# CHAPTER 9500

# DEPARTMENT OF HUMAN SERVICES

# ASSISTANCE PAYMENTS PROGRAMS

## HOSPITAL MEDICAL ASSISTANCE REIMBURSEMENT



## GENERAL ASSISTANCE

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Subp. 4. [Repealed, 14 SR 8]

Subp. 5. [Repealed, 12 SR 624]

Subp. 6. [Repealed, 14 SR 8]

Subp. 7. [Repealed, 12 SR 624]

Subp. 8. [Repealed, 12 SR 624]

Subp. 9. [Repealed, 12 SR 624]

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Subp. 11. [Repealed, 12 SR 624]

Subp. 12. [Repealed, 15 SR 2404]

Subp. 13. [Repealed, 15 SR 2404]

Subp. 14. [Repealed, 15 SR 2404]

Subp. 15. [Repealed, 15 SR 2404]

Subp. 16. [Repealed, 12 SR 624]

Subp. 17. [Repealed, 12 SR 624]

Subp. 18. [Repealed, 12 SR 624]

Subp. 19. [Repealed, 12 SR 624]

Subp. 20. [Repealed, 12 SR 624]

Subp. 21. [Repealed, 12 SR 624]

Subp. 22. [Repealed, 12 SR 624]

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## HOSPITAL MEDICAL ASSISTANCE REIMBURSEMENT

### 9500.1090 PURPOSE AND SCOPE.

Parts 9500.1090 to 9500.1140 establish a prospective payment system for inpatient hospital services provided under the medical assistance and general assistance medical care programs.

Parts 9500.1090 to 9500.1140 are not applicable to inpatient hospital services provided by state-owned hospitals or to facilities of the Indian health service and facilities operated by a tribe or tribal organization under funding authorized by title I or III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, or by United States Code, title 25, chapter 14, subchapter II, sections 450f and 450n.

If it is determined that any provision of parts 9500.1090 to 9500.1140 conflicts with requirements of the federal government with respect to federal financial participation in medical assistance, the federal requirements prevail.

**Statutory Authority:** *MS s 256.9685; 256.969; 256.9695*

**History:** *10 SR 227; 11 SR 1688; 13 SR 1689; 18 SR 1115; 26 SR 976*
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### 9500.1095 STATUTORY AUTHORITY.

Parts 9500.1090 to 9500.1140 are authorized by Minnesota Statutes, sections 256.9685, 256.9686, 256.969, and 256.9695. Parts 9500.1090 to 9500.1140 must be read in conjunction with Titles XVIII and XIX of the Social Security Act, Code of Federal Regulations, title 42, Minnesota Statutes, chapters 256, 256B, and 256D, parts 9505.0170 to 9505.0475 which govern covered services, parts 9505.5000 to 9505.5030 which govern prior authorization, parts 9505.0545 and 9505.5035 to 9505.5105 which govern second surgical opinion, and parts 9505.0500 to 9505.0540 which govern admission certification.

**Statutory Authority:** *MS s 256.9685; 256.969; 256.9695*

**History:** *10 SR 227; 13 SR 1689; 18 SR 1115*
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**9500.1100 DEFINITIONS.**

Subpart 1. **Scope.** As used in parts 9500.1090 to 9500.1140, the terms in subparts 1a to 51 are defined as follows.

Subp. 1a. **Accommodation service.** "Accommodation service" means those inpatient hospital services included by a hospital in a daily room charge. Accommodation services are composed of general routine services and special care units. These routine and special care units include the nursery, coronary, intensive, neonatal, rehabilitation, psychiatric, and chemical dependency care units.

Subp. 2. **Adjusted base year operating cost.** "Adjusted base year operating cost" means a hospital's allowable base year operating cost per admission or per day, adjusted by the hospital cost index.

Subp. 3. **Admission.** "Admission" means the time of birth at a hospital or the act that allows a patient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Subp. 4. [Repealed, 18 SR 1115]

Subp. 4a. [Repealed, 18 SR 1115]

Subp. 5. **Allowable base year operating cost.** "Allowable base year operating cost" means a hospital's base year inpatient hospital cost per admission or per day, that is adjusted for case mix and excludes property costs.

Subp. 6. **Ancillary service.** "Ancillary service" means inpatient hospital services that include laboratory and blood, radiology, anesthesiology, electrocardiology, electroencephalography, pharmacy and intravenous therapy, delivery and labor room, operating and recovery room, emergency room and outpatient clinic, observation beds, respiratory therapy, physical therapy, occupational therapy, speech therapy, medical supplies, renal dialysis, and psychiatric and chemical dependency services customarily charged in addition to an accommodation service charge.

Subp. 7. [Repealed, 18 SR 1115]

Subp. 8. [Repealed, 18 SR 1115]

Subp. 8a. [Repealed, 18 SR 1115]

Subp. 9. **Base year.** "Base year" means a hospital's fiscal year that is recognized by Medicare, or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information with Medicare, from which cost and statistical data are used to establish medical assistance and general assistance medical care rates.

Subp. 10. [Repealed, 18 SR 1115]

Subp. 11. **Case mix.** "Case mix" means a hospital's admissions distribution of relative values among the diagnostic categories.

Subp. 12. [Repealed, 18 SR 1115]

Subp. 12a. **Charges.** "Charges" means the usual and customary payment requested by the hospital of the general public.

Subp. 12b. **City of the first class.** "City of the first class" means a city that has more than 100,000 inhabitants, provided that once a city is defined to be of the first class, it shall not be reclassified unless its population decreases by 25 percent from the census figures which last qualified the city for inclusion in the class.

Subp. 13. [Repealed, 18 SR 1115]

Subp. 14. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or an authorized representative of the commissioner.

Subp. 15. [Repealed, 18 SR 1115]

Subp. 16. **Cost-to-charge ratio.** "Cost-to-charge ratio" means a ratio of a hospital's inpatient hospital costs to its charges.

Subp. 17. [Repealed, 18 SR 1115]

Subp. 18. **Day outlier.** "Day outlier" means an admission whose length of stay exceeds the mean length of stay for neonate and burn diagnostic categories by one standard deviation, and in the case of all other diagnostic categories by two standard deviations.

Subp. 19. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 20. [Repealed, 18 SR 1115]

Subp. 20a. **Diagnostic categories.** "Diagnostic categories" means the diagnostic classifications containing one or more diagnosis related groups (DRG's) used by the Medicare program and identified in parts 9500.1090 to 9500.1140. The DRG classifications must be assigned according to the base year program and specialty groups with modifications as specified in subparts 20b to 20g.

Subp. 20b. **Diagnostic categories eligible under the medical assistance program.** The following diagnostic categories are for persons eligible under the medical assistance program except as provided in subpart 20d, 20e, or 20f:

| DIAGNOSTIC CATEGORIES | DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES | INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed., CLINICAL MODIFICATIONS CODES |
|---|---|---|
| A. Nervous System Diseases and Disorders | | |

| | | |
|---|---|---|
| (1) Intracranial vascular procedures with PDx of hemorrhage | 528 | |
| (2) Craniotomy for multiple significant trauma, Implant of chemotherapeutic agent or complex CNS diagnosis | 484, 543 | |
| (3) Ventricular shunt, all ages, with CC and Craniotomy, age > 17, with CC | 001, 003, 529 | 003 includes shunt with CC as the principal procedure |
| (4) Spinal and Extracranial procedures, and Stroke with thrombolytic agent | 531-533, 559 | |
| (5) Craniotomy, age 0-17 | 003 | 003 excludes shunt as the principal procedure |
| (6) Craniotomy, age > 17 without CC and Other nervous system procedures with CC | 002, 007 | |
| (7) Other nervous system, Ventricular shunt and Extracranial procedures without CC | 003, 008, 530, 534 | 003 includes shunt without CC as the principal procedure |
| (8) Spinal disorders and injury, Nervous system infection, and Hypertensive encephalopathy | 009, 020, 022 | |
| (9) Intracranial hemorrhage or Cerebral infarction | 014 | |
| (10) Neoplasms and Degenerative disorders of the nervous system, Stupor with coma > 1 hour | 010, 012, 027 | |
| (11) Nonspecific cerebrovascular disorders and Stupor with coma < 1 hour with CC, and Other disorders of the nervous system | 016, 028, 034, 035 | |
| (12) Nonspecific CVA, Cranial and peripheral nerve disorder, Other stupor and coma | 015, 018, 023, 030 | |
| (13) Seizure and headache age > 17, with CC | 024 | |
| (14) Nervous system neoplasm without CC, Multiple Sclerosis, and Cerebral Ataxia | 011, 013 | |

| | | |
|---|---|---|
| (15) Other nervous system diseases and disorders | 017, 019, 021, 026, 029, 033, 524 | |
| (16) Seizure and headache without CC and Concussion, age > 17 | 025, 031, 032 | |

B. Eye Diseases and Disorders

| | | |
|---|---|---|
| (1) Surgical procedures of Eyes | 036-042 | |
| (2) Eye disorders and diseases | 043-048 | |

C. Ear, Nose, Throat, and Mouth Diseases and Disorders

| | | |
|---|---|---|
| (1) [Reserved for future use] | | |
| (2) [Reserved for future use] | | |
| (3) [Reserved for future use] | | |
| (4) [Reserved for future use] | | |
| (5) Other ENT and mouth OR procedures | 063 | |
| (6) Miscellaneous and major ear, nose, throat and mouth procedures | 049, 055 | Codes in DRG 049 except 20.96-20.98 |
| (7) Cochlear Implants only | 049 | Codes 20.96-20.97 |
| (8) Sinus, mastoid, salivary gland and nose procedures | 050, 053, 054, 056 | |
| (9) T & A, Myringotomy, and Salivary gland procedures | 051, 057, 060, 061, 062 | |
| (10) Cleft lip and palate repair and Other T & A procedures | 052, 058, 059 | |
| (11) Epiglottis, Nasal trauma, and ENT and mouth malignancy | 064, 067, 072, 073 | |
| (12) Other ENT and mouth diagnoses and other mouth procedures | 066, 068, 074, 168, 169, 185, 187 | |
| (13) Disequilibrium, Otitis media with CC, age 0-17, and Other dental and throat disease | 065, 069, 070, 071, 186 | |

D. Respiratory System Diseases and Disorders

| | | |
|---|---|---|
| (1) With Ventilator support < 96 hrs | 475 | excludes 96.72 |
| (2) With ventilator support 96+ hrs | 475 | includes 96.72 |
| (3) [Reserved for future use] | | |
| (4) [Reserved for future use] | | |
| (5) [Reserved for future use] | | |
| (6) Respiratory neoplasms | 082 | |
| (7) [Reserved for future use] | | |
| (8) [Reserved for future use] | | |
| (9) COPD, Simple pneumonia with CC, Chest trauma without CC, and Other respiratory disorders | 084, 088, 089 | |
| (10) Tracheostomy for face, mouth, and neck diagnoses | 482 | |
| (11) Bronchitis and asthma with CC or Simple pneumonia and pleurisy except with CC | 090, 091, 096 | |
| (12) Pleural effusion, Infection and inflammation with CC, Pulmonary edema and respiratory failure | 079, 085, 087 | |
| (13) Pulmonary embolism and Other respiratory diseases with CC | 078, 101 | |
| (14) [Reserved for future use] | | |
| (15) Specific respiratory system diseases and disorders | 080, 081, 083, 092 | |
| (16) Pleural effusion, Pneumothorax, Bronchitis and Other diagnoses without CC | 086, 095, 097, 098, 100, 102 | |
| (17) Ventilator 96+ hours With ECMO/Tracheostomy with major surgery or With extensive burns with skin graft | 504, 541 | |
| (18) Tracheostomy with ventilator 96+ hours or without major surgery | 542 | |
| (19) Major chest procedures | 075 | |

| | |
|---|---|
| (20) Other respiratory system OR procedures with CC | 076 |
| (21) Other respiratory system OR procedures without CC | 077 |

E. Circulatory System Diseases and Disorders

| | |
|---|---|
| (1) Major cardiac surgeries | 105, 106, 108, 110, 547, 549 |
| (2) [Reserved for future use] | |
| (3) Permanent cardiac pacemaker except device replacement without major CV disease, and other procedures for circulatory disease | 114, 517, 552 |
| (4) Major cardiac surgery and implantable defibrillator | 104, 515, 535, 536 |
| (5) Other cardiac interventional and vascular procedures, and Pacemaker device replacement | 118, 120, 479, 518, 554, 556 |
| (6) Amputation for circulatory disease except upper limb and toe | 113 |
| (7) Drug-eluding stent, Other vascular procedures, Cardiac pacemaker with major CV diagnosis or AICD lead or generator | 551, 553, 557, 558 |
| (8) Heart failure and shock and Unexplained cardiac arrest | 127, 129 |
| (9) AMI without major complications, Cardiac cath without complex diagnoses, and Hypertension | 122, 125, 134 |
| (10) Peripheral vascular disease with CC | 130 |
| (11) Acute MI and Other circulatory diagnoses with CC and endocarditis | 121, 126, 144 |
| (12) ASHD with CC, Other circulatory conditions without CC, and Vein ligation and stripping | 119, 132, 139, 140, 143, 145 |
| (13) Deep vein thrombophlebitis, peripheral vascular disorders without CC, Congenital valve disease, age > 17 and Arrhythmia with CC | 128, 131, 135, 136, 138 |

| | |
|---|---|
| (14) Major CV procedure without CC, Acute MI, expired, and Cardiac cath with complex diagnosis | 111, 123, 124 |
| (15) Syncope and collapse with and without CC | 141, 142 |
| (16) Atherosclerosis with CC, Congenital and valvular disorders, age 0-17 | 133, 137 |
| (17) Coronary bypass with and without cath, without major CV diagnosis | 548, 550 |
| (18) Percutaneous cardiovascular procedure with major CV diagnosis | 555 |

F. Digestive System Diseases and Disorders

| | |
|---|---|
| (1) Anal/stomal, Hernia, Appendectomy and other procedures | 158, 162, 163, 167 |
| (2) Hernia procedures age > 17, Appendectomy without complicating diagnosis with CC | 160, 161, 166 |
| (3) Bowel and other digestive system surgery | 147, 151, 153, 155, 157, 159, 165, 171 |
| (4) Stomach and esophagus procedures and Digestive disease, age 0-17 | 149, 156, 164, 172, 190 |
| (5) Other surgical procedures of the digestive system with CC | 152, 170 |
| (6) Rectal resection, Lysis of peritoneal adhesions and Other major bowel surgery | 146, 148, 150, 154 |
| (7) Digestive system conditions including malignancy, hemorrhage and obstruction | 173, 174, 180, 188 |
| (8) Other bowel, stomach, digestive system diseases with and without CC | 176, 177, 179, 182, 189 |
| (9) Digestive system Obstruction, Uncomplicated ulcer, and GI hemorrhage | 175, 178, 181, 183, 184 |

G. Hepatobiliary System Diseases and Disorders

| | |
|---|---|
| (1) Liver and Biliary tract disorders without CC | 206, 208 |
| (2) Disorders of the pancreas except malignancy | 204 |

| | |
|---|---|
| (3) Other disorders of liver except malignancy, cirrhosis, and alcoholic hepatitis with CC | 205 |
| (4) Malignancy of hepatobiliary system or pancreas and Cirrhosis and alcoholic hepatitis | 202, 203 |
| (5) Biliary tract disorders, laparoscopic chole without CDC, without CC | 194, 207, 494 |
| (6) Cholecystectomy except lap without CC and laparoscopic chole with CC | 196, 198, 493 |
| (7) Other surgery for liver, gall bladder and pancreas disease | 192, 195, 197, 199, 200 |
| (8) Biliary, Pancreas and Liver procedures with CC | 191, 193, 201 |

H. Diseases and Disorders of the Musculoskeletal System and Connective Tissues

| | |
|---|---|
| (1) Combined anterior/posterior spinal fusion | 496, 546 |
| (2) Spinal fusion except cervical without CC | 497 |
| (3) Hip and femur procedures with CC and other musculoskeletal surgery | 210, 217, 233, 471, 498, 501 |
| (4) Surgeries of hip and lower extremity and cervical fusion without CC | 212, 213, 216, 519, 544, 545 |
| (5) Back and neck except fusion and Lower extremity procedures | 211, 218, 220, 228, 234, 491, 499 |
| (6) Other surgeries for soft tissue and removal of fix device | 226, 227, 520, 537 |
| (7) Other orthopedic procedures on lower extremity | 219, 225, 230, 502, 503 |
| (8) Upper extremity and back procedures without CC | 223, 500, 538 |
| (9) Carpal tunnel release and Minor arm procedures | 006, 224, 229, 232 |
| (10) Connective tissue disorders | 240, 242, 244 |
| (11) Pathological fracture, musculoskeletal malignancy and Septic arthritis | 239, 242 |

| | |
|---|---|
| (12) Fractures, sprains and other injuries | 235-238, 241, 243, 245, 248, 250, 253, 255, 256 |
| (13) Other musculoskeletal disorders, Signs and Symptoms, Limb injury, and Aftercare | 246, 247, 249, 251, 252, 254 |

I. Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast

| | |
|---|---|
| (1) Skin graft and debridement with CC and Malignant breast disease | 263, 265, 274 |
| (2) Treated with skin graft, biopsy, or debridement | 262, 264, 266, 269, 271 |
| (3) Other skin and subcutaneous diseases and procedures | 257, 258, 261, 267, 270, 272, 273, 275, 277 |
| (4) Subtotal mastectomy and Other skin, subcutaneous tissue, and breast conditions | 259, 260, 268, 278-280, 282, 283 |
| (5) Nonmalignant breast and Minor skin disorders without CC | 276, 281, 284 |

J. Endocrine, Nutritional, and Metabolic Diseases and Disorders

| | |
|---|---|
| (1) Major surgical procedures | 285-288, 292, 293 |
| (2) Diabetes, age > 35 | 294 |
| (3) Nutritional and miscellaneous metabolic conditions, age > 17 and inborn metabolic errors | 296, 299 |
| (4) Metabolic disorders, age 0-17 and Diabetes, age 0-35 | 295, 298 |
| (5) Metabolic disorders, age > 17 and Endocrine disorders without CC | 297, 301 |
| (6) Other endocrine, nutritional, and metabolic conditions | 289-291, 300 |

K. Kidney and Urinary Tract Diseases and Disorders

| | |
|---|---|
| (1) Kidney, ureter, or major bladder procedures | 303, 304, 315 |
| (2) Prostatectomy and kidney procedures for non-neoplasm | 305, 306, 308, 312 |

| | |
|---|---|
| (3) Neoplasms with CC and other kidney and urinary tract conditions without CC or age 0-17 | 318, 331, 333 |
| (4) Renal failure | 316 |
| (5) Other kidney and urinary tract conditions and Admission for renal dialysis | 317, 320-322, 325, 328, 332 |
| (6) Kidney stones and other kidney and urinary symptoms without CC | 319, 324, 326, 327, 329, 330 |
| (7) TURP and other prostate surgeries | 307, 309-311, 313, 314, 323 |

L. Male Reproductive System Diseases and Disorders

| | |
|---|---|
| (1) Treated with major surgery or with CC | 334, 336, 338, 340, 341, 344 |
| (2) Treated with minor surgery or without CC | 335, 337, 339, 342, 343, 345 |
| (3) Malignancy and other diseases treated without surgery | 346, 347, 348, 349, 350, 351, 352 |

M. Female Reproductive System Diseases and Disorders

| | |
|---|---|
| (1) Tubal interruption and Reconstructive procedures, D & C, conization except for malignancy | 356, 361, 362, 364 |
| (2) Uterine and adnexa procedures without CC | 355, 359, 363, 367 |
| (3) Menstrual and Other female reproductive system infections and disorders | 368, 369 |
| (4) [Reserved for future use] | |
| (5) Other female reproductive system procedures | 358, 360, 365 |
| (6) Pelvic evisceration, radical hysterectomy, surgery and medical treatment for malignancy | 353, 354, 357, 366 |

N. Pregnancy Related Conditions

| | |
|---|---|
| (1) Postpartum and postabortion diagnoses with surgery | 377 |
| (2) Ectopic pregnancy and other antepartum diagnoses without CC | 378, 384 |

| | |
|---|---|
| (3) Postpartum and postabortion conditions treated without surgery | 376 |
| (4) Abortion with surgery | 381 |
| (5) [Reserved for future use] | |
| (6) Threatened abortion | 379 |
| (7) Abortion without D & C, False labor, and Other conditions without surgery | 380, 382, 383 |

O. [Reserved for future use]

P. Blood and Immunity Disorders

| | |
|---|---|
| (1) Splenectomy and Other surgical procedures of blood forming organs | 392, 393, 394 |
| (2) [Reserved for future use] | |
| (3) Red blood cell disorders age > 17 | 395 |
| (4) Red blood cell disorders age 0-17 | 396 |
| (5) Coagulation, reticuloendothelial and immunity disorders with CC | 397, 398 |
| (6) Reticuloendothelial and immunity disorders without CC | 399 |

Q. Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and other Neoplasms

| | |
|---|---|
| (1) [Reserved for future use] | |
| (2) Treated with chemotherpay with acute leukemia as secondary diagnosis | 492 |
| (3) [Reserved for future use] | |
| (4) Treated with radiotherapy or chemotherapy without acute leukemia | 409, 410 |
| (5) [Reserved for future use] | |

| | | |
|---|---|---|
| (6) Surgical treatments for myeloproliferative diseases and disorders | 401, 402, 406-408, 539, 540 | |
| (7) Other nonsurgical treatments for myeloproliferative diseases and disorders | 403-405, 411-414, 473 | |

R. Infections and Parasitic Diseases

| | | |
|---|---|---|
| (1) Treated with surgical procedure | 415 | |
| (2) Other infection and parasitic diseases | 423 | |
| (3) Septicemia age > 17 | 416 | |
| (4) Septicemia age 0-17 | 417 | |
| (5) Postop and post-traumatic infections and Fever of unknown origin (FUO), age > 17 with CC | 418, 419 | |
| (6) Viral illness and fever of unknown origin, age 0-17 | 422 | |
| (7) FUO without CC and Viral illness, age > 17 | 420, 421 | |

S. Mental Diseases and Disorders

| | | |
|---|---|---|
| (1) Treated with surgical procedure (ages 0+) | 424 | |
| (2) (Ages 0-17) | 425, 427-429, 432 | |
| (3) (Ages > 17) | 425, 427-429, 432 | |

T. Substance Use and Substance Induced Organic Mental Disorder

| | | |
|---|---|---|
| (1) Ages 0-20, with CC | 521 | DRG 521 excludes procedures 94.61, 94.63, 94.64, 94.66, 94.67, 94.69 |
| (2) Ages > 20, with CC | 521 | DRG 521 excludes procedures 94.61, 94.63, 94.64, 94.66, 94.67, 94.69 |
| (3) Age 0-20, without CC and Rehab | 523 | |
| (4) Age > 20, without CC and Rehab | 523 | |

U. [Reserved for future use]

V. Injuries, Poisonings, and Toxic Effects of Drugs

| | |
|---|---|
| (1) Treated with surgical procedure | 439, 440, 442 |
| (2) Other surgery without CC and Hand procedures for injuries | 441, 443 |
| (3) [Reserved for future use] | |
| (4) Traumatic injury age 0-17, Allergic reactions, and other poisoning without CC | 446, 447, 448, 451, 453, 455 |
| (5) Other toxic effects and Complications of treatment with CC | 449, 452, 454 |
| (6) Traumatic injury age > 17 and Toxic effects age > 17 without CC | 444, 445, 450 |

W. Burns

| | |
|---|---|
| (1) [Reserved for future use] | |
| (2) [Reserved for future use] | |
| (3) Extensive or full thickness with ventilation 96+ hours without skin graft or Extensive with other inhalation injury or significant trauma | 505, 507, 508 |
| (4) Nonextensive burns with or without CC or significant trauma | 509, 510, 511 |

X. Factors Influencing Health Status

| | |
|---|---|
| (1) OR procedures with diagnosis of other contact with health services | 461 |
| (2) Rehabilitation, Aftercare, and Signs and symptoms | 462-467 |

Y. [Reserved for future use]

Z. [Reserved for future use]

AA. [Reserved for future use]

BB. [Reserved for future use]

CC. Caesarean Sections

| | | |
|---|---|---|
| (1) With complicating diagnosis | 370 | |
| (2) Without complicating diagnosis | 371 | |

DD. Vaginal Delivery

| | | |
|---|---|---|
| (1) With complicating diagnosis | 372 | |
| (2) Without complicating diagnosis or operating room procedures | 373 | |
| (3) With operating room procedure | 374, 375 | |
| (4) [Reserved for future use] | | |

EE. [Reserved for future use]

FF. Depressive Neuroses

| | | |
|---|---|---|
| Depressive Neuroses | 426 | |

GG. Psychoses

| | | |
|---|---|---|
| (1) (Ages 0-17) | 430 | |
| (2) (Ages > 17) | 430 | |

HH. Childhood Mental Disorders

| | | |
|---|---|---|
| Childhood Mental Disorders | 431 | |

II. Unrelated Operating Room Procedures

| | | |
|---|---|---|
| (1) Extensive | 468 | |
| (2) Nonextensive | 476, 477 | |

JJ. [Reserved for future use]

KK. Extreme Immaturity

| | | |
|---|---|---|
| (1) Weight < 750 Grams | 386 | 76501, 76502 |
| (2) [Reserved for future use] | | |
| (3) [Reserved for future use] | | |

| | | |
|---|---|---|
| (4) Weight 750 to 1499 Grams | 386<br>387 | 76503-76505<br>76500 |
| (5) Neonate respiratory distress syndrome | 386 | Codes in DRG 386 except 76501-76505 |

LL. Prematurity with Major Problems

| | | |
|---|---|---|
| (1) Weight < 1250 Grams | 387 | 76511-76514 |
| (2) Weight 1250 to 1749 Grams | 387 | 76506-76510, 76515, 76516 |
| (3) Weight > 1749 Grams | 387 | Codes in DRG 387 except 76500, 76506, 76510-76516 |

MM. Prematurity Without Major Problems and Neonates Died

| | | |
|---|---|---|
| Prematurity Without Major Problems and Neonates Died | 385, 388 | Includes neonates who expire in the birth hospital, and the discharge date is the same as the birth date |

NN. Full Term Neonates With

| | |
|---|---|
| (1) Major problems (Age 0) | 389 |
| (2) Other problems | 390 |

OO. Multiple Significant Trauma

| | |
|---|---|
| (1) Limb reattachment and Hip and Femur OR procedures | 485 |
| (2) Other multiple significant trauma without OR | 487 |
| (3) Full thick burn with skin graft or inhalation injury with CC or significant trauma and Other surgery for multiple significant trauma | 486, 506 |

PP. [Reserved for future use]

QQ. Normal Newborns

| | |
|---|---|
| Normal Newborns | 391 |

RR. [Reserved for future use]

SS. [Reserved for future use]

TT. [Reserved for future use]

UU. Organ and Cell Transplants

| | |
|---|---|
| (1) Heart transplants | 103 |
| (2) Liver and/or intestinal, Bone marrow, Lung, Simultaneous pancreas and kidney, Pancreas transplants and Other heart assist system implant | 480, 481, 495, 512, 513, 525 |
| (3) Kidney transplant | 302 |

VV. [Reserved for future use]

WW. Human Immunodeficiency Virus

| | |
|---|---|
| (1) Treated with extensive operating room procedure | 488 |
| (2) With major related condition | 489 |
| (3) With or without other related condition | 490 |

Subp. 20c. [Repealed, 31 SR 819]

Subp. 20d. **Diagnostic categories for persons eligible under the general assistance medical care program.** The following diagnostic categories are for persons eligible under the general assistance medical care program except as provided in subpart 20e or 20f:

| DIAGNOSTIC CATEGORIES | DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES | INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed., CLINICAL MODIFICATIONS CODES |
|---|---|---|

A. Nervous System Conditions

| | |
|---|---|
| (1) Intracranial vascular procedures with principal diagnosis of hemorrhage | 528 |
| (2) Craniotomy except craniotomy without CC | 001, 003, 484, 531, 543 |
| (3) Ventricular shunt and extracranial procedures with CC and acute stroke with thrombolytic agent | 529, 533, 559 |
| (4) Other neurological OR procedures or intracranial hemorrhage, cerebral infarct, and nervous system neoplasms | 002, 007, 008, 014, 020, 530, 532, 534 |
| (5) Spinal disorders and injuries, encephalopathy, cerebrovascular disorder, stupor and coma with CC | 009, 016, 022, 028 |
| (6) Nervous system neoplasms with CC, degenerative disorders, precerebral occlusion and other specified disorders | 010, 012, 015, 021, 027, 034 |
| (7) Seizure and headache except with CC or specified stupor and coma | 017, 023, 024, 026, 029, 030 |
| (8) Concussion and other nervous system diseases and disorders with and without CC | 011, 013, 018, 019, 025, 031-033, 035, 524 |

B. Eye Diseases and Disorders

| | |
|---|---|
| Eye Diseases and Disorders | 036-048 |

C. Ear, Nose, Throat, and Mouth Diseases and Disorders

| | |
|---|---|
| (1) Major head and ENT procedures | 049, 050, 053, 054, 056, 059, 063 |
| (2) Tonsillectomy, adenoidectomy, and Other ear, nose, throat, and mouth procedures | 051, 052, 055, 057, 058, 060-062, 064, 185-187 |
| (3) Epiglottis, Laryngotracheitis, and Other ENT conditions | 067, 069, 071-073 |
| (4) Disequilibrium, Epitaxis, Otitis media and URI except without CC | 065, 066, 068, 070, 074 |

D. Respiratory System Conditions

| | | |
|---|---|---|
| (1) Treated with ventilator support for < 96 hrs | 475 | excludes procedure 96.72 |
| (2) Treated with ventilator support for 96+ hours | 475 | includes procedure 96.72 |
| (3) [Reserved for future use] | | |
| (4) P.E., Respiratory infections, Neoplasms, Pleural effusion, Pulmonary edema, and respiratory failure, and other conditions with CC | 078-083, 085, 087, 092, 094, 101 | |
| (5) COPD, Pneumonia, Pneumothorax, Bronchitis and Other respiratory system conditions without CC | 086, 088-091, 093, 095-099, 102 | |
| (6) Major chest trauma and Respiratory signs and symptoms without CC | 084, 100 | |
| (7) Tracheostomy for face, mouth, and neck diagnoses and Full thickness burns | 482, 508 | |
| (8) Major chest and other surgical procedure | 075-077 | |

E. Circulatory System Conditions

| | | |
|---|---|---|
| (1) [Reserved for future use] | | |
| (2) [Reserved for future use] | | |
| (3) [Reserved for future use] | | |
| (4) Valve replacement with cath, CABG with PTCA, and AICD implant with AMI, heart failure and shock | 104, 106, 535, 536 | |
| (5) Major cardiothoracic and vascular procedures | 105, 108, 110, 113, 515, 547, 553 | |
| (6) Other cardiac and circulatory surgeries and percutaneous procedures including drug-eluding stents | 111, 120, 548, 549-552, 554, 555, 557, 558 | |
| (7) Procedures for circulatory disorders, Cardiac pacemaker revision or replacement, Acute MI with CC, and Endocarditis | 114, 117, 118, 121, 123, 124, 126, 518, 556 | |
| (8) Heart failure and shock, other circulatory disorders with CC and vascular procedures without CC | 127, 129, 130, 144, 479 | |

| | |
|---|---|
| (9) Vein ligation and stripping, Circulatory disorders with cath without CC | 119, 125 |
| (10) Uncomplicated AMI and Other circulatory system diagnoses without CC | 122, 145 |
| (11) Cardiac arrhythmias, Valve disorders, and Hypertension | 131, 134-138 |
| (12) Thrombophlebitis, Atherosclerosis, Angina, and Syncope | 128, 132, 133, 139-142 |
| (13) Chest pain | 143 |

F. Digestive System Diseases and Disorders

| | |
|---|---|
| (1) Major bowel, stomach, esophagus, and duodenal surgery with CC | 146, 148, 154 |
| (2) Minor bowel and Other digestive system surgeries with CC | 150, 152, 156, 170 |
| (3) Major bowel procedures without CC and Other digestive system procedures with CC | 147, 149, 157, 164, 188 |
| (4) Appendectomy without complicating principal diagnoses, Stomal and Hernia procedures | 158, 160-163, 166-169 |
| (5) Treated with other surgical procedure | 151, 153, 155, 159, 165, 171 |
| (6) GI hemorrhage and CC and Other digestive system diagnoses, age 0-17 | 174, 190 |
| (7) Uncomplicated peptic ulcer and Other digestive system diseases | 172, 177-180, 189 |
| (8) Miscellaneous digestive disorders with CC and Digestive malignancy without CC | 173, 182 |
| (9) GI Hemorrhage and Obstruction without CC and Miscellaneous disorders except CC | 175, 176, 181, 183, 184 |

G. Hepatobiliary System Conditions

| | |
|---|---|
| (1) Pancreas, Liver, Shunt, and Hepatobiliary procedures | 191, 193, 199, 201 |
| (2) Cholecystectomy except laparoscopic and Diagnostic hepatobiliary procedures | 194, 195, 197, 198, 200 |
| (3) Cirrhosis and alcoholic hepatitis and Other liver disorders with CC | 202, 205 |
| (4) Pancreas, liver, shunt procedures without CC and biliary procedures with CC | 192, 196, 493 |
| (5) Lap cholecystectomy without CC | 494 |
| (6) Other disorders of liver and Pancreas and Hepatobiliary malignancy | 203, 204, 206 |
| (7) Disorders of biliary tract | 207, 208 |

H. Diseases and Disorders of the Musculoskeletal System and Connective Tissues

| | |
|---|---|
| (1) Major and high resource utilization surgery: Kidney transplant, Limb reattachment and Hip and femur surgery for trauma, Spinal fusion for curvature or malignancy | 302, 485, 546 |
| (2) Surgery on Hip and Femur, Multiple Joints, and Knee and Spinal Fusion | 210, 471, 496, 497, 501 |
| (3) Muscular system and connective tissue surgery and Wound debridement | 217, 233 |
| (4) Musculoskeletal disorder with Major OR procedure or OR without CC on lower extremity, hip, and spine | 212, 226, 498, 519, 537, 545 |
| (5) Lower extremity Amputation, Joint replacement, and Reattachment and Biopsy of Musculoskeletal tissue | 213, 216, 218, 285, 544 |
| (6) Other surgery on Hip, Lower extremity and Spine | 225, 230, 491, 502, 520 |
| (7) Minor lower extremity joint without CC and Major upper extremity joint procedure with CC | 211, 219, 223, 228, 234 |

| | |
|---|---|
| (8) Upper extremity procedures, Knee procedures without PDx of infection, and Removal of fixation device | 220, 224, 503, 538 |
| (9) Back and neck procedures except fusion, Arthroscopy, and Connective tissue disorders | 232, 240, 241, 499, 500 |
| (10) Pathological fracture and Musculoskeletal and Connective tissue malignancy | 238, 239, 256 |
| (11) Soft tissue procedures, Fractures, Injuries, Sprains and strains | 227, 235, 236, 244, 250, 255 |
| (12) Medical back problems and Other diseases and disorders | 237, 242, 243, 245-248 |
| (13) Aftercare, musculoskeletal system and connective tissue | 249, 252, 253 |
| (14) Injury to extremities without CC | 251, 254 |
| (15) [Reserved for future use] | |
| (16) [Reserved for future use] | |
| (17) [Reserved for future use] | |
| (18) [Reserved for future use] | |
| (19) Hand and wrist procedures and carpal tunnel release | 006, 229, 441 |

I. Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast

| | |
|---|---|
| (1) Treated with skin graft and/or debridement | 263, 265, 287 |
| (2) Malignant breast disorders with CC | 266, 268, 270, 274 |
| (3) Other skin, subcutaneous tissue and breast procedure with CC | 264, 269 |
| (4) Breast biopsy and mastectomy | 257-260, 262, 277 |
| (5) Other skin, subcutaneous tissue, and breast conditions | 261, 267, 272, 276, 281, 283 |

| | |
|---|---|
| (6) Skin ulcers and cellulitis | 271, 279, 280, 282 |
| (7) Malignant breast disorders without complication | 273, 275, 278, 284 |

J. Endocrine, Nutritional, and Metabolic Diseases and Disorders

| | |
|---|---|
| (1) Major surgical procedures | 286, 288, 290-293 |
| (2) Diabetes age > 35 and Inborn errors of metabolism | 294, 299 |
| (3) Diabetes age 0-35 | 295 |
| (4) Endocrine, Nutritional and metabolic disorders | 289, 296 |
| (5) Endocrine disorders with CC | 300 |
| (6) Other endocrine, nutritional, and metabolic conditions except with CC | 297, 298, 301 |

K. Kidney and Urinary Tract Conditions

| | |
|---|---|
| (1) Kidney, ureter, and major bladder procedures | 303, 304, 308, 315 |
| (2) [Reserved for future use] | |
| (3) KUB procedures without CC and Prostatectomy with CC | 305, 306 |
| (4) Other kidney and urinary tract procedures without CC and diagnosis with CC | 307, 309, 310, 317, 319, 320, 331 |
| (5) Kidney and urinary tract infection except with CC and Urethral procedures | 311-314, 321-323 |
| (6) Renal Failure, Neoplasms and Urethral stricture with CC | 316, 318, 328, 333 |
| (7) Other kidney and urinary tract conditions | 324-327, 329, 330, 332 |

L. Male Reproductive System Conditions

| | |
|---|---|
| (1) Major surgery | 334, 335, 338-340, 344, 345 |
| (2) Other medical and surgical treatments | 336, 337, 341-343, 346-352 |

M. Female Reproductive System Diseases and Disorders

| | |
|---|---|
| (1) Tubal interruption, D & C, Malignancy without CC, and Infection | 362, 364, 367, 368 |
| (2) [Reserved for future use] | |
| (3) [Reserved for future use] | |
| (4) Malignancy with CC, Other disorders and Reconstructive procedures | 356, 359, 366, 369 |
| (5) Pelvic evisceration, and Surgery for ovarian malignancy | 353, 357 |
| (6) Uterine, Adnexa, and Other OR procedures | 354, 355, 358, 360, 361, 363, 365 |

N. Pregnancy Related Conditions

| | |
|---|---|
| (1) Cesarean section and Postpartum complications with surgery | 370, 371, 377 |
| (2) Vaginal delivery and Other pregnancy related conditions and procedures | 372-376, 378-384 |

O. [Reserved for future use]

P. Blood and Immunity Disorders

| | |
|---|---|
| (1) Surgical procedure of the blood and blood forming organs and Coagulation disorders | 392-394, 397 |
| (2) RBC and Reticuloendothelial and Immunity disorders | 395, 396, 398, 399 |

Q. Myeloproliferative Diseases and Disorders, Poorly Differentiated Malignancy and Other Neoplasms

| | |
|---|---|
| (1) [Reserved for future use] | |
| (2) [Reserved for future use] | |
| (3) Surgical and other treatment for myeloproliferative diseases and disorders | 401-403, 405, 406, 408, 473, 492, 539, 540 |
| (4) Lymphoma, Leukemia, Radiotherapy and Chemotherapy | 404, 407, 409-414 |

R. Infections and Parasitic Diseases

| | | |
|---|---|---|
| (1) Treated with surgical procedure | 415 | |
| (2) Septicemia and Other infections and parasitic diseases | 416, 417, 423 | |
| (3) Postop and post-traumatic infections | 418 | |
| (4) Viral illness and Fever of unknown origin | 419-422 | |

S. Mental Diseases and Disorders

| | | |
|---|---|---|
| (1) Principal diagnosis of mental illness with surgery | 424 | |
| (2) Adjustment reaction and Other Mental Disorders | 425, 432 | |
| (3) Depressive neuroses and childhood mental disorders | 426, 431 | |
| (4) Other psychiatric diseases and disorders | 427, 428, 429 | |
| (5) Psychoses | 430 | |

T. Substance Use and Substance Induced Organic Mental Disorder

| | | |
|---|---|---|
| (1) With CC | 521 | DRG 521 excludes procedures 94.61, 94.63, 94.64, 94.66, 94.67, 94.69 |
| (2) Without rehab, without CC | 523 | |

U. [Reserved for future use]

V. Injuries, Poisonings, and Toxic Effects of Drugs

| | | |
|---|---|---|
| (1) Treated with Skin grafts and Other surgical procedures for injuries with CC | 439, 442 | |
| (2) Wound debridement and Other surgery for injuries without CC | 440, 443 | |
| (3) Traumatic injury | 444-446 | |
| (4) Allergic reactions | 447, 448, 453 | |
| (5) Poisoning and toxic effects of drugs age > 17 with CC | 449 | |

| | |
|---|---|
| (6) Poisoning and toxic effects of drugs age > 17 without CC and age 0-17 | 450, 451 |
| (7) [Reserved for future use] | |
| (8) Other injuries and toxic effects and Complications of treatment with CC | 452, 454, 455 |

W. Burns

| | |
|---|---|
| (1) Third degree burn without skin graft, without complication and Nonextensive burns | 509-511 |
| (2) [Reserved for future use] | |
| (3) Full thickness with skin graft and extensive third degree burns | 505, 507 |

X. Factors Influencing Health Status

| | |
|---|---|
| (1) OR procedures with diagnosis of other contact with health services | 461 |
| (2) Rehabilitation, Aftercare, and Signs and symptoms | 462-467 |

Y. [Reserved for future use]

AA. [Reserved for future use]

BB. [Reserved for future use]

CC. [Reserved for future use]

DD. [Reserved for future use]

EE. [Reserved for future use]

FF. [Reserved for future use]

GG. [Reserved for future use]

HH. [Reserved for future use]

II. Operating Room Procedure Unrelated to Principal Diagnosis

| | |
|---|---|
| (1) Extensive | 468 |
| (2) Nonextensive | 476, 477 |

JJ. [Reserved for future use]

KK. [Reserved for future use]

LL. [Reserved for future use]

MM. [Reserved for future use]

NN. [Reserved for future use]

OO. Multiple Significant Trauma

| | |
|---|---|
| (1) Third degree burn with graft or inhalation injury with CC and Other surgery for multiple significant trauma | 486, 506 |
| (2) Multiple significant trauma without surgery | 487 |

PP. [Reserved for future use]

QQ. [Reserved for future use]

RR. [Reserved for future use]

SS. [Reserved for future use]

TT. [Reserved for future use]

UU. ECMO/Tracheostomy and Burns

| | |
|---|---|
| ECMO/Tracheostomy and Burns with ventilator 96+ hours, Organ and Cell transplants, and Heart assist system implant | 103, 480, 481, 495, 504, 512, 513, 525, 541, 542 |

VV. [Reserved for future use]

WW. Human Immunodeficiency Virus

| | |
|---|---|
| Human Immunodeficiency Virus | 488-490 |

Subp. 20e. **Diagnostic categories relating to a rehabilitation hospital or a rehabilitation distinct part.** The following diagnostic categories are for services provided within a rehabilitation hospital or a rehabilitation distinct part regardless of program eligibility:

| DIAGNOSTIC CATEGORIES | DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES | INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed., CLINICAL |
|---|---|---|

| | | MODIFICATIONS CODES |
|---|---|---|

A. Nervous System Diseases and Disorders

| | | |
|---|---|---|
| Nervous System Diseases and Disorders | 001-003, 006-035, 524, 528-534, 543, 559 | except codes in category Y and Z |

B. [Reserved for future use]

C. [Reserved for future use]

D. [Reserved for future use]

E. [Reserved for future use]

F. [Reserved for future use]

G. [Reserved for future use]

H. Diseases and Disorders of the Musculoskeletal System and Connective Tissues

| | | |
|---|---|---|
| Diseases and Disorders of the Musculoskeletal System and Connective Tissues | 210-213, 216-220, 223-230, 232-256, 471, 491, 496-503, 519, 520, 537, 538, 544-546 | except codes in category Y and Z |

I. [Reserved for future use]

J. [Reserved for future use]

K. [Reserved for future use]

L. [Reserved for future use]

M. [Reserved for future use]

N. [Reserved for future use]

O. [Reserved for future use]

P. [Reserved for future use]

Q. [Reserved for future use]

R. Mental Diseases and Disorders/Substance Use and Substance Induced Organic Mental Disorders

| | | |
|---|---|---|
| Mental Diseases and Disorders/Substance Use and Substance Induced Organic Mental Disorders | 424-432, 521, 523 | except codes in category Y and Z; DRG 521 excludes procedures 94.61, 94.63, 94.64, 94.66, 94.67, 94.69 |

S. Multiple Significant Trauma/Unrelated Operating Room Procedures

| | | |
|---|---|---|
| Multiple Significant Trauma/Unrelated Operating Room Procedures | 468, 476, 477, 484-487 | except codes in category Y and Z |

T. Other Conditions Requiring Rehabilitation Services

| | | |
|---|---|---|
| Other Conditions Requiring Rehabilitation Services | 036-106, 108, 110, 111, 113, 114, 117-208, 257-399, 401-423, 439-455, 461-467, 473, 475, 479-482, 488-490, 492-495, 504-518, 525, 535, 536, 539, 540-542, 547-558 | except codes in category Y and Z |

U. [Reserved for future use]

V. [Reserved for future use]

W. [Reserved for future use]

X. [Reserved for future use]

Y. Specific late effects or conditions secondary to a spinal cord or intracranial injury or skull fracture which result in paraplegia

| | | |
|---|---|---|
| Specific late effects or conditions secondary to a spinal cord or intracranial injury or skull fracture which result in paraplegia | All DRGs | Diagnosis codes 344.1, 806.21, 806.26, 806.31, 806.36, 952.11, 952.16 in combination with 905.0, 907.0, or 907.2, excluding cases with 781.0, 781.2, 781.3, and 781.4 |

Z. Specific late effects or conditions secondary to a spinal cord or intracranial injury or skull fracture which result in quadriplegia or hemiplegia

| | | |
|---|---|---|
| Specific late effects or conditions secondary to a spinal cord or intracranial | All DRGs | Diagnosis codes 344.01-344.04, 344.09, 806.0x, 806.1x, or 952.0x in combination |

| | |
|---|---|
| injury or skull fracture which result in a quadriplegia or hemiplegia | with 907.2, excluding cases with 781.0, 781.2, and 780.03; or Diagnosis codes 344.00-344.04,<br><br>344.09, 342.01, 342.81, or 342.91 in combination with 907.0 or 905.0, excluding cases 781.0, 781.3, and 780.03 |

Subp. 20f. **Diagnostic categories for neonatal transfers.** The following diagnostic categories are for services provided to neonatal transfers at receiving hospitals with neonatal intensive care units regardless of program eligibility:

| DIAGNOSTIC CATEGORIES | DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES | INTERNATIONAL CLASSIFICATION OF DISEASES, 9th Ed., CLINICAL MODIFICATIONS CODES |
|---|---|---|
| A. [Reserved for future use] | | |
| B. [Reserved for future use] | | |
| C. [Reserved for future use] | | |
| D. [Reserved for future use] | | |
| E. [Reserved for future use] | | |
| F. [Reserved for future use] | | |
| G. [Reserved for future use] | | |
| H. [Reserved for future use] | | |
| I. [Reserved for future use] | | |
| J. [Reserved for future use] | | |
| K. [Reserved for future use] | | |
| L. [Reserved for future use] | | |
| M. [Reserved for future use] | | |
| N. [Reserved for future use] | | |
| O. [Reserved for future use] | | |

P. [Reserved for future use]

Q. [Reserved for future use]

R. [Reserved for future use]

S. [Reserved for future use]

T. [Reserved for future use]

U. [Reserved for future use]

V. [Reserved for future use]

W. [Reserved for future use]

X. [Reserved for future use]

Y. [Reserved for future use]

Z. [Reserved for future use]

AA. [Reserved for future use]

BB. [Reserved for future use]

CC. [Reserved for future use]

DD. [Reserved for future use]

EE. [Reserved for future use]

FF. [Reserved for future use]

GG. [Reserved for future use]

HH. [Reserved for future use]

II. [Reserved for future use]

JJ. [Reserved for future use]

KK. Extreme Immaturity and Tracheostomy

(1) [Reserved for future use]

| | | |
|---|---|---|
| (2) Weight < 750 Grams and Tracheostomy | 386, 482<br>541, 542 | 76501,<br>76502 |

(3) [Reserved for future use]

| | | |
|---|---|---|
| (4) Weight 750 to 1499 Grams | 386, 387 | DRG 386 includes 765.03 to 765.05, DRG 387 includes 765.00 |
| (5) Neonate Respiratory Distress Syndrome | 386 | Codes for DRG 386 except 76501-76505 |
| LL. Prematurity with Major Problems | | |
| Prematurity with Major Problems | 387 | Codes for DRG 387 except 76500 |
| MM. Prematurity without Major Problems | | |
| Weight > 1749 Grams | 388 | |
| NN. Full Term Neonates | | |
| (1) With major problems (age 0) | 389 | |
| (2) With other problems | 390 | |

Subp. 20g. **Additional DRG requirements.**

A. Version 23 of the Medicare grouper and DRG assignment to the diagnostic category must be used uniformly for all determinations of rates and payments.

B. The discharge status will be changed to "discharge to home" for DRG 433.

C. A diagnosis with the prefix "v57" will be excluded when grouping under subpart 20e.

D. The discharge status will be changed to "discharge to home" when grouping under subparts 20b and 20d for a transfer to a Medicare rehabilitation distinct part.

E. A transfer from subpart 20b or 20d, which included ICD-9-CM procedure code 86.06 (implantation of a totally implantable infusion pump) for the treatment of spasticity, to a Medicare rehabilitation distinct part must include ICD-9-CM diagnosis code 781.0 when grouping under subpart 20e.

F. Neonates transferred into a neonatal intensive care unit with a DRG assignment of DRG 482, 541, or 542, age less than one year, will be grouped under subpart 20f.

G. The discharge status will be changed to "discharge to home" for all neonates in DRG 385, except for neonates that expire at the birth hospital and the discharge date is the same as the date of birth.

H. For payment of admissions that result from a home health nurse being unavailable, and there is one or more acute episodes of illness during the admission resulting in changes in physician

orders and the treatment plan, the principal diagnoses V58.89, other specified aftercare and V63.1, medical services in home not available will be excluded.

I. For neonates transferred into a neonatal intensive care unit within 28 days of birth, with a principal diagnosis of congenital anomaly (ICD-9-CM code 740-759) and a secondary diagnosis of conditions originating in the perinatal period (ICD-9-CM code 760-779), the principal diagnosis and the first sequenced secondary diagnosis in the range 760-779 will be interchanged when grouping under subpart 20f.

J. The admission source will be changed to "admitted as a transfer from another hospital" for neonates born before admission to the hospital and admitted directly to a Level IV neonatal intensive care unit.

K. For patients in DRG 386-390 and the age is greater than zero, the principal diagnosis from ICD-9-CM Chapter 15, certain conditions originating in the perinatal period (diagnoses codes 760-779), will be excluded when grouping under subparts 20b and 20d.

L. For payment under DRG 521, alcohol/drug abuse or dependence with complications or comorbidities, payment shall not be made for patients engaged in alcohol and/or drug rehabilitation.

M. The patient age will be changed to 18 years for DRG 003. If the admission subsequently groups to DRG 529 or 530, that DRG will be assigned. Otherwise the admission will remain in DRG 003.

N. The admission source will be changed to "admitted as a transfer from a different acute care hospital" for all newborns admitted to the hospital within the first 28 days after birth with a principal diagnosis of V29.0-V29.9.

O. The prematurity subcategory diagnosis codes 765.20 and 765.26 through 765.29 will be ignored when assigning a DRG if a diagnosis code from 764, 765.0, or 765.1 is not included on the claim.

Subp. 21. [Repealed, 18 SR 1115]

Subp. 22. **General assistance medical care.** "General assistance medical care" means the program established by Minnesota Statutes, section 256D.03.

Subp. 23. [Repealed, 18 SR 1115]

Subp. 24. [Repealed, 18 SR 1115]

Subp. 24a. [Repealed, 18 SR 1115]

Subp. 25. **Hospital.** "Hospital" means a facility defined in Minnesota Statutes, section 144.696, subdivision 3, and licensed under Minnesota Statutes, sections 144.50 to 144.581, or an out-of-state facility licensed to provide acute care under the requirements of the state in which it is located.

Subp. 26. **Hospital cost index.** "Hospital cost index" means the factor annually multiplied by the allowable base year operating cost to adjust for cost changes.

Subp. 26a. **Inpatient hospital costs.** "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare, but not to include the medical assistance surcharge, without regard to adjustments in payments imposed by Medicare.

Subp. 27. **Inpatient hospital service.** "Inpatient hospital service" means a service provided by or under the supervision of a physician after admission to a hospital and furnished in the hospital, including outpatient services provided by the same hospital that directly precede the admission.

Subp. 28. [Repealed, 18 SR 1115]

Subp. 28a. **Local trade area hospital.** "Local trade area hospital" means a metropolitan statistical area hospital located outside Minnesota in a county contiguous to Minnesota that has 20 or more medical assistance admissions in the base year.

Subp. 28b. **Long-term care hospital.** "Long-term care hospital" means a Minnesota hospital or a metropolitan statistical area hospital located outside Minnesota in a county contiguous to Minnesota that meets the requirements under Code of Federal Regulations, title 42, part 412, section 23(e).

Subp. 28c. **Low volume local trade area hospital.** "Low volume local trade area hospital" means a metropolitan statistical area hospital located outside Minnesota in a county contiguous to Minnesota that has less than 20 medical assistance admissions in the base year.

Subp. 29. **Medical assistance.** "Medical assistance" means the program established under Title XIX of the Social Security Act and Minnesota Statutes, sections 256.9685 to 256.9695 and chapter 256B. For purposes of parts 9500.1090 to 9500.1155, "medical assistance" includes general assistance medical care unless otherwise specifically stated.

Subp. 30. [Repealed, 18 SR 1115]

Subp. 30a. [Repealed, 18 SR 1115]

Subp. 31. **Medicare.** "Medicare" means the federal health insurance program established under Title XVIII of the Social Security Act.

Subp. 32. **Medicare crossover.** "Medicare crossover" means a claim submitted by a hospital to request payment for Medicare Part A covered inpatient hospital services provided to a patient who is also eligible for medical assistance.

Subp. 33. **Metropolitan statistical area hospital.** "Metropolitan statistical area hospital" means a hospital located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Subp. 33a. [Repealed, 18 SR 1115]

Subp. 34. **Nonmetropolitan statistical area hospital.** "Nonmetropolitan statistical area hospital" means a Minnesota hospital not located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Subp. 35. **Operating costs.** "Operating costs" means inpatient hospital costs excluding property costs.

Subp. 36. [Repealed, 26 SR 976]

Subp. 37. **Out-of-area hospital.** "Out-of-area hospital" means a hospital located outside Minnesota that is not a local trade area hospital or a low volume local trade area hospital.

Subp. 38. **Property costs.** "Property costs" means inpatient hospital costs not subject to the hospital cost index, including depreciation, interest, rents and leases, property taxes, and property insurance.

Subp. 39. [Repealed, 18 SR 1115]

Subp. 40. [Repealed, 18 SR 1115]

Subp. 41. [Repealed, 18 SR 1115]

Subp. 41a. **Rate year.** "Rate year" means a calendar year from January 1 to December 31.

Subp. 42. [Repealed, 18 SR 1115]

Subp. 43. [Repealed, 18 SR 1115]

Subp. 43a. [Repealed, 18 SR 1115]

Subp. 44. [Repealed, 18 SR 1115]

Subp. 44a. **Rehabilitation distinct part.** "Rehabilitation distinct part" means inpatient hospital services that are provided by a hospital in a unit designated by Medicare as a rehabilitation distinct part.

Subp. 45. **Relative value.** "Relative value" means the mean operating cost within a diagnostic category divided by the mean operating cost in all diagnostic categories within a program at subpart 20b or 20d or specialty group at subpart 20e or 20f.

Subp. 46. [Repealed, 18 SR 1115]

Subp. 47. [Repealed, 18 SR 1115]

Subp. 47a. [Repealed, 18 SR 1115]

Subp. 48. [Repealed, 18 SR 1115]

Subp. 49. [Repealed, 18 SR 1115]

Subp. 50. **Transfer.** "Transfer" means the movement of a patient after admission from one hospital directly to another hospital with a different provider number or to or from a rehabilitation distinct part.

Subp. 51. **Trim point.** "Trim point" means that number of inpatient days beyond which an admission is a day outlier.

Subp. 52. [Repealed, 18 SR 1115]

**Statutory Authority:** *MS s 256.9685; 256.969; 256.9695*

**History:** *10 SR 227; 11 SR 987; 11 SR 1688; 12 SR 1617; 13 SR 1689; 14 SR 8; 14 SR 1005; 18 SR 1115; 19 SR 1191; 23 SR 1627; 25 SR 1021; 26 SR 976; 27 SR 1515; 31 SR 819*

**Published Electronically:** *October 16, 2013*

## 9500.1105 BASIS OF PAYMENT FOR INPATIENT HOSPITAL SERVICES.

Subpart 1. **Reporting requirements.**

A. No later than October 1 preceding a rebased rate year or 60 days from the department's request, whichever is later, a Minnesota and local trade area hospital must provide to the department complete, true, and authorized information as outlined in subitems (1) to (6). Information required in subitems (1) to (6) that is not provided in a timely manner will not be used in calculating the hospital's rates for that rate year and the following year if rebasing does not occur.

(1) The base year Medicare audited cost report of local trade area hospitals.

(2) The decision on whether certified registered nurse anesthetist services are to be paid separately from parts 9500.1090 to 9500.1155. Once elected, the decision to be paid separately is irrevocable.

(3) The elected outlier percentage for other than neonate and burn admissions to a minimum of 60 percent and a maximum of 80 percent. The chosen percentage shall apply to all program and specialty groups of the hospital.

(4) The most recent Medicare cost report submitted to Medicare by October 1 prior to a rebased rate year.

(5) The data on low income utilization necessary to implement the disproportionate population adjustment.

(6) The Medicare adjustments to prior base year data.

B. If Medicare does not require a hospital to file a complete cost report, that hospital must, no later than February 1 preceding a rebased rate year, provide true, complete, and authorized Medicare cost report data under the cost finding methods and allowable costs in effect during the base year.

Subp. 2. **Establishment of base years.**

A. The base year for the 1993 rate year shall be each Minnesota and local trade area hospital's most recent Medicare cost reporting period ending prior to September 1, 1988. If that cost reporting period is less than 12 months, it must be supplemented by information from the prior cost reporting period so that the base year is 12 months except for hospitals that closed during the base year.

B. The base year data will be moved forward three years beginning with the 1995 rate year. The base year data will be moved forward every two years after 1995 or every one year if notice

is provided at least six months prior to the rate year by the department. For long-term care hospitals that open after April 1, 1995, the base year is the year for which the hospital first filed a Medicare cost report as a long-term care hospital. That base year shall remain until it falls within the same period as other hospitals.

**Statutory Authority:** *MS s 256.9685; 256.969; 256.9695;*

**History:** *10 SR 227; 18 SR 1115; 26 SR 976*
**Published Electronically:** *October 16, 2013*

## 9500.1110 DETERMINATION OF RELATIVE VALUES OF THE DIAGNOSTIC CATEGORIES.

Subpart 1. **Determination of relative values.** To determine the relative values of the diagnostic categories the department shall:

A. Select medical assistance claims for Minnesota and local trade area hospitals with admission dates from each hospital's base year.

B. Exclude the claims and charges in subitems (1) to (7):

(1) Medicare crossover claims;

(2) claims paid on a transfer rate per day according to part 9500.1128, subpart 2, item C;

(3) inpatient hospital services for which medical assistance payment was not made;

(4) inpatient hospital claims paid to a long-term care hospital;

(5) inpatient hospital services not covered by the medical assistance program on October 1 prior to a rebased rate year;

(6) inpatient hospital charges for noncovered days calculated as the ratio of noncovered days to total days multiplied by charges; and

(7) inpatient hospital services paid under part 9500.1128, subpart 2, item E.

C. Combine claims into the admission that generated the claim according to part 9500.1128, subpart 4.

D. Determine operating costs for each hospital admission in item C using each hospital's base year data according to subitems (1) to (5).

(1) Determine the operating cost of accommodation services by multiplying the number of accommodation service inpatient days by that accommodation service operating cost per diem and add the products of all accommodation services.

(2) Determine the operating cost of each ancillary service by multiplying the ancillary charges by that ancillary operating cost-to-charge ratio and add the products of all ancillary services. An ancillary operating cost-to-charge ratio will be adjusted for certified registered nurse anesthetist

costs and charges according to the hospital's election under part 9500.1105, subpart 1, item A, subitem (2).

(3) Determine the operating cost of services rendered by interns and residents not in an approved teaching program by multiplying the number of accommodation service inpatient days in subitem (1) by that teaching program accommodation service per diem and add the products of all teaching program accommodation services.

(4) Add subitems (1) to (3).

(5) Multiply the result of subitem (4) by the hospital cost index that corresponds to the hospital's fiscal year end in part 9500.1120, subpart 2, item B.

E. Assign each admission and operating cost identified in item D, subitem (5), to the appropriate program or specialty group and diagnostic category according to part 9500.1100, subparts 20a to 20e and 20g.

F. Determine the mean cost per admission within each program and the rehabilitation distinct part specialty group for the program and rehabilitation distinct part specialty group admissions identified in item E by dividing the sum of the operating costs by the total number of admissions.

G. Determine the mean cost per admission within each program and rehabilitation distinct part specialty group diagnostic category identified in item E by dividing the sum of the operating costs in each diagnostic category by the total number of admissions in each diagnostic category.

H. Determine the relative value for each diagnostic category by dividing item G by the corresponding result of item F within each program and the rehabilitation distinct part specialty group and round the quotient to five decimal places.

I. Determine the mean length of stay within each program and rehabilitation distinct part diagnostic category identified in item E by dividing the total number of inpatient service days in each diagnostic category by the total number of admissions in that diagnostic category and round the quotient to two decimal places.

J. Determine the day outlier trim point for each program and rehabilitation distinct part diagnostic category and round to whole days.

Subp. 2. **Redetermination of relative values.** The department shall reassign the program and specialty group diagnostic category composition in part 9500.1100, subparts 20a to 20g, after notice of the change in the State Register and a 30-day comment period. The relative values in this part and adjusted base year operating costs in part 9500.1115 and 9500.1116 must be redetermined when changes are made to part 9500.1100, subparts 20a to 20g.

Subp. 3. [Repealed, 18 SR 1115]

**Statutory Authority:** *MS s 256.9685; 256.969; 256.9695*

**History:** *10 SR 227; 11 SR 1688; 18 SR 1115; 26 SR 976*

**Published Electronically:** *October 16, 2013*

## 9500.1115 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER ADMISSION AND PER DAY OUTLIER.

Subpart 1. **Adjusted base year operating cost per admission for Minnesota and local trade area hospitals.** The department will determine the adjusted base year operating cost per admission by program and the rehabilitation distinct part specialty group for each Minnesota and local trade area hospital according to items A to D.

A. Determine and classify the operating cost for each admission according to part 9500.1110, subpart 1, items A to E.

B. Determine the operating costs for day outliers for each admission in item A that is recognized in outlier payments.

For each base year admission that is a day outlier, cut the operating cost of that admission at the trim point by multiplying the operating cost of that admission by the ratio of the admission's days of inpatient hospital services in excess of the trim point, divided by the admission's length of stay, and then multiply the cut operating cost by each hospital's elected outlier percentage or 70 percent if an election is not made. When neonate or burn diagnostic categories are used, the department shall substitute 90 percent for the 70 percent or elected percentage.

C. For each admission, subtract item B from item A, and for each hospital, add the results within each program and the rehabilitation distinct part specialty group, and divide this amount by the number of admissions within each program and the rehabilitation distinct part specialty group.

D. Adjust item C for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of admissions by program and the rehabilitation distinct part specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of admissions and round that quotient to five decimal places.

(4) Divide the cost per admission as determined in item C by the quotient calculated in subitem (3) and round that amount to whole dollars.

Subp. 2. **Adjusted base year operating cost per day outlier for Minnesota and local trade area hospitals.** The department will determine the adjusted base year operating cost per day outlier by program and the rehabilitation distinct part specialty group for each Minnesota and local trade area hospital according to items A and B.

A. To determine the allowable operating cost per day that is recognized in outlier payments, add the amounts calculated in subpart 1, item B and divide the total by the total number of days of inpatient hospital services in excess of the trim point.

B. Adjust item A for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of outlier days by program and the rehabilitation distinct part specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital outlier days.

(4) Divide the cost per day outlier as determined in item A by the quotient calculated in subitem (3) and round that amount to whole dollars.

Subp. 3. **Out-of-area hospitals.** The department will determine the adjusted base year operating cost per admission and per day outlier by program for out-of-area hospitals according to items A to C.

A. Multiply each adjusted base year operating cost per admission and per day outlier for each Minnesota and local trade area hospital determined in subparts 1 and 2 by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all the hospitals and round that amount to whole dollars.

Subp. 4. **Minnesota metropolitan statistical area and local trade area hospitals that do not have five or more medical assistance admissions or five or more day outlier medical assistance admissions in the base year and low volume local trade area hospitals.** The department will determine the adjusted base year operating cost per admission or per day outlier by program according to items A to C.

A. Multiply each adjusted base year cost per admission and per day outlier for each Minnesota metropolitan statistical area and local trade area hospital determined in subparts 1 and 2 by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all Minnesota metropolitan statistical area and local trade area hospitals and round that amount to whole dollars.

Subp. 5. **Nonmetropolitan statistical area hospitals that do not have five or more medical assistance admissions or five or more day outlier medical assistance admissions in the base year.** The department will determine the adjusted base year operating cost per admission or per day outlier by program for nonmetropolitan statistical area hospitals by substituting nonmetropolitan statistical area hospitals terms and data for the metropolitan statistical area hospitals terms and data under subpart 4.

Subp. 5a. **Minnesota and local trade area hospitals that do not have five or more medical assistance rehabilitation distinct part specialty group admissions or five or more day outlier medical assistance rehabilitation distinct part specialty group admissions in the base year.** The

department will determine the adjusted base year operating cost per admission or per day outlier for the rehabilitation distinct part specialty group for Minnesota and local trade area hospitals by substituting Minnesota and local trade area hospital terms and data for the metropolitan statistical area hospital terms and data under subpart 4.

Subp. 6. **Limitation on separate payment.** Out-of-area hospitals that have a rate established under subpart 3 may not have certified registered nurse anesthetists services paid separately from parts 9500.1090 to 9500.1155.

**Statutory Authority:** *MS s 256.9685; 256.969; 256.9695*

**History:** *10 SR 227; 11 SR 1688; 18 SR 1115; 26 SR 976*
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## 9500.1116 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER DAY.

Subpart 1. **Neonatal transfers.**

A. For Minnesota and local trade area hospitals, the department will determine the neonatal transfer adjusted base year operating cost per day for Minnesota and local trade area admissions that result from a transfer to a neonatal intensive care unit specialty group according to subitems (1) to (6).

(1) Determine the operating cost per day within each diagnostic category in part 9500.1100, subpart 20f, according to part 9500.1110, subpart 1, items A to E, and divide the total base year operating costs by the total corresponding inpatient hospital days for each admission.

(2) Determine relative values for each diagnostic category at part 9500.1100, subpart 20f, according to part 9500.1110, subpart 1, items F, G, and H, after substituting the term "day" for "admission."

(3) For each Minnesota and local trade area hospital that has admissions that result from a transfer to a neonatal intensive care unit specialty group, determine the operating cost for each admission according to part 9500.1110, subpart 1, items A to E.

(4) Add the results for each admission in subitem (3).

(5) Divide the total from subitem (4) by the total corresponding inpatient hospital days for each admission in subitem (3).

(6) Adjust subitem (5) for case mix according to part 9500.1115, subpart 1, item D, after substituting the term "day" for "admission."

B. For Minnesota and local trade area hospitals that do not have five or more medical assistance neonatal transfer admissions to a neonatal intensive care unit specialty group in the base year, the department will determine the neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a neonatal intensive care unit according to subitems (1) to (3).

(1) Multiply each adjusted base year operating cost per day for each Minnesota and local trade area hospital determined in item A, subitem (6), by the number of corresponding days in the hospital's base year.

(2) Add the products in subitem (1).

(3) Divide the total from subitem (2) by the total days for all Minnesota and local trade area hospitals and round that amount to whole dollars.

Subp. 2. **Long-term care hospital.**

A. The department will determine the base year operating cost per day for a long-term care hospital for the rate year according to subitems (1) and (2).

(1) Determine the operating cost per day according to part 9500.1110, subpart 1, items A to D, except that claims excluded in part 9500.1110, subpart 1, item B, subitems (2) and (4), will be included.

(2) Divide the total base year operating costs for all admissions in subitem (1) by the total corresponding inpatient hospital days for all admissions and round that amount to whole dollars.

B. For long-term care hospitals that do not have five or more medical assistance admissions in the base year, the department will determine a long-term care hospital operating cost per day according to subitems (1) to (3):

(1) Multiply each operating cost per day for each long-term care hospital as determined in item A, subitem (2), by the number of corresponding days in the hospital's base year.

(2) Add the products in subitem (1).

(3) Divide the total from subitem (2) by the total days for all long-term care hospitals and round that amount to whole dollars.

**Statutory Authority:** *MS s 256.9685; 256.9695*

**History:** *18 SR 1115; 26 SR 976*

**Published Electronically:** *October 16, 2013*

## 9500.1120 DETERMINATION OF HOSPITAL COST INDEX.

Subpart 1. **Adoption of hospital cost index.** The hospital cost index will be derived from Health Care Costs as published by Data Resources Incorporated (DRI), 1200 G Street NW, Washington, D.C. 20005. This report is published quarterly. The health care costs report is available through the Minitex interlibrary loan system and this report is incorporated by reference.

Subp. 2. **Determination of hospital cost index.** For the period from the midpoint of each hospital's base year to the midpoint of the rate year, or, when the base year is not rebased, from the midpoint of the prior rate year to the midpoint of the current rate year, the department shall determine the hospital cost index according to items A and B.

A. The commissioner shall obtain from Data Resources, Inc., the average annual historical and projected cost change estimates in a decimal format for the operating costs by applying the change in the Consumer Price Index - All Items (United States city average) (CPI-U) in the third quarter of the prior rate year.

B. Add one to the amounts in item A and multiply these amounts together. Round the result to three decimal places.

Subp. 3. [Repealed, 18 SR 1115]

**Statutory Authority:** *MS s 256.9685; 256.969; 256.9695*

**History:** *10 SR 227; 18 SR 1115; 26 SR 976*

**Published Electronically:** *October 16, 2013*

## 9500.1121 DETERMINATION OF DISPROPORTIONATE POPULATION ADJUSTMENT.

Subpart 1. **Eligibility for disproportionate population adjustment.** To be eligible for a disproportionate population adjustment, a Minnesota or local trade area hospital must meet the requirements of item B under general assistance medical care and item A and item C, D, or E under medical assistance.

A. The hospital, at the time that an admission occurs, must have at least two obstetricians with staff privileges who provide obstetric services to medical assistance patients. For nonmetropolitan statistical area hospitals, an obstetrician may be any physician with staff privileges at the hospital to perform nonemergency obstetrics procedures. This requirement does not apply to hospitals where the majority of admissions are predominately individuals under 18 years of age or hospitals that did not offer nonemergency obstetric services as of December 21, 1987.

B. The hospital has a base year days utilization rate of medical assistance inpatient days, including medical assistance inpatient days with another state but excluding general assistance medical care and Medicare crossovers, divided by total inpatient days that exceeds the arithmetic mean plus one standard deviation for Minnesota and local trade area hospitals. The difference is added to one and rounded to four decimal places.

C. The hospital has a base year days utilization rate of medical assistance inpatient days, including medical assistance inpatient days with another state but excluding general assistance medical care and Medicare crossovers, divided by total inpatient days that exceeds the arithmetic mean for Minnesota and local trade area hospitals. The difference is added to one and rounded to four decimal places.

D. The hospital has a base year days utilization rate of medical assistance inpatient days, including medical assistance inpatient days with another state but excluding general assistance medical care and Medicare crossovers, divided by total inpatient days that exceeds the arithmetic mean plus one standard deviation for Minnesota and local trade area hospitals. The difference is multiplied by 1.1 and added to one and rounded to four decimal places.

E. The hospital has a base year low-income utilization rate that exceeds 0.25. This rate is calculated by dividing medical assistance revenues, including medical assistance revenues with another state but excluding general assistance medical care, plus any cash subsidies received by the hospital directly from state and local government by total revenues plus the cash subsidies amount. This rate is added to the quotient of inpatient "charity care" charges minus the cash subsidies divided by total inpatient charges. The result is added to one and rounded to four decimal places. For purposes of this part, "charity care" is care provided to individuals who have no source of payment from third-party or personal resources.

Subp. 2. **Days utilization rate used in cases where hospital qualifies under two rates.** If a hospital qualifies under both the days utilization rate at subpart 1, item C or D, and the low-income utilization rate at subpart 1, item E, the disproportionate population adjustment amount shall be the days utilization rate.

**Statutory Authority:** *MS s 256.9685; 256.9695*

**History:** *18 SR 1115; 26 SR 976*
**Published Electronically:** *October 16, 2013*

## 9500.1122 DETERMINATION OF PROPERTY COST PER ADMISSION.

Subpart 1. **Minnesota and local trade area hospitals.** The department will determine the property cost per admission for each Minnesota and local trade area hospital according to items A to D.

A. Determine the property cost for each admission in part 9500.1110, subpart 1, item C, using each hospital's base year data according to subitems (1) to (4).

(1) Multiply the number of accommodation service inpatient days by that accommodation service property per diem and add the products.

(2) Multiply each ancillary charge by that ancillary property cost-to-charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the results of subitem (3) for all admissions for each hospital.

B. Determine the property cost for each hospital admission in part 9500.1110, subpart 1, item C, using each hospital's base year data and recent year data from part 9500.1105, subpart 1, item A, subitem (4), according to subitems (1) to (4).

(1) Multiply the base year number of accommodation service inpatient days by that same recent year accommodation service property per diem and add the products.

(2) Multiply each base year ancillary charge by that annualized recent year property cost to base year charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the totals of subitem (3) for all admissions for each hospital.

C. Determine the change in the property cost according to subitems (1) to (3).

(1) Subtract item A, subitem (4) from item B, subitem (4), and, if positive, divide the result by item A, subitem (4).

(2) Multiply the quotient of subitem (1) by 0.85.

(3) Add one to the result of subitem (2) and round to two decimal places.

D. Determine the property cost per admission by program and specialty group according to subitems (1) to (3).

(1) Assign each admission and property cost in item A, subitem (3), to the appropriate program and specialty group according to part 9500.1100, subparts 20a to 20g.

(2) Multiply the cost of each admission in subitem (1) by the factor in item C, subitem (3).

(3) Add the products within each program and specialty group in subitem (2), divide the total by the number of corresponding admissions, and round the resulting amount to whole dollars.

Subp. 2. **Out-of-area hospitals.** The department will determine the property cost per admission by program for out-of-area hospitals according to items A to C.

A. Multiply each property cost per admission for each Minnesota and local trade area hospital determined in subpart 1, item D, subitem (3), by the number of corresponding admissions in that hospital's base year.

B. Add the products in item A.

C. Divide the total from item B by the total admissions for all the hospitals and round the resulting amount to whole dollars.

Subp. 3. **Minnesota metropolitan statistical area hospitals and local trade area hospitals that do not have five or more medical assistance admissions in the base year and low volume local trade area hospitals.** The department will determine the property cost per admission by program according to items A to C.

A. Multiply each property cost per admission for each Minnesota metropolitan statistical area hospital and local trade area hospital determined in subpart 1, item D, subitem (3), by the number of corresponding admissions in the hospital's base year.

B. Add the products in item A.

C. Divide the total from item B by the total admissions for all Minnesota metropolitan statistical area and local trade area hospitals and round the resulting amount to whole dollars.

Subp. 4. **Nonmetropolitan statistical area hospitals that do not have five or more medical assistance admissions in the base year.** The department will determine the property cost per admission by program for nonmetropolitan statistical area hospitals that do not have five or more medical assistance admissions in the base year by substituting nonmetropolitan statistical area hospitals terms and data for the metropolitan statistical area hospitals terms and data under subpart 3.

Subp. 5. **Minnesota and local trade area hospitals that do not have five or more medical assistance rehabilitation distinct part specialty group admissions in the base year.** The department will determine the property cost per admission for the rehabilitation distinct part specialty group for Minnesota and local trade area hospitals that do not have five or more medical assistance admissions in the base year substituting Minnesota and local trade area hospital terms and data for the metropolitan statistical area hospital terms and data under subpart 3.

**Statutory Authority:** *MS s 256.9685; 256.9695*

**History:** *18 SR 1115; 26 SR 976*

**Published Electronically:** *October 16, 2013*

## 9500.1123 DETERMINATION OF HOSPITAL PAYMENT ADJUSTMENT.

Minnesota and local trade area hospitals that do not meet the disproportionate population adjustment payment requirements under part 9500.1121, subpart 1, item A, will receive a hospital payment adjustment according to the amount determined in part 9500.1121, subpart 1, item C, D, or E, subject to part 9500.1121, subpart 2. For purposes of this part, medical assistance does not include general assistance medical care.

**Statutory Authority:** *MS s 256.9685*

**History:** *26 SR 976*

**Published Electronically:** *October 16, 2013*

## 9500.1124 DETERMINATION OF PROPERTY COST PER DAY.

Subpart 1. **Neonatal transfers.**

A. For Minnesota and local trade area hospitals, the department will determine the property cost per day for neonatal transfer admissions that result from a transfer to a neonatal intensive care unit specialty group according to part 9500.1122, subpart 1, item D, after substituting the term "day" for "admission."

B. For Minnesota and local trade area hospitals that do not have five or more medical assistance neonatal transfer admissions in the base year, the department will determine the neonatal transfer property cost per day for admissions in the base year according to part 9500.1122, subpart 3, after substituting the term "day" for "admission."

Subp. 2. **Long-term care hospitals.**

A. For long-term care hospitals, the department will determine the property cost per day according to subpart 1, item A, except that claims excluded in part 9500.1110, subpart 1, item B, subitems (2) and (4), will be included.

B. For long-term care hospitals that do not have five or more medical assistance long-term care hospital admissions in the base year, the department will determine a long-term care hospital property cost per day according to part 9500.1122, subpart 3, after substituting the term "day" for "admission."

**Statutory Authority:** *MS s 256.9685; 256.9695*

**History:** *18 SR 1115; 26 SR 976; 26 SR 1000*
**Published Electronically:** *October 16, 2013*

**9500.1125** [Repealed, 18 SR 1115]
**Published Electronically:** *October 16, 2013*

**9500.1126** [Repealed, L 2014 c 291 art 10 s 14]
**Published Electronically:** *July 16, 2014*

## 9500.1127 DETERMINATION OF SMALL RURAL PAYMENT ADJUSTMENT.

Subpart 1. **Eligibility for small rural payment adjustment of 20 percent.** A Minnesota hospital is eligible for a small rural payment adjustment of 20 percent increase to its payment rates, excluding Medicare crossovers, if it meets the requirements in items A to C. For purposes of this subpart, medical assistance does not include general assistance medical care.

A. The hospital had 100 or fewer medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987, to June 30, 1987.

B. The hospital had 100 or fewer licensed beds on March 1, 1988.

C. The hospital is not located in a city of the first class.

Subp. 2. **Eligibility for small rural payment adjustment of 15 percent.** A Minnesota hospital is eligible for a small rural payment adjustment of 15 percent increase to its payment rates, excluding Medicare crossovers, if it meets the requirements in items A to B. For purposes of this subpart, medical assistance does not include general assistance medical care.

A. The hospital had more than 100 but fewer than 250 medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987, to June 30, 1987.

B. The hospital meets the requirements of subpart 1, items B and C.

Subp. 3. **Limitation of small rural payment adjustment.** A Minnesota hospital eligible for the small rural payment adjustment under subpart 1 or 2 that is also eligible for the disproportionate

population adjustment under part 9500.1121 or the hospital payment adjustment under part 9500.1123, is eligible for payments under those parts plus any amount by which the small rural payment adjustment exceeds the adjustments under those parts.

**Statutory Authority:** *MS s 256.9685*

**History:** *26 SR 976*

**Published Electronically:** *October 16, 2013*

## 9500.1128 DETERMINATION OF PAYMENT RATES.

Subpart 1. **Notification.** Minnesota and local trade area hospitals will be provided a notice of rates and relative values that are to be effective for the rate year by the preceding December 1. The payment rates shall be based on the rates in effect on the date of admission except when the inpatient admission includes both the first day of the rate year and the preceding July 1. In this case, the adjusted base year operating cost on the admission date shall be increased each rate year by the rate year hospital cost index.

Subp. 2. **Rate per admission.**

A. Each admission is classified to the appropriate program or the rehabilitation distinct part specialty group and diagnostic category according to part 9500.1100, subparts 20a to 20g, and the rate per admission will be determined according to subitems (1) and (2):

| | | |
|---|---|---|
| (1) | Medical Assistance Rate Per Admission = | ((Adjusted base year operating cost per admission multiplied by the relative value of the diagnostic category) plus the property cost per admission) and multiplied by the disproportionate population adjustment under part 9500.1121 or the hospital payment adjustment under part 9500.1123 |
| (2) | General Assistance Medical Care Rate per Admission = | (Adjusted base year operating cost per admission multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment under part 9500.1121) plus the property cost per admission |

B. The day outlier rate is in addition to the rate per admission and will be determined by program or the rehabilitation distinct part specialty group as follows:

(1) The rate per day for day outliers, as classified in item A, is determined as follows:

| | | |
|---|---|---|
| Outlier Rate Per Day | = | Adjusted base year operating cost per day outlier multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment under part 9500.1121 or the hospital payment adjustment under part 9500.1123 |

(2) The days of outlier status begin after the trim point for the appropriate diagnostic category and continue for the number of days a patient receives covered inpatient hospital services excluding days paid under item E.

C. Except for admissions subject to subpart 3, a transfer rate per day for both the hospital that transfers a patient and the hospital that admits the patient who is transferred will be determined as follows:

| | | |
|---|---|---|
| Transfer Rate Per Day | = | The rate per admission in item A divided by the arithmetic mean length of stay of the diagnostic category |

(1) A hospital will not receive a transfer payment that exceeds the hospital's applicable rate per admission specified in item A unless that admission is a day outlier.

(2) Except as applicable under subpart 4, rehabilitation hospitals and rehabilitation distinct parts are exempt from a transfer payment.

(3) An admission that directly precedes an admission to a non-state-owned hospital that provides psychiatric inpatient hospital services to persons with serious and persistent mental illness who have been civilly committed or voluntarily hospitalized in lieu of commitment and that is paid according to a contracted rate per day with the department is exempt from a transfer payment.

D. An admission classified to DRG's 386 to 390 whose length of stay is less than 50 percent of the arithmetic mean length of stay for the diagnostic category the admission is classified to under part 9500.1100, subparts 20a to 20g, and whose age at the time of admission is equal to or greater than one year, will be paid according to item C.

E. For an admission whose length of stay exceeds 365 days, the payment for the inpatient hospital services provided beyond 365 days will be the charges for those inpatient hospital services multiplied by the hospital's operating cost-to-charge ratio for all admissions determined under part 9500.1110, subpart 1, item D, subitem (4), and multiplied by the disproportionate population adjustment under part 9500.1121 or the hospital payment adjustment under part 9500.1123. This item is not applicable to rate per day payments under subpart 3.

F. For an admission that is classified to a diagnostic category that includes neonatal respiratory distress syndrome, the hospital must have a level II or level III nursery and the patient must receive treatment in that unit or payment will be made without regard to the respiratory distress syndrome condition.

G. A general assistance medical care admission classified to DRG's 424 to 432, 434, and 435 will be paid according to item C except that the per day rate will be multiplied by a factor of two.

Subp. 3. **Rate per day.**

A. Admissions resulting from a transfer to a neonatal intensive care unit specialty group and classified to a diagnostic category in part 9500.1100, subpart 20f, will have rates determined according to subpart 2, item A, after substituting the word "day" for "admission."

B. Admissions or transfers to a long-term care hospital will have rates determined according to subpart 2, item A, after substituting the word "day" for "admission," without regard to relative values.

Subp. 4. **Readmissions.** An admission and readmission of the same patient to the same or a different hospital within 15 days, excluding the days of discharge and readmission, is eligible for payment according to the criteria in parts 9505.0501 to 9505.0545.

**Statutory Authority:** *MS s 256.9685; 256.9695*

**History:** *18 SR 1115; 26 SR 976*
**Published Electronically:** *October 16, 2013*

## 9500.1129 PAYMENT LIMITATIONS.

Subpart 1. **Charge limitation.**

A. The department will limit payment, including third party and recipient liability, for services provided by an out-of-area hospital to allowable charges for the admission.

B. Payments, in addition to third party and recipient liability, for discharges occurring during a rate year may not exceed, in aggregate, the allowable charges for the same period of time to the hospital. This limitation will exclude payments made under part 9500.1121 and Medicare crossover claims. The limitation will be calculated separately for general assistance medical care and medical assistance and separately from other services for a rehabilitation distinct part.

Subp. 2. **Transfers.** A discharging hospital is not eligible for a transfer payment for services provided to a discharged patient if the admission to the discharging hospital was not due to an emergency, as defined in part 9505.0505, subpart 12, and the discharging hospital knew or had reason to know at the time of admission that the inpatient hospital services were outside the scope of the hospital's available services and the transfer to another hospital resulted because of the patient's need for those services.

**Statutory Authority:** *MS s 256.9685; 256.9695*

**History:** *18 SR 1115; 26 SR 976*
**Published Electronically:** *October 16, 2013*

## 9500.1130 PAYMENT PROCEDURES.

Subpart 1. **Submittal of claims.** Claims may not be submitted to the department until after a patient is discharged or 30 days after admission and every subsequent 30 days, whichever occurs first. A hospital that submits a claim to the department after 30 days from admission, but before discharge, shall submit a final claim after discharge.

Subp. 1a. **Payor of last resort.** A hospital may not submit a claim to the department until a final determination of the patient's eligibility for potential third party payment has been made by a hospital. Any and all available third-party benefits must be exhausted prior to billing medical assistance and the third-party liability amounts must be entered on the claim.

Subp. 1b. **Third-party liability.** Payment for patients that are simultaneously covered by medical assistance and a third party will be determined according to a hierarchy of application as set out in items A to E.

A. Medical assistance payment for a Medicare crossover will be determined by subtracting the third-party liability from the Medicare deductible and coinsurance due from the patient. A negative difference will not be implemented.

B. Medical assistance payment for a Medicare crossover whose Medicare benefits either exhaust or begin during an admission will be determined by subtracting the Medicare payment and third-party liability from the medical assistance rate. A negative difference will not be implemented.

C. Medical assistance payment will not be made for an admission when either charges are paid by a third party or the hospital has an agreement to accept payment for less than charges as payment in full.

D. Medical assistance payment for an admission under item C that requires a deductible or coinsurance will be made at a level equal to the deductible or coinsurance due from the patient.

E. Medical assistance payment for a patient with any third-party benefits will be determined as the lesser of the covered charges minus the third-party liability, or the medical assistance rate minus the third-party liability. A negative difference will not be implemented.

Subp. 1c. **Reduction of recipient resources.** Recipient resources will also be reduced from the amounts in subpart 1b.

Subp. 2. [Repealed, 18 SR 1115]

Subp. 3. [Repealed, 18 SR 1115]

Subp. 4. [Repealed, 18 SR 1115]

Subp. 5. [Repealed, 18 SR 1115]

Subp. 6. [Repealed, 18 SR 1115]

Subp. 7. [Repealed, 18 SR 1115]

Subp. 8. [Repealed, 18 SR 1115]

Subp. 9. [Repealed, 18 SR 1115]

Subp. 10. [Repealed, 18 SR 1115]

Subp. 11. [Repealed, 18 SR 1115]

Subp. 12. [Repealed, 18 SR 1115]

**Statutory Authority:** *MS s 256.9685; 256.969; 256.9695*

**History:** *10 SR 227; 10 SR 867; 11 SR 1688; 13 SR 1689; 18 SR 1115*

**Published Electronically:** *October 16, 2013*

**9500.1135** [Repealed, 18 SR 1115]

**Published Electronically:** *October 16, 2013*

**9500.1140 APPEALS.**

Subpart 1. **Scope of appeals.** A hospital may appeal a decision arising from the application of standards or methods under Minnesota Statutes, section 256.9685, 256.9686, or 256.969, if an appeal would result in a change to the hospital's payment rate or payments. The appeals procedure in subparts 2 to 6 shall apply to all appeals filed on or after August 1, 1989.

Subp. 2. **Filing of appeals.** An appeal must be received by the commissioner within the time period specified in subpart 3, 4, or 5. The appeal must include the information required in items A to D:

A. the disputed items;

B. the authority in federal or state statute or rule upon which the hospital relies for each disputed item;

C. the type of appeal in subpart 3, 4, or 5 that is applicable to each disputed item; and

D. the name and address of the person to contact regarding the appeal.

Subp. 3. **Case mix appeals.** A hospital may appeal a payment change that results from a difference in case mix between the base year and rate year. The appeal must be received by the commissioner or postmarked no later than 120 days after the end of the appealed rate year. A case mix appeal will apply to all medical assistance patients who received inpatient hospital services from the hospital for which the hospital received medical assistance payment excluding Medicare crossovers and the appeal is effective for the entire rate year. A case mix appeal excludes medical assistance admissions whose payments have been made according to part 9500.1130, subpart 1b, item E. A case mix appeal excludes medical assistance admissions that have a relative value of zero for its DRG. The results of case mix appeals do not automatically carry forward into later rate years. Separate case mix appeals must be submitted for each rate year based on the change in the mix of cases for that particular rate year. An adjustment will be made only to the extent that the need is attributable to circumstances that are separately identified by the hospital. The hospital must demonstrate that the average acuity or length of stay of patients in each rate year appealed has increased or services have been added or discontinued according to items A to J.

A. The change must be measured by use of case mix indices derived using all DRG's. Relative values for each DRG will be determined according to part 9500.1110, subpart 1, by substituting DRG terms and data for diagnostic category terms and data. DRG relative values will be determined based on all programs and the rehabilitation distinct part specialty group. Separate DRG relative values will be determined for transfers to the neonatal intensive care unit specialty group. For each program and specialty group, make the determinations in subitems (1) to (6).

(1) Multiply the hospital's number of rate year admissions within each DRG by the relative value of that DRG.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the hospital's number of rate year admissions and round the quotient to five decimal places.

(4) Complete the functions in subitems (1) to (3) for the hospital's base year admissions determined in part 9500.1110, subpart 1, item C.

(5) Divide the quotient determined in subitem (3) by the quotient determined in subitem (4).

(6) Multiply subitem (5) by 100 and round the percentage to five decimal places.

B. The percentage change, in whole numbers, between the recalculated case mix indices under item A will be reduced by the change in indices as measured using diagnostic categories in part 9500.1100, subparts 20b to 20g. For each program and specialty group, make the determinations in subitems (1) to (8).

(1) Multiply the hospital's number of rate year admissions within each diagnostic category by the relative value of that diagnostic category as determined in part 9500.1100.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the hospital's number of rate year admissions and round the quotient to five decimal places.

(4) Complete the functions in subitems (1) to (3) for the hospital's base year admissions determined in part 9500.1110, subpart 1, item C.

(5) Divide the quotient determined in subitem (3) by the quotient determined in subitem (4).

(6) Multiply subitem (5) by 100 and round the percentage to five decimal places.

(7) Divide item A, subitem (6), by subitem (6).

(8) Multiply subitem (7) by 100 and round the percentage change to whole numbers.

C. Determine the payments made for admissions occurring during the appealed rate year under part 9500.1128 reduced by property payments made under parts 9500.1121, 9500.1122, 9500.1123, and 9500.1124 for each program and specialty group.

D. Multiply item B, subitem (8), by item C for each program and specialty group.

E. Subtract item C from item D for each program and specialty group.

F. Add the differences in item E.

G. Add the differences in item C.

H. Divide item F by item G. If the quotient is less than positive 0.05 and more than negative 0.05, there can be no payment adjustment for a change in case mix.

I. Subtract 0.05 from the quotient in item H if the quotient is positive or add 0.05 if the quotient is negative.

J. Multiply item G by item I. If the product is positive, there is an underpayment with that amount due the hospital. If the product is negative, there is an overpayment with that amount due the department.

Subp. 4. **Medicare adjustment appeals.** To appeal a payment rate or payment change that results from Medicare adjustments of base year information, the appeal must be received by the commissioner or postmarked not later than 60 days after the date the medical assistance determination was mailed to the hospital by the department or within 60 days of the date the Medicare determination was mailed to the hospital by Medicare, whichever is later.

Subp. 5. **Rate and payment appeals.** To appeal a payment rate or payment determination that is not a case mix or Medicare adjustment appeal, the appeal must be received by the commissioner within 60 days of the date the determination was mailed to the hospital.

Subp. 6. **Resolution of appeals.** The appeal will be heard by an administrative law judge according to parts 1400.5100 to 1400.8401 and Minnesota Statutes, sections 14.57 to 14.62, and according to the requirements of items A to D.

A. The hospital must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect or not according to law.

B. Both overpayments and underpayments that result from the submission of appeals will be implemented.

C. Facts to be considered in any appeal of base year information are limited to those in existence at the time the payment rates of the first rate year were established from the base year information.

D. Relative values and rates that are based on averages will not be recalculated to reflect the appeal outcome.

**Statutory Authority:** *MS s 256.9685; 256.969; 256.9695*

**History:** *10 SR 227; 18 SR 1115; 26 SR 976; L 2014 c 291 art 10 s 13*

**Published Electronically:** *July 3, 2014*

**9500.1150** [Repealed, 26 SR 976]

**Published Electronically:** *October 16, 2013*

**9500.1155** [Repealed, 26 SR 976]

**Published Electronically:** *October 16, 2013*

## GENERAL ASSISTANCE

### 9500.1200 PURPOSE AND APPLICABILITY.

Subpart 1. **Purpose.** Parts 9500.1200 to 9500.1270 establish the rights and responsibilities of the Department of Human Services, local agencies, and recipients of general assistance as they pertain to the administration of the general assistance program.

Subp. 2. **Applicability.** Part 9500.1254 governs application for maintenance benefits from other sources, execution of an interim assistance agreement and reimbursement for interim assistance. When part 9500.1254 conflicts with parts 9500.1236 to 9500.1248, then part 9500.1254 prevails.

**Statutory Authority:** *MS s 14.388; 256D.04; 256D.051; 256D.05; 256D.06; 256D.09; 256D.101; 256D.10; 256D.111*

**History:** *10 SR 1715; 11 SR 134; 32 SR 1437*
**Published Electronically:** *October 16, 2013*

### 9500.1202 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; and

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

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

**History:** *10 SR 1715; 15 SR 1842; 32 SR 1437*
**Published Electronically:** *October 16, 2013*

**9500.1204** [Repealed, 10 SR 2322]
**Published Electronically:** *October 16, 2013*

**9500.1205** [Repealed, 15 SR 1842]
**Published Electronically:** *October 16, 2013*

### 9500.1206 PROGRAM DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9500.1200 to 9500.1270, the following terms have the meanings given them.

Subp. 1a. **Actual availability.** "Actual availability," when used in reference to income or property, means that which is in hand or can be readily obtained for current use.

Subp. 2. **Adult child.** "Adult child" means a person aged 18 years or older who resides with at least one parent.

Subp. 3. **Advanced age.** "Advanced age" means the condition that applies to an applicant or recipient who is age 55 or older and whose work history shows a marked deterioration compared to the applicant's or recipient's work history before age 55 as indicated by decreasing occupational status, reduced hours of employment, or decreased periods of employment.

Subp. 4. [Repealed, 32 SR 1437]

Subp. 4a. **Affidavit.** "Affidavit" means a written declaration made under oath before a notary public or other authorized officer.

Subp. 4b. **Appeal.** "Appeal" means a written statement from an applicant or recipient that requests a hearing or expresses dissatisfaction with a county agency decision that can be challenged under Minnesota Statutes, section 256.045 and part 9500.1211, subpart 4.

Subp. 5. **Applicant.** "Applicant" means a person who has submitted an application for general assistance to a county agency and whose application has not been approved, denied, or voluntarily withdrawn.

Subp. 5a. **Application.** "Application" means the action by which a person shows in writing a desire to receive assistance by submitting a signed and dated form prescribed by the commissioner to the county agency.

Subp. 6. **Assistance standard.** "Assistance standard" means the amount established by the commissioner under Minnesota Statutes, section 256D.01, to provide for an assistance unit's basic subsistence needs.

Subp. 6a. **Assistance unit.** "Assistance unit" means a person or group of persons who are applying for or receiving assistance and whose needs are included in the calculation of a general assistance payment.

Subp. 6b. **Authorized representative.** "Authorized representative" means a person who is authorized in writing by an applicant or recipient to act on that applicant's or recipient's behalf in matters involving general assistance or emergency general assistance, including submitting applications, making appeals, and providing or requesting information. An authorized representative may exercise the same rights and responsibilities on behalf of the person being represented as an applicant or recipient.

Subp. 7. [Repealed, 10 SR 2322]

Subp. 7a. **Basic needs.** "Basic needs" means the minimum personal requirements of subsistence and are restricted to:

A. food;

B. clothing;

C. shelter;

D. utilities; and

E. other items of which the loss, or lack of, is determined by the county agency to pose a direct, immediate threat to the physical health or safety of the applicant or recipient.

Subp. 7b. **Budget month.** "Budget month" means the calendar month from which a county agency uses the income or circumstances of an assistance unit to determine the amount of the assistance payment for the payment month.

Subp. 8. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or a designated representative.

Subp. 8a. **Corrective payment.** "Corrective payment" means an assistance payment made to correct an underpayment.

Subp. 9. **Costs or disbursements.** "Costs" or "disbursements" means a qualified provider's actual out-of-pocket expenses incurred for the provision of special services to an applicant or recipient.

Subp. 9a. **Countable income.** "Countable income" means gross income minus allowable exclusions, deductions, and disregards.

Subp. 9b. **County agency.** "County agency" has the meaning given in Minnesota Statutes, section 256D.02, subdivision 12.

Subp. 10. [Repealed, 10 SR 2322]

Subp. 11. **Department.** "Department" means the Department of Human Services.

Subp. 11a. **Developmental disability.** "Developmental disability" means the condition of a person who has demonstrated deficits in adaptive behavior and intellectual functioning which is two or more standard deviations below the mean of a professionally recognized standardized test and the condition severely limits the person in obtaining, performing, or maintaining suitable employment.

Subp. 12. **Director of the county agency.** "Director of the county agency" means the director of the county agency or the director's designated representative.

Subp. 12a. **Diversionary work program or DWP.** "Diversionary work program" or "DWP" has the meaning given in Minnesota Statutes, section 256J.95.

Subp. 12b. **Documentation.** "Documentation" means a written statement or record that substantiates or validates an assertion made by a person or an action taken by a county agency.

Subp. 12c. **Earned income.** "Earned income" means compensation from lawful employment or lawful self-employment, including salaries, wages, tips, gratuities, commissions, earnings from self-employment, incentive payments from work or training programs, payments made by an employer for regularly accrued vacation or sick leave, earnings under title I of the Elementary and Secondary Education Act, employee bonuses and profit sharing, jury duty pay, picket duty pay, and profit from other lawful activities which accrues as a result of the individual's effort or labor.

Earned income does not include returns from capital investment or benefits that accrue as compensation for lack of employment.

Subp. 12d. **Earned income tax credit.** "Earned income tax credit" means the payment that can be obtained by a qualified low-income person from an employer or from the United States Internal Revenue Service under United States Code, title 26, section 32.

Subp. 12e. **Emergency.** "Emergency" means a situation that causes or threatens to cause a lack of a basic need item when there are insufficient resources to provide for that need.

Subp. 12f. **Encumbrance.** "Encumbrance" means a legal claim against real or personal property that is payable upon the sale of that property.

Subp. 12g. [Repealed, 32 SR 1437]

Subp. 12g. **Equity value.** "Equity value" means the amount of equity in real or personal property owned by a person. Equity value is determined by subtracting any outstanding encumbrances from the fair market value of the real or personal property.

Subp. 12h. **Fair hearing or hearing.** "Fair hearing" or "hearing" means the department evidentiary hearing conducted by an appeals referee to resolve the issues specified in part 9500.1211, subpart 4.

Subp. 12i. [Repealed, 32 SR 1437]

Subp. 12j. [Repealed, 32 SR 1437]

Subp. 12k. **Federal Insurance Contributions Act or FICA.** "Federal Insurance Contributions Act" or "FICA" means the federal law under United States Code, title 26, sections 3101 to 3126, that requires withholding or direct payment of income to the federal government.

Subp. 13. [Repealed, 32 SR 1437]

Subp. 13a. **Filing unit.** "Filing unit" means a person or persons who reside together and whose income and value of resources must be used to determine the eligibility and benefit level of an assistance unit. The filing unit must include:

A. the applicant;

B. the applicant's spouse;

C. the applicant's family; and

D. the natural or adoptive parents of a single adult applicant or recipient and the minor children of those parents.

Subp. 14. **Full-time student.** "Full-time student" means a person who is enrolled in a graded or ungraded primary, intermediate, secondary, commissioner of education-selected high school equivalency preparatory, trade, technical, vocational, or postsecondary school, and who meets the school's standard for full-time attendance.

Subp. 14a. **General assistance.** "General assistance" means the program authorized under Minnesota Statutes, sections 256D.01 to 256D.21 and parts 9500.1200 to 9500.1272.

Subp. 15. **Good cause.** "Good cause" means a reason for taking an action or failing to take an action that is reasonable and justified when viewed in the context of surrounding circumstances including: illness of the person, illness of another family member that requires the applicant's or recipient's presence, a family emergency, the inability to obtain transportation or adequate child care, or a conflicting obligation which has been determined by the county agency to be reasonable or justified.

Subp. 15a. **Gross income.** "Gross income" means the total amount of cash or in-kind payment or benefit, whether earned or unearned, before any withholdings, deductions, or disregards, paid to, or for the benefit of, a person, including income specified in Minnesota Statutes, section 256D.02, subdivision 8. Gross income does not include personal property previously established as a resource, subject to the limitations under part 9500.1221.

Subp. 15b. **Gross receipts.** "Gross receipts" means the money received by a self-employed person before the expenses of self-employment are deducted.

Subp. 15c. **Homestead.** "Homestead" means the house owned and occupied by a member of the filing unit as the member's dwelling place together with all contiguous land on which the house is situated and other appurtenant structures.

Subp. 15d. **Household report form.** "Household report form" means a form prescribed by the commissioner on which a recipient reports information to a county agency about income and other circumstances.

Subp. 16. [Repealed, 32 SR 1437]

Subp. 16a. **In-kind income.** "In-kind income" means income, benefits, or payments that are provided in a form other than money or liquid assets, and which the applicant or recipient cannot legally require to be paid in cash to the applicant or recipient, including goods, produce, services, privileges, or third-party payments made on behalf of a person for whom the income is intended.

Subp. 17. **Interim assistance.** "Interim assistance" means the total amount of general assistance and Group Residential Housing (GRH) provided for a recipient to cover the period for which a payment of another maintenance benefit is made. The amount of general assistance and GRH considered interim assistance is limited to the total amount the monthly payments for the assistance unit would have been reduced if the other maintenance benefits had been paid at the time of their accrual. The interim assistance period begins with the month of application for general assistance or GRH or the first month of eligibility for the other maintenance benefits, whichever is later.

Subp. 18. **Interim assistance agreement.** "Interim assistance agreement" means the agreement in which the general assistance applicant or recipient agrees to reimburse the county agency for the amount of general assistance or Group Residential Housing (GRH) provided during the period when eligibility for another maintenance benefit program is being determined. The agreement must require reimbursement to the county agency only when the general assistance applicant or recipient

is found eligible for another maintenance benefit program and the initial payment of those other maintenance benefits has been made.

Subp. 18a. **Job Training Partnership Act.** "Job Training Partnership Act" means the Job Training Partnership Act authorized under Public Law 97-300 and its successor programs.

Subp. 18b. **Legal custodian.** "Legal custodian" means a person who has been granted legal custody of a minor child by a court; or, if assistance is being requested for the minor child, a person who is defined as an eligible relative caretaker of the minor child under MFIP requirements in Minnesota Statutes, section 256J.08, subdivision 11.

Subp. 18c. **Liquid assets or liquid resources.** "Liquid assets" or "liquid resources" means personal property in the form of cash or other financial instruments that are readily convertible to cash.

Subp. 18d. **Liquidate.** "Liquidate" means to convert real or personal property into cash or other financial instruments that are readily convertible to cash. The conversion can be by sale or by borrowing using the nonliquid real or personal property as security for a loan.

Subp. 19. [Repealed, 15 SR 1842]

Subp. 19a. **Local labor market.** "Local labor market" means the geographic area in which a registrant can reasonably be expected to search for suitable employment. The geographic area must be limited to an area within two hours' round trip of the registrant's residence, exclusive of time needed to transport the registrant's children to and from child care.

Subp. 19b. **Lump sum.** "Lump sum" means nonrecurring income that is not excluded in part 9500.1223.

Subp. 19c. [Repealed, 32 SR 1437]

Subp. 20. [Repealed, L 2005 c 159 art 5 s 12]

Subp. 20a. [Repealed, 32 SR 1437]

Subp. 21. **Mental illness.** "Mental illness" means the condition of a person who has a psychological disorder resulting in behavior that severely limits the person in obtaining, performing, or maintaining suitable employment.

Subp. 22. [Renumbered subp 11a]

Subp. 22a. **Minnesota family investment program or MFIP.** "Minnesota family investment program" or "MFIP" means the assistance program authorized in Minnesota Statutes, chapter 256J.

Subp. 22b. **Minnesota supplemental aid or MSA.** "Minnesota supplemental aid" or "MSA" means the program established under Minnesota Statutes, sections 256D.33 to 256D.54.

Subp. 23. **Minor child.** "Minor child" means a person who is under the age of 18; or if age 18, who is a member of a family assistance unit and who is enrolled as a full-time student in an accredited high school and who is expected to graduate by age 19.

Subp. 23a. **Month.** "Month" means a calendar month.

Subp. 24. **Negotiated rate.** "Negotiated rate" means the amount a county agency will pay on behalf of recipients living in a room and board, boarding care, supervised living, or adult foster care arrangement.

Subp. 24a. **Nonrecurring income.** "Nonrecurring income" means a form of income that is:

A. received only one time or is not of a continuous nature; or

B. received in a prospective payment month but is no longer received in the corresponding retrospective payment month.

Subp. 24b. **Occupational or vocational literacy program.** "Occupational or vocational literacy program" means a program providing literacy training which emphasizes specific language and reading skills needed to perform in employment, complete employment training programs, or complete work readiness programs.

Subp. 25. **Other maintenance benefits.** "Other maintenance benefits" means any of the following:

A. workers' compensation benefits as provided by Minnesota Statutes, chapter 176 and rules adopted thereunder;

B. unemployment compensation benefits as provided by Minnesota Statutes, sections 268.07 to 268.10 and rules adopted thereunder;

C. railroad retirement benefits as provided by United States Code, title 45, sections 231 to 231s;

D. veteran's disability benefits as provided by United States Code, title 38, sections 301 to 363;

E. any benefits provided by the Social Security Administration under United States Code, title 42; or

F. other sources identified by the county agency that provide periodic payments that can be used to meet basic needs and that, if received, would reduce or eliminate the need for general assistance.

Subp. 25a. **Overpayment.** "Overpayment" means that portion of an assistance payment which is greater than the amount for which an assistance unit is eligible, resulting from a calculation error, a client reporting error, a misapplication of existing program requirements by a county agency, or changes in payment eligibility that cannot be affected due to notification requirements.

Subp. 25b. **Parent.** "Parent" means a child's biological or adoptive parent who is legally obligated to support that child.

Subp. 25c. **Participation in a literacy program.** "Participation in a literacy program" means to receive instruction and complete assignments as part of a literacy program in accordance with the schedule or plan established by the literacy training program provider.

Subp. 25d. **Payment month.** "Payment month" means the calendar month for which the county agency issues an assistance payment.

Subp. 25e. **Permanent employment.** "Permanent employment" means suitable employment that is not, by description, of limited duration.

Subp. 25f. **Personal property.** "Personal property" means an item of value that is not real property. Personal property includes, but is not limited to, the value of a contract for deed held by a seller, assets held in trust on behalf of members of an assistance unit, cash surrender value of life insurance, value of a prepaid burial, savings account, value of stocks and bonds, and value of retirement accounts less any costs and penalties for early withdrawal.

Subp. 26. **Potentially eligible.** "Potentially eligible" means that the county agency has determined that the applicant or recipient shows circumstances which appear to meet the eligibility requirements of another maintenance benefit program.

Subp. 26a. [Repealed, 32 SR 1437]

Subp. 26b. **Probable fraud.** "Probable fraud" means the level of evidence that, if proven as fact, will establish that assistance has been wrongfully obtained.

Subp. 26c. **Prospective budgeting.** "Prospective budgeting" means a method of determining the amount of assistance in which the budget month and payment month are the same.

Subp. 26d. [Repealed, L 2005 c 159 art 5 s 12]

Subp. 27. [Repealed, L 2005 c 159 art 5 s 12]

Subp. 28. [Repealed, 10 SR 2322]

Subp. 28a. **Real property.** "Real property" means the land itself and all buildings, structures, and improvements, or other fixtures on it, belonging or appertaining to the land, and all mines, minerals, fossils, and trees on or under it.

Subp. 28b. **Reasonable compensation.** "Reasonable compensation" means the value received in exchange for property transferred to another owner which equals or exceeds the seller's equity in the property, reduced by costs incurred in the sale.

Subp. 28c. **Recipient.** "Recipient" means an individual currently receiving, or suspended for one month from receiving, general assistance. Recipient includes any person whose needs are included in the payment to an assistance unit.

Subp. 28d. **Redetermination of eligibility.** "Redetermination of eligibility" means the process by which information is collected periodically by a county agency and used to determine a recipient's continued eligibility for assistance.

Subp. 28e. **Reside with.** "Reside with" means to share living quarters such as living rooms, bedrooms, or kitchens. Entrances, laundry rooms, and bathrooms are not considered living quarters.

Subp. 29. **Responsible relative.** "Responsible relative" means the spouse of an applicant or recipient, the parent of an applicant's or recipient's minor child if residing together as a family, the parent of a minor child who is an applicant or recipient, or the parent of an adult child who resides with the parent and is an applicant or recipient.

Subp. 29a. **Retrospective budgeting.** "Retrospective budgeting" means a method of determining the amount of assistance an assistance unit will receive in which the payment month is the second month after the budget month.

Subp. 29b. **Social services.** "Social services" means the services included in a county's community social services plan which are administered by the county board.

Subp. 30. **SSI or Supplementary Security Income.** "SSI" or "Supplementary Security Income" means the Supplemental Security Income program administered by the Social Security Administration under United States Code, title 42, sections 1381 to 1383c.

Subp. 31. [Repealed, 15 SR 1842]

Subp. 32. **Suitable employment.** "Suitable employment" means a job within the local labor market that:

A. meets existing health and safety standards set by federal, state, or local regulations;

B. is within the physical and mental ability of a person;

C. provides a gross weekly income equal to the federal or state minimum wage applicable to the job for 40 hours per week, or a monthly income which, after allowable exclusions, deductions, and disregards would exceed the standard of assistance for the assistance unit, whichever is less; and

D. includes employment offered through the Job Training Partnership Act, Minnesota Employment and Economic Development Act, and other employment and training options, but does not include temporary day labor.

Subp. 32a. [Repealed, 32 SR 1437]

Subp. 32b. **Underpayment.** "Underpayment" means an assistance payment, resulting from a calculation error, a client reporting error, or a misapplication of program requirements by a county agency, which is less than the amount for which an assistance unit is eligible.

Subp. 32c. **Unearned income.** "Unearned income" means income received by a person which does not meet the definition of earned income. Unearned income includes interest, dividends, unemployment compensation, disability insurance payments, veterans benefits, pension payments, return on capital investments, insurance payments or settlements, and severance payments.

Subp. 32d. **Vendor.** "Vendor" means a provider of goods or services.

Subp. 32e. **Vendor payment.** "Vendor payment" means a payment made by a county agency directly to a vendor.

Subp. 32f. **Verification.** "Verification" means the process a county agency must use to establish the accuracy or completeness of information from an applicant, recipient, third-party, or other source as that information relates to an assistance unit's eligibility for general assistance or the amount of a monthly assistance payment.

Subp. 33. **Vocational specialist.** "Vocational specialist" means a counselor of the Department of Employment and Economic Development or Division of Vocational Rehabilitation, or another similarly qualified person who advises persons about occupational goals and employment.

**Statutory Authority:** *MS s 14.388; 256.05; 256D.01; 256D.04; 256D.051; 256D.052; 256D.05; 256D.06; 256D.08; 256D.09; 256D.101; 256D.10; 256D.111*

**History:** *9 SR 593; 10 SR 1715; 11 SR 134; 13 SR 1688; 13 SR 1735; 15 SR 1842; L 1994 c 483 s 1; L 2003 1Sp14 art 11 s 11; L 2005 c 56 s 2; L 2005 c 112 art 2 s 41; L 2005 c 159 art 5 s 12; L 2006 c 212 art 1 s 25; 32 SR 1437; L 2017 1Sp5 art 10 s 7*

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## 9500.1211 APPLICANT AND RECIPIENT RIGHTS AND COUNTY AGENCY RESPONSIBILITIES TO APPLICANTS AND RECIPIENTS.

Subpart 1. **Right to information.** An applicant or recipient has the right to obtain information about the benefits, requirements, and restrictions of the general assistance program.

Subp. 2. **Right to apply.** A person has the right to apply, including the right to reapply, for general assistance. A county agency shall inform a person who inquires about financial assistance of the right to apply, shall explain how to apply, and shall mail or hand deliver an application form to the person inquiring about assistance. When a county agency ends assistance, the county agency shall inform the recipient in writing of the right to reapply.

Subp. 3. **Authorized representative.** An applicant or recipient of general assistance may designate an authorized representative to act on the applicant's or recipient's behalf. An applicant or recipient has the right to be assisted or represented by an authorized representative in the application, eligibility redetermination, fair hearing process, and any other contact with the county agency or the department.

When a county agency determines that it is necessary for a person to assist an applicant or recipient, the county agency shall designate a staff member to assist the applicant or recipient. The

county agency staff member may assist the applicant or recipient to take the actions necessary to submit an application to establish the date of the application.

Upon a request from an applicant or recipient, a county agency shall provide addresses and telephone numbers of organizations that provide legal services at no cost to low-income persons.

Subp. 4. **Appeal rights.** An applicant, recipient, or former recipient has a right to request a fair hearing when aggrieved by an action or inaction of a county agency. A request for a fair hearing must be submitted in writing to the county agency or to the department. The request must be mailed within 30 days after the applicant or recipient receives written notice of the county agency's action or within 90 days when the applicant or recipient shows good cause for not submitting the request within 30 days. A former recipient who receives a notice of overpayment may appeal the action contained in the notice in the manner and within the periods described in this subpart. Issues which may be appealed are:

A. denial of the right to apply for assistance;

B. failure of a county agency to approve or deny an application within 30 days;

C. denial of an application for assistance;

D. suspension, reduction, or termination of assistance;

E. calculated amount of an overpayment and the calculated level of recoupment due to that overpayment;

F. eligibility for and calculation of a corrective payment;

G. other factors involved in the calculation of an assistance payment;

H. a change to protective, vendor, or two-party payments for recipients; and

I. the calculated amount retained by a county agency under an interim assistance authorization agreement from a retroactive benefit payment.

Subp. 5. **Rights pending hearing.** Unless otherwise specified, a county agency shall not reduce, suspend, or terminate payment when an aggrieved recipient requests a fair hearing before the effective date of the action or within ten days of the mailing of the notice, whichever is later, unless the recipient requests in writing not to receive continued assistance pending a hearing decision. A county agency may increase or reduce an assistance payment while an appeal is pending when the circumstances of the recipient change and the change is not related to the issue under appeal. Assistance issued pending a fair hearing is subject to recovery when, as a result of the fair hearing, the commissioner finds that the recipient was not eligible for such assistance. This subpart shall in no way reduce any rights that the recipient may have under part 9500.1259, subpart 2.

A county agency shall reimburse appellants for reasonable and necessary expenses of attending the hearing, such as child care and transportation costs. A county agency shall reimburse appellant's witnesses and representatives for the expenses of transportation to and from the hearing.

Subp. 6. **Right to review records.** A county agency shall allow an applicant or recipient to review his or her case records that are held by the county agency and that are related to eligibility for or the assistance payment from the program, except those case records to which access is denied under Minnesota Statutes, chapter 13. A county agency shall make case records available to an applicant or recipient as soon as possible but in no event later than the fifth business day following the date of the request. When an applicant, recipient, or authorized representative asks for photocopies of material from the case record, the county agency shall provide one copy of each page at no cost.

Subp. 7. **Right to notice.** When a county agency notifies an applicant or recipient of its intention to deny an application or reduce, suspend, or terminate payment, the county agency shall specify in its notice the action it has taken or intends to take, the reason and legal authority for the action, and the right to appeal and request a fair hearing. The notice shall also inform the applicant or recipient of the conditions under which assistance will continue pending the appeal outcome, the responsibility to repay assistance if the appeal is unsuccessful, the right to be reimbursed for reasonable and necessary expenses of attending an appeal hearing, and the right to review county agency records in accordance with subpart 6.

**Statutory Authority:** *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

**History:** *15 SR 1842*
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**9500.1212** [Repealed, 15 SR 1842]
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## 9500.1213 APPLICATION REQUIREMENTS.

Subpart 1. **Application for general assistance, county of residence.** An applicant for general assistance must apply for general assistance in the applicant's county of residence. However, a county agency must not refuse to take an application from an individual who appears to reside in another county, but must promptly forward the completed application to the county of residence. The county of residence must use the date the application was filed in the county of application as the application date.

Subp. 2. **County agency requirements.** A county agency must:

A. inform persons who inquire about cash assistance of general assistance eligibility requirements and how to apply for general assistance;

B. offer, by hand or mail, the application form prescribed by the commissioner when a person makes a written or oral inquiry;

C. inform the person that, if the person is found eligible, the county agency must use the date the application form is submitted to the county agency as the starting point for computing assistance, and that any delay in submitting an application form will reduce the amount of assistance paid for the month of application;

D. upon receipt of a signed and dated application from an applicant, the county agency must sign and date the application;

E. designate a staff member to assist the applicant to take the action necessary to submit an application if a county agency determines an applicant needs assistance in completing an application; and

F. inquire and determine at the time of initial application if the applicant has an emergency as defined in part 9500.1206, subpart 12e, and if so, determine the person's eligibility for emergency assistance under part 9500.1261.

Subp. 3. **Date of application.** The date of application is the date the county agency signs and dates the application.

Subp. 4. **Withdrawal of application.** An applicant may withdraw an application at any time by giving written or oral notice to the county agency. The county agency must issue a written notice confirming the withdrawal and inform the applicant of the agency's understanding that the applicant has withdrawn the application. If, within ten days of the date of the agency's notice, an applicant informs the county agency that the applicant does not wish to withdraw the application, the county agency must reinstate and finish processing the application.

Subp. 5. **Agency verification of information on application.** The county agency shall verify information provided by an applicant as specified in part 9500.1215.

Subp. 6. **Determination of filing unit.** When an application for general assistance is made and when the county agency redetermines the eligibility of a recipient, the county agency must determine the composition of the applicant's or recipient's filing unit. The county agency must determine the composition of a filing unit according to part 9500.1206, subpart 13a.

Subp. 7. **Processing application.** Within 30 days after receiving an application, a county agency must determine the applicant's program eligibility, approve or deny the application, inform the applicant of its decision, and issue assistance when the applicant is eligible. When an applicant establishes the inability to provide required documentation within the 30-day processing period, the county agency shall have an additional 30 days to process the application and to allow the applicant to provide the documentation. If eligibility cannot be determined by the end of the second 30-day period, the application must be denied.

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

**History:** *15 SR 1842; 32 SR 1437*

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**9500.1214** [Repealed, 15 SR 1842]

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## 9500.1215 DOCUMENTING, VERIFYING, AND REVIEWING ELIGIBILITY.

Subpart 1. **Information that must be verified.** A county agency shall require an applicant or recipient to provide documentation only of information necessary to determine program eligibility and the amount of the assistance payment. Information previously verified and retained by the county agency must not be verified again unless the information no longer applies to current circumstances.

Subp. 2. **Sufficiency of documentation.** An applicant or recipient must provide documentation of the information required under subpart 4, or authorize a county agency to verify it by other means; however, the burden of providing documents for a county agency to use to verify eligibility is upon the applicant or recipient. A county agency shall help an applicant or recipient to obtain documents that the applicant or recipient does not possess and cannot obtain. When an applicant or recipient and the county agency are unable to obtain documents needed to verify information, the county agency may accept an affidavit from an applicant or recipient as sufficient documentation.

Subp. 3. **Contacting third parties.** A county agency must obtain an applicant's or recipient's written consent to request information about the applicant or recipient which is not of public record from a source other than county agencies, the department, or the United States Department of Health and Human Services. An applicant's signature on an application form shall constitute this consent for contact with the sources specified on that form. A county agency may use a single consent form to contact a group of similar sources, such as banks or insurance agencies, but the sources to be contacted must be identified by the county agency before requesting an applicant's consent. A county agency shall not provide third parties with access to information about a person's eligibility status or any other part of the case record without that person's prior written consent, except where access to specific case information is granted to agencies designated by the Minnesota Government Data Practices Act under Minnesota Statutes, chapter 13. Information designated as confidential by the Minnesota Government Data Practices Act must only be made available to agencies granted access under that law and must not be provided to an applicant, recipient, or a third party.

Subp. 4. **Factors to be verified.** The county agency must verify the factors of program eligibility in items A to C at the time of application, when a factor of eligibility changes, and at each redetermination of eligibility.

A. A county agency must verify:

(1) the identity of each adult and child for whom assistance is requested;

(2) age, if required to establish eligibility;

(3) state residence; and

(4) the relationship of a caretaker to the child for whom application is made.

B. The county agency must verify the information in subitems (1) to (6) when that information is acknowledged by an applicant or recipient or obtained through a federally mandated verification system:

(1) receipt and amount of earned income, including gross receipts from self-employment;

(2) receipt and amount of unearned income;

(3) termination from employment;

(4) ownership and value of real property;

(5) ownership and value of personal property; and

(6) dependent care costs of an employed filing unit member at the time of application, redetermination, or a change in provider.

C. A county agency may verify additional program eligibility and assistance payment factors when it determines that information on the application is inconsistent with statements made by the applicant, other information on the current application, information on previous applications, or other information received by the county agency. The county agency must document the reason for verifying the factor in the case record of an assistance unit. Additional factors that may be verified, subject to the conditions of this item, are:

(1) the presence of a child in the home;

(2) the death of a parent or spouse;

(3) marital status;

(4) residence address; and

(5) income and property that an applicant or recipient has not acknowledged receiving or having.

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

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**9500.1218** [Repealed, 15 SR 1842]
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## 9500.1219 ASSISTANCE UNIT ELIGIBILITY.

Subpart 1. **Composition of an assistance unit.** The county agency must determine the composition of the assistance unit, as defined in part 9500.1206, subpart 6a, from eligible members

of the filing unit. All members of the filing unit must be included in the assistance unit with the exception of and subject to subparts 2 to 6.

Subp. 2. **Exclusion of persons otherwise provided for by law.** Filing unit members shall not be included in an assistance unit if they meet one or more of the following conditions:

A. a filing unit member is receiving benefits under the DWP, MFIP, refugee cash assistance, SSI, or Minnesota supplemental aid programs, or has benefits paid on the member's behalf for foster care, child welfare, or subsidized adoption;

B. a filing unit member appears to be currently eligible for benefits under DWP, MFIP, or refugee cash assistance, or is eligible to have benefits paid on the member's behalf for foster care, child welfare, or subsidized adoption;

C. a filing unit member has been determined to be eligible for DWP, MFIP, or SSI but cannot receive benefits under those programs because the member refused or failed to comply with a requirement of those programs;

D. a filing unit member is a parent of a single adult applicant or recipient who resides with a single adult applicant together with the parents' other family members;

E. a filing unit member who is in a period of disqualification from DWP, MFIP, SSI, or general assistance due to noncompliance with a program requirement;

F. a filing unit member has, without good cause, refused or failed to comply with part 9500.1254; or

G. a filing unit member has refused to sign an interim assistance agreement as required under Minnesota Statutes, section 256D.06, subdivision 5.

Subp. 3. **State residence requirement.** No applicant shall be included in an assistance unit unless the applicant is a resident of Minnesota. A resident is a person living in the state with the intention of making a home here and, not for any temporary purpose, as determined by items A to E.

A. An applicant must state on a form prescribed by the commissioner that the applicant lives in the state and intends to make a home in Minnesota.

B. The county agency must verify an applicant's statement of intent to make a home in Minnesota if questionable. An applicant's statement of intent to make a home in Minnesota is questionable if:

(1) the applicant has no verified residence address in the state;

(2) the applicant provides identification indicating a residence outside the state;

(3) the applicant indicates that he or she maintains or is having maintained a residence outside the state; or

(4) the applicant has only established residence in the state due to time spent in a facility referenced in Minnesota Statutes, section 256G.02, except that time spent in a battered women's shelter shall not be a basis for determining that a residence is questionable.

C. An applicant's intent to make a home in Minnesota can be verified by:

(1) a residence address on a valid Minnesota driver's license, Minnesota identification card, or voter registration card;

(2) a rent receipt or a statement by the landlord, apartment manager, or homeowner showing that the applicant is residing at an address within the county of application;

(3) a statement by a landlord or apartment manager indicating the applicant has located housing which is affordable for the applicant;

(4) postmarked mail addressed to and received by the applicant at the applicant's address within the county;

(5) a current telephone or city directory with the applicant's residence address within the county;

(6) a written statement by an applicant's roommate verifying the applicant's residence and the date the applicant moved in. The roommate must also verify that the roommate lives in the residence by providing a copy of the roommate's mortgage statement, lease agreement, or postmarked mail addressed to and received by the roommate at that address;

(7) documentation that the applicant came to the state in response to an offer of employment;

(8) documentation that the applicant has looked for work by presenting completed job applications or documentation from employers, the local jobs service office, or temporary employment agencies;

(9) documentation that the applicant was formerly a resident of the state for at least 365 days and is returning to the state after an absence of less than 90 days; or

(10) an affidavit from a person engaged in public or private social services, legal services, law enforcement, or health services that the affiant knows the applicant, has had personal contact with the applicant, and believes the applicant is living in the state with the intent of making Minnesota the applicant's permanent home.

D. In addition to meeting one of the requirements of item C, an applicant described by item B, subitem (2), must document that the applicant has severed the applicant's residence in another state. Documentation may include bank statements indicating the closing of accounts, a document showing cancellation or termination of a lease, or verification that real property used as the applicant's residence in another state is abandoned or for sale.

E. Notwithstanding the provisions of item C, any applicant specified in item B, subitems (2) to (4), who also indicates an intention to leave the state within 30 days of application, will be considered to be in the state for a temporary purpose and is not a resident.

Subp. 4. **Minors.** No child under the age of 18 who is not a member of a family as defined in Minnesota Statutes, section 256D.02, subdivision 5, shall be included in an assistance unit unless:

A. the child is legally emancipated;

B. the child lives with an adult who is not a family member or legal custodian with the express written consent of an agency acting in its legal capacity as a custodian of the child;

C. the child lives with an adult who is not a family member or legal custodian with the express written consent of the child's parents or legal guardian, together with the express written consent of the county agency; or

D. the child does not live with an adult but is at least 16 years of age and whose living arrangement is approved in a social services case plan for the child and includes general assistance as a component of the plan.

Subp. 5. [Repealed, 32 SR 1437]

Subp. 6. [Repealed, 32 SR 1437]

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

**History:** *15 SR 1842; L 2006 c 212 art 1 s 25; 32 SR 1437*
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**9500.1220** [Repealed, 15 SR 1842]
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## 9500.1221 PROPERTY LIMITATIONS.

Subpart 1. **Determination of equity value of property available to assistance unit.** The county agency must determine the equity value of real and personal property available to the assistance unit. The equity value of real and personal property available to a member of the filing unit who is not included in the assistance unit, but who is a responsible relative of an assistance unit member, must be considered real and personal property available to the assistance unit.

A. When real or personal property is owned by two or more persons, the county agency shall assume that each person owns an equal share, except that either person owns the entire sum in a joint personal checking or savings account. When a person documents greater or lesser ownership, the county agency shall use that share to determine the equity value held by an applicant or recipient.

B. Real or personal property owned by an applicant or recipient is presumed legally available unless the applicant or recipient documents that the property is not legally available. When real or

personal property is not legally available, its equity must not be applied against the limits in subpart 2.

C. An applicant must disclose whether the applicant transferred, within one year before the application or redetermination, real or personal property valued in excess of the property limits in subpart 2 for which reasonable compensation was not received. A recipient shall disclose all transfers of property valued in excess of the limits in subpart 2 according to the reporting requirements in part 9500.1245, subpart 5. When a transfer of real or personal property has occurred, the applicant or recipient shall comply with subitems (1) and (2) as a condition of eligibility for general assistance.

(1) The applicant or recipient who transferred the property must provide a description of the property, information necessary to determine the property's equity value, the name of the individual who received the property, and the circumstances of and reason for the transfer.

(2) If reasonable compensation for the property was not received and the property can be reasonably reacquired, or when reasonable compensation can be secured, the property is presumed legally available to the applicant or recipient.

D. A recipient may build the equity value of the recipient's real and personal property to the limits in subpart 2.

Subp. 2. **Equity value; excluded real and personal property.** The equity value of all nonexcluded real and personal property must not exceed $1,000. The county agency shall exclude the value of the real or personal property in items A to T when determining equity value.

A. The applicant's or recipient's homestead according to subitems (1) to (3).

(1) An applicant or recipient who is purchasing real property through a contract for deed and using that property as a home is considered the owner of the real property.

(2) The amount of land that can be excluded under this item is limited to surrounding property which is not separated from the home by intervening property owned by others. Additional property must be assessed as to its legal and actual availability according to subpart 1.

(3) When real property that has been used as a home by an applicant or recipient is sold, the county agency shall treat the cash proceeds from that sale as excluded property for a period of six months if the applicant or recipient intends to reinvest those proceeds in another home and agrees to maintain the proceeds, unused for other purposes, in a separate account.

B. One motor vehicle, not otherwise excluded, when its equity value does not exceed $1,500 exclusive of the value of special equipment for a household member with a disability. The county agency shall establish the equity value of a motor vehicle by subtracting any outstanding encumbrances from the loan value listed in the N.A.D.A. Official Used Car Guide, Midwest Edition, for newer model cars. When a vehicle is not listed in the N.A.D.A. Official Used Car Guide, or when an applicant or recipient disputes the value listed in the guide as unreasonable given the condition of a particular vehicle, the county agency may require the applicant or recipient to document the value of the vehicle by securing a written statement from a motor vehicle dealer

licensed under Minnesota Statutes, section 168.27, stating the amount that the dealer would pay to purchase the vehicle. The N.A.D.A. Official Used Car Guide, Midwest Edition, is incorporated by reference. It is published monthly by the National Automobile Dealers Used Car Guide Company and is available through the Minitex interlibrary loan system. It is subject to frequent change.

C. The value of nonliquid real or personal property that is essential to the owner's self-support, self-care, or needed to obtain or retain suitable employment.

D. The value of nonliquid property which currently produces net earned income and is being used for the support of the assistance unit or a reasonable expectation exists that the property will be used within six months or the next income-producing season, whichever is later, to produce net earned income for the support of the assistance unit.

E. The value of real or personal property owned exclusively by the stepparent or sibling of a single adult applicant or recipient who resides with the stepparent or sibling.

F. The value of real and personal property owned exclusively by a recipient of supplemental security income or Minnesota supplemental aid.

G. The value of corrective payments but only for the month in which the payment is received and the following month.

H. Money escrowed in a separate account that is needed to pay real estate taxes or insurance and that is used for that purpose at least semiannually.

I. A mobile home used by an applicant or recipient as a home.

J. Money held in escrow by a self-employed person to cover employee FICA, employee tax withholding, sales tax withholding, employee workers' compensation, employee unemployment compensation, business insurance, property rental, property taxes, and other costs that are commonly paid at least annually, but less often than monthly.

K. Income received in a budget month until the end of that month. This includes monthly general assistance payments and emergency general assistance payments.

L. The value of school loans, grants, or scholarships over the period they are intended to cover if the income from these sources is either excluded by rule or has been used in the calculation of a grant.

M. The value of personal property not otherwise specified which is commonly used by household members in day-to-day living.

N. Payments listed in part 9500.1223, subpart 2, item O, which are held in escrow for the period necessary to replace or repair the personal or real property. This period must not exceed three months.

O. One burial plot per member of a filing unit.

P. The value of a prepaid burial account, burial plan, or burial trust up to $1,000 for each member of a filing unit who is covered by that account, plan, or trust.

Q. The value of an applicant's nonliquid resources if the applicant's need for assistance will not exceed 30 days.

R. The value of real and personal property in excess of the limits in this subpart if the applicant is making a good faith effort to sell the property at a reasonable price.

S. Other real or personal property specifically disregarded by federal law, state law, or federal regulation.

T. In addition to the limits specified in items A to S, an amount up to $1,000 which is accumulated in a separate account from earnings by a resident in a facility licensed under parts 9520.0500 to 9520.2500 or a resident in a supervised apartment with services funded under parts 9535.0100 to 9535.1600 for whom discharge and work are part of a treatment plan. This item applies during residency and for up to 18 additional months if the person moves to an inpatient hospital setting. The accumulated earnings, and the interest on the earnings, are to be used upon discharge from the facility. Any withdrawal before discharge must be counted as income in the month of withdrawal and treated as an available resource in the following months.

Subp. 3. **Exclusion of excess property.** If the county agency determines that an assistance unit is not eligible for general assistance due to owning property in excess of the limit in subpart 2, the county agency must inform the applicant or recipient in writing of the conditions under which excess property may be excluded.

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

**History:** *15 SR 1842; L 2005 c 56 s 2; 32 SR 1437*

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**9500.1222** [Repealed, 15 SR 1842]

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## 9500.1223 EXCLUDED INCOME.

Subpart 1. **Evaluation of income.** The county agency must determine income available to members of an assistance unit to determine program eligibility and the assistance amount. Income available to members of an assistance unit includes all nonexcluded income whether received by assistance unit members or filing unit members who are not members of the assistance unit when that income is deemed available to members of the assistance unit.

Subp. 2. **Excluded income of all filing unit members.** The county agency shall exclude items A to AA from the income of all filing unit members:

A. food stamps or food support;

B. United States Department of Housing and Urban Development (HUD) refunds or rebates for excess rents charged and HUD relocation and rehabilitation funds;

C. rental security deposit refunds to the client whether paid by the client or by emergency assistance or emergency general assistance;

D. benefits under title IV and title VII of the Older Americans Act of 1965;

E. all Volunteers in Service to America (VISTA) payments;

F. title I loans or grants through the Minnesota Housing Finance Agency;

G. payments for basic care, difficulty of care, and clothing allowance received for providing family foster care under parts 9545.0010 to 9545.0260 or adult foster care under parts 9555.5105 to 9555.6265;

H. work and training allowances received from county agency social services programs that are not classified as wages subject to FICA withholding;

I. reimbursement for employment training received through the Job Training Partnership Act;

J. reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, or employment;

K. loans, whether from private, public, or governmental lending institutions, governmental agencies, and private individuals provided the filing unit member documents that the lender expects repayment. This exclusion does not include education loans on which payment is deferred;

L. state and federal income tax refunds including Minnesota property tax refunds and the earned income tax credit;

M. funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made from public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency subsequent to a presidential declaration of disaster;

N. payments issued by insurance companies which are specifically designated as compensation to a member of an assistance unit for partial or total permanent loss of function or body part or insurance payments specified under Minnesota Statutes, section 256.74, subdivision 1, clause (7);

O. reimbursements for medical expenses which cannot be paid by medical assistance;

P. payments by the vocational rehabilitation program administered by the state under Minnesota Statutes, chapter 129A, except those payments that are for current living expenses;

Q. in kind income, as defined in part 9500.1206, subpart 16a, except for payments made for room, board, tuition, or fees by a parent on behalf of a single adult applicant who is enrolled as a full-time student in a postsecondary institution;

R. assistance payments to correct underpayments in a previous month;

S. payments to an applicant or recipient issued under part 9500.1261, 9500.2800, or 9500.2820 for emergency or special needs; however, an initial month's grant may be reduced by the amount of emergency assistance issued to cover that month's needs;

T. nonrecurring cash gifts, such as those received for holidays, birthdays, and graduations, not to exceed $30 per filing unit member in a calendar quarter;

U. tribal settlements excluded under Code of Federal Regulations, title 45, section 233.20(a)(4)(ii)(e), (k), and (m);

V. any form of energy assistance payment made by the Low Income Home Energy Assistance Program, payments made directly to energy providers by other public and private agencies, benefits issued by energy providers when the Minnesota Department of Employment and Economic Development determines that those payments qualify under Code of Federal Regulations, title 45, section 233.53, and any form of credit or rebate payment issued by energy providers;

W. the first $50 of child support received;

X. proceeds from the sale of real or personal property;

Y. payments made from state funds for subsidized adoptions under Minnesota Statutes, section 259.67;

Z. interest payments and dividends from property that is not excluded from and does not exceed the $1,000 limit under part 9500.1221, subpart 2; and

AA. income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation.

Subp. 3. **Additional income exclusions, filing unit member who is not a member of assistance unit.** In addition to the income exclusions in subpart 2, the county agency shall exclude the following income of a filing unit member who is not a member of the assistance unit:

A. income that was excluded, disregarded, or allocated in the calculation of a public assistance grant unless the allocation was to meet the needs of persons in the general assistance unit;

B. benefits from the Retirement, Survivors, and Disability Insurance program and any income based on a disability that is received by the parent or parents of a single adult applicant or recipient;

C. income of a stepparent or of a sibling of a single adult applicant or recipient;

D. an amount equal to the standards assigned to filing unit members who are not in the general assistance unit in part 9500.1231, subpart 6, item A; and

E. child support, spousal support, or other payments to meet the needs of a person who lives outside of the household who is or could be claimed as a dependent for federal personal income tax liability or for whom payment is required by court order.

Subp. 4. [Repealed, 32 SR 1437]

Subp. 5. **Additional income exclusions, assistance unit consisting of individuals who are not members of a family.** In addition to the income exclusions in subpart 2, the county agency shall exclude the following costs from the income of filing unit members when the assistance unit consists of individuals who are not members of a family:

A. the first $50 of earned income for each individual who receives earned income;

B. the cost of transportation to and from employment which is not reimbursed, based on the lesser of the actual cost, or the amount allowed for the use of a personal car in the United States Internal Revenue Code for a maximum of 100 miles per day;

C. a meal allowance of $2 for each day that the individual has a break for a meal during work hours and eats a meal at work, unless the individual can establish that higher costs are both necessary and reasonable;

D. the cost incurred by an applicant or paid by a recipient for uniforms, tools, and equipment which are necessary to accept or retain a job;

E. mandatory payments or deductions from pay for insurance premiums, union dues, association dues, retirement contributions, FICA, state and federal personal income tax withholding, not to exceed the amount specified in the state or federal tax withholding tables for an individual with the same income and number of dependents as the applicant or recipient;

F. other work expenses required for employment and approved by the county agency;

G. stipends received from the displaced homemaker services program; and

H. in addition to the $50 specified in item A, up to $150 per month from the earnings of a resident of a facility licensed under parts 9520.0500 to 9520.0690 or a resident of a supervised apartment with services funded under parts 9535.0100 to 9535.1600 for whom discharge and work are part of a treatment plan, provided that the disregarded sum is placed in a separate savings account by the resident.

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

**History:** *15 SR 1842; L 1994 c 483 s 1; L 1994 c 631 s 31; L 2003 1Sp14 art 1 s 106; L 2005 c 112 art 2 s 41; L 2006 c 212 art 1 s 25; 32 SR 1437*

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**9500.1224** [Repealed, 15 SR 1842]

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**9500.1225 EARNED INCOME.**

Subpart 1. **County agency duty to determine earned income.** The county agency must determine the total amount of earned income available to the filing unit. Earned income from self-employment must be calculated according to subpart 2. Earned income from contractual

agreements must be calculated according to subpart 3. The total amount of earned income available to an individual for a month must be determined by combining the amounts of earned income calculated under subparts 2 to 4. The total amount of earned income available to an assistance unit for a month must be determined by combining the total earned income of each filing unit member.

Subp. 2. **Earned income from self-employment.** The county agency must determine the amount of earned income from self-employment by subtracting business costs from gross receipts according to items A to D.

A. Self-employment expenses must be subtracted from gross receipts except for the expenses listed in subitems (1) to (14):

(1) purchases of capital assets;

(2) payments on the principal of loans for capital assets;

(3) depreciation;

(4) amortization;

(5) the wholesale costs of items purchased, processed, or manufactured that are unsold inventory with a deduction for the costs of those items allowed at the time they are sold;

(6) transportation costs that exceed the amount allowed for use of a personal car in the United States Internal Revenue Code;

(7) the cost of transportation between the individual's home and place of employment;

(8) salaries and other employment deductions made for members of an individual's assistance unit or for individuals who live in the individual's household for whom the individual is legally responsible;

(9) monthly expenses in excess of $71 for a roomer;

(10) monthly expenses in excess of $86 for a boarder;

(11) monthly expenses in excess of $157 for a roomer-boarder;

(12) annual expenses in excess of $103 or two percent of the estimated market value on a county tax assessment form, whichever is greater, as a deduction for upkeep and repair against rental income;

(13) expenses not allowed by the United States Internal Revenue Code for self-employment income; and

(14) expenses which exceed 60 percent of gross receipts for child care performed in an individual's home unless the individual can document a higher amount. When funds are received from the quality child care program, those funds are excluded from gross receipts, and the expenses covered by those funds must not be claimed as a business expense that offsets gross receipts.

B. Except for farm income under item C, the self-employment budget period begins in the month of application for applicants and in the first month of self-employment for recipients. Gross receipts from self-employment must be budgeted in the month in which they are received. Expenses must be budgeted against gross receipts in the month in which those expenses are paid except for subitems (1) to (3):

(1) The purchase cost of inventory items, including materials that are processed or manufactured, must be deducted as an expense at the time payment is received for the sale of those inventory items, processed materials, or manufactured items, regardless of when those costs are incurred or paid.

(2) Expenses to cover employee FICA, employee tax withholding, sales tax withholding, employee worker's compensation, employee unemployment compensation, business insurance, property rental, property taxes, and other costs that are commonly paid at least annually, but less often than monthly, must be prorated forward as deductions from gross receipts over the period they are intended to cover, beginning with the month in which the payment for these items is made.

(3) Gross receipts from self-employment may be prorated forward to equal the period over which the expenses were incurred except that gross receipts must not be prorated over a period that exceeds 12 months. This provision applies only when gross receipts are not received monthly but expenses are incurred on an ongoing monthly basis.

C. Farm income must be annualized. Farm income is gross receipts minus operating expenses, subject to item A. Gross receipts include sales, rents, subsidies, soil conservation payments, production derived from livestock, and income from sale of home-produced foods.

D. Income from rental property must be considered self-employment earnings when the owner spends an average of 20 hours per week on maintenance or management of the property. A county agency must deduct an amount for upkeep and repairs, according to item A, subitem (11), for real estate taxes, insurance, utilities, and interest on principal payments. When an applicant or recipient lives on the rental property, the county agency must divide the expenses for upkeep, taxes, insurance, utilities, and interest by the number of rooms to determine the expense per room. The county agency shall deduct expenses from rental income only for the number of rooms rented, not for rooms occupied by an assistance unit. When an owner does not spend an average of 20 hours per week on maintenance or management of the property, income from rental property must be considered unearned income. The deductions described in this item must be subtracted from gross rental receipts.

Subp. 3. **Earned income from contractual agreements.** The county agency must prorate the amount of earned income received by individuals employed on a contractual basis over the period covered by the contract even if the payments are received over a shorter period.

Subp. 4. **Other earned income.** The county agency must consider all other forms of earned income not specifically provided for under subparts 2 and 3 to be earned income available to the individual in the month it is received.

**Statutory Authority:** *MS s 256D.01; 256D.03; 256D.04; 256D.05; 256D.051; 256D.06; 256D.07; 256D.08; 256D.09; 256D.111*

**History:** *10 SR 2322; 15 SR 1842*

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## 9500.1226 UNEARNED INCOME.

Subpart 1. **County agency duty to determine unearned income.** The county agency must determine the total amount of unearned income available to the filing unit. The total amount of unearned income available to a filing unit for a month must be determined by combining the total unearned income of each filing unit member.

Subp. 2. [Repealed, 15 SR 1842]

Subp. 3. [Repealed, 15 SR 1842]

Subp. 4. [Repealed, 15 SR 1842]

Subp. 5. **Deductions for certain costs.** Costs incurred to secure payments of unearned income shall be deducted from unearned income. These costs include legal fees, medical fees, and mandatory deductions such as federal and state income taxes.

Subp. 6. **Payments for disability or illness.** Payments for illness or disability must be considered unearned income whether the premium payments are made wholly or in part by an employer or a recipient.

Subp. 7. **Education grants, scholarships, and loans.** Educational grants, scholarships, and loans, including assistance funded under title IV of the Higher Education Act, which are available to an assistance unit that does not contain a member of a family must be considered unearned income, together with the in-kind income derived from the payment of room and board and tuition and fees paid by the parents of the student. The county agency must subtract tuition and fees, in addition to books, supplies, transportation, and miscellaneous personal expenses as indicated by the school, from the total educational grants, loans, scholarships, and in-kind income. The deductions of these expenses are to be made at the time that the educational funds become available for the student's benefit, and any excess funds prorated over the remainder of the time they were intended to cover. School expenses that exceed loans, grants, and scholarships may be deducted from work study income.

Subp. 8. **Nonexcluded filing unit member income.** Income from a filing unit member who is not a member of the assistance unit which is not excluded under part 9500.1223 is deemed unearned income available to the assistance unit.

Subp. 9. **Lump sums received by filing unit.** Lump sums received by a filing unit must be considered as earned income under parts 9500.1223 and 9500.1225 or as unearned income under subparts 5 to 8. For recipients of general assistance, lump sums are considered income in the month received and a resource in the following months.

**Statutory Authority:** *MS s 256D.01; 256D.03; 256D.04; 256D.05; 256D.051; 256D.06; 256D.07; 256D.08; 256D.09; 256D.111*

**History:** *10 SR 2322; 15 SR 1842*
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**9500.1228** [Repealed, 15 SR 1842]
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**9500.1229** [Repealed, 15 SR 1842]
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**9500.1230** [Repealed, 15 SR 1842]
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**9500.1231 ASSISTANCE STANDARDS.**

Subpart 1. **Standard, single individual.** Except as provided in subpart 2, the standard of assistance for a single adult who does not reside with his or her parents; an adult applicant or recipient who resides with his or her parents and those parents have no minor children; or an emancipated minor applicant or recipient is $203 per month. The standard in this subpart shall be increased by the same percentage as any increase in subpart 4.

Subp. 2. **Standard, individuals residing in a nursing home, negotiated rate facility, or regional treatment center.** The standard of assistance for an assistance unit composed of one individual who resides in a nursing home, negotiated rate facility, or regional treatment center is the amount established as the clothing and personal needs allowance for medical assistance recipients under Minnesota Statutes, section 256B.35, subdivision 1.

Subp. 3. **Standard, married couples without children.** The standards of assistance for a married couple without children are the same as the first and second adult standards under subpart 4. If one member of the couple is not included in the general assistance grant, the standard for the other is the second adult standard under subpart 4.

Subp. 4. **Standards, filing units with a minor child.** The county agency shall use the standards in items A to M to determine the amount of assistance for a filing unit with a minor child or children. The standard of assistance shall increase or decrease to remain equal to the equivalent MFIP standards under part 9500.2440, subpart 6:

A. first adult, $187;

B. second adult, $73;

C. first child, $250;

D. second child, $95;

E. third child, $89;

F. fourth child, $76;

G. fifth child, $76;

H. sixth child, $77;

I. seventh child, $66;

J. eighth child, $64;

K. ninth child, $55;

L. tenth child, $54; and

M. each additional child, $53.

Subp. 5. **Standard, single adult residing with parents with minor children.** A single adult applicant or recipient who resides with his or her parents who have minor children will receive a child standard from subpart 4 as though the single adult were an additional minor child added to an assistance unit composed of the parent and minor child or children.

Subp. 6. **Standard, assistance unit composed of part or all members of a family.** The county agency shall determine the assistance standard for a family assistance unit as follows:

A. The county agency shall assign standards from subpart 4 to each member of the filing unit as though each was a member of an MFIP assistance unit composed of the entire filing unit. If a member or members of a family are not to be included in the assistance unit, the county agency shall assign standards from subpart 4 to those members first and to the remaining members of the assistance unit last. Each adult in the filing unit except the first will receive a second adult standard. A minor parent family member shall be treated as provided in subitem (1) or (2).

(1) A minor parent family member who resides with his or her parent will be assigned a child standard.

(2) A minor parent family member who does not reside with his or her parent or parents shall be assigned an adult standard. If two adult standards have already been assigned to filing unit members, the minor parent will be assigned a second adult standard.

B. The county agency shall add together the standards assigned to the members of the general assistance unit in item A. That total is the standard for the assistance unit. In no case shall the standard for family members who are in the assistance unit for general assistance, when combined with the standard for family members who are not in the assistance unit, total more than the standard for the entire family if all members were in an MFIP assistance unit.

Subp. 7. **Standard applies to full month.** Except when an increase must be made in the standard of assistance applicable to an assistance unit due to the addition of a member to the assistance unit or when a recipient enters the community from a negotiated rate facility, the standard of assistance applicable to an assistance unit the first day of a payment month or at the time of

application, whichever is later, applies to the assistance unit for the entire month. When a decrease must be made in the standard of assistance for an assistance unit, the decrease shall be effective in the month following the month in which the change necessitating the reduction in the standard took place.

**Statutory Authority:** *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

**History:** *15 SR 1842; L 2006 c 212 art 1 s 25*
**Published Electronically:** *October 16, 2013*

## 9500.1232 STATE PARTICIPATION.

Subpart 1. [Repealed, 15 SR 1842]

Subp. 2. [Repealed, 15 SR 1842]

Subp. 3. [Repealed, 15 SR 1842]

Subp. 4. **State participation for payment in excess of state standards.** State participation is not available for special need items or the amount of the higher county agency standard authorized under Minnesota Statutes, section 256D.03, subdivision 2a, which exceed the applicable state assistance standards.

Subp. 5. [Repealed, 32 SR 1437]

**Statutory Authority:** *MS s 256.05; 256D.01; 256D.03; 256D.04; 256D.05; 256D.051; 256D.052; 256D.06; 256D.07; 256D.08; 256D.09; 256D.111*

**History:** *10 SR 2322; 13 SR 1688; 13 SR 1735; 15 SR 1842; 32 SR 1437*
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## 9500.1233 FINANCIAL ELIGIBILITY TESTS.

Subpart 1. **Prospective eligibility.** A county agency shall determine whether the eligibility requirements that pertain to an assistance unit will be met prospectively for the payment month. To prospectively assess income, a county agency shall estimate the amount of income an assistance unit expects to receive in the payment month.

Subp. 2. **Termination and suspension of assistance when prospectively ineligible.** When an assistance unit is prospectively ineligible for general assistance for at least two consecutive months due to excess income, assistance must be terminated. When an assistance unit is prospectively ineligible for general assistance for only one month and is prospectively eligible the following month, assistance must continue. The income for the single month in which prospective ineligibility exists must be applied retrospectively as described in subpart 3, resulting in suspension for the corresponding payment month.

Subp. 3. **Retrospective eligibility.** After the first two months of program eligibility, a county agency must determine whether an assistance unit is prospectively eligible for the payment month.

The county agency must then determine whether the assistance unit is retrospectively eligible by applying the gross income test for family assistance and the payment eligibility test to the income from the budget month. When either the gross income test for family assistance units or the payment eligibility test is not satisfied, assistance must be suspended when ineligibility exists for one month, or terminated when ineligibility exists for more than one month.

Subp. 4. [Repealed, 32 SR 1437]

Subp. 5. **Payment eligibility test.** Each assistance unit must pass a test of payment eligibility prospectively and retrospectively for each program month that the unit is otherwise eligible.

A. Assistance units which do not contain a member of a family must use the income determined in parts 9500.1223 to 9500.1226 to determine payment eligibility.

B. The county agency must apply the assistance unit's countable income against the assistance unit's standard. If the income is equal to or greater than the standard, the assistance unit must be denied assistance or assistance must be terminated.

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

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**9500.1234** [Repealed, 10 SR 2322]
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## 9500.1237 AMOUNT OF ASSISTANCE PAYMENT.

Subpart 1. **Amount of assistance payment.** The county agency must issue an assistance payment to an assistance unit in an amount equal to the difference between the standard of assistance determined in part 9500.1231 and the assistance unit's countable income as determined in parts 9500.1223 to 9500.1226, for a whole month without separate standards for shelter, utilities, or other needs, except as provided under subparts 2 to 6.

Subp. 2. **Prorate the month of application.** When program eligibility exists for the month of application, the amount of the assistance payment for the month of application must be prorated from the date of application or the date all eligibility factors are met for that applicant, whichever is later. This provision must apply when an applicant loses at least one day of program eligibility.

Subp. 3. [Repealed, 32 SR 1437]

Subp. 4. **Persons without a verified residence address.** A county agency may make payments to eligible persons without a verified address as specified in items A to G.

A. A county agency which chooses to make payments under this subpart must notify the department of its intention to do so 30 days before implementation.

B. A county agency must apply this subpart equally to all applicants or recipients who are without a verified residence, except that this subpart must not be applied to persons who are certified as having mental illness, developmental disability, or a family assistance unit unless requested in writing by the family assistance unit.

C. A county agency may divide the monthly assistance grant into four payments to be issued weekly for four weeks each month.

D. A county agency may determine eligibility and provide assistance on a weekly basis as specified in subitems (1) to (5).

(1) The amount of assistance issued under this item may be determined either by prorating the monthly assistance standard which applies to the individual at the time of application and at the time of weekly redetermination, or as specified in part 9500.1261.

(2) Forms required for weekly redetermination of eligibility must be approved by the department. The form must contain a statement of need by the recipient.

(3) Notwithstanding part 9500.1259, subpart 4, the county agency must notify the recipient each time weekly assistance is issued under this item that subsequent weekly assistance will not be issued unless the recipient claims need.

(4) Weekly determination of eligibility under this item must not continue beyond the first full calendar month subsequent to the month of application. Beginning with the second full calendar month, assistance may be issued as specified in item C to a recipient who has not verified a residence address but who is a resident of the state as determined by part 9500.1219, subpart 3.

(5) The provisions of this item must not be applied to any assistance unit which receives, or is expected to receive countable income within the month of application or the following month.

E. Assistance provided under items C and D may be in the form of cash or separate vouchers or vendor payments for food, shelter, or other needs.

F. Except for weekly redetermination for assistance under item D, notices must be provided to recipients under this subpart as specified by part 9500.1259, subpart 4.

G. Assistance must not continue under this subpart when the recipient has verified a residence address as specified in part 9500.1219, subpart 3, item C.

Subp. 5. [Repealed, 32 SR 1437]

Subp. 6. **Assistance payment when need will not exceed 30 days.** The county agency shall issue a grant determined by subtracting any countable income that the applicant has received since the first of the calendar month of application and any countable income the applicant is expected to receive before the date on which the county agency has anticipated that the applicant will lose eligibility for general assistance, from his or her prorated standard of assistance. The prorated

standard of assistance must be determined by comparing the number of days between the date of application or the date all eligibility factors have been met, whichever is later, and the date which the county agency has anticipated that the applicant will lose eligibility for general assistance, with a 30-day month.

Subp. 7. [Repealed, 32 SR 1437]

Subp. 8. [Repealed, 32 SR 1437]

Subp. 9. [Repealed, 32 SR 1437]

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

**History:** *15 SR 1842; L 2005 c 56 s 2; L 2006 c 212 art 1 s 25; 32 SR 1437*
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## 9500.1239 PAYMENT PROVISIONS.

Subpart 1. **Grant issuance.** Grants of general assistance shall be issued to the recipient according to subparts 2 and 3.

Subp. 2. **Time period for issuance of assistance.** The state or county agency shall mail assistance payments to the address where the assistance unit lives, or an alternate address when approved by the county agency, within time to allow postal service delivery to occur no later than the first day of each month unless:

A. the county agency has exercised its option to issue assistance weekly under part 9500.1237, subpart 4, item C or D, in which case the county agency must provide the recipient with a schedule by which the recipient is to visit the agency to pick up the payments or notices; and

B. the state or county agency issues payments by means other than checks, in which case the payments must conform to the time limits in this subpart.

Subp. 3. **Special voucher or vendor payment provisions.** Assistance must be paid directly to a recipient, except as provided in items A to F.

A. When a county agency has determined that a voucher or vendor payment is the most effective way to resolve an emergency situation under part 9500.1261, payment shall be made by voucher or directly to a vendor.

B. When the county agency has reason to suspect that a client is drug dependent, payment shall be made as provided under part 9500.1272.

C. When the applicant or recipient has no verified residence address, payment shall be made as provided under part 9500.1237, subpart 4, item C, D, or E.

D. When the applicant or recipient requests in writing that all or part of the assistance be issued in the form of vendor payments and the county agency approves the request, payment shall be made by vendor payment.

E. When an assistance unit consists of only minor children due to the disqualification of one or both parents who have not complied with the work readiness program, payment shall be made by vendor or protective payment.

F. When a county agency has determined that a recipient has exhibited a continuing pattern of money mismanagement, payment shall be made by vendor or protective payment. A continuing pattern of money mismanagement exists when a recipient has received a total of two or more grants of emergency assistance within an 18-month period. For the purposes of this provision, grants of emergency assistance are payments made under part 9500.1261 or 9500.2820 or emergency payments from county funds. In order to be counted for this provision, the emergencies for which grants were issued must have resulted from the recipient's failure to use available resources for the payment of basic need items. The county agency must review the use of protective or vendor payments under this item at each redetermination of eligibility.

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

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**9500.1242** [Repealed, 15 SR 1842]
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**9500.1243 BUDGETING.**

Subpart 1. **Prospective budgeting.** A county agency shall use prospective budgeting to calculate the assistance payment amount for the first two months for an applicant who has not received general assistance for at least one payment month preceding the first month of payment under a current application, subject to items A to E.

A. Income received or anticipated in the first month of program eligibility must be applied against the need of the first month. Income received or anticipated in the second month must be applied against the need of the second month.

B. When the assistance payment for any part of the first two months is based on anticipated income, an initial assistance payment amount must be determined based on information available at the time the initial assistance payment is made. When the amount of actual countable income is different than the anticipated countable income which was budgeted to determine the assistance payment for the first two months, the assistance unit is liable for an overpayment or is eligible for a corrective payment for the difference between anticipated and actual countable income for those two months.

C. The assistance payment for the first two months of program eligibility must be determined by budgeting both recurring and nonrecurring income for those two months.

D. An assistance unit shall have the assistance payment amount determined prospectively according to items A to C if the assistance unit:

(1) has had assistance suspended for a month as provided by part 9500.1233, subpart 2; and

(2) has experienced a recurring change of at least $50 in net income in the month preceding the month of suspension or in the month of suspension.

E. An individual who enters a facility with a negotiated rate or a shelter facility described in Minnesota Statutes, section 256D.05, subdivision 3, shall have an assistance payment determined prospectively from the date the individual entered the facility. Any income, including grants of public assistance, received by the individual before entering the facility must only be applied against the assistance unit's standard specified under part 9500.1231, subpart 2. Any assistance payments made to the individual beginning two months after the month the individual leaves the facility must be determined retrospectively according to subpart 2.

Subp. 2. **Retrospective budgeting.** Retrospective budgeting must be used to calculate the monthly assistance payment amount after the payment for the first two months has been made under subpart 1. Retrospective budgeting is subject to items A and B.

A. Retrospective budgeting is used to determine the amount of the assistance payment in the first two months of program eligibility when:

(1) an assistance unit applies for general assistance for the same month for which general assistance has been terminated, the interruption in eligibility is less than one payment month, and the general assistance payment for the immediately preceding month was determined retrospectively; or

(2) a person applies to be added to an assistance unit, that assistance unit has received general assistance for at least two preceding months, and that person has been receiving general assistance for at least two months as a member of another assistance unit.

B. Income received in the budget month by an assistance unit and by a filing unit member who is not included in the assistance unit must be applied against the standard of assistance to determine the assistance payment to be issued for the payment month, except as provided in subitems (1) to (4).

(1) When a source of income ends before the third payment month, that income is not considered in calculation of the assistance payment for the third payment month. When a source of income ends before the fourth payment month, that income is not considered when determining the assistance payment for the fourth payment month.

(2) When a member of a filing unit leaves the household of the assistance unit, the income of that member is not budgeted retrospectively for any full payment month in which that household member does not live with that household and is not included in the filing unit.

(3) When a child is removed from an assistance unit because the child is no longer a dependent, the income of that child is not budgeted retrospectively for payment months in which that child is not included in the assistance unit.

(4) When a person ceases to have financial responsibility for one or more members of an assistance unit, the income of that person is not budgeted retrospectively for the payment months which follow the month in which financial responsibility ends.

Subp. 3. [Repealed, L 2011 1Sp9 art 9 s 19]

Subp. 4. **Correction of underpayments.** A county agency must correct an underpayment within seven calendar days after the underpayment has been identified, by adding the corrective payment amount to the monthly assistance payment or by issuing a separate payment to a current recipient. When an underpayment occurs in a payment month specified in subpart 1, and is not identified until the next payment month or later, that underpayment must first be subtracted from any overpayment balance before issuing the corrective payment. An underpayment for a current payment month must not be applied against an overpayment balance and payment must be issued within seven calendar days after the underpayment is identified.

Subp. 5. **Prohibition against use of general assistance grant to recover overpayment from other maintenance programs.** Subpart 4 applies only to overpayments or underpayments of assistance from the general assistance program. A county agency may not recover an overpayment by another maintenance benefit program from a general assistance grant.

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

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## 9500.1245 APPLICANT AND RECIPIENT RESPONSIBILITIES.

Subpart 1. **Applicant reporting requirements.** An applicant shall provide information about circumstances that affect the applicant's program eligibility or the assistance payment. The applicant shall provide the information on an application form and supplemental forms. An applicant shall report any changes in those circumstances under subpart 5 while the application is pending.

Subp. 2. **Responsibility to inquire.** An applicant or recipient who does not know or who is unsure whether a change in circumstances will affect program eligibility or assistance payments shall contact the county agency for information about whether or not to report the change.

Subp. 3. **Household report forms.** An assistance unit with a member who has earned income or a recent work history, and an assistance unit that has income allocated to it from a filing unit member who has earned income or a recent work history, shall complete a monthly household report form. "Recent work history" means the individual received earned income in any one of the three calendar months preceding the current payment month. To be complete, a household report form must be signed and dated no earlier than the last day of the reporting period. All questions required to determine assistance payment eligibility must be answered and documentation of earned income must be included. A recipient shall submit the household report form by the eighth calendar day of the month following the reporting period covered by the form, or, if the eighth calendar day of the month falls on a weekend or holiday, by the first working day that follows the eighth calendar day. Delays in submitting the completed household report form may delay an assistance payment in the month following the month in which the form is due.

Subp. 4. **Late household report forms.** When a household report form is late or incomplete, items A, B, or C apply.

A. When a complete household report form is not received by a county agency before the last ten days of the month in which the form is due, the county agency shall send notice of proposed termination of assistance. When a recipient submits an incomplete form on or after the date the notice of proposed termination has been sent, the termination is valid unless the recipient submits a complete form before the end of the month.

B. When a recipient submits an incomplete household report form before the last ten days of the month in which it is due, a county agency's ten-day notice of termination of assistance for failure to provide a complete household report form is invalid unless the county agency has returned the incomplete form on or before the ten-day notice deadline.

C. If a complete household report form is received by the county agency within a calendar month after the month in which assistance was received, an assistance unit required to submit a household report form is considered to have continued its application for assistance effective the date the required report is received by the county agency. However, no assistance shall be paid for the period beginning with the first day of the month after the month in which the report was due and ending with the date the report was received by the county agency.

Subp. 5. **Changes which must be reported.** Recipients shall report the changes or anticipated changes specified in items A to J within ten days after the date they occur, within ten days after the date the recipient learns that the change will occur, at the time of the periodic redetermination under subpart 6, or within eight calendar days after a reporting period as in subpart 3, whichever occurs first. A recipient shall report other changes at the time of the periodic redetermination of eligibility under subpart 6 or at the end of a reporting period under subpart 3 as applicable. A recipient shall make these reports in writing or in person to the county agency. Changes in circumstances which must be reported within ten days must also be reported on the household report form for the reporting period in which those changes occurred. Within ten days, a recipient must report changes in:

A. initial employment;

B. the initial receipt of unearned income;

C. a recurring change of more than $50 per month of net earned or unearned income;

D. the receipt of a lump sum;

E. an increase in resources;

F. the marriage or divorce of an assistance unit member;

G. a change in the household composition including departures from and returns to the home of filing unit members, or the birth or death of a member of the filing unit;

H. a change in the address or living quarters of an assistance unit;

I. the sale, purchase, or other transfer of property; and

J. a change in school attendance of a child over 15 years of age or an adult member of an assistance unit.

Subp. 6. **Redetermination of eligibility.** Except as provided in items A to C, a county agency must redetermine eligibility of a recipient once each year. A recipient must complete forms prescribed by the commissioner and required for redetermination of eligibility.

A. A county agency that has opted to provide assistance on a weekly basis to persons without a verified residence address may redetermine eligibility each week. In redetermining eligibility, the county agency must use the form in part 9500.1237, subpart 4, item D, subitem (2). The form must include a claim of need by the recipient.

B. A county agency must redetermine eligibility when a recipient who has been disqualified from receiving cash assistance due to noncompliance with a program provision requests assistance after the expiration of the disqualification period.

C. A county agency may redetermine the eligibility of a recipient when a change that affects program eligibility is reported to the county agency.

Subp. 7. **Other maintenance benefits.** An applicant or recipient must apply, according to part 9500.1254, for other maintenance benefits that the county agency has determined the applicant or recipient is potentially eligible for. An applicant or recipient who fails or refuses to take the actions specified by the county agency according to part 9500.1254 must be terminated from general assistance and remains ineligible for assistance until the applicant or recipient takes the actions specified by the county agency under this subpart.

Subp. 8. [Repealed, 32 SR 1437]

Subp. 9. [Repealed, 32 SR 1437]

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

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## 9500.1248 DETERMINATION OF COUNTY OF FINANCIAL RESPONSIBILITY.

Subpart 1. [Repealed, 15 SR 1842]

Subp. 2. [Repealed, 15 SR 1842]

Subp. 3. **Determination of county of financial responsibility.** The county of financial responsibility shall be determined according to Minnesota Statutes, chapter 256G.

**Statutory Authority:** *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

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## 9500.1250 LOCAL AGENCY REPORTS.

The county agencies shall collect and report information necessary to administer, monitor, and evaluate the general assistance program, including work requirements.

**Statutory Authority:** *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

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## 9500.1254 REFERRAL TO OTHER MAINTENANCE BENEFIT PROGRAMS.

Subpart 1. **Screening requirement.** The county agency must determine the potential eligibility of each general assistance applicant or recipient for other maintenance benefits as follows:

A. The county agency must determine an applicant's potential eligibility for other maintenance benefits when application for general assistance is made.

B. The county agency must determine a recipient's potential eligibility for other maintenance benefits at the recipient's semiannual redetermination of eligibility for general assistance. The county agency must also determine a recipient's potential eligibility for other maintenance benefits

whenever it determines that changes in the recipient's circumstances, including eligibility for medical assistance, indicate potential eligibility for other maintenance benefits.

C. If the county agency determines that the applicant or recipient is potentially eligible for other maintenance benefits, the county agency must document its determination on forms prescribed by the commissioner and must retain the forms in the county agency case record for the applicant or recipient.

Subp. 2. **Informing and referral requirement.** When the county agency determines that the applicant or recipient is potentially eligible for other maintenance benefits, the county agency shall refer the applicant or recipient to the other maintenance benefit program on a form prescribed by the commissioner by informing the applicant or recipient orally and in writing of the following:

A. that the applicant or recipient must apply for the other maintenance benefit program, according to subpart 4, item A;

B. that the applicant or recipient must execute an interim assistance agreement, according to subpart 4, item D;

C. that the applicant or recipient must comply with all procedures necessary to determine eligibility or ineligibility for the other maintenance benefits according to subpart 4, item C;

D. that the applicant or recipient must authorize the county agency and the qualified provider, when one is chosen, to exchange relevant data concerning the applicant's or recipient's eligibility with the other maintenance benefit program office, according to subpart 4, item B;

E. the estimated amount of benefits the applicant or recipient may be eligible to receive under the other maintenance benefit program, if known;

F. the address at which the applicant or recipient shall apply for the other maintenance benefit program;

G. general instructions regarding how to apply for the other maintenance benefit program;

H. that the applicant or recipient may elect to receive special services to assist in applying for SSI benefits;

I. notice of the actions which the county agency must take, according to subpart 5, if the applicant or recipient fails to comply with the requirements under subpart 4, items A to D; and

J. notice of the applicant's or recipient's right to appeal a determination of ineligibility for general assistance due to noncompliance with subpart 4, items A to D.

Subp. 3. [Repealed, 32 SR 1437]

Subp. 4. **Requirements upon referral for other maintenance benefits.** When the county agency refers an applicant or recipient to another maintenance benefit program as provided under subpart 2, the applicant or recipient shall do the following:

A. The applicant or recipient shall apply for those benefits within 30 days of the date of referral. If the recipient has not provided the county agency with verification of an application for those benefits within 30 days of the date of referral, the county agency must contact the other maintenance benefit program county office to determine if the recipient has applied for benefits. If the county office of the other maintenance benefit program verifies that the recipient has applied for those benefits, the recipient shall be deemed to have met the requirement of applying for other maintenance benefits. If the county office of the other maintenance benefit program verifies that the recipient has not applied for those benefits, the local agency shall mail or give the recipient notice of termination from general assistance according to subpart 5.

B. The applicant or recipient shall, within 30 days of the date of referral, provide informed written consent and authorization for the county agency or a qualified provider, if one is chosen, to exchange data concerning the applicant or recipient with the other maintenance benefit program county office. The data exchanged must be relevant to a determination of the applicant's or recipient's eligibility or ineligibility for benefits from the other program.

For purposes of exchanging private or confidential data about a person for whom a qualified provider has contracted to provide special services, a qualified provider other than the county agency shall not be considered part of the welfare system under Minnesota Statutes, section 13.46, subdivision 1.

If the county agency determines that the recipient has not given informed written consent and authorization for the county agency or a qualified provider to exchange data concerning eligibility or ineligibility for the other maintenance benefit program within the prescribed 30 days, the county agency shall mail or give the recipient notice of termination from general assistance according to subpart 5.

C. A recipient shall comply with all procedures necessary to determine eligibility or ineligibility for the other maintenance benefit program.

If the county agency determines that the recipient has not complied with the procedures necessary to determine eligibility or ineligibility for other maintenance benefits, the county agency shall mail or give the recipient notice of termination from general assistance according to subpart 5.

D. An applicant or recipient shall execute an interim assistance agreement with the county agency within 30 days of the date of referral.

If the recipient fails to execute an interim assistance agreement within the 30 days prescribed, the county agency shall mail or give the recipient notice of termination from general assistance according to subpart 5.

Subp. 5. **Ineligibility.** This subpart governs termination of general assistance eligibility for a recipient who fails, without good cause, to comply with the requirements of subpart 4.

A. Upon determining that a recipient has failed, without good cause, to comply with the requirements of subpart 4, the county agency shall mail or give the recipient notification of termination from general assistance. The county agency shall hand deliver or mail the written notice to the recipient at least 30 days before reducing, suspending, or terminating the recipient's monthly

general assistance payment. The notice must be on a form prescribed by the commissioner and must:

(1) list the requirements with which the county agency believes the recipient has not complied and inform the recipient that the recipient must comply with the requirements to avoid or end a period of ineligibility;

(2) inform the recipient that the recipient will be terminated from general assistance if the recipient fails to comply with the listed requirements, specify the date that the recipient's general assistance will be terminated if the recipient does not comply, and explain the recipient's right to appeal the action according to subpart 6;

(3) offer assistance to resolve the circumstances or concerns which prevent the recipient from complying with the requirements of subpart 4; and

(4) inform the recipient of the continued availability of special services.

B. If the recipient complies with the requirements specified in the notice in item A before the termination date stated in the notice, a period of ineligibility must not be imposed.

C. A recipient who fails to comply with the requirements specified in the notice in item A before the termination date stated in the notice is ineligible for general assistance. The period of ineligibility begins on the date specified in the notice and continues until the person fulfills the requirements of subpart 4. The period of ineligibility always begins on the first day of a calendar month. If the ineligible person subsequently applies for general assistance, the application must be denied unless the requirements of subpart 4 have been met.

D. If the person is determined to be ineligible under item C, the assistance standard applicable to the person's assistance unit must be based on the number of remaining eligible members of the assistance unit.

Subp. 6. **Appeals.** A recipient to whom the county agency has given or mailed a notice of termination according to subpart 5 may appeal the determination by submitting a written request for a hearing according to Minnesota Statutes, section 256.045. If the recipient files a written request for an appeal on or before the first day of the period of ineligibility under subpart 5, item C, the recipient shall continue to receive general assistance while the appeal is pending, provided that the recipient is otherwise eligible for general assistance.

Subp. 7. **Reimbursement for interim assistance.** A county agency must seek reimbursement for the interim assistance provided to a person who has executed an interim assistance agreement under subpart 4, item D, when the person receives a retroactive payment of other maintenance benefits unless reimbursement is prohibited under federal or state law.

The county agency must request reimbursement for interim assistance from the person receiving other retroactive maintenance benefits, except for SSI, or in those instances where the state or county agency has rights of subrogation under Minnesota Statutes, section 256.03. If a request for reimbursement under this subpart is denied, the county agency may institute a civil action to recover

the interim assistance based on the interim assistance agreement. The county agency must take no action other than a civil action to recover the interim assistance.

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

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**9500.1258** [Repealed, 15 SR 1842]
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## 9500.1259 COUNTY AGENCY RESPONSIBILITIES.

Subpart 1. [Repealed, 32 SR 1437]

Subp. 2. **Appeals.** The participant may appeal a proposed termination of benefits until five days after the effective date specified in the notice and continue benefits otherwise due, pending the outcome of the appeal. Appeals from proposed terminations of benefits of participants must be heard within 30 days from the date that the appeal was filed.

Subp. 3. **Information about other programs.** A county agency must inform an applicant or recipient about other programs administered by the county agency for which, from the county agency's knowledge of the person's situation, the person may be eligible.

Subp. 4. **Notices.** The county agency shall mail or hand deliver a notice to a recipient no later than ten days before the effective date of the action except as provided in items A to C. A recipient who has failed to provide the county agency with a mailing address must be assigned a schedule by which the recipient is to visit the agency to pick up any notices. Notices will be deemed to have been delivered on the date of the recipient's next scheduled visit to the county agency.

A. A county agency shall mail a notice to a recipient no later than five days before the effective date of the action when the county agency has factual information which requires an action to reduce, suspend, or terminate assistance based on probable fraud.

B. A county agency must mail or hand deliver a notice to a recipient no later than the effective date of the action when:

(1) the county agency receives a recipient's household report form which includes facts that require payment reduction, suspension, or termination and which contains the recipient's signed acknowledgment that this information will be used to determine program eligibility or the assistance payment amount;

(2) the county agency verifies the death of a recipient or the payee;

(3) the county agency receives a signed statement from a recipient that assistance is no longer wanted;

(4) the county agency receives a signed statement from a recipient that provides information which requires the termination or reduction of assistance, and the recipient shows in that statement that the recipient understands the consequences of providing that information;

(5) the county agency verifies that a member of an assistance unit has been approved to receive assistance by another county or state; or

(6) the county agency cannot locate a payee's whereabouts and mail from the local agency has been returned by the post office showing that the post office has no forwarding address.

C. Whenever any provision of this subpart conflicts with any special notice requirements of another part, those special notice provisions shall prevail.

**Statutory Authority:** *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

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**9500.1261 EMERGENCY ASSISTANCE.**

Subpart 1. **Emergency assistance.** A county agency shall make grants of general assistance for emergency situations to eligible individuals, married couples, or families whether residents or nonresidents of the state. The emergency assistance grant may be in excess of the standard amounts for eligible individuals, married couples, or families under part 9500.1231.

Subp. 2. **Emergency situation.** An emergency situation is a situation in which an assistance unit is without, or will lose within 30 days after application, a basic need item as defined in part 9500.1206, subpart 7a.

A. The emergency situation must require immediate financial assistance.

B. The financial assistance required by the emergency must be temporary and must not exceed 30 days subsequent to the date of application. Assistance must be paid for needs that accrue before the 30-day period when it is necessary to resolve emergencies arising or continuing during the 30-day period subject to subpart 4.

Subp. 3. **Eligible persons.** Eligible individuals, married couples, or families are those:

A. who are not current recipients of DWP or MFIP;

B. who are not recipients under or eligible for county emergency assistance through the MFIP consolidated fund program under Minnesota Statutes, section 256J.626, in the month of application for emergency general assistance;

C. whose resources are not adequate to resolve the emergency situation. For the purpose of this part, "resources" means any funds or services which can actually be available to the applicant or recipient or any member of the filing unit before the loss of a basic need item. Resources include available income without exclusion or disregard, and any resource otherwise excluded under part 9500.1221, subpart 2, which could be liquidated before the loss of a basic need item, so long as the terms of any borrowing cannot be reasonably expected to place the borrower in another emergency situation within three months including the month of application;

D. [Repealed, L 2011 1Sp9 art 1 s 35]

E. [Repealed, L 2011 1Sp9 art 1 s 35]

Subp. 4. [Repealed, L 2011 1Sp9 art 1 s 35]

Subp. 5. [Repealed, L 2011 1Sp9 art 1 s 35]

Subp. 6. **Excess grants, county agency payment responsibility.** A county agency may issue emergency assistance grants that exceed the limitations in subpart 4 if the county agency does not include the additional costs on its claim for state aid reimbursement.

**Statutory Authority:** *MS s 14.388; 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

**History:** *15 SR 1842; L 2005 c 56 s 2; 32 SR 1437; L 2011 1Sp9 art 1 s 35*
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## 9500.1272 ASSIGNMENT OF REPRESENTATIVE PAYEE FOR RECIPIENTS WHO ARE DRUG DEPENDENT.

Subpart 1. **Definitions.** As used in this part, the following terms have the meanings given them in this subpart.

A. "Basic needs" means the minimum personal requirements of subsistence and is restricted to:

(1) shelter;

(2) utilities;

(3) food;

(4) clothing; and

(5) other items the loss or lack of which is determined by the county agency to pose a direct, immediate threat to the physical health or safety of the applicant or recipient.

B. "Chemical use assessment" means the assessment defined in part 9530.6605, subpart 8.

C. "Client" means an applicant for or recipient of general assistance.

D. "Detoxification" means the program of services provided under Minnesota Statutes, section 254A.08.

E. "Disconjugate gaze" means an inability to move both eyes in unison.

F. "Drug abuse" means chemical abuse as defined in part 9530.6605, subpart 6.

G. "Drug dependency" means chemical dependency as defined in part 9530.6605, subpart 7.

H. "Representative payee" means a person or agency selected to receive and manage general assistance benefits provided by the county agency on behalf of a general assistance recipient.

I. "Vendor payment" means a payment made by a county agency directly to a provider of goods or services.

Subp. 2. **Referral for chemical use assessment.** A county agency may refer an applicant or a recipient for a chemical use assessment by an assessor as defined in part 9530.6605, subpart 4, when there is a reasonable basis for questioning whether a person is drug dependent. A reasonable basis for referral exists when:

A. The person has required detoxification two or more times in the last 12 months;

B. The person appears intoxicated at the county agency as indicated by two or more of the following:

(1) odor of alcohol;

(2) slurred speech;

(3) disconjugate gaze;

(4) impaired balance;

(5) difficulty in remaining awake;

(6) consumption of a chemical;

(7) responding to sights or sounds that are not actually present; and

(8) extreme restlessness, fast speech, or unusual belligerence;

C. The person has been involuntarily committed for drug dependency at least once in the past 12 months; or

D. The person has received treatment, including domiciliary care, for drug abuse or dependency at least twice in the past 12 months.

Subp. 3. **Referral procedures for chemical use assessment.** A referral for a chemical use assessment must be made according to items A and B.

A. When the county agency decides to refer a client for a chemical use assessment, the county agency shall notify the client of the referral in writing. The notice must inform the client of:

(1) the basis for the referral;

(2) the name, address, and phone number of the individual to contact to schedule the assessment, or the time, date, and location of the chemical use assessment if one has already been scheduled by the county agency;

(3) the fact that the applicant's general assistance benefits will be paid in the form of vendor payments or emergency general assistance as specified in subpart 4 until the local agency decides whether to assign a representative payee under subpart 8;

(4) the fact that if the recipient has been receiving cash general assistance that those benefits will be changed to emergency general assistance payments or general assistance vendor payments under subpart 4 until the county agency decides whether to assign a representative payee under subpart 8;

(5) the effect under subpart 8 of failing to participate in the chemical use assessment within 30 days of the date of referral;

(6) the client's right to appeal the county agency's decision to refer the client for an assessment, and the right to appeal the assessment results when the assessment has been completed; and

(7) the need to contact the county agency and consult with the county agency concerning the choice of representative payee.

B. The client must be given the opportunity to participate in a chemical use assessment within 15 days after the date the notice of referral is mailed or delivered to the client.

Subp. 4. **Form of payment pending completion of assessment.** A county agency shall provide only emergency general assistance (EGA) or general assistance vendor payments to a client who has been referred for a chemical use assessment under subpart 2. EGA may be provided to clients only in emergency situations as provided in part 9500.1261. All other payments made under this subpart must be general assistance vendor payments.

Subp. 5. **Timing and duration of general assistance vendor payments or EGA.** A county agency shall not change the form of a recipient's benefit payments from cash general assistance to general assistance vendor payments under subpart 4 until ten days after the notice of referral under subpart 3 is mailed or delivered to the recipient. If the client meets the criteria for assignment of a representative payee under subpart 8, the county agency shall continue to provide EGA or general assistance vendor payments until the county agency begins making general assistance payments through the client's representative payee. If the client does not meet the criteria under subpart 8 for assignment of a representative payee, the county agency shall provide future general assistance benefits to which the client is entitled in cash beginning on the first day of the payment month immediately following the date of the determination that the client does not meet the criteria for assignment of a representative payee.

Subp. 6. **Amount of vendor payments.** EGA or general assistance vendor payments may be provided only to the extent needed to meet the client's basic needs. If the county agency is unable to vendor pay the entire standard of assistance to which the client is entitled, the remaining amount of the standard of assistance must not be issued until a representative payee is assigned or until the county agency decides not to assign a representative payee. If a representative payee is assigned, the unissued amount must be provided to the representative payee within 15 days after the date the county agency begins making payments through the representative payee. If the client does not meet the criteria under subpart 8 for assignment of a representative payee, the unissued amount must be provided directly to the client within 15 days after the date of the determination that the client does not meet the criteria for assignment of a representative payee.

Subp. 7. **Assessment.** The chemical use assessment must be conducted according to parts 9530.6600 to 9530.6655.

Subp. 8. **Criteria governing assignment of representative payee.** The county agency may assign a representative payee to manage a client's general assistance if the client fails, without good cause as defined in part 9500.1206, subpart 15, to participate in a chemical use assessment within 30 days after referral under subparts 2 and 3; or if an assessment performed within the last six months indicates that the client is drug dependent and eligible for placement in extended care under part 9530.6640.

Subp. 9. **Procedures governing assignment of representative payee after referral.** A representative payee must be assigned according to items A to C.

A. The county agency shall provide the client with an opportunity to consult with the county agency in selecting a representative payee. The county agency shall consider the client's preferences for particular individuals to serve as payees but the county agency's preference must prevail.

B. The county agency shall notify the client in writing of:

(1) its decision to assign a representative payee;

(2) the basis for its decision to assign a representative payee;

(3) the identity, address, and phone number of the representative payee;

(4) the date the county agency will begin making payments through the representative payee;

(5) the circumstances under which a representative payee may be removed or replaced; and

(6) the client's right to appeal the assignment under Minnesota Statutes, section 256.045.

C. The notice under item B must be mailed or delivered to the client or the client's last known address within 15 days after the date of the chemical use assessment on which the assignment is based, or within 30 days after the date of the referral under subparts 2 and 3 if a representative payee is assigned because of the client's failure to participate in an assessment. The notice must also be mailed or delivered at least ten days before the county agency begins making payments through the representative payee.

Subp. 10. **Procedures governing assignment of representative payee without referral.** A county agency may assign a representative payee to a client who meets the criteria for assignment under subpart 8 but who has not been referred for a chemical use assessment under subparts 2 and 3. A representative payee assigned under this subpart must be assigned according to items A to E.

A. The county agency may provide only emergency general assistance or general assistance vendor payments to a client who meets the criteria for assignment of a representative payee under subpart 8 until the county agency begins making general assistance payments through the client's representative payee or until the first day of the payment month following a determination that the client does not meet the criteria for assignment of a representative payee. Payments under this item shall be made according to subparts 4 and 6 and shall not begin until the date the county agency mails or delivers the notice under item C.

B. The county agency shall provide a client with an opportunity to consult with the county agency on the choice of representative payee as provided in subpart 9, item A.

C. The county agency shall notify a client in writing of:

(1) its decision to assign a representative payee;

(2) the basis for its decision to assign a representative payee;

(3) the client's right to consult with the county agency on the choice of representative payee;

(4) the date by which the county agency must select a representative payee under item D; and

(5) the fact that the county agency will provide the client's general assistance benefits in the form of emergency assistance or vendor payments until the county agency begins making payments through a representative payee.

D. The county agency shall notify a client in writing of its selection of a representative payee within 15 days after issuing the notice required under item C. The notice shall inform the client of:

(1) the identity, address, and phone number of the representative payee assigned to the client;

(2) the date the county agency will begin making payments through the representative payee;

(3) the circumstances under which a representative payee may be removed or replaced; and

(4) the client's right to appeal the assignment of a representative payee under Minnesota Statutes, section 256.045.

E. The county agency shall not begin making payments through a representative payee until at least ten days after the notice under item D is mailed or delivered to the client.

Subp. 11. **Criteria governing the choice of representative payee.** A county agency shall appoint as representative payee an individual or agency who is likely to manage the client's income and resources in a manner that meets the client's basic needs. A county agency shall not appoint as representative payee any individual to whom the client is in financial debt. In selecting the representative payee, the county agency shall consider all factors relevant to the prospective payee's ability to manage the client's general assistance to meet the client's basic needs, including the following factors:

A. the prospective payee's experience and training in managing the finances of others;

B. the prospective payee's familiarity with the geographic area and the community resources available to meet the client's basic needs; and

C. the relationship between the prospective payee and the client, including any legal authority the prospective payee has to act on behalf of the client.

Subp. 12. **Responsibilities of the representative payee.** The representative payee assigned to a client must:

A. use the client's general assistance benefits to meet the client's current basic needs;

B. maintain clear and current records of all expenditures made on behalf of the client; and

C. complete a report every six months containing the client's general assistance financial records and a recommendation as to whether the client continues to require a representative payee. The report must be provided to the county agency and the client on request.

Subp. 13. **Review of client's representative payee status.** The county agency shall conduct a review of a client's need to continue receiving benefits through a representative payee within 12 months of the client's previous chemical use assessment. The county agency shall conduct the review under this subpart no earlier than six months after the client's previous chemical use

assessment. A review requested by a client must be conducted within 15 days of the client's request. Each review conducted under this subpart must include a chemical use assessment to determine whether the recipient remains drug dependent and eligible for placement in extended care and an examination of the representative payee's report required under subpart 12.

Subp. 14. **Discontinuing a client's representative payee status.** A county agency shall discontinue the use of a representative payee only if a review conducted under subpart 13 indicates that the client is no longer eligible for placement in extended care. A county agency shall not discontinue the use of a representative payee until at least six months have elapsed since the client last underwent a chemical use assessment showing the client to be chemically dependent and eligible for placement in extended care.

Subp. 15. **Investigating need for change in representative payee.** The county agency shall review a representative payee's performance and determine whether to appoint a new representative payee if the client alleges or the county agency has reason to believe that the representative payee is not complying with the requirements of subpart 12. When an investigation is initiated in response to a client's complaint, the county agency's decision to retain the current representative payee or appoint a new one must be made within 30 days of the date the complaint is received by the county agency. An investigation conducted under this subpart must include a review of all financial records maintained by the representative payee concerning the use of the client's general assistance benefits and any other relevant evidence.

Subp. 16. **Duration of a representative payee designation.** Notwithstanding any gaps in the receipt of general assistance, the designation of a specific representative payee shall continue for at least six months unless:

A. the client no longer meets the criteria for assignment of a representative payee under subpart 8;

B. the representative payee is not fulfilling the responsibilities under subpart 12; or

C. the representative payee requests to discontinue serving as the client's representative payee.

Subp. 17. **Change in representative payee.** The county agency shall appoint a new representative payee if the current representative payee fails to comply with the requirements of subpart 12 or requests that the county agency appoint a new representative payee.

Subp. 18. **Appealable issues.** A client may appeal:

A. the proposed assignment of a representative payee, including the results of the chemical use assessment upon which the assignment is based;

B. the county agency's choice of representative payee; and

C. the decision to refer a person for an assessment.

However, notwithstanding any provision of Minnesota Statutes, section 256.045 to the contrary, an applicant or recipient who is referred for an assessment and is otherwise eligible to receive a

general assistance benefit may only be provided with emergency general assistance or vendor payments pending the outcome of an administrative or judicial review.

If a representative payee is assigned under subpart 8 without a chemical use assessment, the client may appeal the county agency's determination that the client did not have good cause for failing to participate in the chemical use assessment.

Subp. 19. **Appeal procedures and timing of appeals.** If the client appeals before the date the representative payee is scheduled to begin receiving the client's general assistance benefits, the county agency shall continue to vendor pay the client's general assistance and shall not make general assistance payments through the representative payee until after the appeal is decided unless the client requests in writing to have payments made through the representative payee pending the outcome of the appeal.

**Statutory Authority:** *MS s 256D.01; 256D.04; 256D.051; 256D.06; 256D.08; 256D.09; 256D.111*

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## ADMINISTRATION OF THE PREPAID MEDICAL ASSISTANCE PROGRAM

### 9500.1450 INTRODUCTION.

Subpart 1. **Scope.** Parts 9500.1450 to 9500.1464 govern administration of the prepaid medical assistance program (PMAP) in Minnesota. Parts 9500.1450 to 9500.1464 shall be read in conjunction with title XIX of the Social Security Act, Code of Federal Regulations, title 42, and waivers approved by the Centers for Medicare and Medicaid Services, Minnesota Statutes, chapters 256 and 256B, and rules adopted under them, governing the administration of the title XIX program and PMAP in Minnesota.

Subp. 2. **References.** Parts 9500.1450 to 9500.1464 shall be interpreted as necessary to comply with federal laws and regulations and state laws applicable to the prepaid medical assistance program.

Subp. 3. [Repealed, L 2014 c 291 art 10 s 14]

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086; L 2002 c 277 s 32; L 2014 c 291 art 10 s 14*
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### 9500.1451 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 9500.1450 to 9500.1464, the following terms have the meanings given them in this part.

Subp. 2. [Repealed, 16 SR 1086]

Subp. 2a. **Appeal.** "Appeal" means an enrollee's written request for a hearing, filed with the commissioner according to Minnesota Statutes, section 256.045, related to the delivery of health services or participation in a health plan.

Subp. 2b. **Authorization.** "Authorization" means a participating provider's written referral for health services provided by a nonparticipating provider. Authorization includes an admission request by a participating provider, on behalf of a PMAP enrollee, following the established health plan admission procedures for inpatient health services.

Subp. 2c. **Authorized representative.** "Authorized representative" means a person authorized in writing by a PMAP consumer to act on the PMAP consumer's behalf in matters involving the prepaid medical assistance program.

Subp. 3. [Repealed, 16 SR 1086]

Subp. 4. **Capitation.** "Capitation" means a method of payment for health services that involves a monthly per person rate paid on a prospective basis to a health plan.

Subp. 4a. **Case management.** "Case management" means a method of providing health care in which the health plan coordinates the provision of health services to an enrollee.

Subp. 4b. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's designated representative.

Subp. 4c. **Complaint.** "Complaint" means an enrollee's written or oral communication to a health plan expressing dissatisfaction with the provision of health services. The subject of the complaint may include, but is not limited to, the scope of covered services, quality of care, or administrative operations.

Subp. 5. [Repealed, 16 SR 1086]

Subp. 6. **Department.** "Department" means the Department of Human Services.

Subp. 7. **Enrollee.** "Enrollee" means a PMAP consumer who is enrolled in a health plan.

Subp. 7a. **Health plan.** "Health plan" means an organization contracting with the state to provide medical assistance health services to enrollees in exchange for a monthly capitation payment.

Subp. 8. **Health services.** "Health services" means the services and supplies given to a recipient by a provider for a health related purpose under Minnesota Statutes, section 256B.0625.

Subp. 9. **Insolvency.** "Insolvency" means the condition in which a health plan is financially unable to meet the financial and health care service delivery obligations in the contract between the department and the health plan.

Subp. 10. **Local agency.** "Local agency" means a county or multicounty agency that is authorized under Minnesota Statutes, sections 393.01, subdivision 7, and 393.07, subdivision 2, as the agency responsible for determining recipient eligibility for the medical assistance program.

Subp. 11. [Repealed, 16 SR 1086]

Subp. 12. [Repealed, 16 SR 1086]

Subp. 13. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 14. **Medical assistance population or MA population.** "Medical assistance population" or "MA population" means a category of eligibility for the medical assistance program, the eligibility standards for which are in parts 9505.0010 to 9505.0150 and Minnesota Statutes, section 256B.055.

Subp. 14a. **Multiple health plan model.** "Multiple health plan model" means a health services delivery system that allows PMAP consumers to enroll in one of two or more health plans.

Subp. 14b. **Nonparticipating provider.** "Nonparticipating provider" means a provider who is not employed by or under contract with a health plan to provide health services.

Subp. 14c. **Ombudsperson.** "Ombudsperson" means an individual designated by the commissioner under Minnesota Statutes, section 256B.031, subdivision 6, to advocate for PMAP consumers and enrollees and to assist them in obtaining necessary health services.

Subp. 14d. **Open enrollment.** "Open enrollment" means the annual 30-day period during which PMAP enrollees in a multiple health plan model may change to another health plan.

Subp. 14e. **Participating provider.** "Participating provider" means a provider who is employed by or under contract with a health plan to provide health services.

Subp. 14f. **Personal care assistant.** "Personal care assistant" means a provider of personal care services prescribed by a physician, supervised by a registered nurse, and provided to a medical assistance recipient under Minnesota Statutes, section 256B.0659. A personal care assistant must not be the recipient's spouse, legal guardian, or parent if the recipient is a minor child.

Subp. 14g. **Personal care services.** "Personal care services" has the meaning given it in Minnesota Statutes, section 256B.0655, subdivision 2.

Subp. 14h. **Prepaid medical assistance program or PMAP.** "Prepaid medical assistance program" or "PMAP" means the prepaid medical assistance program authorized under Minnesota Statutes, section 256B.69.

Subp. 14i. **PMAP consumer.** "PMAP consumer" means a medical assistance recipient who is selected to participate in PMAP.

Subp. 14j. **Prepayment coordinator.** "Prepayment coordinator" means the individual designated by the local agency under Minnesota Statutes, section 256B.031, subdivision 9.

Subp. 14k. **Primary care provider health plan model.** "Primary care provider health plan model" means a health services delivery system that allows PMAP consumers to select a primary care physician and primary care dentist from a list of physicians and dentists under contract with the state or a county to provide health services to PMAP consumers.

Subp. 15. **Provider.** "Provider" means a person or entity providing health services.

Subp. 16. **Rate cell.** "Rate cell" means a grouping of recipients by demographic characteristics, established by the commissioner for use in determining capitation rates. The following are deemed to be demographic characteristics: a recipient's age, sex, medicare status, basis of medical assistance eligibility, county of residence, and residence in a long-term care facility.

Subp. 16a. **Rate cell year.** "Rate cell year" means the period beginning on the date of enrollment in the health plan and ending on the date of the annual eligibility review or the date of enrollment in a new plan, whichever occurs sooner, and thereafter the 12-month period between eligibility reviews during which an enrollee's rate cell assignment is fixed.

Subp. 17. **Recipient.** "Recipient" means a person who has been determined by the local agency to be eligible for the medical assistance program.

Subp. 17a. **Spenddown.** "Spenddown" means the process by which a person who has income in excess of the medical assistance income standard becomes eligible for medical assistance by incurring health services expenses, other than nursing home facility per diem charges, that are not covered by a liable third party and that reduce the excess income to zero.

Subp. 17b. **State institution.** "State institution" means all regional treatment centers as defined in Minnesota Statutes, section 245.0312, and all state operated facilities as defined in Minnesota Statutes, section 252.50.

Subp. 18. [Repealed, 16 SR 1086]

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086*
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## 9500.1452 ELIGIBILITY TO ENROLL IN A HEALTH PLAN.

Subpart 1. **Medical assistance eligibility required for PMAP participation.** Only persons who have been determined eligible for medical assistance under parts 9505.0010 to 9505.0140 shall be eligible to participate in the prepaid medical assistance program.

Subp. 2. **Medical assistance categories ineligible for PMAP.** A person who belongs to a category listed in items A to N is ineligible to enroll in a health plan under the prepaid medical assistance program:

A. a person who is eligible for medical assistance on a spenddown basis as defined in part 9500.1451, subpart 17a;

B. [Repealed, L 1995 c 207 art 6 s 124]

C. a person who is a resident of a state institution;

D. a person who is receiving benefits under the Refugee Assistance Program, established at United States Code, title 8, section 1522(e);

E. a person who is eligible for medical assistance through an adoption subsidy;

F. a person who is determined eligible for medical assistance due to blindness or disability as certified by the Social Security Administration or the state medical review team, unless the recipient is 65 years of age or older;

G. a person who is eligible for medical assistance but currently has private health insurance coverage through a health maintenance organization licensed under Minnesota Statutes, chapter 62D;

H. a person who resides in Itasca County but who lives near the county border and who chooses to use a primary care provider located in a neighboring county;

I. a person who is a qualified medicare beneficiary, as defined in United States Code, title 42, section 1396(d), who is not otherwise eligible for medical assistance;

J. a person who is terminally ill as defined under part 9505.0297, subpart 2, item N, and who, at the time of notification of mandatory enrollment in PMAP, has a permanent relationship with a primary physician who is not part of any PMAP health plan;

K. a person who is in foster placement;

L. a child who prior to enrollment in a health plan is determined to be in need of protection under Minnesota Statutes, sections 626.556 to 626.5561, is identified to the state by the county

social service agency, and is receiving medical assistance covered services through a provider who is not a participating provider in PMAP;

M. a child who prior to enrollment in a health plan is determined to be severely emotionally disturbed under Minnesota Statutes, sections 245.487 to 245.4889, and is:

(1) coded as severely emotionally disturbed on the Minnesota welfare information system;

(2) receiving county mental health case management services; and

(3) under the primary care of a mental health professional as defined in Minnesota Statutes, section 245.4871, subdivision 27, who is not a participating provider in PMAP; or

N. a person who, at the time of notification of mandatory enrollment in PMAP:

(1) has a communicable disease;

(2) the prognosis of the communicable disease is terminal illness, however, for the purpose of this subitem, "terminal illness" may exceed six months;

(3) the person's primary physician is not a participating provider in any PMAP health plan; and

(4) the physician certifies that disruption of the existing physician-patient relationship is likely to result in the patient becoming noncompliant with medication or other health services.

Subp. 3. [Repealed, L 2014 c 291 art 10 s 14]

Subp. 4. **Elective enrollment.** An individual categorically excluded from PMAP under subpart 2, item G, may enroll in PMAP on an elective basis if the private health insurance health plan is the same as the health plan the consumer will select under PMAP.

Individuals categorically excluded from PMAP under subpart 2, items K, L, and M, may enroll in the prepaid medical assistance program on an elective basis.

Program requirements are the same for elective and mandatory PMAP enrollees under Minnesota Statutes, section 256B.69.

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086; L 1995 c 207 art 6 s 124; L 2007 c 147 art 8 s 38; L 2014 c 291 art 10 s 14*

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## 9500.1453 MANDATORY PARTICIPATION; FREE CHOICE OF HEALTH PLAN.

Subpart 1. **Local agency enrollment of PMAP consumers.** Each local agency shall enroll recipients to participate as PMAP consumers in the prepaid medical assistance program. Health services may be provided to PMAP consumers under a multiple health plan model or a primary care provider health plan model.

Subp. 2. **Counties using a multiple health plan model, choice.** In a county that uses a multiple health plan model, the local agency shall notify each PMAP consumer, in writing, of the health plan choices available. The PMAP consumer shall be given 30 days after receiving the notification to select a health plan and to inform the local agency of the health plan choice. If a PMAP consumer fails to select a health plan within 30 days, the local agency must randomly assign the PMAP consumer to a health plan at the end of the 30-day period. The commissioner shall notify each PMAP consumer in writing before the effective date of enrollment, of the health plan in which the PMAP consumer will be enrolled.

Subp. 3. **Counties using primary care provider health plan model, provider choice.** In a county that uses a primary care provider health plan model, the local agency shall notify each PMAP consumer, in writing, of the primary care physicians and dentists available. The PMAP consumer shall be given 30 days after receiving the notification to select a primary care physician and dentist and to inform the local agency of the choice. If a PMAP consumer fails to select a primary care physician or dentist within 30 days, the local agency must randomly assign the PMAP consumer to a primary care physician and dentist at the end of the 30-day period. The local agency shall notify each PMAP consumer in writing of the assigned primary care physician or dentist before the effective date of enrollment.

Subp. 4. **Designation of prepayment coordinator.** To carry out its responsibilities under this part, each local agency shall designate a prepayment coordinator. The prepayment coordinator shall perform the duties set forth under Minnesota Statutes, section 256B.031, subdivision 9. The commissioner shall monitor the tasks performed by the prepayment coordinator.

Subp. 5. **Enrollment period in counties using a multiple health plan model; change.** In a county that uses a multiple health plan model, a PMAP consumer shall be enrolled in a health plan for up to one year from the date of enrollment but shall have the right to change to another health plan once within the first year of initial enrollment in PMAP. In addition, when a PMAP consumer is enrolled in a health plan whose participation in PMAP is subsequently terminated for any reason, the PMAP consumer shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. An enrollee shall also have the opportunity to change to another health plan during the annual 30-day open enrollment period. The local agency shall notify enrollees of the opportunity to change to another health plan before the start of each annual open enrollment period.

Subp. 6. **Enrollment period in counties using primary care provider health plan model; change.** In a county that uses a primary care provider health plan model, an enrollee shall select a primary care physician or dentist for a period up to one year from the date of enrollment but shall have the right to select a new primary care physician or dentist during the first year of initial enrollment. An enrollee shall also have the opportunity to change primary care physicians and dentists on an annual basis. The local agency shall notify an enrollee of this change option.

Subp. 7. **Enrollment changes without a hearing, substantial travel time.** An enrollee in a multiple health plan model may change a health plan and an enrollee in a primary care provider health plan model may change a primary care provider without a hearing if the travel time to the

enrollee's primary care provider is over 30 minutes from the enrollee's residence. The county shall notify the commissioner, in writing, prior to making a change under this subpart.

Subp. 8. **Enrollment changes without a hearing when agency error.** Upon an enrollee's request, the county shall change an enrollee's health plan or primary care physician or dentist without a hearing when the enrollee's health plan or primary care physician or dentist choice was incorrectly designated due to local agency error.

The county shall notify the commissioner, in writing, prior to making a change under this subpart.

Subp. 9. **Authorized representative.** A PMAP consumer may designate an authorized representative to act on the PMAP consumer's behalf in matters involving the PMAP.

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086*

**Published Electronically:** *October 16, 2013*

### 9500.1454 RECORDS.

A health plan shall maintain fiscal and medical records as required in part 9505.0205. A local agency shall comply with part 9505.0135 and maintain a list showing the enrollment choices of recipients who participate in the PMAP.

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086*

**Published Electronically:** *October 16, 2013*

### 9500.1455 THIRD-PARTY LIABILITY.

To the extent required under Minnesota Statutes, section 62A.046 and part 9505.0070, the health plan shall coordinate benefits for or recover the cost of medical care provided to its enrollees who have private health care or Medicare coverage. Coordination of benefits includes paying applicable co-payment or deductibles on behalf of an enrollee.

The health plan must comply with the claims settlement requirements under Minnesota Statutes, section 256B.69, subdivision 6, paragraph (b).

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086*

**Published Electronically:** *October 16, 2013*

**9500.1456** [Repealed, L 2014 c 291 art 10 s 14]

**Published Electronically:** *July 16, 2014*

## 9500.1457 SERVICES COVERED BY PMAP.

Subpart 1. **In general.** Services currently available under the medical assistance program in Minnesota Statutes, section 256B.0625 and parts 9505.0170 to 9505.0475 are covered under PMAP. Chemical dependency services provided under this part must fully comply with the requirements of parts 9530.4100 to 9530.6655. The following services are not covered:

A. case management services for serious and persistent mental illness as defined in Minnesota Statutes, section 256B.0625, subdivision 20;

B. nursing home facility per diem services as defined in Minnesota Statutes, section 256B.0625, subdivision 2, and parts 9549.0010 to 9549.0080; and

C. services provided under home-based and community-based waivers authorized under United States Code, title 42, section 1396.

Subp. 2. **Additional services.** A health plan may provide services in addition to those available under the medical assistance program.

Subp. 3. **Prior authorization of services.** A health plan shall be exempt from the requirements of Minnesota Statutes, chapter 256B, parts 9505.0170 to 9505.0475 and 9505.5000 to 9505.5030, that require prior authorization before providing health services to an enrollee.

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086*
**Published Electronically:** *October 16, 2013*

## 9500.1458 DATA PRIVACY.

Under Minnesota Statutes, section 13.46, subdivisions 1 and 2, a health plan under contract with the department is considered an agent of the department and shall have access to information on its enrollees to the extent necessary to carry out its responsibilities under the contract. The health plan must comply with Minnesota Statutes, chapter 13, the Minnesota Government Data Practices Act.

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086*
**Published Electronically:** *October 16, 2013*

## 9500.1459 CAPITATION POLICIES.

Subpart 1. **Rates.** On or before the tenth day of each month, the commissioner shall prepay each health plan the capitation rates specified in the contract between the health plan and the state. The capitation rates shall be developed in accordance with Minnesota Statutes, section 256B.69. The capitation rates established under this part, the rate methodology and the contracts with the health plan shall be made available to the public upon request. The rates established must be less

than the average per capita fee-for-service medical assistance costs for an actuarially equivalent population.

Subp. 2. [Repealed, 16 SR 1086]

Subp. 3. [Repealed, 16 SR 1086]

Subp. 4. [Repealed, 16 SR 1086]

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086*
**Published Electronically:** *October 16, 2013*

**9500.1460 ADDITIONAL REQUIREMENTS.**

Subpart 1. **Health plan requirements.** An organization that seeks to participate as a health plan under the PMAP shall meet the criteria in subparts 2 to 17.

Subp. 2. **Medical assistance populations covered.** A health plan may choose to serve the medical assistance population defined in part 9500.1452 or the aged medical assistance population exclusively.

Subp. 3. **Services provided.** A health plan shall provide its enrollees all health services eligible for medical assistance payment under Minnesota Statutes, section 256B.0625, and parts 9505.0170 to 9505.0475 except for services excluded in part 9500.1457, subpart 1, items A to C.

Subp. 4. **Prohibition against copayments.** A health plan shall not charge its enrollees for any health service eligible for medical assistance payment under parts 9505.0170 to 9505.0475 or for a medically necessary health service that is provided as a substitute for a health service eligible for medical assistance payment.

Subp. 5. **Plan organization.** A health plan may choose to organize itself as either a profit or not-for-profit organization.

Subp. 6. **Contractual arrangements.** A health plan shall contract with providers as necessary to meet the health service needs of its enrollees. Before contracting with the state, and on an annual basis after contracting with the state, the health plan shall give the commissioner a current list of the names and locations of the providers under contract with the health plan. These subcontracts shall be submitted to the commissioner upon request. The commissioner shall require a health plan to terminate a subcontract under the following conditions:

A. the subcontractor is terminated as a medical assistance provider under the provisions of parts 9505.2160 to 9505.2245;

B. the commissioner finds through the quality assurance review process contained in subpart 17 that the quality of services provided by the subcontractor is deficient in meeting the department's quality assurance standards and the subcontractor has failed to take action to correct the area of deficiency within 60 days; or

C. the subcontractor has failed to comply with the Department of Health licensure standards under Minnesota Statutes, chapter 62D.

Subp. 7. **Enrollment capacity.** A health plan shall accept all PMAP consumers who choose or are assigned to the health plan, regardless of the PMAP consumers' health conditions, if the PMAP consumers are from the medical assistance category or categories and the geographic area or areas specified in the contract between the health plan and the state. The commissioner shall limit the number of enrollees in the health plan upon the issuance of a contract termination notice under subpart 12.

Subp. 8. **Financial capacity.** A health plan shall demonstrate its financial risk capacity through a reserve fund or other mechanism agreed upon by the providers within the health plan in the contract with the department. A health plan that is licensed as a health maintenance organization under Minnesota Statutes, chapter 62D, or a nonprofit health plan licensed under Minnesota Statutes, chapter 62C, is not required to demonstrate a financial risk capacity beyond the financial risk capacity required to comply with the requirements of Minnesota Statutes, chapter 62C or 62D.

Subp. 9. **Insolvency.** A health plan must have a plan approved by the commissioner for transferring its enrollees to other sources of health services if the health plan becomes insolvent.

Subp. 10. **Limited number of contracts.** The commissioner may limit the number of health plan contracts in effect under PMAP.

Subp. 11. **Liability for payment for unauthorized services.** Except for emergency health services under Minnesota Statutes, section 256B.0625, subdivision 4, or unless otherwise specified in contract, a health plan shall not be liable for payment for unauthorized health services rendered by a nonparticipating provider. The department is not liable for payment for health services rendered by a nonparticipating provider.

Subp. 11a. **Liability for payment for authorized services rendered by a nonparticipating provider.** When a health plan or participating provider authorizes services for out-of-plan care, the health plan shall reimburse the nonparticipating provider for the out-of-plan care. The health plan is not required to reimburse the nonparticipating provider more than the comparable medical assistance fee for service rate, unless another rate is otherwise required by law. A nonparticipating provider shall not bill the PMAP enrollee for any portion of the cost of the authorized service.

Subp. 12. **Termination of participation as a health plan.** The state may terminate a contract upon 90 days' written notice to the health plan. When the state issues a contract termination notice, the health plan must notify its enrollees in writing at least 60 days before the termination.

Subp. 13. **Financial requirements placed on health plan.** Each health plan shall be accountable to the commissioner for the fiscal management of the health services it provides enrollees. The state and the health plan's enrollees shall be held harmless for the payment of obligations incurred by a health plan if the health plan or a participating provider becomes insolvent and if the state has made the payments due the health plan under part 9500.1459.

Subp. 14. **Required educational and enrollee materials.** When contracting with the state, a health plan must provide to the commissioner educational materials to be given to the medical

assistance population specified in the contract. The material should explain the services to be furnished to enrollees. No educational materials designed to solicit the enrollment of PMAP consumers shall be disseminated without the commissioner's prior approval.

When a person enrolls in the health plan, the health plan shall provide each enrollee with a certificate of coverage, a health plan identification card, a listing of plan providers, and a description of the health plan's complaint and appeal procedure.

According to Minnesota Statutes, section 256.016, any educational materials, new enrollee information, complaint and appeal information, or other enrollee materials must be understandable to a person who reads at the seventh grade level as determined by the Flesch readability scale index defined in Minnesota Statutes, section 72C.09.

Subp. 15. **Required case management system.** A health plan shall implement a system of case management in which an enrollee's individual medical needs are assessed to determine the appropriate plan of care. The individual plan of care shall be developed, implemented, evaluated, monitored, revised, and coordinated with other health care providers, as appropriate and necessary.

Subp. 16. **Required submission of information.** The contract between the state and the health plan shall specify the information the health plan shall submit to the commissioner and the Centers for Medicare and Medicaid Services, and the form in which the information shall be submitted. The information submitted must enable the commissioner to make the calculations required under part 9500.1459 and to carry out the requirements of parts 9505.2160 to 9505.2245 and the Centers for Medicare and Medicaid Services. A health plan shall make the required information available to the commissioner at times specified in the contract or, if the commissioner requires additional information for the purposes in this subpart, within 30 days of the date of the commissioner's written request for the additional information.

Subp. 17. **Required quality assurance system.** Each health plan shall have an internal quality assurance system in operation that meets the requirements of title XIX of the Social Security Act. This quality assurance system shall encompass an ongoing review of:

A. use of services;

B. case review of all problem cases and a random sample of all cases, including review of medical records and an assessment of medical care provided in each case;

C. enrollee complaints and the disposition of the complaints; and

D. enrollee satisfaction, as monitored through an annual survey.

Based on the results of the review, the health plan shall develop an appropriate corrective action plan and monitor the effectiveness of the corrective action or actions taken.

The health plan shall permit the commissioner and United States Department of Health and Human Services or their agents to evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed under its contract with the commissioner. If the commissioner or Department of Health and Human Services finds that the quality of services

offered by the health plan is deficient in any area, and, after giving the health plan at least 60 days in which to correct the deficiency, the health plan has failed to take action to correct the area of deficiency, the commissioner shall withhold all or part of the health plan's capitation premiums until the deficiency identified under subpart 6 is corrected to the satisfaction of the commissioner or the Department of Health and Human Services.

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086; L 2002 c 277 s 32*
**Published Electronically:** *October 16, 2013*

## 9500.1462 SECOND MEDICAL OPINION.

A health plan must indicate in the certificate of coverage that enrollees have a right to a second medical opinion according to items A to C.

A. A health plan must provide, at its expense, a second medical opinion within the health plan upon enrollee request.

B. According to Minnesota Statutes, section 62D.103, a health plan is required to provide a second medical opinion by a qualified nonparticipating provider when it determines that an enrollee's chemical dependency or mental health problem does not require structured treatment.

C. According to Minnesota Statutes, section 256.045, subdivision 3a, paragraph (b), a health plan must provide, at its expense, a second medical opinion by a participating provider or nonparticipating provider when ordered by a state human services referee.

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086*
**Published Electronically:** *October 16, 2013*

## 9500.1463 COMPLAINT AND APPEAL PROCEDURES.

Subpart 1. [Repealed, 16 SR 1086]

Subp. 2. [Repealed, 16 SR 1086]

Subp. 3. **Health plan complaint procedure.** A health plan shall have a written procedure for reviewing enrollee complaints. This complaint procedure must be approved by the commissioner. The complaint procedure must include both an informal process, in which a determination is made within ten calendar days after the date a health plan receives a verbal complaint, and a formal process to handle written complaints. The formal process shall provide for an impartial hearing containing the elements in items A to D.

A. A person or persons with authority to resolve the case shall be designated to hear the complaint.

B. The enrollee has the right to be represented at the hearing by a representative of his or her choice, including legal counsel.

C. The enrollee and the health plan may call witnesses to provide relevant testimony.

D. A determination shall be made and written notice of the decision shall be issued to the enrollee within 30 days after the date the written complaint is received by the health plan. The written notice shall include notice of the enrollee's right to appeal to the state.

Each health plan shall provide its enrollees with a written description of the health plan's complaint procedure and the state's appeal procedure at the time of enrollment. The written description shall clearly state that exhaustion of the health plan's complaint procedure is not required before appealing to the state. The health plan's complaint procedure and revisions to the complaint procedure must be approved by the commissioner. Approved revisions in the health plan's complaint procedure must be communicated, in writing, to its enrollees at least two weeks before the revisions are implemented.

Subp. 4. **Health plan notice requirements.** When a health plan denies, reduces, or terminates a health service, it must notify the enrollee or the enrollee's authorized representative in writing of the right to file a complaint or appeal according to Minnesota Statutes, section 256.045, subdivision 3. The notice must explain:

A. the right to a second opinion within the plan;

B. how to file a complaint;

C. how to file a state appeal, including the name and telephone number of the state ombudsperson;

D. the circumstances under which health services may be continued pending an appeal; and

E. the right to request an expedited hearing under Minnesota Statutes, section 256.045, subdivision 3a, paragraph (c).

For purposes of this subpart, a health plan does not include the treating physician, second opinion physician, or other treating health care professional whether employed by, or contracting with, the health plan.

Subp. 5. **State appeal procedure.** An enrollee may appeal the refusal to change a health plan or primary care provider under part 9500.1453, subparts 7 and 8, a health plan's or participating provider's denial, delay, reduction, or termination of health services or a health plan's resolution of a complaint or any other ruling of a prepaid health plan by submitting a written request for a hearing as provided in Minnesota Statutes, section 256.045, subdivision 3. The enrollee may request an expedited hearing by contacting the appeals referee or ombudsperson. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner. An enrollee is not required to exhaust the health plan's complaint system before filing a state appeal. An enrollee may request the assistance of the ombudsperson or other persons in the appeal process.

Subp. 6. **Services pending state appeal or resolution of complaint.** If an enrollee files a written complaint with the health plan or appeals in writing to the state under Minnesota Statutes,

section 256.045, on or before the tenth day after the decision is communicated to the enrollee by the health plan to reduce, suspend, or terminate services the enrollee had been receiving on an ongoing basis, or before the date of the proposed action, whichever is later, and the treating plan physician or another plan physician has ordered the services at the present level and is authorized by the contract with the health plan to order the services, the health plan must continue to provide services at a level equal to the level ordered by the plan physician until written resolution of the complaint is made by the health plan or a decision on the appeal is made by the human services referee. If the resolution is adverse, in whole or part, to the enrollee, the enrollee must be notified of the right to a state appeal. If the enrollee appeals a health plan's written resolution within ten days after it is issued, or before the date of the proposed action, whichever is later, services must be continued pending a decision by the human services referee. A resolution is made or issued on the date it is mailed or the date postmarked, whichever is later. For the purposes of this subpart, "plan physician," where appropriate, includes a plan dentist, mental health professional, chiropractor, or osteopathic physician, nurse practitioner, or nurse midwife.

Subp. 7. **State ombudsperson.** The commissioner shall designate a state ombudsperson to help enrollees resolve health plan service related problems. Upon an enrollee's request, the ombudsperson shall investigate the enrollee's case and when appropriate attempt to resolve the problem in an informal manner by serving as an intermediary between the enrollee and the health plan. If the enrollee requests appeal information, or if the ombudsperson believes that an informal resolution is not feasible or is unable to obtain a resolution of the problem, the ombudsperson shall explain to the enrollee what his or her complaint and appeal options are, how to file a complaint or appeal, how the complaint or appeal process works and assist the enrollee in presenting the enrollee's case to the appeals referee, when requested. The ombudsperson must be available to help the enrollee file a written complaint or appeal request. The ombudsperson must notify the appropriate health plan of a state appeal within three working days after the state appeal is filed.

Subp. 8. **Record keeping and reporting requirements.** The health plan must maintain a record of all written complaints from enrollees, actions taken in response to those complaints, and the final disposition of the complaints. The health plan must report this information to the commissioner on a semiannual basis.

**Statutory Authority:** *MS s 256.045; 256B.031; 256B.69*

**History:** *11 SR 1107; 16 SR 1086; 32 SR 565; L 2016 c 119 s 7*

**Published Electronically:** *September 12, 2016*

## 9500.1464 SURVEILLANCE AND UTILIZATION REVIEW.

The provisions of parts 9505.2160 to 9505.2245 apply to MAPDP.

**Statutory Authority:** *MS s 256B.69*

**History:** *11 SR 1107*

**Published Electronically:** *October 16, 2013*

## COMMISSIONER'S CONSENT TO PATERNITY SUIT SETTLEMENTS

### 9500.1650 APPLICABILITY.

Parts 9500.1650 to 9500.1663 govern the procedures and the standards applicable to the way in which the commissioner decides, as a party under Minnesota Statutes, section 257.60, whether to agree to a particular lump-sum settlement or compromise agreement in a paternity action under Minnesota Statutes, sections 257.51 to 257.74. Parts 9500.1650 to 9500.1663 apply equally to lump-sum settlements and compromise agreements proposed as part of a maternity suit under Minnesota Statutes, section 257.71.

**Statutory Authority:** *MS s 257.60*

**History:** *11 SR 957*

**Published Electronically:** *October 16, 2013*

### 9500.1655 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 9500.1650 to 9500.1663, the following terms have the meanings given to them in this part.

Subp. 2. **Admission of paternity.** "Admission of paternity" means a written acknowledgment by a male that he is the biological father of a child.

Subp. 3. [Repealed, 32 SR 565]

Subp. 4. **Alleged father.** "Alleged father" means a male alleged to be the biological father of a child.

Subp. 5. **Blood test.** "Blood test" means a test using blood group identification of a mother, child, and alleged father that is used to predict the probability or exclude the possibility that the alleged father is the biological father of the child.

Subp. 6. **Child.** "Child" means an individual under age 18 whose parental relationship with the alleged father is being determined and whose legal rights and privileges are at issue.

Subp. 7. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subp. 8. **Compromise agreement.** "Compromise agreement" has the meaning given it by Minnesota Statutes, section 257.64, subdivision 1, clause (b).

Subp. 9. **Costs.** "Costs" has the meaning given it under Minnesota Statutes, section 257.69.

Subp. 10. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 11. **Depository.** "Depository" means a person or organization entrusted to safekeep a father's or an alleged father's lump-sum settlement or compromise agreement payments and to make periodic payments of the money on behalf of the child.

Subp. 12. **Guardian ad litem.** "Guardian ad litem" means the person designated by the court to represent the interests of a child in a paternity suit, according to Minnesota Statutes, section 257.60.

Subp. 13. **Income.** "Income" has the meaning given it under Minnesota Statutes 2004, section 518.54, subdivision 6.

Subp. 14. **Interest rate.** "Interest rate" means the rate of interest used to calculate the present value of periodic payments a father is required to pay and is equal to the current market rate of interest on a United States Treasury obligation using as its maturity date the child's 18th birthday.

Subp. 15. **Liability for past support.** "Liability for past support" means the financial obligation of the noncustodial parent to reimburse the local child support enforcement agency for all or a portion of past expenses furnished on behalf of a child under Minnesota Statutes, sections 257.66 and 257.67.

Subp. 16. **Local IV-D agency.** "Local IV-D agency" means the county or multicounty agency that is authorized under Minnesota Statutes, section 393.07, to administer the child support enforcement program under the requirements of title IV-D of the Social Security Act, United States Code, title 42, sections 651 to 658, 660, 664, 666, 667, 1302, 1396(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396(k).

Subp. 17. **Lump-sum settlement.** "Lump-sum settlement" means a single payment to satisfy the remaining obligations of a noncustodial parent for support of the parent's minor child.

Subp. 18. **Medical support.** "Medical support" has the meaning given it under Minnesota Statutes, section 518A.41.

Subp. 19. **Mother.** "Mother" means a woman who was not married to her child's father when the child was born or when the child was conceived.

Subp. 20. **Office of Child Support Enforcement.** "Office of Child Support Enforcement" means the office within the department that administers the child support enforcement program for the purposes of locating absent parents, establishing paternity, and establishing and enforcing orders for support under the requirements of title IV-D of the Social Security Act, United States Code, title 42, sections 651 to 658, 660, 664, 666, 667, 1302, 1396(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396(k).

Subp. 21. **Party.** "Party" means a person as defined in Minnesota Statutes, sections 257.57 and 257.60, who is involved in a paternity suit.

Subp. 22. **Paternity suit.** "Paternity suit" means a legal action brought to establish that a man is the biological father of a child and has legally enforceable duties and responsibilities in regard to that child.

Subp. 23. **Periodic payments.** "Periodic payments" means payments of support on a schedule established by the court under Minnesota Statutes, section 518A.44.

Subp. 24. **Present value.** "Present value" means the current monetary worth of future periodic payments. The formula used to determine present value is $An = V\ 1-(1+i)^{-n}/i$ where:

"An" means present value of the periodic payments,

"V" means value of the periodic payments,

"n" means number of periodic payments, and

"i" means interest rate.

Subp. 24a. **Public assistance.** "Public assistance" has the meaning given in Minnesota Statutes, section 256.741, subdivision 1, paragraph (b).

Subp. 25. **Reimbursement.** "Reimbursement" means payment of a sum for public funds expended for the care and support of a child under Minnesota Statutes, sections 256.87; 257.66, subdivisions 3 and 4; 257.69; and 393.07, subdivision 9.

Subp. 26. **Support.** "Support" has the meaning given to "support money" under Minnesota Statutes, section 518A.26, subdivision 20.

**Statutory Authority:** *MS s 257.60*

**History:** *11 SR 957; L 2005 c 164 s 29; L 2005 1Sp7 s 28; L 2006 c 280 s 46; 32 SR 565*
**Published Electronically:** *October 16, 2013*

## 9500.1656 CONSENT BY COMMISSIONER TO A COMPROMISE AGREEMENT.

The commissioner shall not consent to a compromise agreement.

**Statutory Authority:** *MS s 257.60*

**History:** *11 SR 957*
**Published Electronically:** *October 16, 2013*

## 9500.1657 COMMISSIONER'S CONSENT TO A LUMP-SUM SETTLEMENT.

The commissioner shall consider each proposed lump-sum settlement that is submitted to the commissioner. If a submitted proposed lump-sum settlement does not comply with parts 9500.1650 to 9500.1663, the commissioner shall not consent to the proposed lump-sum settlement.

**Statutory Authority:** *MS s 257.60*

**History:** *11 SR 957*
**Published Electronically:** *October 16, 2013*

## 9500.1658 STANDARDS USED BY COMMISSIONER TO DETERMINE WHETHER TO CONSENT TO A PROPOSED LUMP-SUM SETTLEMENT.

Subpart 1. **Standards.** The commissioner shall consent to a proposed lump-sum settlement only if the conditions of subparts 1a to 6 are met.

Subp. 1a. **Parties.** Under Minnesota Statutes, section 257.60, when the child is a minor, the child and the commissioner must be made parties to the action. The court must appoint a general guardian or a guardian ad litem to represent the child.

Subp. 2. **Admission of paternity.** The alleged father must admit paternity and either waive blood tests or the results of blood tests indicate a likelihood of more than 92 percent that the alleged father is the biological father of the child.

Subp. 3. **Comparison of proposed lump-sum settlement to present value of periodic payments.** The proposed lump-sum settlement must be equal to or greater than the present value of periodic payments.

Subp. 4. **Liability for past support and costs.** A provision must be made for a partial or full reimbursement consisting of the alleged father's liability for past support and costs. The alleged father's liability for past support and costs includes:

A. all or a proportion of the amount of assistance furnished the child during the two years immediately preceding the start of the paternity action under Minnesota Statutes, section 257.66, subdivision 4;

B. expenses of the mother's pregnancy and confinement under Minnesota Statutes, section 257.66, subdivision 3; and

C. all or a proportion of costs and fees detailed under Minnesota Statutes, section 257.69, subdivision 2.

If a reimbursement is to be made through payments to the local IV-D agency, provisions for income withholding shall be included in the proposed lump-sum settlement agreement under Minnesota Statutes, section 518A.53.

Subp. 5. **Protection over lump-sum settlement amount.** A plan to invest the lump-sum settlement to meet the child's future needs and to prevent rapid depletion of the lump-sum settlement must be made part of the lump-sum settlement. The plan to invest the lump-sum settlement must include:

A. an agreement to deposit the lump-sum settlement amount in an interest bearing account with a rate of interest based on a United States Treasury obligation that matures on the date of the child's 18th birthday;

B. provisions for making periodic payments to the child until the child is 18 years of age;

C. provisions for making the periodic payments under item B to the public agency, if the child receives public assistance or becomes eligible to receive public assistance and rights to support are assigned under Minnesota Statutes, section 256.741;

D. the name of the depository that will hold and disburse the lump-sum settlement under this subpart;

E. the name of the person or agency designated to make decisions on managing the lump-sum settlement account; and

F. the amounts charged by the depository for the costs of administering the lump-sum settlement account.

Subp. 6. **Medical benefits.** The lump-sum settlement must provide for maintenance of health and dental insurance for the child under Minnesota Statutes, section 518A.41.

**Statutory Authority:** *MS s 257.60*

**History:** *11 SR 957; L 1997 c 203 art 6 s 92; L 2005 c 164 s 29; L 2005 1Sp7 s 28; L 2006 c 280 s 46; 32 SR 565*

**Published Electronically:** *October 16, 2013*

## 9500.1659 CONTENTS OF PROPOSED LUMP-SUM SETTLEMENT AGREEMENT.

A proposed lump-sum settlement must include:

A. the names and addresses of the parties to the paternity suit;

B. a statement indicating whether there has been an admission of paternity;

C. the amount of reimbursement agreed to be paid to the local IV-D agency and the method by which payments will be made as required under part 9500.1658, subpart 4;

D. the amount of the proposed lump-sum settlement;

E. a plan for distributing the lump-sum settlement amount on behalf of the child under part 9500.1658, subpart 5;

F. a written statement showing compliance with part 9500.1658, subpart 6, by the responsible parent; and

G. a signature line for each of the parties and the guardian ad litem.

**Statutory Authority:** *MS s 257.60*

**History:** *11 SR 957*

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## 9500.1660 DOCUMENTS THAT MUST ACCOMPANY A PROPOSED LUMP-SUM SETTLEMENT AGREEMENT.

The documents in items A to G must accompany the proposed lump-sum settlement submitted to the commissioner:

A. the statement of blood test results or a statement that blood tests were waived by the alleged father;

B. a statement of the reasons a lump-sum settlement is proposed rather than periodic payments;

C. a copy of the alleged father's affidavit of earnings, income, and resources, including real and personal property;

D. the mathematical calculation used to make the computation required under part 9500.1658, subpart 3;

E. an itemization of amounts previously expended by each public agency as support on behalf of the child, including dates and amounts of public assistance expended, pregnancy and confinement expenses, costs of blood tests, filing fees, service of process fees, and county attorney's fees;

F. a written statement showing how the plan for reimbursement of the alleged father's liability for support and costs owed to the local IV-D agency was derived; and

G. a written, signed statement from the guardian ad litem that indicates how the proposed lump-sum settlement is in the best interest of the child.

**Statutory Authority:** *MS s 257.60*

**History:** *11 SR 957; 32 SR 565*
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### 9500.1661 TIME FOR SUBMISSION OF PROPOSAL.

The proposed lump-sum settlement agreement under part 9500.1659 and documents required under part 9500.1660 must be submitted to the Office of Child Support Enforcement for review at least 30 days before the date scheduled for the court hearing on the proposed lump-sum settlement. If the 30-day period is not complied with, parties must not presume that the commissioner has consented to the proposed lump-sum settlement unless a written statement to that effect is made by the commissioner and submitted to the parties.

**Statutory Authority:** *MS s 257.60*

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### 9500.1662 REVIEW PROCESS.

On receipt of a proposed lump-sum settlement, the commissioner shall review the submitted proposal and documents for compliance with parts 9500.1650 to 9500.1663. If the commissioner consents to the proposal, the commissioner will sign the proposal and return it to the submitting party. If the commissioner does not consent to the proposal, the commissioner will send a letter to the submitting party indicating the reasons for not consenting to the proposal. The commissioner will send copies of either response to the court of jurisdiction. The commissioner will also send copies of either response to the other parties and guardian ad litem if addresses for those parties are provided by the submitting party.

**Statutory Authority:** *MS s 257.60*

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### 9500.1663 NOTIFICATION OF FINAL DISPOSITION.

If the lump-sum settlement or compromise agreement is approved by the court, a copy of the final order must be provided to the commissioner within 30 days of the date of the court order. If the submitted agreement is not approved by the court, the commissioner must be notified in writing of any other disposition made regarding the paternity suit. The parties other than the commissioner must agree between themselves as to the party responsible for notification to the commissioner in accordance with this part.

**Statutory Authority:** *MS s 257.60*

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Subp. 5. [Repealed, L 1999 c 159 s 154]

Subp. 6. [Repealed, L 1999 c 159 s 154]

Subp. 7. [Repealed, L 1999 c 159 s 154]

Subp. 8. [Repealed, L 1999 c 159 s 154]

Subp. 9. [Repealed, L 1999 c 159 s 154]

Subp. 10. [Repealed, L 1999 c 159 s 154]

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