CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

256B.02 DEFINITIONS.

[For text of subd 1, see M.S.1984]

Subd. 2. "Excluded time" means any period of time an applicant spends in a hospital, sanatorium, nursing home, boarding home, shelter, halfway house, correctional facility, foster home, semi-independent living domicile, residential facility offering care, board and lodging facility offering 24-hour care or supervision of persons with mental illness, mental retardation, related conditions, or physical disabilities; or other treatment facility for the hospitalization or care of human beings, as defined in section 144.50, 144A.01, or 245.782, subdivision 6.

Subd. 3. "County of financial responsibility" means:

(a) for an applicant who resides in the state and is not in a facility described in subdivision 2, the county in which he or she resides at the time of application;

(b) for an applicant who resides in a facility described in subdivision 2, the county in which he or she resided immediately before entering the facility; and

(c) for an applicant who has not resided in this state for any time other than the excluded time, the county in which the applicant resides at the time of making application. For this limited purpose, an infant who has resided only in an excluded time facility is the responsibility of the county which would have been responsible for the infant if eligibility could have been established with the birth mother under section 256B.06, subdivision 1, clause (9).

Notwithstanding clauses (a) to (c), the county of financial responsibility for medical assistance recipients is the same county as that from which a recipient is receiving a maintenance grant or money payment under the program of aid to families with dependent children. There can be a redetermination of the county of financial responsibility for former recipients of the medical assistance program who have been ineligible for at least one month, so long as that redetermination is in accord with the provisions of this subdivision.

[For text of subds 4 to 7, see M.S.1984]

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

(1) Inpatient hospital services. A second medical opinion is required prior to reimbursement for elective surgeries. The commissioner shall publish in the State Register a proposed list of elective surgeries that require a second medical opinion

prior to reimbursement. The list is not subject to the requirements of sections 14.01 to 14.70. The commissioner's decision whether a second medical opinion is required, made in accordance with rules governing that decision, is not subject to administrative appeal;

(2) Skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 256B.50, subdivision 1, for persons with mental retardation or related conditions who are residing in intermediate care facilities for persons with mental retardation or related conditions. Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562;

(3) Physicians' services;

(4) Outpatient hospital or nonprofit community health clinic services or physician-directed clinic services. The physician-directed clinic staff shall include at least two physicians, one of whom is on the premises whenever the clinic is open, and all services shall be provided under the direct supervision of the physician who is on the premises. Hospital outpatient departments are subject to the same limitations and reimbursements as other enrolled vendors for all services, except initial triage, emergency services, and services not provided or immediately available in clinics, physicians' offices, or by other enrolled providers. "Emergency services" means those medical services required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death or are necessary to alleviate severe pain. Neither the hospital, its employees, nor any physician or dentist, shall be liable in any action arising out of a determination not to render emergency services or care if reasonable care is exercised in determining the condition of the person, or in determining the appropriateness of the facilities, or the qualifications and availability of personnel to render these services consistent with this section;

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

(6) Home health care services;

(7) Private duty nursing services;

(8) Physical therapy and related services;

(9) Dental services, excluding cast metal restorations;

(10) Laboratory and X-ray services;

(11) The following if prescribed by a licensed practitioner: drugs, eyeglasses, dentures, and prosthetic devices. The commissioner shall designate a formulary committee which shall advise the commissioner on the names of drugs for which payment shall be made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The commissioner shall appoint the formulary committee members no later than 30 days following July 1, 1981. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, three of whom shall be pharmacists who are not employed by the department of human services, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve two year terms and shall serve without compensation. The commissioner may establish a drug formulary. Its establishment and publication shall not be subject to the require-

ments of the administrative procedure act, but the formulary committee shall review and comment on the formulary contents. Prior authorization may be required by the commissioner, with the consent of the drug formulary committee, before certain formulary drugs are eligible for payment. The formulary shall not include: drugs or products for which there is no federal funding; over the counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, prenatal vitamins, and vitamins for children under the age of seven; or any other over the counter drug identified by the commissioner, in consultation with the appropriate professional consultants under contract with or employed by the state agency, as necessary, appropriate and cost effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14, the administrative procedure act; nutritional products, except for those products needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as requiring a similarly necessary nutritional product; anorectics; and drugs for which medical value has not been established. Separate payment shall not be made for nutritional products for residents of long-term care facilities; payment for dietary requirements is a component of the per diem rate paid to these facilities. Payment to drug vendors shall not be modified before the formulary is established except that the commissioner shall not permit payment for any drugs which may not by law be included in the formulary, and his determination shall not be subject to chapter 14, the administrative procedure act. The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

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

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

(12) Diagnostic, screening, and preventive services;

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

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

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

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

the report shall be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct; or

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

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

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

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

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

[For text of subds 9 and 10, see M.S.1984]

Subd. 11. "Related condition" means that condition defined in section 252.27, subdivision 1.

History: *1985 c 21 s 52-54; 1985 c 252 s 19,20; 1Sp1985 c 3 s 19*

256B.04 DUTIES OF STATE AGENCY.

[For text of subds 1 to 13, see M.S.1984]

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) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; and

(4) 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;

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

(5) wheelchair transportation services.

[For text of subd 15, see M.S.1984]

History: *1Sp1985 c 9 art 2 s 37*

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, United States Code, title 42, sections 670 to 676 under Minnesota Statutes, section 259.40 or 259.431; or

(2) who is a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676; or

(3) who is eligible for or receiving public assistance under the aid to families with dependent children program, the Minnesota supplemental aid program; or

(4) who is a pregnant woman, as certified in writing by a physician or nurse midwife, and who (a) meets the other eligibility criteria of this section, and (b) would be categorically eligible for assistance under the aid to families with dependent children program if the child had been born and was living with the woman; or

(5) who is a pregnant woman, as certified in writing by a physician or nurse midwife, who meets the other eligibility criteria of this section and whose unborn child would be eligible as a needy child under clause (9) if born and living with the woman; or

(6) who meets the categorical eligibility requirements of the supplemental security income program and the other eligibility requirements of this section; or

(7) 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 who meets the other eligibility requirements of this section; or

(8) 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

(9) who is an infant less than one year of age born on or after October 1, 1984, whose mother was eligible at the time of birth and who remains in the mother's household. Eligibility under this clause is concurrent with the mother's and does not depend on the father's income except as the income affects the mother's eligibility; or

(10) 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

(11) 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

(12) 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 or recipient as his primary place of residence, together with the contiguous land upon which it is situated. The homestead shall continue to be excluded for persons residing in a long-term care facility if it is used as a primary residence by the spouse, minor child, or disabled child of any age; or the applicant/recipient is expected to return to the home as a principal residence

within six calendar months of entry to the long-term care facility. Certification of expected return to the homestead shall be documented in writing by the attending physician. 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 the commissioner determines that sale of the real estate would cause undue hardship or unless the equity in the real estate when combined with the equity in the homestead totals $15,000 or less; and

(13) who individually does not own more than $3,000 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 $6,000 in cash or liquid assets, plus $200 for each additional legal dependent. Cash and liquid assets may include a prepaid funeral contract and insurance policies with cash surrender value. 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

(14) who has or anticipates receiving an annual income not in excess of the income standards by family size used in the aid to families with dependent children program, 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 due solely to increases in federal retiree, survivor's, and disability insurance benefits, veterans administration benefits, and railroad retirement benefits in the percentage amount established in the biennial appropriations law 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

(15) 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 human services, is to be applied to the cost of institutional care. The commissioner of human services may establish a schedule of contributions to be made by the spouse of a nursing home resident to the cost of care; and

(16) 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.

[For text of subd 3, see M.S.1984]

History: *1985 c 252 s 21*

256B.062 CONTINUED ELIGIBILITY.

Subdivision 1. 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.

Subd. 2. A family whose eligibility for aid to families with dependent children is terminated because of the loss of the $30, or the $30 and one-third earned income disregard is eligible for medical assistance for 12 calendar months following the month in which the family loses medical assistance eligibility as an aid to families with dependent children recipient.

History: *1Sp1985 c 9 art 2 s 38*

256B.0641 RECOVERY OF OVERPAYMENTS.

Subdivision 1. Notwithstanding section 256B.72 or any law or rule to the contrary, when the commissioner or the federal government determines that an overpayment has been made by the state to any medical assistance vendor, the commissioner shall recover the overpayment as follows:

(1) if the federal share of the overpayment amount is due and owing to the federal government under federal law and regulations, the commissioner shall recover from the medical assistance vendor the federal share of the determined overpayment amount paid to that provider using the schedule of payments required by the federal government; and

(2) if the overpayment to a medical assistance vendor is due to a retroactive adjustment made because the medical assistance vendor's temporary payment rate was higher than the established desk audit payment rate or because of a department error in calculating a payment rate, the commissioner shall recover from the medical assistance vendor the total amount of the overpayment within 120 days after the date on which written notice of the adjustment is sent to the medical assistance vendor or according to a schedule of payments approved by the commissioner.

History: *1Sp1985 c 9 art 2 s 39*

256B.07 EXCEPTIONS IN DETERMINING RESOURCES.

A local agency may, within the scope of regulations set by the commissioner of human services, waive the requirement of liquidation of excess assets when the liquidation would cause undue hardship. When an undue hardship waiver is granted due to excess assets created through a transfer of property under section 256B.17, subdivision 1, a cause of action exists against the person to whom the assets were transferred for that portion of medical assistance granted within 24 months of the transfer, or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action may be brought by the state or county agency responsible for providing medical assistance under section 256B.02, subdivision 3. Household goods and furniture in use in the home, wearing apparel, and personal property used as a regular abode by the applicant or recipient and a lot in a burial plot shall not be considered as resources available to meet medical needs.

History: *1985 c 252 s 22*

256B.091 NURSING HOME PREADMISSION SCREENING PROGRAM.

Subdivision 1. **Purpose.** It is the purpose of this section to prevent inappropriate nursing home or boarding care home placement by establishing a program of preadmission screening teams for all applicants seeking admission to a licensed nursing home or boarding care home participating in the medical assistance program. Further, it is the purpose of this section and the program to gain further information about how to contain costs associated with inappropriate nursing home or boarding care home admissions. The commissioners of human services and health shall seek to maximize use of available federal and state funds and establish the broadest program possible within the appropriation available.

Subd. 2. **Screening teams; establishment.** Each county agency designated by the commissioner of human services to participate in the program shall contract with the local board of health organized under sections 145.911 to 145.922 or other public or nonprofit agency to establish a screening team to assess the health and social needs of all applicants prior to admission to a nursing home or a boarding care home licensed under section 144A.02 or sections 144.50 to 144.56, that is certified for medical assistance as a skilled nursing facility, intermediate care facility level I, or intermediate care facility level II. Each local screening team shall be composed of a public health nurse from the local public health nursing service and a social worker from the local community welfare agency. Each screening team shall have a physician available for consultation and shall utilize individuals' attending physicians' physical assessment forms, if any, in assessing needs. The individual's physician shall be included on the screening team if the physician chooses to participate. If a person who has been screened must be reassessed for purposes of assigning a case mix classification because admission to a nursing home occurs later than the time allowed by rule following the initial screening and assessment, the reassessment may be completed by the public health nurse member of the screening team. If the individual is being discharged from an acute care facility, a discharge planner from that facility may be present, at the facility's request, during the screening team's assessment of the individual and may participate in discussions but not in making the screening team's recommendations under subdivision 3, clause (e). If the assessment procedure or screening team recommendation results in a delay of the individual's discharge from the acute care facility, the facility shall not be denied medical assistance reimbursement or incur any other financial or regulatory penalty of the medical assistance program that would otherwise be caused by the individual's extended length of stay; 50 percent of the cost of this reimbursement or financial or regulatory penalty shall be paid by the state and 50 percent shall be paid by the county. Other personnel as deemed appropriate by the county agency may be included on the team. The county agency may contract with an acute care facility to have the facility's discharge planners perform the functions of a screening team with regard to individuals discharged from the facility and in those cases the discharge planners may participate in making recommendations under subdivision 3, clause (e). No member of a screening team shall have a direct or indirect financial or self-serving interest in a nursing home or noninstitutional referral such that it would not be possible for the member to consider each case objectively.

[For text of subd 3, see M.S.1984]

Subd. 4. **Screening of persons.** Prior to nursing home or boarding care home admission, screening teams shall assess the needs of all applicants, except (1) patients transferred from other nursing homes; (2) patients who, having entered acute care facilities from nursing homes, are returning to nursing home care; (3) persons entering a facility described in section 256B.431, subdivision 4, paragraph (b); or (4)

persons entering a facility conducted by and for the adherents of a recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing. The cost for screening persons who are receiving medical assistance or who would be eligible for medical assistance within 180 days of nursing home or boarding care home admission, must be paid by state, federal, and county money. Other persons shall be assessed by a screening team upon payment of a fee approved by the commissioner.

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

[For text of subds 6 and 7, see M.S.1984]

Subd. 8. **Alternative care grants.** The commissioner shall provide grants to counties participating in the program to pay costs of providing alternative care to individuals screened under subdivision 4. Payment is available under this subdivision only for individuals (1) for whom the screening team would recommend nursing home admission if alternative care were not available; (2) who are receiving medical assistance or who would be eligible for medical assistance within 180 days of admission to a nursing home; (3) who need services that are not available at that time in the county through other public assistance; and (4) who are age 65 or older.

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

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

The commissioner shall apply for a waiver for federal financial participation to expand the availability of services under this subdivision. The commissioner shall provide grants to counties from the nonfederal share, unless the commissioner obtains a federal waiver for medical assistance payments, of medical assistance appropriations. A county agency may use grant money to supplement but not supplant services available through other public assistance or service programs and shall not use grant money to establish new programs for which public money is available through sources other than grants provided under this subdivision. A

county agency shall not use grant money to provide care under this subdivision to an individual if the anticipated cost of providing this care would exceed the average payment, as determined by the commissioner, for the level of nursing home care that the recipient would receive if placed in a nursing home. The nonfederal share may be used to pay up to 90 percent of the start-up and service delivery costs of providing care under this subdivision. Each county agency that receives a grant shall pay ten percent of the costs.

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

[For text of subd 9, see M.S.1984]

History: *1Sp1985 c 3 s 20-24*

256B.092 CASE MANAGEMENT OF PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

Subdivision 1. **County of financial responsibility; duties.** Before any services shall be rendered to persons with mental retardation or related conditions who are in need of social service and medical assistance, the county of financial responsibility shall conduct a diagnostic evaluation in order to determine whether the person is or may be mentally retarded or has or may have a related condition. If a client is diagnosed as mentally retarded or as having a related condition, that county must conduct a needs assessment, develop an individual service plan, provide ongoing case management services at the level identified in the individual service plan, and authorize placement for services. If the county of financial responsibility places a client in another county for services, the placement shall be made in cooperation with the host county of service, and arrangements shall be made between the two counties for ongoing social service, including annual reviews of the client's individual service plan. The host county may not make changes in the service plan without approval by the county of financial responsibility.

Subd. 1a. **Case management services.** Case management services include diagnosis, an assessment of the individual's service needs, an individual service plan, an individual habilitation plan, and methods for providing, evaluating and monitoring the services identified in the plan.

Subd. 1b. **Individual service and habilitation plans.** The individual service and habilitation plans must

(1) include the results of the diagnosis and assessment,

(2) identify goals and objectives for the client, and

(3) identify specific services to be provided to the client.

The individual habilitation plan shall carry out the goals and objectives of the individual service plan.

Subd. 2. **Medical assistance.** To assure quality case management to those county clients who are eligible for medical assistance, the commissioner shall, upon request by the county board: (a) provide consultation on the case management process; (b) assist county agencies in the screening and annual reviews of clients to assure that appropriate levels of service are provided; (c) provide consultation on service planning and development of services with appropriate options; (d) provide training and technical assistance to county case managers; and (e) authorize payment for medical assistance services.

Subd. 3. **Termination of services.** County agency case managers, under rules of the commissioner, shall authorize and terminate services of community and state

hospital providers in accordance with individual service plans. Medical assistance services not needed shall not be authorized by county agencies nor funded by the commissioner.

Subd. 4. **Alternative home and community-based services.** The commissioner shall make payments to county boards participating in the medical assistance program to pay costs of providing alternative home and community-based services to medical assistance eligible persons with mental retardation or related conditions who have been screened under subdivision 7. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with mental retardation or related conditions.

Subd. 5. **Federal waivers.** The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 to 1396p, as amended through December 31, 1982, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a state hospital or a community intermediate care facility for persons with mental retardation or related conditions. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 to 1396p, as amended through December 31, 1982, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services that would have been provided without the waivered services.

Subd. 6. **Rules.** The commissioner shall adopt emergency and permanent rules to establish required controls, documentation, and reporting of services provided in order to assure proper administration of the approved waiver plan.

Subd. 7. **Screening teams established.** Each county agency shall establish a screening team which, under the direction of the county case manager, shall make an evaluation of need for home and community-based services of persons who are entitled to the level of care provided by an intermediate care facility for persons with mental retardation or related conditions or for whom there is a reasonable indication that they might require the level of care provided by an intermediate care facility. The screening team shall make an evaluation of need within 15 working days of the request for service and within five working days of an emergency admission of an individual to an intermediate care facility for persons with mental retardation or related conditions. The screening team shall consist of the case manager, the client, a parent or guardian, a qualified mental retardation professional, as defined in the Code of Federal Regulations, title 42, section 442.401, as amended through December 31, 1982. For individuals determined to have overriding health care needs, a registered nurse must be designated as either the case manager or the qualified mental retardation professional. The case manager shall consult with the client's physician, other health professionals or other persons as necessary to make this evaluation. The case manager, with the concurrence of the client or the client's legal representative, may invite other persons to attend meetings of the screening team. No member of the screening team shall have any direct or indirect service provider interest in the case.

Subd. 8. **Screening team duties.** The screening team shall:

(a) review diagnostic data;

(b) review health, social, and developmental assessment data using a uniform screening tool specified by the commissioner;

(c) identify the level of services needed to maintain the person in the most normal and least restrictive setting that is consistent with treatment needs;

(d) identify other noninstitutional public assistance or social service that may prevent or delay long-term residential placement;

(e) assess whether a client is in serious need of long-term residential care;

(f) make recommendations regarding placement and payment for: (1) social service or public assistance support to maintain a client in the client's own home or other place of residence; (2) training and habilitation service, vocational rehabilitation, and employment training activities; (3) community residential placement; (4) state hospital placement; or (5) a home and community-based alternative to community residential placement or state hospital placement;

(g) identify the cost implications of recommendations in (f), above;

(h) make recommendations to a court as may be needed to assist the court in making commitments of mentally retarded persons; and

(i) inform clients that appeal may be made to the commissioner pursuant to section 256.045.

Subd. 9. **Reimbursement.** Payment shall not be provided to a service provider for any recipient placed in an intermediate care facility for persons with mental retardation or related conditions prior to the recipient being screened by the screening team. The commissioner shall not deny reimbursement for: (a) an individual admitted to an intermediate care facility for persons with mental retardation or related conditions who is assessed to need long-term supportive services, if long-term supportive services other than intermediate care are not available in that community; (b) any individual admitted to an intermediate care facility for persons with mental retardation or related conditions under emergency circumstances; (c) any eligible individual placed in the intermediate care facility for persons with mental retardation or related conditions pending an appeal of the screening team's decision; or (d) any medical assistance recipient when, after full discussion of all appropriate alternatives including those that are expected to be less costly than intermediate care for persons with mental retardation or related conditions, the individual or the individual's legal representative insists on intermediate care 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.

History: *1985 c 21 s 55; 1Sp1985 c 9 art 2 s 40-45*

256B.17 TRANSFERS OF PROPERTY.

[For text of subds 1 to 5, see M.S.1984]

Subd. 6. **Prohibited transfers of excluded resources.** Any individual who is an inpatient in a skilled nursing facility or an intermediate care facility who, at any time during or after the 24-month period immediately prior to application for medical assistance, disposed of a homestead for less than fair market value shall be ineligible for medical assistance in accordance with subdivisions 1 to 4. An individual shall not be ineligible for medical assistance if one of the following conditions applies to the homestead transfer:

(1) a satisfactory showing is made that the individual can reasonably be expected to return to the homestead as a permanent residence;

(2) title to the homestead was transferred to the individual's spouse, child who is under age 21, or blind or permanently and totally disabled child as defined in the supplemental security income program;

(3) a satisfactory showing is made that the individual intended to dispose of the homestead at fair market value or for other valuable consideration; or

(4) the local agency grants a waiver of the excess resources created by the uncompensated transfer because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well-being.

When a waiver is granted, a cause of action exists against the person to whom the homestead was transferred for that portion of medical assistance granted within 24 months of the transfer or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action may be brought by the state or the county agency responsible for providing medical assistance under section 256B.02, subdivision 3.

[For text of subds 7 and 8, see M.S.1984]

History: *1985 c 252 s 23*

256B.19 DIVISION OF COST.

Subdivision 1. **Division of cost.** 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 that participate in a medicaid demonstration project under sections 256B.69 and 256B.71, the division of the nonfederal share of medical assistance expenses for payments made to prepaid health plans or 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.

In counties where prepaid health plans are under contract to the commissioner to provide services to medical assistance recipients, the cost of court ordered treatment that does not include diagnostic evaluation, recommendation, or referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

[For text of subds 2 and 3, see M.S.1984]

History: *1Sp1985 c 9 art 2 s 46*

256B.36 PERSONAL ALLOWANCE FOR CERTAIN RECIPIENTS OF MEDICAL ASSISTANCE.

In addition to the personal allowance established in section 256B.35, any recipient of medical assistance with a handicap, mental retardation, or a related condition, 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: *1985 c 21 s 56*

256B.41 INTENT.

[For text of subds 1 and 2, see M.S.1984]

Subd. 3. **Payment rates.** Payment rates paid to any nursing home receiving medical assistance payments must be those rates established pursuant to this chapter and rules adopted under it.

History: *1Sp1985 c 9 art 2 s 47*

256B.411 COMPLIANCE WITH STATE STATUTES.

Subdivision 1. **Funding.** Subject to exceptions in section 256B.25, subdivision 3, no nursing home may receive any state or local payment for providing care to a person eligible for medical assistance, except under the medical assistance program.

Subd. 2. **Requirements.** No medical assistance payments shall be made to any nursing home unless the nursing home is certified to participate in the medical assistance program under title XIX of the federal Social Security Act and has in effect a provider agreement with the commissioner meeting the requirements of state and federal statutes and rules. No medical assistance payments shall be made to any nursing home unless the nursing home complies with all requirements of Minnesota Statutes including, but not limited to, this chapter and rules adopted under it that govern participation in the program. This section applies whether the nursing home participates fully in the medical assistance program or is withdrawing from the medical assistance program. No future payments may be made to any nursing home which has withdrawn or is withdrawing from the medical assistance program except as provided in section 256B.48, subdivision 1a; provided, however, that payments may also be made under a court order entered on or before June 7, 1985, unless the court order is reversed on appeal.

History: *1Sp1985 c 9 art 2 s 48*

256B.421 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this section and sections 256B.41, 256B.411, 256B.431, 256B.47, 256B.48, 256B.50, and 256B.502, the following terms and phrases shall have the meaning given to them.

[For text of subds 2 to 4, see M.S.1984]

Subd. 5. **General and administrative costs.** "General and administrative costs" means all allowable costs for administering the facility, including but not limited to: salaries of administrators, assistant administrators, accounting personnel, data processing personnel, and all clerical personnel; board of directors fees; business office functions and supplies; travel, except as necessary for training programs for nursing personnel and dieticians required to maintain licensure, certification, or professional standards requirements; telephone and telegraph; advertising; membership dues and subscriptions; postage; insurance, except as included as a fringe benefit under

subdivision 14; professional services such as legal, accounting and data processing services; central or home office costs; management fees; management consultants; employee training, for any top management personnel and for other than direct resident care related personnel; and business meetings and seminars.

[For text of subds 6 and 7, see M.S.1984]

Subd. 8. **Operating costs.** "Operating costs" means the day-to-day costs of operating the facility in compliance with licensure and certification standards. Operating cost categories are: nursing, including nurses and nursing assistants training; dietary; laundry and linen; housekeeping; plant operation and maintenance; other care-related services; medical directors; licenses, other than license fees required by the Minnesota department of health; permits; general and administration; payroll taxes; real estate taxes, license fees required by the Minnesota department of health, and actual special assessments paid; and fringe benefits, including clerical training; and travel necessary for training programs for nursing personnel and dieticians required to maintain licensure, certification, or professional standards requirements.

[For text of subds 9 to 15, see M.S.1984]

History: *1985 c 267 s 2; 1Sp1985 c 3 s 26; 1Sp1985 c 9 art 2 s 49*

256B.431 RATE DETERMINATION.

[For text of subds 1 to 2a, see M.S.1984]

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

(b) The commissioner shall contract with an econometric firm with recognized expertise in and access to national economic change indices that can be applied to the appropriate cost categories when determining the operating cost payment rate.

(c) The commissioner shall analyze and evaluate each nursing home's cost report of allowable operating costs incurred by the nursing home during the reporting year immediately preceding the rate year for which the payment rate becomes effective.

(d) The commissioner shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs for the reporting year that begins October 1, 1983, taking into consideration relevant factors including resident needs, geographic location, size of the nursing home, and the costs that must be incurred for the care of residents in an efficiently and economically operated nursing home. In developing the geographic groups for purposes of reimbursement under this section, the commissioner shall ensure that nursing homes in any county contiguous to the Minneapolis-St. Paul seven-county metropolitan area are included in the same geographic group. The limits established by the commissioner shall not be less, in the aggregate, than the 60th percentile of total actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year. The limits established under this paragraph remain in effect until the commissioner establishes a new base period. Until the new base period is established, the commissioner shall adjust the limits annually using the appropriate economic change indices established in paragraph (e). In determining allowable historical operating cost per diems for purposes of setting limits and nursing home payment rates, the commissioner shall divide the allowable historical

operating costs by the actual number of resident days, except that where a nursing home is occupied at less than 90 percent of licensed capacity days, the commissioner may establish procedures to adjust the computation of the per diem to an imputed occupancy level at or below 90 percent. The commissioner shall establish efficiency incentives as appropriate. The commissioner may establish efficiency incentives for different operating cost categories. The commissioner shall consider establishing efficiency incentives in care related cost categories. The commissioner may combine one or more operating cost categories and may use different methods for calculating payment rates for each operating cost category or combination of operating cost categories. For the rate year beginning on July 1, 1985, the commissioner shall:

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

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

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

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

(f) Each nursing home shall receive an operating cost payment rate equal to the sum of the nursing home's operating cost payment rates for each operating cost category. The operating cost payment rate for an operating cost category shall be the lesser of the nursing home's historical operating cost in the category increased by the appropriate index established in paragraph (e) for the operating cost category plus an efficiency incentive established pursuant to paragraph (d) or the limit for the operating cost category increased by the same index. If a nursing home's actual historic operating costs are greater than the prospective payment rate for that rate year, there shall be no retroactive cost settle-up. In establishing payment rates for one or more operating cost categories, the commissioner may establish separate rates for different classes of residents based on their relative care needs.

(g) The commissioner shall include the reported actual real estate tax liability of each proprietary nursing home as an operating cost of that nursing home. The commissioner shall include a reported actual special assessment, and reported actual license fees required by the Minnesota department of health, for each nursing home as an operating cost of that nursing home. Total real estate tax liability, actual special assessments paid, and license fees paid as required by the Minnesota department of health, for each nursing home (1) shall be divided by actual resident days in order to compute the operating cost payment rate for this operating cost category, (2) shall not be used to compute the 60th percentile or other operating cost limits established by the commissioner, and (3) shall not be increased by the composite index or indices established pursuant to paragraph (e).

[For text of subds 2c to 2f, see M.S.1984]

Subd. 2g. **Required consultants.** Costs considered general and administrative costs under section 256B.421 must be included in general and administrative costs in total, without direct or indirect allocation to other cost categories. In a nursing home of 60 or fewer beds, part of an administrator's salary may be allocated to other cost categories to the extent justified in records kept by the nursing home. Central

or home office costs representing services of required consultants in areas including, but not limited to, dietary, pharmacy, social services, or activities may be allocated to the appropriate department, but only if those costs are directly identified by the nursing home. Central, affiliated, or corporate office costs representing services of consultants not required by law in the areas of nursing, quality assurance, medical records, dietary, other care related services, and plant operations may be allocated to the appropriate operating cost category of a nursing home according to paragraphs (a) to (e).

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

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

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

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

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

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

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

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

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

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

Subd. 3. **Property-related costs, 1983-1985.** (a) For rate years beginning July 1, 1983 and July 1, 1984, property-related costs shall be reimbursed to each nursing home at the level recognized in the most recent cost report received by December 31, 1982 and audited by March 1, 1983, and may be subsequently adjusted to reflect the costs recognized in the final rate for that cost report, adjusted for rate limitations in effect before the effective date of this section. Property-related costs include: depreciation, interest, earnings or investment allowance, lease, or rental payments. No adjustments shall be made as a result of sales or reorganizations of provider entities.

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

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

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

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

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

(c) Annual per diem shall be computed by dividing total property-related costs by 96 percent of the nursing home's licensed capacity days for nursing homes with more than 60 beds and 94 percent of the nursing home's licensed capacity days for nursing homes with 60 or fewer beds. For a nursing home whose residents' average length of stay is 180 days or less, the commissioner may waive the 96 or 94 percent factor and divide the nursing home's property-related costs by the actual resident days to compute the nursing home's annual property-related per diem. The commissioner shall promulgate emergency and permanent rules to recapture excess depreciation upon sale of a nursing home.

Subd. 3a. **Property-related costs after July 1, 1985.** (a) For rate years beginning on or after July 1, 1985, the commissioner, by permanent rule, shall reimburse nursing home providers that are vendors in the medical assistance program for the rental use of real estate and depreciable equipment. "Real estate" means land improvements, buildings, and attached fixtures used directly for resident care. "Depreciable equipment" means the standard moveable resident care equipment and support service equipment generally used in long-term care facilities.

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

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

(2) minimize discretionary or appealable decisions;

(3) eliminate any incentives to sell nursing homes;

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

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

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

(7) establish an investment per bed limitation;

(8) reward efficient management of capital assets;

(9) provide equitable treatment of facilities;

(10) consider a variable rate; and

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

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

Subd. 4. **Special rates.** (a) For the rate years beginning July 1, 1983, and July 1, 1984, a newly constructed nursing home or one with a capacity increase of 50 percent or more may, upon written application to the commissioner, receive an interim payment rate for reimbursement for property-related costs calculated pursuant to the statutes and rules in effect on May 1, 1983 and for operating costs negotiated by the commissioner based upon the 60th percentile established for the appropriate group under subdivision 2a, to be effective from the first day a medical

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

(b) For the rate years beginning on or after July 1, 1985, a newly constructed nursing home or one with a capacity increase of 50 percent or more may, upon written application to the commissioner, receive an interim payment rate for reimbursement for property related costs, operating costs, and real estate taxes and special assessments calculated under rules promulgated by the commissioner.

(c) For rate years beginning on or after July 1, 1983, the commissioner may exclude from a provision of 12 MCAR S 2.050 any facility that is licensed by the commissioner of health only as a boarding care home, certified by the commissioner of health as an intermediate care facility, is licensed by the commissioner of human services under 12 MCAR S 2.036, and has less than five percent of its licensed boarding care capacity reimbursed by the medical assistance program. Until a permanent rule to establish the payment rates for facilities meeting these criteria is promulgated, the commissioner shall establish the medical assistance payment rate as follows:

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

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

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

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

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

For the rate year beginning July 1, 1985, each nursing home total payment rate must be effective two calendar months from the first day of the month after the commissioner issues the rate notice to the nursing home. From July 1, 1985, until the total payment rate becomes effective, the commissioner shall make payments to each nursing home at a temporary rate that is the prior rate year's operating cost payment rate increased by 2.6 percent plus the prior rate year's property-related payment rate and the prior rate year's real estate taxes and special assessments payment rate. The commissioner shall retroactively adjust the property-related

payment rate and the real estate taxes and special assessments payment rate to July 1, 1985, but must not retroactively adjust the operating cost payment rate.

[For text of subds 5 and 6, see M.S.1984]

History: *1985 c 248 s 40; 1985 c 267 s 3; 1Sp1985 c 3 s 25,27-29,31*

256B.48 CONDITIONS FOR PARTICIPATION.

[For text of subd 1, see M.S.1984]

Subd. 1a. **Termination.** If a nursing home terminates its participation in the medical assistance program, whether voluntarily or involuntarily, the commissioner may authorize the nursing home to receive continued medical assistance reimbursement only on a temporary basis until medical assistance residents can be relocated to nursing homes participating in the medical assistance program.

Subd. 1b. **Exception.** Notwithstanding any agreement between a nursing home and the department of human services or the provisions of this section or section 256B.411, other than subdivision 1a of this section, the commissioner may authorize continued medical assistance payments to a nursing home which ceased intake of medical assistance recipients prior to July 1, 1983, and which charges private paying residents rates that exceed those permitted by subdivision 1, paragraph (a), for (i) residents who resided in the nursing home before July 1, 1983, or (ii) residents for whom the commissioner or any predecessors of the commissioner granted a permanent individual waiver prior to October 1, 1983. In the event that the state is determined by the federal government to be no longer eligible for the federal share of medical assistance payments made to a nursing home under this subdivision, the commissioner may cease medical assistance payments, under this subdivision, to that nursing home.

[For text of subds 2 to 5, see M.S.1984]

Subd. 6. **Medicare certification.** All nursing homes certified as skilled nursing facilities under the medical assistance program shall participate in medicare part A and part B unless, after submitting an application, medicare certification is denied by the federal health care financing administration. Medicare review shall be conducted at the time of the annual medical assistance review. Charges for medicare-covered services provided to residents who are simultaneously eligible for medical assistance and medicare must be billed to medicare part A or part B before billing medical assistance. Medical assistance may be billed only for charges not reimbursed by medicare.

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

History: *1Sp1985 c 3 s 31; 1Sp1985 c 9 art 2 s 50-52*

256B.50 APPEALS.

Subdivision 1. **Scope.** A nursing home may appeal a decision arising from the application of standards or methods pursuant to sections 256B.41 and 256B.47 if the appeal, if successful, would result in a change to the nursing home's payment rate, or appraised value. The appeal procedures also apply to appeals of payment rates calculated under 12 MCAR S 2.049 filed with the commissioner on or after May 1, 1984. This section does not apply to a request from a resident or nursing home for reconsideration of the classification of a resident under section 144.0722. To appeal, the nursing home shall notify the commissioner in writing of its intent to appeal within 30 days and submit a written appeal request within 60 days of receiving notice of the payment rate determination or decision. The appeal request shall specify each disputed item, the reason for the dispute, an estimate of the dollar amount involved for each disputed item, the computation that the nursing home believes is correct, the authority in statute or rule upon which the nursing home relies for each disputed item, the name and address of the person or firm with whom contacts may be made regarding the appeal, and other information required by the commissioner.

Except as provided in subdivision 2, the appeal shall be heard by an administrative law judge according to sections 14.48 to 14.56, or upon agreement by both parties according to a modified appeals procedure established by the commissioner and the administrative law judge. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect. Regardless of any rate appeal, the rate established shall be the rate paid and shall remain in effect until final resolution of the appeal or subsequent desk or field audit adjustment, notwithstanding any provision of law or rule to the contrary. To challenge the validity of rules established by the commissioner pursuant to this section and sections 256B.41, 256B.421, 256B.431, 256B.47, 256B.48, and 256B.502, a nursing home shall comply with section 14.44.

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

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

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

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

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

History: *1Sp1985 c 3 s 32*

256B.501 RATES FOR COMMUNITY-BASED SERVICES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meaning given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Facility" means a facility licensed as a mental retardation residential facility under section 252.28, licensed as a supervised living facility under chapter 144, and certified as an intermediate care facility for persons with mental retardation or related conditions.

(c) "Waivered service" means home or community-based service authorized under United States Code, title 42, section 1396n(c), as amended through December 31, 1982, and defined in the Minnesota state plan for the provision of medical assistance services. Waivered services include, at a minimum, case management, family training and support, developmental training homes, supervised living arrangements, semi-independent living services, respite care, and training and habilitation services.

(d) "Training and habilitation services" are those health and social services needed to ensure optimal functioning of persons with mental retardation or related conditions. Training and habilitation services shall be provided to a client away from the residence unless medically contraindicated by an organization which does not have a direct or indirect financial interest in the organization which provides the person's residential services. This requirement shall not apply to any developmental achievement center which has applied for licensure prior to April 15, 1983.

Subd. 2. **Authority.** The commissioner shall establish procedures and rules for determining rates for care of residents of intermediate care facilities for persons with mental retardation or related conditions which qualify as vendors of medical assistance, waivered services, and for provision of training and habilitation services. Approved rates shall be established on the basis of methods and standards that the commissioner finds adequate to provide for the costs that must be incurred for the quality care of residents in efficiently and economically operated facilities and services. The procedures shall specify the costs that are allowable for payment through medical assistance. The commissioner may use experts from outside the department in the establishment of the procedures.

Subd. 3. **Rates for intermediate care facilities for persons with mental retardation or related conditions.** The commissioner shall establish, by rule, procedures for determining rates for care of residents of intermediate care facilities for persons with mental retardation or related conditions. The procedures shall be based on methods and standards that the commissioner finds are adequate to provide for the costs that must be incurred for the care of residents in efficiently and economically operated facilities. In developing the procedures, the commissioner shall include:

(a) cost containment measures that assure efficient and prudent management of capital assets and operating cost increases which do not exceed increases in other sections of the economy;

(b) limits on the amounts of reimbursement for property, general and administration, and new facilities;

(c) requirements to ensure that the accounting practices of the facilities conform to generally accepted accounting principles; and

(d) incentives to reward accumulation of equity.

In establishing rules and procedures for setting rates for care of residents in intermediate care facilities for persons with mental retardation or related conditions, the commissioner shall consider the recommendations contained in the February 11, 1983, Report of the Legislative Auditor on Community Residential Programs for the Mentally Retarded and the recommendations contained in the 1982 Report of the Department of Public Welfare Rule 52 Task Force. Rates paid to supervised living facilities for rate years beginning during the fiscal biennium ending June 30, 1985, shall not exceed the final rate allowed the facility for the previous rate year by more than five percent.

Subd. 4. **Waivered services.** In establishing rates for waivered services the commissioner shall consider the need for flexibility in the provision of those services to meet individual needs identified by the screening team.

Subd. 5. **Training and habilitation services.** (a) Except as provided in subdivision 6, rates for reimbursement under medical assistance for training and habilitation services provided by a developmental achievement center either as a waivered service or to residents of an intermediate care facility for persons with mental retardation or related conditions shall be established and paid in acccordance with this subdivision effective January 1, 1984.

(b) Prior to August 1, 1983, the county board shall submit to the commissioner its contractual per diem rate and its maximum per client annual payment limitations, if any, for each developmental achievement center it administers pursuant to section 252.24, subdivision 1, for the period from July 1, 1983, through December 31, 1983, which shall be the medical assistance reimbursement rate established for that developmental achievement center for 1983. If the county rate is based on average daily attendance which is less than 93 percent of the developmental achievement center's average enrollment for the period from July 1, 1983, to December 31, 1983, the commissioner shall adjust that rate based on 93 percent average daily attendance.

(c) The base per diem reimbursement rate established for 1983 may be increased by the commissioner in 1984 in an amount up to the projected percentage change in the average value of the consumer price index (all urban) for 1984 over 1983. In subsequent years, the increase in the per diem rate shall not exceed the projected percentage change in the average annual value of the consumer price index (all urban) for the same time period.

(d) The county board in which an intermediate care facility for persons with mental retardation or related conditions is located shall contract annually with that facility and with the appropriate developmental achievement center or training and habilitation service provider for provision of training and habilitation services for each resident of the facility for whom the services are required by the resident's individual service plan. This contract shall specify the county payment rate or the medical assistance reimbursement rate, as appropriate; the training and habilitation services to be provided; and the performance standards for program provision and evaluation. A similar contract shall be entered into between the county and the developmental achievement center for persons receiving training and habilitation services from that center as a waivered service.

(e) The commissioner shall reimburse under medical assistance up to 210 days of training and habilitation services at developmental achievement centers for those centers which provided less than or equal to 210 days of training and habilitation services in calendar year 1982. For developmental achievement centers providing

more than 210 days of services in 1982, the commissioner shall not reimburse under medical assistance in excess of the number of days provided by those programs in 1982.

(f) Medical assistance payments for training and habilitation services shall be made directly to the training and habilitation provider after submission of invoices to the medical assistance program following procedures established by the medical assistance program.

(g) Nothing in this subdivision shall prohibit county boards from contracting for rates for services not reimbursed under medical assistance.

Subd. 6. **New developmental achievement programs; rates.** The commissioner, upon the recommendation of the local county board, shall determine the medical assistance reimbursement rate for new developmental achievement programs. The payment rate shall not exceed 125 percent of the average payment rate in the region.

Subd. 7. **Alternative rates for training and habilitation services.** Alternative methods may be proposed by the counties or the commissioner for provision of training and habilitation services during daytime hours apart from a residential facility to persons for whom needs identified in their individual service plan are not met by the training and habilitation services provided at a developmental achievement center. The commissioner shall establish procedures for approval of the proposals and for medical assistance payment of rates which shall not exceed the average rate allowed in that county for training and habilitation services pursuant to subdivision 5. Nothing in this subdivision prohibits a county from contracting with a developmental achievement center for those purposes.

Subd. 8. **Payment for persons with special needs.** The commissioner shall establish by December 31, 1983, procedures to be followed by the counties to seek authorization from the commissioner for medical assistance reimbursement for waivered services or training and habilitation services for very dependent persons with special needs in an amount in excess of the rates allowed pursuant to subdivisions 2, 4, 5, and 6, and procedures to be followed for rate limitation exemptions for intermediate care facilities for persons with mental retardation or related conditions. No excess payment or limitation exemption shall be authorized unless the need for the service is documented in the individual service plan of the person or persons to be served, the type and duration of the services needed are stated, and there is a basis for estimated cost of the services.

The commissioner shall evaluate the services provided pursuant to this subdivision through program and fiscal audits.

Subd. 9. **Reporting requirements.** The developmental achievement center shall submit to the county and the commissioner no later than March 1 of each year an annual report which includes the actual program revenues and expenditures, client information, and program information. The information shall be submitted on forms prescribed by the commissioner.

Subd. 10. **Rules.** To implement this section, the commissioner shall promulgate emergency and permanent rules in accordance with chapter 14. To implement subdivision 3, the commissioner shall promulgate emergency rules and permanent rules in accordance with sections 14.01 to 14.38. Notwithstanding the provisions of section 14.35, the emergency rule promulgated to implement subdivision 3 shall be effective for up to 720 days.

History: *1985 c 21 s 57*

256B.503 RULES.

To implement Laws 1983, chapter 312, article 9, sections 1 to 7, the commissioner shall promulgate emergency and permanent rules in accordance with sections

14.01 to 14.38. Rules adopted to implement Laws 1983, chapter 312, article 9, section 5, must (a) be in accord with the provisions of Minnesota Statutes, chapter 256E, (b) set standards for case management which include, encourage and enable flexible administration, (c) require the county boards to develop individualized procedures governing case management activities, (d) consider criteria promulgated under section 256B.092, subdivision 3, and the federal waiver plan, (e) identify cost implications to the state and to county boards, and (f) require the screening teams to make recommendations to the county case manager for development of the individual service plan.

The commissioner shall adopt permanent rules to implement this section by July 1, 1986. Emergency rules adopted under this section are effective until that date.

History: *1Sp1985 c 9 art 2 s 53*

256B.504 LEGISLATIVE COMMISSION ON LONG-TERM HEALTH CARE.

Subdivision 1. A legislative commission is created

(a) to monitor the inspection and regulation activities, including rule developments, of the departments of health and human services with the goals of improving quality of care and controlling health care costs;

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

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

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

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

The commission shall consider the use of such alternatives as private insurance, private annuities, health maintenance organizations, preferred provider organizations, medicare, and such other alternatives as the commission may deem worthy of study.

[For text of subds 2 to 5, see M.S.1984]

History: *1Sp1985 c 3 s 33*

256B.72 RIGHT OF APPEAL.

The commissioner shall not recover overpayments from medical assistance vendors if an administrative appeal or judicial action challenging the proposed recovery is pending.

History: *1Sp1985 c 9 art 2 s 54*