laboratory and radiological service ordered by a licensed physician, dentist, or other licensed practitioner within the scope of his practice as defined by state law and who is not employed by that laboratory. The MA program shall pay for such services only when provided by or under the direction of a physician or licensed practitioner in an office or similar facility other than a hospital outpatient department or clinic. Such laboratory must be qualified to participate under title XVIII of the Social Security Act, or be currently determined to meet the requirements for such participation. Eligible providers are facilities that render professional and technical laboratory services as described herein.

Subp. 18. **Pharmacy services.** A "pharmacy" is a facility licensed by the State Board of Pharmacy in which prescriptions, drugs, medicines, chemicals, and poisons are compounded, dispensed, vended, or sold on a retail basis. "Prescribed drugs" are any simple or compounded substance or mixture of substances prescribed for the care, mitigation, or prevention of disease or for health maintenance, by a physician, dentist, or other licensed medical practitioner within the scope of his professional practice as defined by state law. The MA program covers prescribed drugs obtained from a licensed pharmacy or from a hospital in which drug dispensing is under the supervision of a licensed pharmacist. All licensed pharmacies are eligible to participate in the MA program when the pharmacist in charge has enrolled as a provider in accordance with state agency requirements. The MA program shall pay for pharmaceuticals prescribed and dispensed by a physician or dentist in his office when there is no licensed pharmacy within the recipient's local trade area, as defined in part 9500.0900.

A. The following are service limitations of the MA pharmacy program:

(1) Pharmaceuticals must be prescribed by a licensed physician, dentist or other authorized licensed practitioner of the healing arts. The drug dispenser must keep the signed prescription on file for five years, subject to audit at any reasonable time. See part 9500.0930, subpart 4.

(2) Telephone orders, where legal, must be reduced to writing with the name of the prescribing physician shown and must be signed by the pharmacist.

(3) Prescription refills: the prescriber must indicate, either verbally or by specification on the original prescription, approval for refilling the prescription. As many as five refills may be authorized by the prescriber, but in such cases the total amount authorized must be dispensed within six months of the original prescription date, except when the patient is in a long term care facility where no such limit shall exist. In the absence of specific refill instructions, the prescription will be interpreted to be not refillable. Refills are covered only when refilled by the pharmacy where the original prescription was filled.

(4) The quantity supplied will depend on the usual and customary prescribing practice of the physician provided that the quantity does not exceed 30 days for acute illness and 100 days for maintenance therapy.

B. The following services must receive prior authorization: supplemental and tube feedings for patients who have special nutritional needs. The patient's dietary requirements must be identified on a physician's prescription and the product(s) must be available from an eligible supplier.

C. The following items are not covered under the MA pharmacy program:

(1) nonlegend drugs, stocked by a long term care facility and administered to a patient in such facility for short term (up to 36 hours) therapy;

(2) cosmetic products (including hypoallergenic cosmetics);

(3) toiletries (nonmedicated soaps, body lotions, powders) used for personal cleaning and grooming;

(4) oral antiseptics;

(5) dentifrices and other dental hygiene equipment and supplies;

(6) throat lozenges;

(7) contact lens wetting solutions and cleaners;

(8) investigational drugs;

(9) biologicals (i.e., vaccines, serums, toxoids) generally considered inappropriate for self-administration;

(10) amphetamines, amphetamine derivates, and any other Drug Enforcement Agency Schedule II anorexient agents for weight control purposes, except as provided in part 9500.1060, item N;

(11) nutritional services:

(a) modified diets consisting of conventional foods;

(b) salt and suger substitutes; salt or sugar-free specialty food and beverage products;

(c) baby foods;

(d) hypoallergenic foods (see item C);

(e) alcoholic beverages.

(12) any medication not prescribed by a licensed physician, dentist, or other licensed practitioner authorized by the state to prescribe drugs within the scope of practice.

Subp. 19. **Other diagnostic, screening, preventive, and rehabilitative services.** The MA program provides for these services as described herein:

A. "Diagnostic services," other than those for which provision is made elsewhere in this rule, include any medical procedure or supplies recommended for a patient by his physician or other licensed medical practitioner within the scope of his practice as defined by state law, as necessary to enable him to identify the existence, nature or extent of illness, injury, or other health deviation of the patient.

B. "Screening services" consist of the use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations, or to identify suspects for more definitive studies.

C. "Preventive services" are those services provided by a licensed physician or other licensed medical practitioner within the scope of his practice as defined by state law, to prevent illness, disease, disability, and other health deviations or their progression, and to prolong life and promote physical and mental health efficiency.

D. "Rehabilitative services" include any medical remedial items or services, except those expressly excluded under this rule, which are prescribed by a licensed physician or other licensed medical practitioner within the scope of his practice as defined by state law, for the purpose of reducing physical or mental disability and restoring the patient to his best possible functional level. Prior authorization must be obtained on any services for which payment is claimed under this section.

Subp. 20. **Early periodic screening, diagnosis, and treatment (EPSDT).** The MA program provides for early and periodic screening and diagnosis of individuals under the age of 21 to ascertain physical or mental defects and for health care, treatment, and other measures to correct or ameliorate defects and

chronic conditions discovered thereby. Services rendered by providers other than licensed physicians are reimbursable only if the Minnesota Department of Health has previously approved the screening activities.

In order to comply with federal and state EPSDT requirements, local welfare agencies shall:

A. notify in writing on an annual basis all recipients eligible for EPSDT services about the existence of such services;

B. provide or arrange for provision of screening services when they are requested;

C. arrange for needed corrective treatment; and

D. maintain adequate EPSDT records and report activities as required by federal and state agencies.

In order to comply with federal and state EPSDT requirements, providers shall follow required EPSDT billing/reporting procedures and adhere to free choice of provider policy when making referrals for recipients.

Subp. 21. **Health care insurance premiums.** The MA program shall pay health insurance premiums determined by the state agency to be cost-effective, for:

A. eligible recipients not covered under Title XVIII of the Social Security Act, when coverage under the insurance policy justifies the premium charged and the policy provides coverage only for health care;

B. supplemental medical insurance (SMI) on a buy-in basis for eligible recipients covered under title XVIII of the Social Security Act.

C. such other insurance programs as the state agency may approve for eligible recipients.

Subp. 22. **Other medical care.** The MA program shall pay for other necessary medical and/or remedial care as follows:

A. Transportation only when furnished by an enrolled medical provider licensed by the Minnesota Department of Health. See part 9500.0910.

The following services rendered by medical transportation providers are not covered under the MA program: any routine service determined by the local welfare agency not to be medically necessary, and ambulance service in cases where another means of transportation would have sufficed.

B. Emergency hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital equipped to furnish such services even though the hospital does not currently meet the conditions for participation under title XVIII of the Social Security Act or the definitions of inpatient or outpatient services.

C. Personal care services in a recipient's home rendered by an individual, other than a member of the patient's family, who is qualified to provide such services, when the services are prescribed by a physician and supervised by a registered nurse in accordance with a plan of treatment.

D. Whole blood, including items and services required in the collection, storage and administration thereof, when it has been ordered by a licensed physician and is not available to the patient from other sources.

E. Crippled children services program (CCS). Pursuant to a cooperative agreement between the Minnesota Department of Human Services and the Minnesota Department of Health, the Department of Human Services will reimburse the state's CCS program (title V) for diagnosis, evaluation, and ongoing medical follow-up services in CCS field clinics for medical assistance eligible children up to 21 years of age. The Department of Human Services will also reimburse CCS for evaluation, diagnosis, and/or consultation provided medical assistance eligible children who are residents of the Minnesota School

for the Deaf, the Minnesota School for the Blind and Visually Handicapped, and certain other state institutions.

Subp. 23. **Mental health centers.** "Mental health centers" are centers currently receiving grant-in-aid who are operating in accordance with parts 9520.0010 to 9520.0230. Services provided by mental health centers must be provided under the auspices and direction of a physiciatrist licensed to practice medicine in the United States or Canada or a licensed consulting psychologist, currently enrolled as an eligible provider under the MA program. The MA program will pay for mental health center services provided to residents of long term care facilities only if the attending physician helped develop the plan of treatment and periodically reviews that plan.

Mental health centers are subject to the same service limitations and prior authorization requirements as is the practitioner under whose auspices or direction the services are rendered. See part 9500.1070, subpart 4, items A and B, and subpart 6, item D.

The following mental health center services are not covered under the MA program: community planning, community consultation, program consultation, program and service monitoring and evaluation, public information and education, resource development, and training and education.

Subp. 24. **Abortions.** The cost of abortion services shall be paid only when the conditions under items A, B, and C are met:

A. The abortion is necessary to prevent the death of the mother. The cost of the abortion shall be covered only if the following documentation accompanies the provider's invoice to the state agency:

(1) the signed written statement of two physicians that it was their professional judgment that the abortion was necessary to prevent the death of the mother; and

(2) the signed written statement of the recipient that she voluntarily consented to the abortion. In the event that the recipient is physically or legally incapable of providing informed consent, consent may be obtained as is otherwise provided by law.

B. The abortion is to terminate a pregnancy which is the result of a sexual assault. The cost of the abortion shall be covered only if a report of the assault was made to a valid law enforcement agency within 48 hours of the time the assault occurred and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. In the event the recipient was physically unable to make the report within 48 hours of the assault, the report must have been made within 48 hours after the recipient became physically able to make the report.

The statement of the law enforcement agency shall include the following information:

(1) the name of the victim;

(2) the date of the alleged incident;

(3) the date the report was made to the law enforcement agency;

(4) the name and address of the person who signed the report to the law enforcement agency; and

(5) a statement by the law enforcement agency that the report alleges at least one of the following:

(a) circumstances existing at the time of the assault caused the recipient to have a reasonable fear of imminent great bodily harm to herself or to another;

(b) the assailant was armed with a dangerous weapon or an article used or fashioned in a manner which led the recipient to reasonably believe it to be a dangerous weapon, and used or threatened to use the weapon or article to cause the complainant to submit;

(c) the assailant caused personal injury to the complainant and used force or coercion to accomplish sexual penetration;

(d) the assailant was aided or abetted by one or more accomplices and either an accomplice used force or coercion to cause the recipient to submit, or an accomplice was armed with a dangerous weapon or an article used or fashioned in a manner to lead the complainant reasonably to believe it to be a dangerous weapon and used or threatened to use the weapon or article to cause the recipient to submit.

The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the sexual assault reported, and a statement, signed by the recipient's physician, that in his/her professional opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

C. The abortion is to terminate a pregnancy which is the result of incest. The cost of the abortion shall be covered only if a report of incest was made to a valid law enforcement agency prior to the time of the abortion and a signed statement from the law enforcement agency accompanies the provider's invoice to the state agency. The statement shall include the following information:

(1) the name of the victim;

(2) the date of the alleged incident;

(3) the date the report was made to the law enforcement agency;

(4) the name and address of the person who signed the report to the law enforcement agency; and

(5) a statement by the law enforcement agency that the name of the relative who allegedly committed incest with the victim appears in its report.

The provider's invoice shall also be accompanied by a statement, signed by the recipient, that her pregnancy resulted from the incest reported, and a statement, signed by the recipient's physician, that in his/her professional opinion the length of the pregnancy at the time of the abortion was not inconsistent with the recipient's statement.

D. For the purposes of this subpart only, the following definitions apply:

(1) "Abortion services" mean medical service performed for the purpose of terminating a pregnancy. This shall not be construed to include drugs or devices which prevent implantation of the fertilized ovum, or medical procedures necessary for the termination of an ectopic pregnancy.

(2) "Assailant" means a person who allegedly committed the sexual assault reported to the law enforcement agency.

(3) "Incest" means sexual intercourse with another nearer in kin than first cousin, of the whole or half-blood.

(4) "Valid law enforcement agency" means an agency charged under applicable law with enforcement of the general penal statutes of the United States, or of any state or local jurisdiction.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9500.1080 REIMBURSEMENT.

Subpart 1. **Payments to eligible providers.** Participation in the MA program is limited to those providers of medical care, service and supplies who accept as payment in full amounts paid in accordance with the Department of Human Services's maximum allowable charges. Providers are prohibited from requesting or receiving additional payment from the recipient, his relatives or guardian, except to meet the spend-down provision of state law. Providers will be directly paid for providing medical care and services rendered within the

scope of practice recognized under federal and state law and regulations. The state agency or, where appropriate, the local welfare agency, may pay an agency, institution or group pursuant to a contract with an approved provider only if required under a written contract between the provider and the agency, institution or group. The state agency shall have access to all such contracts at its request.

Subp. 2. **Billing procedures.** Providers of medical care and services shall bill the state agency up to their usual and customary fee and only after the medical care or services have been provided. Providers proven to consistently bill in excess of their usual and customary fee shall be referred to the SURS program for investigation and, if appropriate, shall be determined ineligible to participate in the MA program. Medical bills should be presented for payment at the conclusion of each month's service. Providers shall bill within 12 months of the date of service or, in unusual circumstances, in accordance with applicable federally-imposed time restrictions. The state agency shall deny payment until the following criteria have been met:

A. Providers submit all necessary forms and reports to the appropriate state or local welfare agency.

B. All prior authorization requirements are fulfilled.

C. Providers bill for care or services rendered on prescribed forms according to state agency instructions. The state agency shall require providers to submit diagnosis and procedure codes on all billings when deemed necessary for proper administration of the MA program, to comply with applicable federal regulations and to maximize federal financial participation.

D. Providers shall bill the state agency directly, except as follows:

(1) where a written contract or other formal arrangement exists between the provider of the service and any agency, institution or group, in which case such agency, institution, or group shall bill the state agency;

(2) if a provider of service who is eligible to accept Medicare assignments wishes to be paid by the MA program, such provider shall accept assignments on Medicare billings and shall bill Medicare prior to billing the MA program.

Subp. 3. **Authority to recover from medical providers.** The state agency is authorized to recover any medical assistance funds paid to providers when it determines that such payment was obtained fraudulently or erroneously. Such recovery may be accomplished through withholding current obligations due the provider or by demanding that the provider refund amounts so received. Recovery under the MA program is permitted for intentional as well as unintentional error on the part of the provider or state or local welfare agency; for failure to comply fully with all utilization control requirements, prior authorization procedures or billing procedures; for failure to properly report third-party payments; and for fraudulent actions on the part of the provider.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*