CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

256B.01 POLICY.

Medical assistance for needy persons whose resources are not adequate to meet the cost of such care is hereby declared to be a matter of state concern. To provide such care, a statewide program of medical assistance, with free choice of vendor, is hereby established.

History: *Ex1967 c 16 s 1*

256B.011 POLICY FOR CHILDBIRTH AND ABORTION FUNDING.

Between normal childbirth and abortion it is the policy of the state of Minnesota that normal childbirth is to be given preference, encouragement and support by law and by state action, it being in the best interests of the well being and common good of Minnesota citizens.

History: *1978 c 508 s 1*

256B.02 DEFINITIONS.

Subdivision 1. "Reside" means to have an established place of abode in one state or county and not to have an established place of abode in another state or county.

Subd. 2. "Excluded time" means any period of time an applicant spends in a hospital, sanatorium, nursing home, or other institution for the hospitalization or care of human beings, as defined in sections 144.50 or 144A.01.

Subd. 3. "County of financial responsibility" means the county in which the applicant resides at the time of making application.

Subd. 4. "Medical institution" means any licensed medical facility that receives a license from the Minnesota health department or department of public

welfare or appropriate licensing authority of this state, any other state, or a Canadian province.

Subd. 5. "State agency" means the commissioner of public welfare.

Subd. 6. "County agency" means a county welfare board operating under and pursuant to the provisions of chapter 393.

Subd. 7. "Vendor of medical care" means any person or persons furnishing, within the scope of his respective license, any or all of the following goods or services: medical, surgical, hospital, optical, visual, dental and nursing services; drugs and medical supplies; appliances; laboratory, diagnostic, and therapeutic services; nursing home and convalescent care; screening and health assessment services provided by public health nurses; health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided; and such other medical services or supplies provided or prescribed by persons authorized by state law to give such services and supplies.

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

(1) Inpatient hospital services.

(2) Skilled nursing home services and services of intermediate care facilities.

(3) Physicians' services.

(4) Outpatient hospital or clinic services.

(5) Home health care services.

(6) Private duty nursing services.

(7) Physical therapy and related services.

(8) Dental services, excluding cast metal restorations.

(9) Laboratory and x-ray services.

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

formulary is established. The commissioner may promulgate conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

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

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

(11) Diagnostic, screening, and preventive services.

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

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

(a) The abortion is a medical necessity. "Medical necessity" means (1) the signed written statement of two physicians indicating the abortion is medically necessary to prevent the death of the mother, and (2) the patient has given her consent to the abortion in writing unless the patient is physically or legally incapable of providing informed consent to the procedure, in which case consent will be given as otherwise provided by law;

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

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

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

(15) To the extent authorized by rule of the state agency, costs of bus or taxicab transportation incurred by any ambulatory eligible person for obtaining non-emergency medical care.

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

Subd. 9. "Private health care coverage" means any plan regulated by chapters 62A, 62C or 64A. Private health care coverage also includes any self-insurance plan providing health care benefits.

Subd. 10. "Automobile accident coverage" means any plan, or that portion of a plan, regulated under chapter 65B, which provides benefits for medical expenses incurred in an automobile accident.

History: *Ex1967 c 16 s 2; 1969 c 395 s 1; 1973 c 717 s 17; 1975 c 247 s 9; 1975 c 384 s 1; 1975 c 437 art 2 s 3; 1976 c 173 s 56; 1976 c 236 s 1; 1976 c 312 s 1; 1978 c 508 s 2; 1978 c 560 s 10; 1981 c 360 art 2 s 26; 1Sp1981 c 2 s 12; 3Sp1981 c 2 art 1 s 31; 1982 c 562 s 2*

NOTE: The amendments to subdivision 8 by Laws 1981, Chapter 360, Article 2, Section 26 are repealed by Laws 1981, Chapter 360, Article 2, Section 54, as amended by First Special Session Laws 1981, Chapter 4, Article 4, Section 22, effective June 30, 1983.

256B.03 PAYMENTS TO VENDORS.

Subdivision 1. **General limit.** All payments for medical assistance hereunder must be made to the vendor.

Subd. 2. **Limit on annual increase to long-term care providers.** Notwithstanding the provisions of sections 256B.42 to 256B.48, Laws 1981, Chapter 360, Article II, Section 2, or any other provision of chapter 360, and rules promulgated under those sections, rates paid to a skilled nursing facility or an intermediate care facility, including boarding care facilities and supervised living facilities, except state owned and operated facilities, for rate years beginning during the biennium ending June 30, 1983, shall not exceed by more than ten percent the final rate allowed to the facility for the preceding rate year.

Notwithstanding provisions of section 256B.45, subdivision 1, the commissioner shall not increase the percentage for investment allowances.

History: *Ex1967 c 16 s 3; 1981 c 360 art 2 s 27; 1Sp1981 c 2 s 13*

NOTE: The amendment to this section by Laws 1981, Chapter 360, Article 2, Section 27 is repealed by Laws 1981, Chapter 360, Article 2, Section 54, as amended by First Special Session Laws 1981, Chapter 4, Article 4, Section 22 effective June 30, 1983.

256B.04 DUTIES OF STATE AGENCY.

Subdivision 1. The state agency shall: Supervise the administration of medical assistance for eligible recipients by the county agencies hereunder.

Subd. 2. Make uniform rules and regulations, not inconsistent with law, for carrying out and enforcing the provisions hereof in an efficient, economical, and impartial manner, and to the end that the medical assistance system may be administered uniformly throughout the state, having regard for varying costs of medical care in different parts of the state and the conditions in each case, and in all things to carry out the spirit and purpose of this program, which rules and regulations shall be made with the approval of the attorney general on form and legality, shall be furnished immediately to all county agencies, and shall be binding on such county agencies.

Subd. 3. Prescribe the form of, print, and supply to the county agencies, blanks for applications, reports, affidavits, and such other forms as it may deem necessary or advisable.

Subd. 4. Cooperate with the federal department of health, education, and welfare in any reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program, including the making of such reports in such form and containing such information as the department of health, education, and welfare may, from time to time, require, and comply with such provisions as such department may, from time to time, find necessary to assure the correctness and verifications of such reports.

Subd. 5. The state agency within 60 days after the close of each fiscal year, shall prepare and print for the fiscal year a report that includes a full account of the operations and expenditure of funds under this chapter, a full account of the activities undertaken in accordance with subdivision 10, adequate and complete

statistics divided by counties about all medical assistance provided in accordance with this chapter, and any other information it may deem advisable.

Subd. 6. Prepare and release a summary statement monthly showing by counties the amount paid hereunder and the total number of persons assisted.

Subd. 7. Establish and enforce safeguards to prevent unauthorized disclosure or improper use of the information contained in applications, reports of investigations and medical examinations, and correspondence in the individual case records of recipients of medical assistance.

Subd. 8. Furnish information to acquaint needy persons and the public generally with the plan for medical assistance of this state.

Subd. 9. Cooperate with agencies in other states in establishing reciprocal agreements to provide for payment of medical assistance to recipients who have moved to another state, consistent with the provisions hereof and of Title XIX of the Social Security Act of the United States of America.

Subd. 10. Establish by rule general criteria and procedures for the identification and prompt investigation of suspected medical assistance fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by a vendor of medical care, and for the imposition of sanctions against a vendor of medical care. If it appears to the state agency that a vendor of medical care may have acted in a manner warranting civil or criminal proceedings, it shall so inform the attorney general in writing.

Subd. 11. Report at least quarterly to the legislative auditor on its activities under subdivision 10 and include in each report copies of any notices sent during that quarter to the attorney general to the effect that a vendor of medical care may have acted in a manner warranting civil or criminal proceedings.

Subd. 12. Place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an individual recipient, and the amount paid for each covered service. The state agency shall promulgate rules, including temporary rules, establishing maximum reimbursement rates for emergency and non-emergency transportation.

The rules shall provide:

(a) An opportunity for all recognized transportation providers to be reimbursed for non-emergency transportation consistent with the maximum rates established by the agency;

(b) Reimbursement of public and private nonprofit providers serving the handicapped population generally at reasonable maximum rates that reflect the cost of providing the service regardless of the fare that might be charged by the provider for similar services to individuals other than those receiving medical assistance or medical care under this chapter; and

(c) Reimbursement for each additional passenger carried on a single trip at a substantially lower rate than the first passenger carried on that trip.

The commissioner shall encourage providers reimbursed under this chapter to coordinate their operation with similar services that are operating in the same community. To the extent practicable, the commissioner shall encourage eligible individuals to utilize less expensive providers capable of serving their needs.

For the purpose of this subdivision and section 256B.02, subdivision 8, and effective on January 1, 1981, "recognized provider of transportation services" means an operator of special transportation service as defined in section 174.29 that has been issued a current certificate of compliance with operating standards of the commissioner of transportation or, if those standards do not apply to the operator, that the agency finds is able to provide the required transportation in a

safe and reliable manner. Until January 1, 1981, "recognized transportation provider" includes an operator of special transportation service that the agency finds is able to provide the required transportation in a safe and reliable manner.

Subd. 13. Each person appointed by the commissioner to participate in decisions whether medical care to be provided to eligible recipients is medically necessary shall abstain from participation in those cases in which he (a) has issued treatment orders in the care of the patient or participated in the formulation or execution of the patient's treatment plan or (b) has, or a member of his family has, an ownership interest of five percent or more in the institution that provided or proposed to provide the services being reviewed.

Subd. 14. **Competitive bidding.** The commissioner shall utilize volume purchase through competitive bidding under the provisions of chapter 16, to provide the following items:

(1) Eyeglasses;

(2) Hearing aids and supplies; and

(3) Durable medical equipment, including but not limited to:

(a) hospital beds;

(b) commodes;

(c) glide-about chairs;

(d) patient lift apparatus;

(e) wheelchairs and accessories;

(f) oxygen administration equipment;

(g) respiratory therapy equipment; and

(h) electronic diagnostic, therapeutic and life support systems.

History: *Ex1967 c 16 s 4; 1976 c 273 s 1-3; 1977 c 185 s 1; 1977 c 347 s 39,40; 1978 c 560 s 11; Ex1979 c 1 s 46; 1980 c 349 s 3,4; 1982 c 640 s 3*

256B.041 CENTRALIZED DISBURSEMENT OF MEDICAL ASSISTANCE PAYMENTS.

Subdivision 1. The state agency shall establish on a statewide basis a system for the centralized disbursement of medical assistance payments to vendors.

Subd. 2. An account is established in the state treasury from which medical assistance payments to vendors shall be made. Into such account there shall be deposited federal funds, state funds, and other moneys which are available and which may be paid to the state agency for medical assistance payments and reimbursements from counties or others for their share of such payments.

Subd. 3. The state agency shall prescribe and furnish vendors suitable forms for submitting claims under the medical assistance program.

Subd. 4. The state agency in establishing a statewide system of centralized disbursement of medical assistance payments shall comply with federal requirements in order to receive the maximum amount of federal funds which are available for the purpose, together with such additional federal funds which may be made available for the operation of a centralized system of disbursement of medical assistance payments to vendors.

Subd. 5. If required by federal law or rules promulgated thereunder, or by authorized regulation of the state agency, each county shall pay to the state treasurer the portion of medical assistance paid by the state for which it is responsible. The county's share of cost shall be ten percent of that portion not met by federal funds.

Subd. 6. The commissioners of public welfare and administration may contract with any agency of government or any corporation for providing all or a

portion of the services for carrying out the provisions of this section. Local welfare agencies may pay vendors of transportation for non-emergency medical care when so authorized by rule of the commissioner of public welfare.

Subd. 7. Federal funds available for administrative purposes shall be distributed between the state and the county on the same basis that reimbursements are earned.

History: *1973 c 717 s 2; 1975 c 437 art 2 s 4; 1978 c 560 s 12*

256B.042 THIRD PARTY LIABILITY.

Subdivision 1. When the state agency provides, pays for or becomes liable for medical care, it shall have a lien for the cost of the care upon any and all causes of action which accrue to the person to whom the care was furnished, or to his legal representatives, as a result of the injuries which necessitated the medical care.

Subd. 2. The state agency may perfect and enforce its lien by following the procedures set forth in sections 514.69, 514.70 and 514.71, except that it shall have one year from the date when the last item of medical care was furnished in which to file its verified lien statement, and the statement shall be filed with the appropriate clerk of court in the county of financial responsibility. The verified lien statement shall contain the following: the name and address of the person to whom medical care was furnished, the date of injury, the name and address of the vendor or vendors furnishing medical care, the dates of the service, the amount claimed to be due for the care, and, to the best of the state agency's knowledge, the names and addresses of all persons, firms or corporations claimed to be liable for damages arising from the injuries. This section shall not affect the priority of any attorney's lien.

Subd. 3. To recover under this section the attorney general, or the appropriate county attorney acting at the direction of the attorney general, shall represent the state agency.

History: *1975 c 247 s 6; 1976 c 236 s 2*

256B.05 ADMINISTRATION BY COUNTY AGENCIES.

Subdivision 1. The county agencies shall administer medical assistance in their respective counties under the supervision of the state agency and shall make such reports, prepare such statistics, and keep such records and accounts in relation to medical assistance as the state agency may require.

Subd. 2. In administering the medical assistance program, no county welfare department shall pay a fee or charge for medical, dental, surgical, hospital, nursing, licensed nursing home care, medicine, or medical supplies in excess of the schedules of maximum fees and charges as established by the state agency.

Subd. 3. Notwithstanding the provisions of subdivision 2, the commissioner of public welfare shall establish a schedule of maximum allowances to be paid by the state on behalf of recipients of medical assistance toward fees charged for services rendered such medical assistance recipients.

History: *Ex1967 c 16 s 5; 1971 c 961 s 28; 1982 c 640 s 4*

256B.06 ELIGIBILITY REQUIREMENTS.

Subdivision 1. Medical assistance may be paid for any person:

(1) Who is a child eligible for or receiving adoption assistance payments under Title IV-E of the Social Security Act, 42 U.S.C. Sections 670 to 676; or

(2) Who is a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, 42 U.S.C. Sections 670 to 676; or

(3) Who is eligible for or receiving public assistance, or a woman who is pregnant, as medically verified, and who would be eligible for assistance under the aid to families with dependent children program if the child had been born and living with the woman; or

(4) Who is eligible for or receiving supplemental security income for the aged, blind and disabled; or

(5) Who except for the amount of income or resources would qualify for supplemental security income for the aged, blind and disabled, or aid to families with dependent children and is in need of medical assistance; or

(6) Who is under 21 years of age and in need of medical care that neither he nor his relatives responsible under sections 256B.01 to 256B.26 are financially able to provide; or

(7) Who is residing in a hospital for treatment of mental disease or tuberculosis and is 65 years of age or older and without means sufficient to pay the per capita hospital charge; and

(8) Who resides in Minnesota, or, if absent from the state, is deemed to be a resident of Minnesota in accordance with the regulations of the state agency; and

(9) Who alone, or together with his spouse, does not own real property other than the homestead. For the purposes of this section, "homestead" means the house owned and occupied by the applicant as his dwelling place, together with the land upon which it is situated and an area no greater than two contiguous lots in a platted or laid out city or town or 80 contiguous acres in unplatted land. Occupancy or exemption shall be determined as provided in chapter 510 and applicable law, including continuing exemption by filing notice under section 510.07. Real estate not used as a home may not be retained unless it produces net income applicable to the family's needs or the family is making a continuing effort to sell it at a fair and reasonable price or unless sale of the real estate would net an insignificant amount of income applicable to the family's needs, or unless the commissioner determines that sale of the real estate would cause undue hardship; and

(10) Who individually does not own more than $2,000 in cash or liquid assets, or if a member of a household with two family members (husband and wife, or parent and child), does not own more than $4,000 in cash or liquid assets, plus $200 for each additional legal dependent. The value of the following shall not be included:

(a) the homestead, and (b) one motor vehicle licensed pursuant to chapter 168 and defined as: (1) passenger automobile, (2) station wagon, (3) motorcycle, (4) motorized bicycle or (5) truck of the weight found in categories A to E, of section 168.013, subdivision 1e; and

(11) Who has or anticipates receiving an annual income not in excess of $2,600 for a single person, or $3,250 for two family members (husband and wife, parent and child, or two siblings), plus $625 for each additional legal dependent, or who has income in excess of these maxima and in the month of application, or during the three months prior to the month of application, incurs expenses for medical care that total more than one-half of the annual excess income in accordance with the regulations of the state agency. In computing income to determine eligibility of persons who are not residents of long term care facilities, the commissioner shall disregard increases in income of social security or supplementary security income recipients due solely to increases required by sections 215(i) and 1617 of the social security act, and shall disregard income of disabled persons that is also disregarded in determining eligibility for supplemental aid under section 256D.37, subdivision 1, unless prohibited by federal law or regulation. If prohibited, the commissioner shall first seek a waiver. In excess income

cases, eligibility shall be limited to a period of six months beginning with the first of the month in which these medical obligations are first incurred; and

(12) Who has continuing monthly expenses for medical care that are more than the amount of his excess income, computed on a monthly basis, in which case eligibility may be established before the total income obligation referred to in the preceding paragraph is incurred, and medical assistance payments may be made to cover the monthly unmet medical need. In licensed nursing home and state hospital cases, income over and above that required for justified needs, determined pursuant to a schedule of contributions established by the commissioner of public welfare, is to be applied to the cost of institutional care. The commissioner of public welfare may establish a schedule of contributions to be made by the spouse of a nursing home resident to the cost of care and shall seek a waiver from federal regulations which establish the amount required to be contributed by either spouse when one spouse is a nursing home resident; and

(13) Who has applied or agrees to apply all proceeds received or receivable by him or his spouse from automobile accident coverage and private health care coverage to the costs of medical care for himself, his spouse, and children. The state agency may require from any applicant or recipient of medical assistance the assignment of any rights accruing under private health care coverage. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment shall not be effective as to benefits paid or provided under automobile accident coverage and private health care coverage prior to receipt of the assignment by the person or organization providing the benefits.

Subd. 2. [Repealed, 1974 c 525 s 3]

Subd. 3. Notwithstanding any law to the contrary, a migrant worker who meets all of the eligibility requirements of this section other than that he has a permanent place of abode in another state, shall be eligible for medical assistance and shall have his medical needs met by the county in which he resides at the time of making application.

History: *Ex1967 c 16 s 6; 1969 c 841 s 1; 1973 c 717 s 18; 1974 c 525 s 1,2; 1975 c 247 s 10; 1976 c 236 s 3; 1977 c 448 s 6; 1978 c 760 s 1; 1979 c 309 s 4; 1980 c 509 s 106; 1980 c 527 s 1; 1981 c 360 art 2 s 28; 1Sp1981 c 2 s 14; 3Sp1981 c 2 art 1 s 32; 3Sp1981 c 3 s 17; 1982 c 553 s 6; 1982 c 640 s 5*

256B.061 ELIGIBILITY.

If any individual has been determined to be eligible for medical assistance, it will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application for such assistance, if such individual was, or upon application would have been, eligible for medical assistance at the time the care and services were furnished.

History: *1973 c 717 s 3*

256B.062 CONTINUED ELIGIBILITY.

Any family which was eligible for aid to families with dependent children in at least three of the six months immediately preceding the month in which the family became ineligible for aid to families with dependent children because of increased income from employment shall, while a member of the family is employed, remain eligible for medical assistance for four calendar months following the month in which the family would otherwise be determined to be ineligible due to the income and resources limitations of this chapter.

History: *1973 c 717 s 4; 1981 c 231 s 1*

256B.063 COST SHARING.

Notwithstanding the provisions of section 256B.05, subdivision 2, the commissioner is authorized to promulgate rules pursuant to the administrative procedures act, and to require a nominal enrollment fee, premium, or similar charge for recipients of medical assistance, if and to the extent required by applicable federal regulation.

History: *1973 c 717 s 5*

256B.064 INELIGIBLE PROVIDER.

Subdivision 1. The commissioner may terminate payments under this chapter to any person or facility providing medical assistance which, under applicable federal law or regulation, has been determined to be ineligible for payments under Title XIX of the Social Security Act.

Subd. 1a. The commissioner may seek monetary recovery and impose sanctions against vendors of medical care for any of the following: fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; a pattern of presentment of false or duplicate claims or claims for services not medically necessary; a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; suspension or termination as a Medicare vendor; and refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients. No sanction may be imposed or monetary recovery obtained against any vendor of nursing home or convalescent care for providing services not medically necessary when the services provided were ordered by a licensed health professional not an employee of the vendor. The determination of abuse or services not medically necessary shall be made by the commissioner in consultation with a review organization as defined in section 145.61 or other provider advisory committees as appointed by the commissioner on the recommendation of appropriate professional organizations.

Subd. 1b. The commissioner may impose the following sanctions for the conduct described in subdivision 1a: referral to the appropriate state licensing board, suspension or withholding of payments to a vendor, and suspending or terminating participation in the program.

Subd. 1c. The commissioner may obtain monetary recovery for the conduct described in subdivision 1a by the following methods: assessing and recovering moneys erroneously paid and debiting from future payments any moneys erroneously paid, except that patterns need not be proven as a precondition to monetary recovery for false claims, duplicate claims, claims for services not medically necessary, or false statements.

Subd. 2. The commissioner shall determine monetary amounts to be recovered and the sanction to be imposed upon a vendor of medical care for conduct described by subdivision 1a. Neither a monetary recovery nor a sanction will be sought by the commissioner without prior notice and an opportunity for a hearing, pursuant to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

History: *1973 c 717 s 6; 1976 c 188 s 1; 1980 c 349 s 5,6; 1982 c 424 s 130*

256B.065 SOCIAL SECURITY AMENDMENTS.

The commissioner shall comply with requirements of the social security amendments of 1972 (P.L. 92-603) necessary in order to avoid loss of federal funds, and shall implement by rule, pursuant to the administrative procedures act, those provisions required of state agencies supervising Title XIX of the Social Security Act.

History: *1973 c 717 s 7*

256B.07 EXCEPTIONS IN DETERMINING RESOURCES.

A local agency may, within the scope of regulations set by the commissioner of public welfare, waive the requirement of liquidation of excess assets when the liquidation would cause undue hardship. Household goods and furniture in use in the home, wearing apparel, insurance policies with cash surrender value not in excess of $1,500 per insured person, personal property used as a regular abode by the applicant or recipient, a prepaid funeral contract not in excess of $750 per person plus accrued interest of not more than $200, and a lot in a burial plot shall not be considered as resources available to meet medical needs.

History: *Ex1967 c 16 s 7; Ex1971 c 16 s 3; 1973 c 141 s 2; 1975 c 437 art 2 s 5; 1979 c 309 s 5; 3Sp1981 c 3 s 18*

256B.08 APPLICATION.

An applicant for medical assistance hereunder, or a person acting in his behalf, shall file his application with a county agency in such manner and form as shall be prescribed by the state agency. When a married applicant resides in a nursing home or applies for medical assistance for nursing home services, the county agency shall consider an application on behalf of the applicant's spouse only upon specific request of the applicant or upon specific request of the spouse and separate filing of an application.

History: *Ex1967 c 16 s 8; 1Sp1981 c 2 s 15*

256B.09 INVESTIGATIONS.

When an application for medical assistance hereunder is filed with a county agency, such county agency shall promptly make or cause to be made such investigation as it may deem necessary. The object of such investigation shall be to ascertain the facts supporting the application made hereunder and such other information as may be required by the rules of the state agency. Upon the completion of such investigation the county agency shall promptly determine eligibility. No approval by the county agency shall be required prior to payment for medical care provided to recipients determined to be eligible pursuant to this section.

History: *Ex1967 c 16 s 9; 1973 c 717 s 19*

256B.091 NURSING HOME PRE-ADMISSION SCREENING PROGRAM.

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

available. The commissioner of public welfare shall promulgate temporary rules in order to implement this section by September 1, 1980.

Subd. 2. **Screening teams; establishment.** Each county agency designated by the commissioner of public welfare to participate in the program shall contract with the local board of health organized under section 145.911 to 145.922 or other public or non-profit agency to establish a screening team to assess, prior to admission to a nursing home licensed under section 144A.02, the health and social needs of medical assistance recipients and individuals who would become eligible for medical assistance within 90 days of nursing home admission. Each local screening team shall be composed of a public health nurse from the local public health nursing service and a social worker from the local community welfare agency. Each screening team shall have a physician available for consultation and shall utilize individuals' attending physicians' physical assessment forms, if any, in assessing needs. The individual's physician shall be included on the screening team if the physician chooses to participate. If the individual is being discharged from an acute care facility, a discharge planner from that facility may be present, at the facility's request, during the screening team's assessment of the individual and may participate in discussions but not in making the screening team's recommendations under subdivision 3, clause (e). If the assessment procedure or screening team recommendation results in a delay of the individual's discharge from the acute care facility, the facility shall not be denied reimbursement or incur any other financial or regulatory penalty caused by the individual's extended length of stay. Other personnel as deemed appropriate by the county agency may be included on the team. No member of a screening team shall have a direct or indirect financial or self-serving interest in a nursing home or non-institutional referral such that it would not be possible for the member to consider each case objectively.

Subd. 3. **Screening team; duties.** Local screening teams shall seek cooperation from other public and private agencies in the community which offer services to the disabled and elderly. The responsibilities of the agency responsible for screening shall include:

(a) Provision of information and education to the general public regarding availability of the screening program;

(b) Acceptance of referrals from individuals, families, human service professionals and nursing home personnel of the community agencies;

(c) Assessment of health and social needs of referred individuals and identification of services needed to maintain these persons in the least restrictive environments;

(d) Identification of available noninstitutional services to meet the needs of individuals referred;

(e) Recommendations for individuals screened regarding:

(1) Nursing home admission; and

(2) Maintenance in the community with specific service plans and referrals and designation of a lead agency to implement each individual's plan of care;

(f) Provision of follow up services as needed; and

(g) Preparation of reports which may be required by the commissioner of public welfare.

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

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

Subd. 6. **Reimbursement.** The commissioner of public welfare shall amend the Minnesota medical assistance plan to include reimbursement for the local screening teams. Reimbursement shall not be provided for any recipient placed in a nursing home in opposition to the screening team's recommendation after January 1, 1981; provided, however, the commissioner shall not deny reimbursement for (1) an individual admitted to a nursing home who is assessed to need long-term supportive services if long-term supportive services other than nursing home care are not available in that community; (2) any eligible individual placed in the nursing home pending an appeal of the preadmission screening team's decision; (3) any eligible individual placed in the nursing home by a physician in an emergency situation and where the screening team has not made a decision within five working days of its initial contact; or (4) any medical assistance recipient when, after full discussion of all appropriate alternatives including those that are expected to be less costly than nursing home care, the individual or the individual's legal representative insists on nursing home placement. The screening team shall provide documentation that the most cost effective alternatives available were offered to this individual or the individual's legal representative.

Subd. 7. **Report.** The commissioner of public welfare, in consultation with the commissioner of health, shall evaluate the screening program established pursuant to this section and provide a report to the legislature by April 1, 1981, which shall include a description of:

(a) The cost effectiveness of the program;

(b) The unmet needs in the community;

(c) Similar screening activities in the counties;

(d) Methods to improve the program.

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

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

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

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

Subd. 9. **Rules.** The commissioner of public welfare shall promulgate temporary rules and permanent rules to implement the provisions of subdivisions 6 and 8 and permanent rules to implement the provisions of subdivisions 2 and 4.

History: *1980 c 575 s 1; 1981 c 360 art 2 s 29; 1982 c 424 s 130; 1982 c 455 s 1-5*

256B.10 [Repealed, 1976 c 131 s 2]

256B.11 [Repealed, 1976 c 131 s 2]

256B.12 LEGAL REPRESENTATION.

The attorney general or the appropriate county attorney appearing at the direction of the attorney general shall be the attorney for the state agency, and the county attorney of the appropriate county shall be the attorney for the local agency in all matters pertaining hereto. To prosecute under this chapter or sections 609.466 and 609.52, subdivision 2, or to recover payments wrongfully made under this chapter, the attorney general or the appropriate county attorney, acting independently or at the direction of the attorney general may institute a criminal or civil action.

History: *Ex1967 c 16 s 12; 1975 c 437 art 2 s 6; 1976 c 188 s 2*

256B.121 TREBLE DAMAGES.

Any vendor of medical care who willfully submits a cost report, rate application or claim for reimbursement for medical care which the vendor knows is a false representation and which results in the payment of public funds for which the vendor is ineligible shall, in addition to other provisions of Minnesota law, be subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. The damages awarded shall include three times the payments which result from the false representation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent.

History: *1976 c 188 s 4*

256B.13 SUBPOENAS.

Each county agency and the state agency shall have the power to issue subpoenas for witnesses and compel their attendance and the production of papers

and writing; and officers and employees designated by any county agency or the state agency may administer oaths and examine witnesses under oath in connection with any application or proceedings hereunder.

History: *Ex1967 c 16 s 13*

256B.14 RELATIVE'S RESPONSIBILITY.

Subdivision 1. **In general.** Subject to the provisions of section 256B.06, responsible relative means the spouse of a medical assistance recipient or parent of a minor recipient of medical assistance.

Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to determine the ability of responsible relatives to contribute partial or complete repayment of medical assistance furnished to recipients for whom they are responsible. These rules shall not require repayment when payment would cause undue hardship to the responsible relative or his or her immediate family. The county agency shall give the responsible relative notice of the amount of the repayment. If the state agency or county agency finds that notice of the payment obligation was given to the responsible relative, but that the relative failed or refused to pay, a cause of action exists against the responsible relative for that portion of medical assistance granted after notice was given to the responsible relative, which the relative was determined to be able to pay.

The action may be brought by the state agency or the county agency in the county where assistance was granted, for the assistance, together with the costs of disbursements incurred due to the action.

In addition to granting the county or state agency a money judgment, the court may, upon a motion or order to show cause, order continuing contributions by a responsible relative found able to repay the county or state agency. The order shall be effective only for the period of time during which the recipient receives medical assistance from the county or state agency.

History: *Ex1967 c 16 s 14; 1973 c 725 s 46; 1977 c 448 s 7; 1982 c 640 s 6*

256B.15 CLAIMS AGAINST ESTATES.

If a person receives any medical assistance hereunder, on his death, if he is single, or on the death of the person and his surviving spouse, if he is married, and only at a time when he has no surviving child who is under 21 or is blind or totally disabled, the total amount paid for medical assistance rendered for the person, after age 65, without interest, shall be filed as a claim against the estate of the person in the court having jurisdiction to probate the estate. The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Counties may retain one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort.

History: *Ex1967 c 16 s 15; 1981 c 360 art 1 s 22; 1Sp1981 c 4 art 1 s 126*

256B.16 [Repealed, 1971 c 550 s 2]

256B.17 TRANSFERS OF PROPERTY.

Subdivision 1. **Transfers for less than market value.** In determining the resources of an individual and an eligible spouse, there shall be included any resource or interest therein which was given away or sold for less than fair market value within the 24 months preceding application for medical assistance or during the period of eligibility.

Subd. 2. **Presumption of purpose.** Any transaction described in subdivision 1 shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this chapter unless the individual or eligible spouse furnishes convincing evidence to establish that the transaction was exclusively for another purpose.

Subd. 3. **Resource value.** For purposes of subdivision 1, the value of the resource or interest shall be the fair market value at the time it was sold or given away, less the amount of compensation received.

Subd. 4. **Period of ineligibility.** In any case where the uncompensated value of transferred resources exceeds $12,000, the commissioner shall require a period of ineligibility which exceeds 24 months, provided that the period of ineligibility bears a reasonable relationship to the excess uncompensated value of the transferred asset.

History: *Ex1967 c 16 s 17; 1981 c 360 art 2 s 30*

256B.18 METHODS OF ADMINISTRATION.

The state agency shall prescribe such methods of administration as are necessary for compliance with requirements of the social security act, as amended, and for the proper and efficient operation of the program of assistance hereunder. The state agency shall establish and maintain a system of personnel standards on a merit basis for all such employees of the county agencies and the examination thereof, and the administration thereof shall be directed and controlled exclusively by the state agency except in those counties in which such employees are covered by a merit system that meets the requirements of the state agency and the social security act, as amended.

History: *Ex1967 c 16 s 18*

256B.19 DIVISION OF COST.

Subdivision 1. The cost of medical assistance paid by each county of financial responsibility shall be borne as follows: Payments shall be made by the state to the county for that portion of medical assistance paid by the federal government and the state on or before the 20th day of each month for the succeeding month upon requisition from the county showing the amount required for the succeeding month. Ninety percent of the expense of assistance not paid by federal funds available for that purpose shall be paid by the state and ten percent shall be paid by the county of financial responsibility.

For counties where health maintenance organizations are under contract to the state to provide services to medical assistance recipients, the division of the nonfederal share of medical assistance expenses for payments made to health maintenance organizations in the form of prepaid capitation payments, this division of medical assistance expenses shall be 95 percent by the state and five percent by the county of financial responsibility.

State contracts with health maintenance organizations shall assure medical assistance recipients of at least the comprehensive health maintenance services defined in section 62D.02, subdivision 7. The contracts shall require health maintenance organizations to provide information to the commissioner concerning the number of people receiving services, the number of encounters, the type of services received, evidence of an operational quality assurance program pursuant to section 62D.04 and information about utilization. Persons who become eligible for medical assistance after July 1, 1982 and who choose to receive services from a health maintenance organization under contract to the state pursuant to this section shall be guaranteed six months medical assistance eligibility.

The commissioner of public welfare shall seek a waiver to charge a coinsurance fee to recipients of medical assistance who become eligible for medical assistance benefits and who choose not to receive the benefits of a health maintenance organization contracted for by the state pursuant to this section. The coinsurance fee shall be limited to the maximum monthly charge allowed by 42 CFR, sections 447.50 to 447.59, as amended through December 31, 1981. The local welfare agency may waive the coinsurance fee when it determines that the medical needs of the recipient would not be best served by enrollment in a health maintenance organization. The coinsurance fee shall be charged only to recipients who become eligible for medical assistance after the commissioner has reported to the legislature regarding the proposed method of implementing this paragraph.

Subd. 2. Federal funds available for administrative purposes shall be distributed between the state and the county in the same proportion that expenditures were made.

History: *Ex1967 c 16 s 19; 1971 c 547 s 1; 1975 c 437 art 2 s 7; 1982 c 640 s 7*

256B.20 COUNTY APPROPRIATIONS.

The providing of funds necessary to carry out the provisions hereof on the part of the counties and the manner of administering the funds of the counties and the state shall be as follows:

(1) The board of county commissioners of each county shall annually set up in its budget an item designated as the county medical assistance fund and levy taxes and fix a rate therefor sufficient to produce the full amount of such item, in addition to all other tax levies and tax rate, however fixed or determined, sufficient to carry out the provisions hereof and sufficient to pay in full the county share of assistance and administrative expense for the ensuing year; and annually on or before October 10 shall certify the same to the county auditor to be entered by him on the tax rolls. Such tax levy and tax rate shall make proper allowance and provision for shortage in tax collections.

(2) Any county may transfer surplus funds from any county fund, except the sinking or ditch fund, to the general fund or to the county medical assistance fund in order to provide moneys necessary to pay medical assistance awarded hereunder. The money so transferred shall be used for no other purpose, but any portion thereof no longer needed for such purpose shall be transferred back to the fund from which taken.

(3) Upon the order of the county agency the county auditor shall draw his warrant on the proper fund in accordance with the order, and the county treasurer shall pay out the amounts ordered to be paid out as medical assistance hereunder. When necessary by reason of failure to levy sufficient taxes for the payment of the medical assistance in the county, the county auditor shall carry any such payments as an overdraft on the medical assistance funds of the county until sufficient tax funds shall be provided for such assistance payments. The board of county commissioners shall include in the tax levy and tax rate in the year following the year in which such overdraft occurred, an amount sufficient to liquidate such overdraft in full.

(4) Claims for reimbursement shall be presented to the state agency by the respective counties in such manner as the state agency shall prescribe, not later than 10 days after the close of the month in which the expenditures were made. The state agency shall audit such claims and certify to the commissioner of finance the amounts due the respective counties without delay. The amounts so certified shall be paid within 10 days after such certification, from the state treasury upon warrant of the commissioner of finance from any moneys available therefor. The

moneys available to the state agency to carry out the provisions hereof, including all federal funds available to the state, shall be kept and deposited by the state treasurer in the revenue fund and disbursed upon warrants in the same manner as other state funds.

History: *Ex1967 c 16 s 20; 1973 c 492 s 14*

256B.21 CHANGE OF RESIDENCE.

When a recipient changes his place of residence, he shall notify the county agency by which his medical assistance hereunder is paid. If he removes to another county, he shall declare whether such absence is temporary or for the purpose of residing therein.

History: *Ex1967 c 16 s 21*

256B.22 COMPLIANCE WITH SOCIAL SECURITY ACT.

The various terms and provisions hereof, including the amount of medical assistance paid hereunder, are intended to comply with and give effect to the program set out in Title XIX of the federal Social Security Act. During any period when federal funds shall not be available or shall be inadequate to pay in full the federal share of medical assistance as defined in Title XIX of the federal Social Security Act, as amended by Public Law 92-603, the state may reduce by an amount equal to such deficiency the payments it would otherwise be obligated to make pursuant to section 256B.041.

History: *Ex1967 c 16 s 22; 1973 c 717 s 20*

256B.23 USE OF FEDERAL FUNDS.

All federal funds made available for the purposes hereof are hereby appropriated to the state agency to be disbursed and paid out in accordance with the provisions hereof.

History: *Ex1967 c 16 s 23*

256B.24 PROHIBITIONS.

No enrollment fee, premium, or similar charge shall be required as a condition of eligibility for medical assistance hereunder.

History: *Ex1967 c 16 s 24*

256B.25 PAYMENTS TO LICENSED FACILITIES.

Payments may not be made hereunder for care in any private or public institution, including but not limited to hospitals and nursing homes, unless licensed by an appropriate licensing authority of this state, any other state, or a Canadian province.

History: *Ex1967 c 16 s 25; 1969 c 395 s 2*

256B.26 AGREEMENTS WITH OTHER STATE DEPARTMENTS.

The commissioner of the department of public welfare is authorized to enter into cooperative agreements with other state departments or divisions of this state or of other states responsible for administering or supervising the administration of health services and vocational rehabilitation services in the state for maximum utilization of such service in the provision of medical assistance under sections 256B.01 to 256B.26.

History: *Ex1967 c 16 s 26*

256B.27 MEDICAL ASSISTANCE; COST REPORTS.

Subdivision 1. In the interests of efficient administration of the medical assistance to the needy program and incident to the approval of rates and charges therefor, the commissioner of public welfare may require any reports, information, and audits of medical vendors which he deems necessary.

Subd. 2. All reports as to the costs of operations or of medical care provided which are submitted by vendors of medical care for use in determining their rates or reimbursement shall be submitted under oath as to the truthfulness of their contents by the vendor or an officer or authorized representative of the vendor.

Subd. 2a. Each year the commissioner shall provide for the onsite audit of the cost reports of nursing homes participating as vendors of medical assistance. The commissioner shall select for audit at least five percent of these nursing homes at random and at least 20 percent from the remaining nursing homes, using factors including, but not limited to: change in ownership; frequent changes in administration in excess of normal turnover rates; complaints to the commissioner of health about care, safety, or rights; where previous inspections or reinspections under section 144A.10 have resulted in correction orders related to care, safety, or rights; or where persons involved in ownership or administration of the facility have been indicted for alleged criminal activity.

Subd. 3. The commissioner of public welfare, with the written consent of the recipient, shall be allowed access to all personal medical records of medical assistance recipients solely for the purposes of investigating whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which the vendor knows to be false in whole or in part; or (b) the medical care was medically necessary. The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records. The determination of abuse or provision of services not medically necessary shall be made by the commissioner in consultation with a review organization as defined in section 145.61 or other advisory committees of vendors as appointed by the commissioner on the recommendation of appropriate professional organizations. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of public welfare pursuant to this section.

Subd. 4. No person shall be eligible for medical assistance unless he has authorized the commissioner of public welfare in writing to examine all personal medical records developed while receiving medical assistance for the purpose of investigating whether or not a vendor has submitted a claim for reimbursement, a cost report or a rate application which the vendor knows to be false in whole or in part, or in order to determine whether or not the medical care provided was medically necessary. A vendor of medical care shall require presentation of this written authorization before the state agency can obtain access to the records unless the vendor already has received written authorization.

Subd. 5. Medical records obtained by the commissioner of public welfare pursuant to this section are private data, as defined in section 13.02, subdivision 12.

History: *1971 c 961 s 24; 1976 c 188 s 3; 1977 c 326 s 11; 1980 c 349 s 7,8; 1981 c 311 s 39; 1982 c 476 s 1; 1982 c 545 s 24; 1982 c 640 s 8*

256B.30 HEALTH CARE FACILITY REPORT.

Every facility required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, shall provide annually to the commissioner of public welfare the reports as may be required under law and under rules adopted by the

commissioner of public welfare under the administrative procedures act. The rules shall provide for the submission of a full and complete financial report of a facility's operations including:

(1) An annual statement of income and expenditures;

(2) A complete statement of fees and charges;

(3) The names of all persons other than mortgage companies owning any interest in the facility including stockholders with an ownership interest of ten percent or more of the facility.

The financial reports and supporting data of the facility shall be available for inspection and audit by the commissioner of public welfare.

History: *1973 c 688 s 8; 1976 c 173 c 57*

256B.35 PERSONAL ALLOWANCE, PERSONS IN SKILLED NURSING HOMES OR INTERMEDIATE CARE FACILITIES.

Subdivision 1. Notwithstanding any law to the contrary, welfare allowances for clothing and personal needs for individuals receiving medical assistance while residing in any skilled nursing home or intermediate care facility, including recipients of supplemental security income, in this state shall not be less than $35 per month from all sources.

Provided that this personal needs allowance may be paid as part of the Minnesota supplemental aid program, notwithstanding the provisions of section 256D.37, subdivision 2, and payments to the recipients from Minnesota supplemental aid funds may be made once each three months beginning in October, 1977 covering liabilities that accrued during the preceding three months.

Subd. 2. Neither the skilled nursing home, the intermediate care facility nor the department of public welfare shall withhold or deduct any amount of this allowance for any purpose contrary to this section.

Subd. 3. The nursing home may not commingle the patient's funds with nursing home funds or in any way use the funds for nursing home purposes.

Subd. 4. The commissioner of public welfare shall conduct field audits at the same time as cost report audits required under section 256B.27, subdivision 2a, and at any other time but at least once every four years, without notice, to determine whether this section was complied with and that the funds provided residents for their personal needs were actually expended for that purpose.

Subd. 5. The nursing home may transfer the personal allowance to someone other than the recipient only when the recipient or his guardian or conservator designates that person in writing to receive or expend funds on behalf of the recipient and that person certifies in writing that the allowance is spent for the well being of the recipient. Persons, other than the recipient, in possession of the personal allowance, may use the allowance only for the well being of the recipient. Any person, other than the recipient, who, with intent to defraud, uses the personal needs allowance for purposes other than the well being of the recipient shall be guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3, clauses (1), (2) and (5). To prosecute under this subdivision, the attorney general or the appropriate county attorney, acting independently or at the direction of the attorney general, may institute a criminal action. A nursing home that transfers personal needs allowance funds to a person other than the recipient in good faith and in compliance with this section shall not be held liable under this subdivision.

Subd. 6. In addition to the remedies otherwise provided by law, any person injured by a violation of any of the provisions of this section, may bring a civil action and recover damages, together with costs and disbursements, including

costs of investigation and reasonable attorney's fees, and receive other equitable relief as determined by the court.

History: *1974 c 575 s 15; 1977 c 271 s 1,2; 1980 c 563 s 1; 1982 c 476 s 2*

256B.36 PERSONAL ALLOWANCE, HANDICAPPED OR MENTALLY RETARDED RECIPIENTS OF MEDICAL ASSISTANCE.

In addition to the personal allowance established in section 256B.35, any handicapped or mentally retarded recipient of medical assistance confined in a skilled nursing home or intermediate care facility shall also be permitted a special personal allowance drawn solely from earnings from any productive employment under an individual plan of rehabilitation. This special personal allowance shall not exceed (1) the limits set therefor by the commissioner, or (2) the amount of disregarded income the individual would have retained had he or she been a recipient of aid to the disabled benefits in December, 1973, whichever amount is lower.

History: *1974 c 575 s 16*

256B.37 PRIVATE INSURANCE POLICIES.

Subdivision 1. Upon furnishing medical assistance to any person having private health care coverage, the state agency shall be subrogated, to the extent of the cost of medical care furnished, to any rights the person may have under the terms of any private health care coverage. The right of subrogation does not attach to benefits paid or provided under private health care coverage prior to the receipt of written notice of the exercise of subrogation rights by the carrier issuing the health care coverage.

Subd. 2. To recover under this section, the attorney general, or the appropriate county attorney, acting upon direction from the attorney general, may institute or join a civil action against the carrier of the private health care coverage.

History: *1975 c 247 s 7*

256B.39 AVOIDANCE OF DUPLICATE PAYMENTS.

Billing statements forwarded to recipients of medical assistance by vendors seeking payment for medical care rendered shall clearly state that reimbursement from the state agency is contemplated.

History: *1975 c 247 s 8*

256B.40 SUBSIDY FOR ABORTIONS PROHIBITED.

No medical assistance funds of this state or any agency, county, municipality or any other subdivision thereof and no federal funds passing through the state treasury or the state agency shall be authorized or paid pursuant to this chapter to any person or entity for or in connection with any abortion that is not eligible for funding pursuant to section 256B.02, subdivision 8.

History: *1978 c 508 s 3*

NURSING HOME RATES

256B.41 INTENT.

Subdivision 1. The state agency shall by rule establish a formula for establishing payment rates for nursing homes which qualify as vendors of medical assistance.

Subd. 2. It is the intent of the legislature to establish certain limitations on the state agency in setting standards for nursing home rate setting for the care of

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

History: *1976 c 282 s 1*

256B.42 DEFINITIONS.

Subdivision 1. For the purpose of sections 256B.41 to 256B.48 the following terms and phrases shall have the meaning given to them.

Subd. 2. "Facility" means the building in which a nursing home is located and all permanent fixtures attached to it. "Facility" does not include the land or any supplies and equipment which are not fixtures.

Subd. 3. "Original value" means the value of the facility established pursuant to section 256B.43, subdivisions 1 and 2.

Subd. 4. "Purchase" means the acquisition of a nursing home by a new owner or the construction of a new nursing home.

Subd. 5. "Net asset value" means the total of the original value of the facility less accumulated depreciation on it and the value of the land.

Subd. 6. "Net debt" means the total of capital indebtedness and loans used for operating expenses.

History: *1976 c 282 s 2*

256B.43 FIXED ASSETS; DEPRECIATION.

Subdivision 1. The state agency shall by rule establish a depreciation allowance for nursing homes purchased on or after January 1, 1977. The depreciation allowance shall be based on the lesser of the purchase price or the appraised value of the facility at the time of the purchase. After the purchase of a nursing home, the purchaser of the nursing home or the state agency may request an appraisal of the facility pursuant to the provisions of subdivision 3. The value of the facility determined pursuant to this subdivision shall be the original value and shall be the basis for depreciation.

Subd. 2. If any nursing home expands its facility or makes any other capital expenditures which increases the value of the facility subsequent to January 1, 1977, the cost of the expansion or capital expenditure shall be added to the original value, and the total shall become the new original value and basis for depreciation. If the state agency disputes the cost attributed to the expansion or capital expenditure, it may request an appraisal pursuant to subdivision 3.

Subd. 3. The state agency shall establish a list of not more than 25 appraisers who have experience in appraising nursing homes. In the event that an appraisal is requested pursuant to this section, or section 256B.45, the state agency and the owner of the nursing home shall select an appraiser from the list in accordance with procedures established by the state agency by rule. The appraisal shall be based on the depreciated replacement cost of the facility. The cost of the appraisal shall be paid by the party requesting it. The cost of an appraisal requested by a nursing home shall not be reimbursed by the state agency.

Subd. 4. Depreciation on any new construction or expansion of facilities commenced on or after January 1, 1977, other than governmentally owned facilities, shall be on a basis of not less than 30 years.

Subd. 5. Depreciation shall be allowed for all governmentally owned nursing homes regardless of the source of funds used to construct or expand the facility. The provisions of this subdivision shall apply to all cost reports submitted on or after November 1, 1972.

Subd. 6. The state agency shall by rule establish a separate depreciation allowance for land improvements, equipment and vehicles.

History: *1976 c 282 s 3; 1977 c 326 s 12*

256B.44 INTEREST EXPENSE.

Subdivision 1. Except as provided in subdivision 2, the state agency shall recognize interest expense as an allowable cost for any nonproprietary or governmentally owned nursing home if the interest rate is not in excess of what a borrower would have had to pay in an arms-length transaction in the money market at the time the loan was made, and the net debt is directly related to purchasing or improving the nursing home or providing patient care at the nursing home. Except as provided in subdivision 3, the state agency shall not recognize interest expense as an allowable cost for any proprietary nursing home.

Subd. 2. [Repealed, 1979 c 336 s 18]

Subd. 3. A proprietary nursing home which pays interest on capital indebtedness at an interest rate in excess of nine percent may be reimbursed for its interest expenses in excess of the nine percent up to 12 percent if (1) the proceeds of the indebtedness are used for the purchase or operation of the nursing home and (2) the interest rate is not in excess of what a borrower would have had to pay in an arms-length transaction at the time the loan was made.

History: *1976 c 282 s 4; 1977 c 326 s 13*

256B.45 INVESTMENT ALLOWANCE.

Subdivision 1. The state agency shall by rule establish an investment allowance for nursing homes. For the fiscal year beginning July 1, 1977, the allowance for proprietary homes shall be nine percent of the original value of the facility for depreciation purposes. For the fiscal year beginning July 1, 1977, the allowance for nonproprietary homes shall be two percent of the original value of the facility for depreciation purposes. Beginning in 1978 the state agency shall, no later than May 1 of each year, conduct a public hearing pursuant to the rule making provisions of chapter 14 to determine the percentages to be used in the following fiscal year. There shall be no other cost of capital or profit allowance for proprietary homes.

Subd. 2. For each year after the year in which the nursing home was originally purchased in which there is no transfer of ownership of a nursing home, the investment allowance shall be increased by one percent of the original investment allowance, but the increases shall be limited to a maximum of 25 percent of the original investment allowance.

Subd. 3. If a nursing home is operated on a lease basis, the state agency shall not recognize as an allowable cost any rental fee in excess of the total amount it would pay to the owner of the facility as interest, investment allowance and depreciation allowance. A lease entered into before April 13, 1976 is not subject to this subdivision until the date of the next renewal.

History: *1976 c 282 s 5; 1977 c 326 s 14; 1982 c 424 s 130*

256B.46 INCENTIVE ALLOWANCE.

In the event that the United States government disallows the investment allowance provided for in section 256B.45 for nonproprietary homes, the state agency shall by rule establish an incentive allowance for nonproprietary nursing homes consistent with federal requirements. The incentive allowance shall include incentives to reward efficient management and quality care. The incentive allowance may also be graduated so that it increases with (1) the length of time that a nursing home is owned by the same owner and (2) the owner's net investment as a percentage of the net asset value of the facility. The rule shall provide that if a nonproprietary nursing home is operated on a lease basis, the state agency shall not recognize as an allowable cost for the operator any rental fee in excess of the total amount it would pay for depreciation and pursuant to this section.

History: *1976 c 282 s 6*

256B.47 RATE LIMITS; NOTICE OF INCREASES TO PRIVATE PAYING RESIDENTS.

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

Subd. 2. The following costs shall not be recognized as allowable to the extent that these costs cannot be demonstrated by the nursing home to the state agency to be directly related to the provision of patient care: (1) political contributions; (2) salaries or expenses of a lobbyist, as defined in section 10A.01, subdivision 11, for lobbying activities; (3) advertising designed to encourage potential residents to select a particular nursing home; (4) assessments levied by the health department for uncorrected violations; (5) legal fees for unsuccessful challenges to decisions by state agencies; and (6) dues paid to a nursing home or hospital association. The state agency shall promulgate rules establishing standards which shall distinguish between any patient-care related components and nonpatient-care related components of these costs, where applicable. For purposes of these rules, the state agency shall exercise emergency powers and establish emergency rules pursuant to section 15.0412, subdivision 5, before September 1, 1977. The state agency shall by rule exclude the costs of any other items which it determines are not directly related to the provision of patient care.

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

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

A nursing home may adjust its rates without giving the notice required by this subdivision when the purpose of the rate adjustment is to: (a) reflect a necessary change in the level of care provided to a resident; or (b) retroactively or prospectively equalize private pay rates with rates charged to medical assistance

recipients as required by section 256B.48, subdivision 1, clause (a) and applicable federal law.

Subd. 5. The commissioner shall promulgate rules no later than August 1, 1980, to amend the current rules governing nursing home reimbursement, in accordance with sections 14.01 to 14.70, to allow providers to allocate their resources in order to provide as many nursing hours as necessary within the total cost limitations of the per diem already granted.

History: *1976 c 282 s 7; 1977 c 305 s 45; 1977 c 326 s 15,16; 1979 c 35 s 1; 1980 c 570 s 2; 1982 c 424 s 130*

256B.48 CONDITIONS FOR PARTICIPATION.

Subdivision 1. No nursing home shall be eligible to receive medical assistance payments unless it agrees in writing that it will refrain from:

(a) Charging nonmedical assistance residents rates for similar services which exceed by more than ten percent those rates which are approved by the state agency for medical assistance recipients. For nursing homes charging nonmedical assistance residents rates less than ten percent more than those rates which are approved by the state agency for medical assistance recipients, the maximum differential in rates between nonmedical assistance residents and medical assistance recipients shall not exceed that differential which was in effect on April 13, 1976. If a nursing home has exceeded this differential since April 13, 1976, it shall return the amount collected in excess of the allowable differential stated by this subdivision to the nonmedical assistance resident, or that person's representative, by July 1, 1977. Effective July 1, 1978, no nursing home shall be eligible for medical assistance if it charges nonmedical assistance recipients rates for similar services which exceed those which are approved by the state agency for medical assistance recipients; provided, however, that the nursing home may (1) charge nonmedical assistance residents a higher rate for a private room, and (2) charge for special services which are not included in the daily rate if medical assistance patients are charged separately at the same rate for the same services in addition to the daily rate paid by the state agency;

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

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

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

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

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

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

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

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

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

(a) Provide the state agency with its most recent (1) balance sheet and statement of revenues and expenses as audited by a certified public accountant licensed by this state or by a public accountant as defined in section 412.222; (2) statement of ownership for the nursing home; and (3) a separate audited balance sheet and statement of revenues and expenses for each nursing home if more than one nursing home or other business operation is owned by the same owner; a governmentally owned nursing home may comply with the auditing requirements of this clause by submitting an audit report prepared by the state auditor's office;

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

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

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

History: *1976 c 282 s 8; 1977 c 309 s 1; 1977 c 326 s 17; 1978 c 674 s 28*

256B.51 NURSING HOMES; COST OF HOME CARE.

Subdivision 1. To determine the effectiveness of home care in providing or arranging for the care and services which would normally be provided in a nursing home, the commissioner of public welfare may establish an experimental program to subsidize a limited number of eligible agencies or households which agree to carry out a planned program of in-home care for an elderly or physically disabled person. The household or agency to provide the services shall be selected by the person who will receive the services.

This program shall be limited to agencies or households caring for persons who are physically disabled or 60 years of age or older, and who otherwise would require and be eligible for placement in a nursing home.

Subd. 2. Grants to eligible agencies or households shall be determined by the commissioner of public welfare. In determining the grants, the commissioner shall consider the cost of diagnostic assessments, homemaker services, specialized equipment, visiting nurses' or other pertinent therapists' costs, social services, day program costs, and related transportation expenses, not to exceed 50 percent of the average medical assistance reimbursement rate for nursing homes in the region of the person's residence.

Subd. 3. An individual care plan for the person shall be established and agreed upon by the person or agency providing the care, the person or agency receiving the subsidy, the person receiving the care, and the appropriate local welfare agency. The plan shall be periodically evaluated to determine the person's progress.

History: *1976 c 312 s 2*

DENTAL CARE FOR SENIOR CITIZENS

256B.56 PURPOSE.

The purpose of the pilot dental program is to determine the need for and the feasibility of establishing a statewide dental program for eligible senior citizens, the

optimal methods of providing dental service, whether the provision of dental services causes the general health of the participants to be improved and whether the provision of dental services to the eligible senior citizens provides comparable benefits to society as if provided to others.

History: *1976 c 305 s 1*

256B.57 PILOT PROGRAMS; ESTABLISHMENT.

The commissioner of public welfare, hereinafter the commissioner, shall establish two pilot programs to provide dental care to senior citizens. One pilot program shall be established in the metropolitan area, composed of Hennepin, Ramsey, Anoka, Washington, Dakota, Scott, and Carver counties; and one pilot program shall be established in an area selected by the commissioner and located outside of the seven metropolitan counties.

History: *1976 c 305 s 2*

256B.58 ADMINISTRATION.

The pilot programs shall be administered by the commissioner. The commissioner may employ staff to administer the programs. The cost of the staff shall be met solely by funds authorized to be spent for administering the programs. The commissioner shall appoint a seven member advisory task force to advise the commissioner on the operation of the pilot programs. All of the members of the advisory task force shall be senior citizens. The compensation of members, their removal from office, and the filling of vacancies shall be as provided in section 15.059.

History: *1976 c 305 s 3; 1978 c 760 s 2*

256B.59 SERVICE CONTRACTS; REVIEW.

Subdivision 1. **Service contracts.** For each pilot program, the commissioner shall contract for the provision and financing of dental services under the terms set forth in sections 256B.56 to 256B.63. The commissioner may contract (a) with an insurance company regulated under chapter 62A, or a nonprofit health service plan corporation regulated under chapter 62C, or a health maintenance organization established pursuant to chapter 62D; or (b) directly with one or more qualified providers of dental services. The party or parties with whom the commissioner contracts under clause (a) shall be known as the dental carriers. All participants in the pilot programs shall have a free choice of vendor for the delivery of dental services.

Subd. 2. **Review.** The commissioner and the dental carriers shall monitor the pilot programs. Review of the extent and quality of dental service provided shall be done only by one or more licensed dentists.

Subd. 3. **Evaluation and report.** The commissioner shall evaluate and make reports of the results of the pilot programs to the legislature by January 2, 1978, January 30, 1979, and March 1, 1980. The reports shall include but not be limited to: (a) the optimal methods of providing dental services including the cost effectiveness of each pilot program; (b) the effect, if any, upon the general health of the individual receiving the dental services; (c) the extent and quality of dental services provided by the pilot program; (d) the number of participants in each pilot program; and (e) the types of dental care most used or needed by the participants.

History: *1976 c 305 s 4; 1978 c 760 s 3*

256B.60 ELIGIBILITY FOR BENEFITS.

Subdivision 1. The commissioner shall select participants for each pilot program from among the applicants who meet the eligibility criteria set forth in subdivision 2. At least ten percent of the senior citizens selected by the commissioner for participation in each pilot program must be residents of a nursing home.

Subd. 2. The full cost of premiums for participation in a pilot program shall be paid by the commissioner for individuals who live in an area to be serviced by a pilot program and who;

(a) Are not eligible to receive dental services or reimbursement for dental services under any other program authorized by law, or who do not have coverage for dental services from an insurance company, a nonprofit service plan corporation, or a health maintenance organization; and

(b) Are retired and aged 62 or over; and

(c) Have an annual net income of less than $3,900 if single, or $4,875 if married.

History: *1976 c 305 s 5*

256B.61 SERVICES AND PAYMENT.

Subdivision 1. **Services covered.** Services to be made available to participants in each pilot program shall include the following if provided or prescribed by a licensed dentist:

(a) routine examinations,

(b) x-rays,

(c) emergency treatment for relief of pain,

(d) restorative services,

(e) oral surgery, including preoperative and post operative care,

(f) surgical and nonsurgical periodontics,

(g) endodontics, including pulpal therapy and root canal filling, and

(h) prosthetics.

Subd. 2. **Payment.** The cost of the dental services, equal to at least 80 percent of the usual, customary and reasonable fee of the treating dentist, will be paid by the dental carrier, or if the commissioner has contracted directly with the provider of the services, by the commissioner, with no deductible amount. Participants shall be responsible for the remaining 20 percent of the fee and for any amounts in excess of the limits set forth in subdivision 3.

Subd. 3. **Limitation.** No services shall be provided nor shall any payment for services be made by the commissioner or by a dental carrier in excess of $500 per participant per year.

History: *1976 c 305 s 6*

256B.62 FINANCIAL REQUIREMENTS.

Subdivision 1. The commissioner shall have access to all financial data of each dental carrier relating to the pilot programs.

Subd. 2. Any amount of profit earned by a dental carrier over ten percent of the total annual premiums, after payment of claims and administrative expenses, shall be returned by the dental carrier to the commissioner.

History: *1976 c 305 s 7*

256B.63 OUTSIDE FUNDING.

The commissioner shall investigate the availability of additional public and private funding for the purposes of sections 256B.56 to 256B.63. The commissioner may solicit and accept, on behalf of the pilot programs established pursuant to sections 256B.56 to 256B.63, contributions, gifts, and grants from any public or private sources.

History: *1976 c 305 s 8*