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, 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 the applicant resides at the time of application;

(b) for an applicant who resides in a facility described in subdivision 2, the county in which the applicant 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.

Subd. 4. "Medical institution" means any licensed medical facility that receives a license from the Minnesota health department or department of human services or appropriate licensing authority of this state, any other state, or a Canadian province.

Subd. 5. "State agency" means the commissioner of human services.

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 the vendor's 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; 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 requirements of the administrative procedure act, but the formulary committee shall review and comment on the formulary contents. Prior authorization may be required by the commissioner, with the consent of the drug formulary committee, before certain formulary drugs are eligible for payment. The formulary shall not include: drugs or products for which there is no federal funding; over-the-counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, prenatal vitamins, and vitamins for children under the age of seven; or any other over-the-counter drug identified by the commissioner, in consultation with the appropriate professional consultants under contract with or employed by the state agency, as necessary, appropriate and cost effective for the

treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14, the administrative procedure act; nutritional products, except for those products needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as requiring a similarly necessary nutritional product; anorectics; and drugs for which medical value has not been established. Separate payment shall not be made for nutritional products for residents of long-term care facilities; payment for dietary requirements is a component of the per diem rate paid to these facilities. Payment to drug vendors shall not be modified before the formulary is established except that the commissioner shall not permit payment for any drugs which may not by law be included in the formulary, and the commissioner's 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, except licensed chemical dependency treatment programs or primary treatment or extended care treatment units in hospitals that are covered under Laws 1986, chapter 394, sections 8 to 20. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but payment must be made under Laws 1986, chapter 394, sections 8 to 20.

Subd. 9. "Private health care coverage" means any plan regulated by chapter 62A, 62C or 64B. 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.

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

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 26,54; 1Sp1981 c 2 s 12; 1Sp1981 c 4 art 4 s 22; 3Sp1981 c 2 art 1 s 31; 1982 c 562 s 2; 1983 c 151 s 1,2; 1983 c 312 art 1 s 27; art 5 s 10; art 9 s 4; 1984 c 654 art 5 s 58; 1985 c 21 s 52-54; 1985 c 49 s 41; 1985 c 252 s 19,20; 1Sp1985 c 3 s 19; 1986 c 394 s 17; 1986 c 444*

NOTE: Subdivision 8, as amended by Laws 1986, chapter 394, section 17, is effective July 1, 1987. See Laws 1986, chapter 394, section 24.

NOTE: The amendment to subdivision 8 by Laws 1986, chapter 394, section 17, is repealed July 1, 1987, unless adequate funding is made available to meet the cash-flow and capital needs of the regional treatment center chemical dependency units as determined by the commissioner in consultation with the chief executive officers of those units. See Laws 1986, chapter 394, section 23.

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. For purposes of this section, "final rate" means the rate established after any adjustment by the commissioner, including but not limited to adjustments resulting from cost report reviews, field audits, and computations of unimplemented cost changes. Regardless of any rate appeal, the rate established shall be the rate paid and shall remain in effect until final resolution of the appeal, subsequent desk or field audit adjustment, notwithstanding any provision of law or rule to the contrary.

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 27,54; 1Sp1981 c 2 s 13; 1Sp1981 c 4 art 4 s 22; 3Sp1982 c 1 art 2 s 4; 1983 c 312 art 1 s 27*

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, 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 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 emergency rules, establishing maximum reimbursement rates for emergency and nonemergency transportation.

The rules shall provide:

(a) An opportunity for all recognized transportation providers to be reimbursed for nonemergency 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 the appointee(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 the appointee's 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) 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.

Subd. 15. **Utilization review.** Establish on a statewide basis a new program to safeguard against unnecessary or inappropriate use of medical assistance services, against excess payments, against unnecessary or inappropriate hospital admissions or lengths of stay, and against underutilization of services in prepaid health plans, long-

term care facilities or any health care delivery system subject to fixed rate reimbursement. In implementing the program, the state agency shall utilize both prepayment and postpayment review systems to determine if utilization is reasonable and necessary. The determination of whether services are reasonable and necessary shall be made by the commissioner in consultation with a professional services advisory group appointed by the commissioner. An aggrieved party may appeal the commissioner's determination pursuant to the contested case procedures of chapter 14.

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; 1983 c 312 art 5 s 11,12; 1984 c 640 s 32; 1985 c 248 s 70; 1Sp1985 c 9 art 2 s 37; 1986 c 444*

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. **Account.** An account is established in the state treasury from which medical assistance payments to vendors shall be made. Into this account there shall be deposited federal funds, state funds, county 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. **Payment by county to state treasurer.** If required by federal law or rules promulgated thereunder, or by authorized rule 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.

The county shall advance its portion of medical assistance costs, based upon estimates submitted by the state agency to the county agency, stating the estimated expenditures for the succeeding month. Upon the direction of the county agency, payment shall be made monthly by the county to the state for the estimated expenditures for each month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.

Subd. 6. The commissioners of human services 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 nonemergency medical care when so authorized by rule of the commissioner of human services.

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; 1983 c 312 art 5 s 13,14; 1984 c 654 art 5 s 58; 1985 c 248 s 70*

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 the person's 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 court administrator 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; 1986 c 444; 1Sp1986 c 3 art 1 s 82*

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 human services 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.

Subd. 4. **Presentation materials.** In counties where health maintenance organizations or other prepaid health plans are under contract with the state to provide medical services, the county agency shall present all of the health care options available to recipients and shall include any audiovisual presentations or written materials provided to the county agency by the state agency. The state agency shall monitor county agency presentations.

History: *Ex1967 c 16 s 5; 1971 c 961 s 28; 1982 c 640 s 4; 1984 c 580 s 3; 1984 c 654 art 5 s 58*

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 the person nor the person's 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 rules of the state agency; and

(12) who alone, or together with the person's 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 a 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. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. For residents of long-term care facilities, the accumulation of the clothing and personal needs allowance pursuant to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. 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 rules of the state agency. Notwithstanding any laws or rules to the contrary, in computing

income to determine eligibility of persons who are not residents of long-term care facilities, the commissioner shall disregard increases in income as required by Public Law Number 94-566, section 503. 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 the person's 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 the person or the person's spouse from automobile accident coverage and private health care coverage to the costs of medical care for the person, the 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 except for having a permanent place of abode in another state, shall be eligible for medical assistance and shall have medical needs met by the county in which the worker 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; 1983 c 312 art 5 s 15; 1984 c 422 s 1; 1984 c 534 s 22; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1985 c 252 s 21; 1986 c 444; 1Sp1986 c 1 art 8 s 5*

256B.061 ELIGIBILITY.

If any individual has been determined to be eligible for medical assistance, it will be made available for care and services included under the plan and furnished in or after the third month before the month in which the individual 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. The commissioner may limit, restrict, or suspend the eligibility of an individual for up to one year upon that individual's conviction of a criminal offense related to application for or receipt of medical assistance benefits.

History: *1973 c 717 s 3; 1983 c 312 art 5 s 16; 1986 c 444*

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: *1973 c 717 s 4; 1981 c 231 s 1; 1Sp1985 c 9 art 2 s 38*

256B.063 COST SHARING.

Notwithstanding the provisions of section 256B.05, subdivision 2, the commissioner is authorized to promulgate rules pursuant to the administrative procedure 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. **Grounds for monetary recovery and sanctions against vendors.** 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 services not medically necessary shall be made by the commissioner in consultation with a provider advisory committee 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; 1983 c 312 art 5 s 17*

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.065 SOCIAL SECURITY AMENDMENTS.

The commissioner shall comply with requirements of the social security amendments of 1972 (Public Law Number 92-603) necessary in order to avoid loss of federal funds, and shall implement by rule, pursuant to the administrative procedure 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 rules 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: *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; 1983 c 312 art 5 s 18; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1985 c 252 s 22*

256B.08 APPLICATION.

An applicant for medical assistance hereunder, or a person acting in the applicant's behalf, shall file an 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; 1986 c 444*

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 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.

Individuals not eligible for medical assistance who are being transferred from a

hospital to a nursing home may be screened by only one member of the screening team in consultation with the other member. The interagency board for quality assurance, with the participation of members of screening teams, shall identify other circumstances when it would be appropriate for only one member of a screening team to conduct the nursing home preadmission screenings. The committee shall report its recommendations to the legislature in January, 1987.

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 human services.

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 (c); (4) individuals not eligible for medical assistance whose length of stay is expected to be 30 days or less based on a physician's certification, if the facility notifies the screening team upon admission and provides an update to the screening team on the 30th day after admission; (5) individuals who have a contractual right to have their nursing home care paid for indefinitely by the veteran's administration; or (6) 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 applicants who are receiving medical assistance must be paid by the medical assistance program. The total screening cost for each county for applicants who are not eligible for medical assistance must be paid monthly by nursing homes and boarding care homes participating in the medical assistance program in the county. The monthly amount to be paid by each nursing home and boarding care home must be determined by dividing the county's estimate of the total annual cost of screenings allowed by the commissioner in the county for the following rate year by 12 to determine the monthly cost estimate and allocating the monthly cost estimate to each nursing home and boarding care home based on the number of licensed beds in the nursing home or boarding care home. The monthly cost estimate for each nursing home must be submitted to the nursing home and the state by the county no later than February 15 of each year for inclusion in the nursing home's payment rate on the following rate year. The commissioner shall include the reported annual estimated cost of screenings for each nursing home or boarding care home as an operating cost of that nursing home in accordance with section 256B.431, subdivision 2b, clause (g). For all individuals regardless of payment source, if delay-of-screening timelines are not met because a county is late in screening an individual who meets the delay-of-screening criteria, the county is solely responsible

for paying the nursing home rate for the resident days that exceed the delay-of-screening timelines until the screening is completed. Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

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.

Subd. 6. **Reimbursement.** The commissioner of human services 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 human services, 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 and nursing home residents who request a screening. Prior to July of each year, the commissioner shall allocate state funds available for alternative care grants to each local agency. This allocation must be made as follows: half of the state funds available for alternative care grants must be allocated to each county according to the total number of adults in that county who are recipients age 65 or older who are reported to the department by March 1 of each state fiscal year and half of the state funds available for alternative care grants must be allocated to a county according to that county's number of medicare enrollments age 65 or older for the most recent statistical report. Payment is available under this subdivision only for individuals (1) for whom the screening team would recommend nursing home admission or continued stay 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.

The commissioner shall establish by rule, in accordance with chapter 14, procedures for determining grant reallocations, limits on the rates for payment of approved services, including screenings, and submittal and approval of a biennial county plan for the administration of the preadmission screening and alternative care grants program. Grants may be used for payment of costs of providing care-related supplies, equipment, and 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), and that a client's service needs and eligibility is reassessed at least every six months. 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 and to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private. The county agency shall document to the commissioner that the agency made reasonable efforts to inform potential providers of the anticipated need for services under the alternative care grants program and that the agency allowed potential providers an opportunity to be selected to contract with the county board. 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.

Subd. 9. **Rules.** The commissioner of human services shall promulgate emergency 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; 1983 c 199 s 6-9; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1Sp1985 c 3 s 20-24; 1986 c 420 s 7-10; 1Sp1986 c 3 art 1 s 28*

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: *1983 c 312 art 9 s 5; 1984 c 640 s 32; 1985 c 21 s 55; 1Sp1985 c 9 art 2 s 40-45*

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. In determining the resource contribution of a spouse at the time of the first medical assistance application, all medical assistance exclusions shall be allowed, and a resource limit of $10,000 for nonexcluded resources shall be implemented. Above these limits, a contribution of one-third of the excess resources shall be required. These rules shall not require repayment when payment would cause undue hardship to the responsible relative or that relative's immediate family. These rules shall be consistent with the requirements of section 252.27, subdivision 2, for parents of children whose eligibility for medical assistance was determined without deeming of the parents' resources and income. For parents of children receiving services under a federal medical assistance waiver while living in their natural home, including in-home family support services, respite care, homemaker services, and minor adaptations to the home, the state agency shall take into account the room, board, and services provided by the parents in determining the parental contribution to the cost of care. 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; 1983 c 312 art 5 s 19; 1984 c 530 s 4; 1986 c 444*

256B.15 CLAIMS AGAINST ESTATES.

If a person receives any medical assistance hereunder, on the person's death, if single, or on the death of the person and the surviving spouse, if married, and only when there is 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; 1986 c 444*

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, sold, or disposed of 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 given away, sold, or disposed of, less the amount of compensation received.

Subd. 4. **Period of ineligibility.** For any uncompensated transfer, the period of ineligibility shall be calculated by dividing the uncompensated transferred amount by the statewide average monthly skilled nursing facility per diem for the previous calendar year to determine the number of months of ineligibility. The individual shall remain ineligible until this fixed ineligibility period has expired. The period of ineligibility may exceed 24 months, and a reapplication for benefits after 24 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired.

Subd. 5. **Excluded resources.** Except for the limitations contained in subdivision 6, a resource which is transferred while otherwise excluded under sections 256B.06 and 256B.07 shall not be considered an available resource for purposes of medical assistance eligibility. This exception shall not apply to applicants for or recipients of general assistance medical care benefits under chapter 256D.

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.

Subd. 7. **Exception for asset transfers.** Notwithstanding the provisions of subdivisions 1 to 6, an institutionalized spouse who applies for medical assistance on or after July 1, 1983, may transfer liquid assets to a noninstitutionalized spouse without loss of eligibility if all of the following conditions apply:

(a) The noninstitutionalized spouse is not applying for or receiving assistance;

(b) The noninstitutionalized spouse has less than $10,000 in liquid assets, including assets singly owned and 50 percent of assets owned jointly with the institutionalized spouse;

(c) The amount transferred, together with the noninstitutionalized spouse's own assets, totals no more than $10,000 in liquid assets; and

(d) The transfer may be effected only once, at the time of initial medical assistance application.

Subd. 8. **Conformance with federal law.** Notwithstanding the other provisions of this section, uncompensated property transfers shall be treated no more restrictively than allowed by federal law.

History: *Ex1967 c 16 s 17; 1981 c 360 art 2 s 30; 1983 c 312 art 5 s 20-24; 1984 c 534 s 23; 1985 c 252 s 23; 1986 c 444*

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. **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.

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.

Subd. 3. **Study of medical assistance financial participation.** The commissioner shall study the feasibility and outcomes of implementing a variable medical assistance county financial participation rate for long-term care services to mentally retarded persons in order to encourage the utilization of alternative services to long-term intermediate care for the mentally retarded. The commissioner shall submit findings and recommendations to the legislature by January 20, 1984.

History: *Ex1967 c 16 s 19; 1971 c 547 s 1; 1975 c 437 art 2 s 7; 1982 c 640 s 7; 1983 c 312 art 9 s 6; 1984 c 534 s 24; 1Sp1985 c 9 art 2 s 46; 1986 c 444*

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 the auditor 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 money 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 a 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 ten 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 ten days after such certification, from the state treasury upon warrant of the commissioner of finance from any money available therefor. The money 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; 1986 c 444*

256B.21 CHANGE OF RESIDENCE.

On changing residence, a recipient shall notify the county agency through which the recipient's medical assistance hereunder is paid. On removing to another county, the recipient shall declare whether such absence is temporary or for the purpose of residing therein.

History: *Ex1967 c 16 s 21; 1986 c 444*

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 Number 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 CERTIFIED FACILITIES.

Subdivision 1. 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 and if applicable, certified by an appropriate authority under United States Code, title 42, sections 1396-1396p.

Subd. 2. The payment of state or county funds to nursing homes, boarding care homes, and supervised living facilities, except payments to state operated institutions, for the care of persons who are eligible for medical assistance, shall be made only through the medical assistance program, except as provided in subdivision 3.

Subd. 3. The limitation in subdivision 2 shall not apply to:

(a) payment of Minnesota supplemental assistance funds to recipients who reside in facilities which are involved in litigation contesting their designation as an institution for treatment of mental disease;

(b) payment or grants to a boarding care home or supervised living facility licensed by the department of human services under Minnesota Rules, parts 9520.0500 to 9520.0690, 9530.2500 to 9530.4000, 9545.0900 to 9545.1090, or 9545.1400 to 9545.1500, or payment to recipients who reside in these facilities;

(c) payments or grants to a boarding care home or supervised living facility which are ineligible for certification under United States Code, title 42, sections 1396-1396p;

(d) payments or grants otherwise specifically authorized by statute or rule.

History: *Ex1967 c 16 s 25; 1969 c 395 s 2; 1984 c 641 s 13; 1984 c 654 art 5 s 58; 1985 c 248 s 69*

256B.26 AGREEMENTS WITH OTHER STATE DEPARTMENTS.

The commissioner of the department of human services 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; 1984 c 654 art 5 s 58*

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 human services may require any reports, information, and audits of medical vendors which the commissioner 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 on-site 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 human services, with the written consent of the recipient, on file wih the local welfare agency, 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 provision of services not medically necessary shall be made by the commissioner in consultation with an advisory committee 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 human services pursuant to this section.

Subd. 4. **Authorization of commissioner to examine records.** A person determined to be eligible for medical assistance shall be deemed to have authorized the commissioner of human services 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.

Subd. 5. Medical records obtained by the commissioner of human services 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; 1983 c 312 art 5 s 25,26; 1984 c 654 art 5 s 58; 1986 c 444*

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 human services the reports as may be required under law and under rules adopted by the commissioner of human services under the administrative procedure 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 human services.

History: *1973 c 688 s 8; 1976 c 173 c 57; 1984 c 654 art 5 s 58*

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 $40 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 human services 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 human services 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 the recipient's 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; 1984 c 534 s 25; 1984 c 654 art 5 s 58; 1986 c 444*

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 as a recipient of aid to the disabled benefits in December, 1973, whichever amount is lower.

History: *1974 c 575 s 16; 1985 c 21 s 56; 1986 c 444*

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. **Authority.** The commissioner shall establish, by rule, procedures for determining rates for care of residents of nursing homes which qualify as vendors of medical assistance, and for implementing the provisions of this section and sections 256B.421, 256B.431, 256B.47, 256B.48, 256B.50, and 256B.502. 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 nursing homes and shall specify the costs that are allowable for establishing payment rates through medical assistance.

Subd. 2. **Federal requirements.** If any provision of this section and sections 256B.421, 256B.431, 256B.47, 256B.48, 256B.50, and 256B.502, 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.

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: *1976 c 282 s 1; 1983 c 199 s 10; 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.42 [Repealed, 1983 c 199 s 19]

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.

Subd. 2. **Actual allowable historical operating cost per diem.** "Actual allowable historical operating cost per diem" means the per diem operating costs allowed by the commissioner for the most recent reporting year.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 4. **Final rate.** "Final rate" means the rate established after any adjustment by the commissioner, including but not limited to adjustments resulting from cost report reviews and field audits.

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.

Subd. 6. **Historical operating costs.** "Historical operating costs" means the allowable operating costs incurred by the facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective, after the commissioner has reviewed those costs and determined them to be allowable costs under the medical assistance program, and after the commissioner has applied appropriate limitations such as the limit on administrative costs.

Subd. 7. **Nursing home.** "Nursing home" means a facility licensed under chapter 144A or a boarding care facility licensed under sections 144.50 to 144.56.

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.

Subd. 9. **Payment rate.** "Payment rate" means the rate determined under section 256B.431.

Subd. 10. **Private paying resident.** "Private paying resident" means a nursing home resident who is not a medical assistance recipient and whose payment rate is not established by another third party, including the veterans administration or medicare.

Subd. 11. **Rate year.** "Rate year" means the fiscal year for which a payment rate determined under section 256B.431 is effective, from July 1 to the next June 30.

Subd. 12. **Reporting year.** "Reporting year" means the period from October 1 to September 30, immediately preceding the rate year, for which the nursing home submits reports required under section 256B.48, subdivision 2.

Subd. 13. **Actual resident day.** "Actual resident day" means a billable, countable day as defined by the commissioner.

Subd. 14. **Fringe benefits.** "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, and uniform allowances.

Subd. 15. **Payroll taxes.** "Payroll taxes" means the employer's share of FICA taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes.

History: *1983 c 199 s 11; 1984 c 641 s 14-16; 1984 c 654 art 5 s 58; 1985 c 267 s 2; 1Sp1985 c 3 s 26; 1Sp1985 c 9 art 2 s 49*

256B.43 [Repealed, 1983 c 199 s 19]

256B.431 RATE DETERMINATION.

Subdivision 1. **In general.** The commissioner shall determine prospective payment rates for resident care costs. In determining the rates, the commissioner shall group nursing homes according to different levels of care and geographic location until July 1, 1985. For rates established on or after July 1, 1985, the commissioner shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs, geographic location, and other factors as determined by the commissioner. The commissioner shall consider whether the fact that a facility is attached to a hospital or has an average length of stay of 180 days or less should be taken into account in determining rates. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. Until the commissioner establishes procedures for determining operating cost payment rates, the commissioner shall group all convalescent and nursing care units attached to hospitals into one group for purposes of determining reimbursement for operating costs. On or before June 15, 1983, the commissioner shall mail notices to each nursing home of the rates to be effective from July 1 of that year to June 30 of the following year. In subsequent years, the commissioner shall provide notice to each nursing home on or before May 1 of the rates effective for the following rate year. If a statute enacted after May 1 affects the rates, the commissioner shall provide a revised notice to each nursing home as soon as possible.

The commissioner shall establish, by rule, limitations on compensation recognized in the historical base for top management personnel. For rate years beginning July 1, 1985, the commissioner shall not provide, by rule, limitations on top management personnel. Compensation for top management personnel shall continue to be categorized as a general and administrative cost and is subject to any limits imposed on that cost category. The commissioner shall also establish, by rule, limitations on allowable nursing hours for each level of care for the rate years beginning July 1, 1983 and July 1, 1984. For the rate year beginning July 1, 1984, nursing homes in which the nursing hours exceeded 2.9 hours per day for skilled nursing care or 2.3 hours per day for intermediate care for the reporting year ending on September 30, 1983, shall be limited to a maximum of 3.2 hours per day for skilled nursing care and 2.6 hours per day for intermediate care.

Subd. 2. **Operating costs, 1984-1985.** (a) For the rate year beginning July 1, 1984, the commissioner shall establish, by rule, procedures for determining per diem reimbursement for operating costs based on actual resident days. The commissioner shall disallow any portion of the general and administration cost category, exclusive of fringe benefits and payroll taxes, that exceeds:

(1) for nursing homes with more than 100 certified beds in total, the greater of ten percent or the 25th percentile of general and administrative cost per diems of nursing homes grouped by level of care;

(2) for nursing homes with fewer than 101 but more than 40 certified beds in total, the greater of 12 percent or the 25th percentile of general and administrative cost per diems of nursing homes grouped by level of care;

(3) for nursing homes with 40 or fewer certified beds in total, the greater of 14 percent or the 25th percentile of general and administrative cost per diems of nursing homes grouped by level of care; and

(4) 15 percent for convalescent and nursing care units attached to hospitals for the

rate year beginning July 1, 1984, of the expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administration.

Subd. 2a. **Operating costs, 1983-1984.** For the rate year beginning July 1, 1983, and ending June 30, 1984, the prospective operating cost payment rate for each nursing home shall be determined by the commissioner based on the allowed historical operating costs as reported 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 allowed. To determine the allowed historical operating cost, the commissioner shall update the historical per diem shown in those cost reports to June 30, 1983, using a nine percent annual rate of increase after applying the general and administrative cost limitation described in subdivision 2. The commissioner shall calculate the 60th percentile of actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1.

(a) Within each group, each nursing home whose actual allowable historical operating cost per diem as determined under this subdivision is above the 60th percentile shall receive the 60th percentile increased by six percent plus 80 percent of the difference between its actual allowable operating cost per diem and the 60th percentile.

(b) Within each group, each nursing home whose actual allowable historical operating cost per diem is at or below the 60th percentile shall receive that actual allowable historical operating cost per diem increased by six percent.

For the rate year beginning July 1, 1984, and ending June 30, 1985, the prospective operating cost payment rate for each nursing home shall be determined by the commissioner based on actual allowable historical operating costs incurred during the reporting year preceding the rate year. The commissioner shall analyze and evaluate each nursing home's report of allowable operating costs incurred by the nursing home during the reporting year immediately preceding the rate year. The actual allowable historical operating costs, after the commissioner's analysis and evaluation, shall be added together and divided by the number of actual resident days to compute the actual allowable historical operating cost per diems. The commissioner shall calculate the 60th percentile of actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1.

(c) Within each group, each nursing home whose actual allowable historical operating cost per diem is above the 60th percentile of payment rates shall receive the 60th percentile increased at an annual rate of six percent plus 75 percent of the difference between its actual allowable historical operating cost per diem and the 60th percentile.

(d) Within each group, each nursing home whose actual allowable historical operating cost per diem is at or below the 60th percentile shall receive that actual allowable historical operating cost per diem increased at an annual rate of six percent.

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).

Subd. 2c. **Operating costs after July 1, 1986.** For rate years beginning on or after July 1, 1986, the commissioner may allow a one time adjustment to historical operating

costs of a nursing home that has been found by the commissioner of health to be significantly below care related minimum standards appropriate to the mix of resident needs in that nursing home when it is determined by the commissioners of health and human services that the nursing home is unable to meet minimum standards through reallocation of nursing home costs and efficiency incentives or allowances. In developing procedures to allow adjustments, the commissioner shall specify the terms and conditions governing any additional payments made to a nursing home as a result of the adjustment. The commissioner shall establish procedures to recover amounts paid under this subdivision, in whole or in part, and to adjust current and future rates, for nursing homes that fail to use the adjustment to satisfy care related minimum standards.

Subd. 2d. If an annual cost report or field audit indicates that expenditures for direct resident care have been reduced in amounts large enough to indicate a possible detrimental effect on the quality of care, the commissioner shall notify the commissioner of health and the interagency board for quality assurance. If a field audit reveals that unallowable expenditures have been included in the nursing home's historical operating costs, the commissioner shall disallow the expenditures and recover the entire overpayment. The commissioner shall establish, by rule, procedures for assessing an interest charge at the rate determined for unpaid taxes or penalties under section 270.75 on any outstanding balance resulting from an overpayment or underpayment.

Subd. 2e. **Negotiated rates.** Until procedures for determining operating cost payment rates according to mix of resident needs are established, the commissioner may negotiate, with a nursing home that is eligible to receive medical assistance payments, a payment rate of up to 125 percent of the allowed payment rate to be paid for a period of up to three months for individuals who have been hospitalized for more than 100 days, or who have extensive care needs based on nursing hours actually provided or mental or physical disability, or who need respite care for a specified and limited time period. In addition, the commissioner shall take into consideration facilities which historically provided nursing hours at or near the maximum limits which were subsequently reduced as a consequence of payment rate reductions. The payment rate shall be based on an assessment of the nursing home's resident mix as determined by the commissioner of health. When circumstances dictate, the commissioner has authority to renegotiate payment rates for an additional period of time. The payment rate negotiated and paid pursuant to this paragraph is specifically exempt from the definition of "rule" and the rulemaking procedures required by chapter 14 and section 256B.502.

Subd. 2f. **Exclusion.** Until procedures for determining operating cost payment rates according to mix of resident needs are established, nursing homes licensed on June 1, 1983 by the commissioner to provide residential services for the physically handicapped and nursing homes that have an average length of stay of less than 180 days shall not be included in the calculation of the 60th percentile of any group. For rate year beginning July 1, 1983 and July 1, 1984, each of these nursing homes shall receive their actual allowed historical operating cost per diem increased by six percent. The commissioner shall also apply to these nursing homes the percentage limitation on the general and administrative cost category as provided in subdivision 2.

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 promul-

gate 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 Minnesota Rules, parts 9520.0500 to 9520.0690, 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.

Subd. 5. **Adjustments.** When resolution of appeals or on-site field audits of the records of nursing homes within a group result in adjustments to the 60th percentile of the payment rates within the group in the reporting year ending on September 30, 1983, the 60th percentile established for the following rate year for that group shall be increased or decreased by the adjustment amount.

Subd. 6. **Rules.** The commissioners of health and human services shall adopt emergency rules necessary for the implementation and enforcement of the reimbursement system established in Laws 1984, chapter 641, sections 10 to 20. The commissioner of health may adopt emergency rules relating to the licensure requirements of boarding care homes and nursing homes promulgated under sections 144.56 and 144A.08 if appropriate due to the changes in the reimbursement system. Until June 30, 1987, any emergency rules adopted by the commissioner of health or the commissioner of human services under this section shall be adopted in accordance with the provisions contained in sections 14.29 to 14.36 in effect on March 1, 1984. Emergency rules adopted under this subdivision have the force and effect of law and remain in effect until June 30, 1987, unless otherwise superseded by rule. The procedures for the adoption of the emergency rules authorized by this subdivision shall prevail over any other act that amends chapter 14 regardless of the date of final enactment of those amendments. The rules shall be developed in consultation with the interagency board for quality assurance, provider groups and consumers and the board shall conduct public hearings as appropriate. The commissioners of health and human services shall consider all comments received and shall not implement the emergency rules until a report on the proposed rules has been presented to the senate health and human services committee and the house of representatives health and welfare committee. The rules are effective five days after publication in the State Register.

History: *1983 c 199 s 12; 1984 c 640 s 32; 1984 c 641 s 17-20,22; 1984 c 654 art 5*

s 58; 1984 c 655 art 1 s 40,41; 1985 c 248 s 40,69; 1985 c 267 s 3; 1Sp1985 c 3 s 25,27-29,31; 1986 c 316 s 2

256B.433 ANCILLARY SERVICES.

The commissioner shall promulgate rules pursuant to the administrative procedure act to set the amount and method of payment for ancillary materials and services provided to recipients residing in long-term care facilities. Payment for materials and services may be made to either the nursing home in the operating cost per diem, to the vendor of ancillary services pursuant to Minnesota Rules, parts 9500.0750 to 9500.1080 or to a nursing home pursuant to Minnesota Rules, parts 9500.0750 to 9500.1080. Payment for the same or similar service to a recipient shall not be made to both the nursing home and the vendor. The commissioner shall ensure that charges for ancillary materials and services are as would be incurred by a prudent buyer.

History: *1983 c 199 s 18; 1985 c 248 s 69*

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 [Repealed, 1983 c 199 s 19]

256B.46 [Repealed, 1983 c 199 s 19]

256B.47 NONALLOWABLE COSTS; NOTICE OF INCREASES TO PRIVATE PAYING RESIDENTS.

Subdivision 1. **Nonallowable costs.** The following costs shall not be recognized as allowable: (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 commissioner of health for uncorrected violations; (5) legal and related expenses for unsuccessful challenges to decisions by governmental agencies; (6) memberships in sports, health or similar social clubs or organizations; and (7) costs incurred for activities directly related to influencing employees with respect to unionization. The commissioner shall by rule exclude the costs of any other items not directly related to the provision of resident care.

Subd. 2. **Notice to residents.** 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 reflect a necessary change in

the level of care provided to a resident. If the state fails to set rates as required by section 256B.431, the time required for giving notice is decreased by the number of days by which the state was late in setting the rates.

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; 1983 c 199 s 13*

256B.48 CONDITIONS FOR PARTICIPATION.

Subdivision 1. **Prohibited practices.** A nursing home is not eligible to receive medical assistance payments unless it refrains from:

(a) Charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate, except under the following circumstances: the nursing home may (1) charge private paying 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 residents are charged separately at the same rate for the same services in addition to the daily rate paid by the commissioner. Services covered by the payment rate must be the same regardless of payment source. Special services, if offered, must be offered to all residents and charged separately at the same rate. Residents are free to select or decline special services. Special services must not include services which must be provided by the nursing home in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing home. Services beyond those required to comply with licensure or certification standards must not be charged separately as a special service if they were included in the payment rate for the previous reporting year. A nursing home that charges a private paying resident a rate in violation of this clause is subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing home that charges the resident rates in violation of this clause. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing home may request a hearing to determine the allowed rate or rates at issue in the cause of action. Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of an administrative law judge under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The administrative law judge shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this clause shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance;

(b) Requiring an applicant for admission to the home, or the guardian or conservator of the applicant, as a condition of admission, to pay any fee or deposit 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;

(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;

(d) Providing differential treatment on the basis of status with regard to public assistance;

(e) Discriminating in admissions, services offered, or room assignment on the basis of status with regard to public assistance. Admissions discrimination shall include, but is not limited to:

(1) basing admissions decisions upon assurance by the applicant to the nursing home, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek public assistance for payment of nursing home care costs;

(2) engaging in preferential selection from waiting lists based on an applicant's ability to pay privately.

The collection and use by a nursing home of financial information of any applicant pursuant to the preadmission screening program established by section 256B.091 shall not raise an inference that the nursing home is utilizing that information for any purpose prohibited by this paragraph;

(f) Requiring any vendor of medical care as defined by section 256B.02, subdivision 7, who is reimbursed by medical assistance under a separate fee schedule, to pay any portion of the vendor's fee to the nursing home except as payment for renting or leasing space or equipment of the nursing home or purchasing support services, if those agreements are disclosed to the commissioner; and

(g) Refusing, for more than 24 hours, to accept a resident returning to the same bed or a bed certified for the same level of care, in accordance with a physician's order authorizing transfer, after receiving inpatient hospital services.

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) accounts for all of the applicant's assets which are required to be assigned to the home so that only expenses for the cost of care of the applicant may be charged against the account; and

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

For a period not to exceed 180 days, the commissioner may continue to make medical assistance payments to a nursing home or boarding care home which is in violation of this section if extreme hardship to the residents would result. In these cases the commissioner shall issue an order requiring the nursing home to correct the violation. The nursing home shall have 20 days from its receipt of the order to correct the violation. If the violation is not corrected within the 20-day period the commissioner may reduce the payment rate to the nursing home by up to 20 percent. The amount of the payment rate reduction shall be related to the severity of the violation, and shall remain in effect until the violation is corrected. The nursing home or boarding care home may appeal the commissioner's action pursuant to the provisions of chapter 14 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of notice of the commissioner's proposed action.

In the event that the commissioner determines that a nursing home is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing home to receive reimbursement on a temporary basis until the resident can be relocated to a participating nursing home.

Certified beds in facilities which do not allow medical assistance intake on July 1, 1984, or after shall be deemed to be decertified for purposes of section 144A.071 only.

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, 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. Nursing homes seeking continued medical assistance payments under this subdivision shall make the reports required under subdivision 2, except that on or after December 31, 1985, the financial statements required need not be audited by or contain the opinion of a certified public accountant or licensed public accountant, but need only be reviewed by a certified public accountant or licensed public accountant. 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.

Subd. 2. **Reporting requirements.** No later than December 31 of each year, a skilled nursing facility or intermediate care facility, including boarding care facilities, which receives medical assistance payments or other reimbursements from the state agency shall:

(a) Provide the state agency with a copy of its audited financial statements. The audited financial statements must include a balance sheet, income statement, statement of the rate or rates charged to private paying residents, statement of retained earnings, statements of changes in financial position (cash and working capital methods), notes to the financial statements, applicable supplemental information, and the certified public accountant's or licensed public accountant's opinion. The examination by the certified public accountant or licensed public accountant shall be conducted in accordance with generally accepted auditing standards as promulgated and adopted by the American Institute of Certified Public Accountants;

(b) Provide the state agency with a statement of ownership for the facility;

(c) Provide the state agency with separate, audited financial statements as specified in clause (a) for every other facility owned in whole or part by an individual or entity which has an ownership interest in the facility;

(d) Upon request, provide the state agency with separate, audited financial statements as specified in clause (a) for every organization with which the facility conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

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

(f) Upon request, provide the state agency with copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs; and

(g) Permit access by the state agency to the certified public accountant's and licensed public accountant's audit workpapers which support the audited financial statements required in clauses (a), (c), and (d).

Documents or information provided to the state agency pursuant to this subdivision shall be public. If the requirements of clauses (a) to (g) are not met, the reimbursement rate may be reduced to 80 percent of the rate in effect on the first day of the fourth calendar month after the close of the reporting year, and the reduction shall continue until the requirements are met.

Subd. 3. **Incomplete or inaccurate reports.** The commissioner may reject any annual cost report filed by a nursing home pursuant to this chapter if the commissioner 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 commissioner shall reduce the reimbursement rate to a nursing home to 80 percent of its most recently established rate until the information is completely and accurately filed.

Subd. 4. **Extensions.** The commissioner may grant a 15-day extension of the reporting deadline to a nursing home for good cause. To receive such an extension, a

nursing home shall submit a written request by December 1. The commissioner will notify the nursing home of the decision by December 15.

Subd. 5. **False reports.** If a nursing home knowingly supplies inaccurate or false information in a required report that results in an overpayment, the commissioner shall:

(a) immediately adjust the nursing home's payment rate to recover the entire overpayment within the rate year; or

(b) terminate the commissioner's agreement with the nursing home; or

(c) prosecute under applicable state or federal law; or

(d) use any combination of the foregoing actions.

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.

Subd. 7. **Refund of excess charges.** Any nursing home which has charged a resident a rate for a case-mix classification upon admission which is in excess of the rate for the case-mix classification established by the commissioner of health and effective on the date of admission, must refund the amount of charge in excess of the rate for the case-mix classification established by the commissioner of health and effective on the date of admission. Refunds must be credited to the next monthly billing or refunded within 15 days of receipt of the classification notice from the department of health. Failure to refund the excess charge shall be considered to be a violation of this section.

History: *1976 c 282 s 8; 1977 c 309 s 1; 1977 c 326 s 17; 1978 c 674 s 28; 1983 c 199 s 14; 1984 c 640 s 32; 1984 c 641 s 23; 1Sp1985 c 3 s 31; 1Sp1985 c 9 art 2 s 50-52; 1986 c 420 s 11,12; 1986 c 444*

256B.49 CHRONICALLY ILL CHILDREN; HOME AND COMMUNITY-BASED WAIVER STUDY AND APPLICATION.

Subdivision 1. **Study; waiver application.** The commissioner shall authorize a study to assess the need for home and community-based waivers for chronically ill children who have been and will continue to be hospitalized without a waiver, and for disabled individuals under the age of 65 who are likely to reside in an acute care or nursing home facility in the absence of a waiver. If a need for these waivers can be demonstrated, the commissioner shall apply for federal waivers necessary to secure, to the extent allowed by law, federal participation under United States Code, title 42, sections 1396-1396p, as amended through December 31, 1982, for the provision of

home and community-based services to chronically ill children who, in the absence of such a waiver, would remain in an acute care setting, and to disabled individuals under the age of 65 who, in the absence of a waiver, would reside in an acute care or nursing home setting. If the need is demonstrated, the commissioner shall request a waiver under United States Code, title 42, sections 1396-1396p, to allow medicaid eligibility for blind or disabled children with ineligible parents where income deemed from the parents would cause the applicant to be ineligible for supplemental security income if the family shared a household and to furnish necessary services in the home or community to disabled individuals under the age of 65 who would be eligible for medicaid if institutionalized in an acute care or nursing home setting. These waivers are requested to furnish necessary services in the home and community setting to children or disabled adults under age 65 who are medicaid eligible when institutionalized in an acute care or nursing home setting. The commissioner shall assure that the cost of home and community-based care will not be more than the cost of care if the eligible child or disabled adult under age 65 were to remain institutionalized.

Subd. 2. **Rules.** The commissioner of human services may adopt emergency and permanent rules as necessary to implement subdivision 1.

History: *1984 c 640 s 32; 1984 c 654 art 5 s 24,58*

256B.491 WAIVERED SERVICES.

Subdivision 1. **Study.** The commissioner of human services shall prepare a study on the characteristics of providers who have the potential for offering home and community-based services under federal waivers authorized by United States Code, title 42, sections 1396 to 1396p. The study shall include, but not be limited to:

(a) An analysis of the characteristics of providers presently involved in offering services to the elderly, chronically ill children, disabled persons under age 65, and mentally retarded persons;

(b) The potential for conversion to waivered services of facilities which currently provide services to the disability groups enumerated in clause (a);

(c) Proposals for system redesign to include (1) profiles of the types of providers best able, within reasonable fiscal constraints, to serve the needs of clients and to fulfill public policy goals in provision of waivered services, (2) methods for limiting concentration of facilities providing services under waiver, (3) methods for ensuring that services are provided by the widest array of provider groups.

The commissioner shall present the study to the legislature no later than March 15, 1985.

Subd. 2. **Control limited.** Until July 1, 1985, no one person shall control the delivery of waivered services to more than 50 persons receiving waivered services as authorized by section 256B.501. For the purposes of this section the following terms have the meanings given them:

(1) A "person" is an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, a subsidiary of an organization, and an affiliate. A "person" does not include any governmental authority, agency or body.

(2) An "affiliate" is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with another person.

(3) "Control" including the terms "controlling," "controlled by," and "under the common control with" is the possession, direct or indirect, or the power to direct or cause the direction of the management, operations or policies of a person, whether through the ownership of voting securities, by contract, through consultation or otherwise.

History: *1984 c 641 s 24; 1984 c 654 art 5 s 58*

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 Minnesota Rules, parts 9510.0010 to 9510.0480 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: *1983 c 199 s 15; 1984 c 640 s 32; 1984 c 641 s 21; 1985 c 248 s 69; 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;

(d) incentives to reward accumulation of equity; and

(e) appeals procedures that satisfy the requirements of section 256B.50 for appeals of decisions arising from the application of standards or methods pursuant to Minnesota Rules, parts 9510.0500 to 9510.0890, 9553.0010 to 9553.0080, and 12 MCAR 2.05301 to 2.05315 (temporary).

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 accordance 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: *1983 c 312 art 9 s 7; 1984 c 640 s 32; 1984 c 654 art 5 s 25,58; 1985 c 21 s 57; 1986 c 420 s 13*

256B.502 EMERGENCY AND PERMANENT RULES; REPORT.

The commissioners of health and human services shall promulgate emergency and permanent rules necessary to implement Laws 1983, chapter 199, except as otherwise indicated in accordance with sections 14.01 to 14.38. Emergency rules promulgated by August 15, 1983 to implement the rate determination provisions of section 256B.431 are retroactive to and effective as of July 1, 1983. Notwithstanding the provisions of section 14.35, emergency rules promulgated to implement Laws 1983, chapter 199, shall be effective for up to 360 days after July 1, 1983, and may be continued in effect for two additional periods of 180 days each if the commissioner gives notice of continuation of each additional period by publishing notice in the State Register and mailing the same notice to all persons registered with the commissioner to receive notice of rulemaking proceedings in connection with Laws 1983, chapter 199. The emergency rules promulgated in accordance with this section shall not be effective 720 days after their effective date without following the procedures in sections 14.13 to 14.20. The commissioner shall report to the legislature by January 1, 1985, on likely groups and shall establish groups of nursing homes based on the mix of resident care needs, and on geographic area, by July 1, 1985.

History: *1983 c 199 s 16; 1984 c 640 s 32; 1984 c 654 art 5 s 58*

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: *1983 c 312 art 9 s 8; 1984 c 640 s 32; 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.

Subd. 2. The commission shall consist of seven members of the house of representatives appointed by the speaker and seven members of the senate appointed by the subcommittee on committees.

Subd. 3. The commission shall report its findings and recommendations to the governor and the legislature not later than January 1, 1985.

Subd. 4. The commission shall hold meetings and hearings at the times and places it designates to accomplish the purposes set forth in this section. It shall select a chair and other officers from its membership as it deems necessary.

Subd. 5. The commission shall make use of existing legislative facilities and staff of the house and senate research department and senate counsel, but it may also request the legislative coordinating commission to supply it with additional necessary staff, office space, and administrative services. All additional personnel shall be hired and supervised by the directors of the house and senate research departments and senate counsel. The commission shall have full authority to contract for expert services and opinions relevant to the purposes of this section. The commission, by a two-thirds vote of its members, may request the issuance of subpoenas, including subpoenas duces tecum, requiring the appearance of persons, production of relevant records, and giving of relevant testimony.

History: *1983 c 199 s 17; 1984 c 654 art 5 s 55,58; 1Sp1985 c 3 s 33; 1986 c 444*

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 human services 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 human services. 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; 1984 c 654 art 5 s 58*

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 human services, 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; 1984 c 654 art 5 s 58*

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.

History: *1976 c 305 s 3; 1978 c 760 s 2; 1983 c 260 s 57*

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 postoperative 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*

256B.69 PREPAYMENT DEMONSTRATION PROJECT.

Subdivision 1. **Purpose.** The commissioner of human services shall establish a medical assistance demonstration project to determine whether prepayment combined with better management of health care services is an effective mechanism to ensure that all eligible individuals receive necessary health care in a coordinated fashion while containing costs. For the purposes of this project, waiver of certain statutory provisions is necessary in accordance with this section.

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Commissioner" means the commissioner of human services. For the remainder of this section, the commissioner's responsibilities for methods and policies for implementing the project will be proposed by the project advisory committees and approved by the commissioner.

(b) "Demonstration provider" means an individual, agency, organization, or group of these entities that participates in the demonstration project according to criteria, standards, methods, and other requirements established for the project and approved by the commissioner.

(c) "Eligible individuals" means those persons eligible for medical assistance benefits as defined in section 256B.06.

(d) "Limitation of choice" means suspending freedom of choice while allowing eligible individuals to choose among the demonstration providers.

Subd. 3. **Geographic area.** The commissioner shall designate the geographic areas in which eligible individuals may be included in the demonstration project. The geographic areas shall include one urban, one suburban, and at least one rural county. In order to encourage the participation of long-term care providers, the project area may be expanded beyond the designated counties for eligible individuals over age 65.

Subd. 4. **Limitation of choice.** The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6. Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner.

Subd. 5. **Prospective per capita payment.** The project advisory committees with the commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment. Notwithstanding section 62D.02, subdivision 1, payments for services rendered as part of the project may be made to providers that are not licensed health maintenance organizations on a risk-based, prepaid capitation basis.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun.

Subd. 6. **Service delivery.** Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(a) Shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in section 256B.02, subdivision 8, in order to ensure appropriate health care is delivered to enrollees;

(b) Shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(c) May contract with other health care and social service practitioners to provide services to enrollees; and

(d) Shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

Subd. 7. **Enrollee benefits.** All eligible individuals enrolled by demonstration providers shall receive all needed health care services as defined in subdivision 6.

All enrolled individuals have the right to appeal if necessary services are not being authorized as defined in subdivision 11.

Subd. 8. **Preadmission screening waiver.** Except as applicable to the project's operation, the provisions of section 256B.091 are waived for the purposes of this section for recipients enrolled with demonstration providers.

Subd. 9. **Reporting.** Each demonstration provider shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. Required information shall be specified before the commissioner contracts with a demonstration provider.

Subd. 10. **Information.** Notwithstanding any law or rule to the contrary, the commissioner may allow disclosure of the recipient's identity solely for the purposes of (a) allowing demonstration providers to provide the information to the recipient regarding services, access to services, and other provider characteristics, and (b) facilitating monitoring of recipient satisfaction and quality of care. The commissioner shall develop and implement measures to protect recipients from invasions of privacy and from harassment.

Subd. 11. **Appeals.** A recipient may appeal to the commissioner a demonstration provider's delay or refusal to provide services. The commissioner shall appoint a panel of health practitioners, including social service practitioners, as necessary to determine the necessity of services provided or refused to a recipient. The deliberations and decisions of the panel replace the administrative review process otherwise available under this chapter. The panel shall follow the time requirements and other provisions of the Code of Federal Regulations, title 42, sections 431.200 to 431.246. The time requirements shall be expedited based on request by the individual who is appealing for emergency services. If a service is determined to be necessary and is included among the benefits for which a recipient is enrolled, the service must be provided by the demonstration provider as specified in subdivision 5. The panel's decision is a final agency action that may be appealed under the contested case provisions of chapter 14.

History: *1983 c 312 art 5 s 27; 1984 c 654 art 5 s 58*

256B.70 DEMONSTRATION PROJECT WAIVER.

Each hospital that participates as a provider in a demonstration project, established by the commissioner of human services to deliver medical assistance, or chemical dependency services on a prepaid, capitation basis, is exempt from the prospective payment system for inpatient hospital service during the period of its participation in that project.

History: *1983 c 312 art 5 s 28; 1984 c 654 art 5 s 58; 1986 c 394 s 18*

NOTE: This section, as amended by Laws 1986, chapter 394, section 18, is effective July 1, 1987. See Laws 1986, chapter 394, section 24.

NOTE: The amendment to this section by Laws 1986, chapter 394, section 18, is repealed July 1, 1987, unless adequate funding is made available to meet the cash-flow and capital needs of the regional treatment center chemical dependency units as determined by the commissioner in consultation with the chief executive officers of those units. See Laws 1986, chapter 394, section 23.

256B.71 SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION.

Subdivision 1. **Purpose.** The commissioner of human services may participate in social health maintenance organization demonstration projects to determine if prepayment combined with the delivery of alternative services is an effective method of delivering services while containing costs.

Subd. 2. **Case management.** Each participating provider approved by the commissioner shall serve as case manager for recipients enrolled in its plan. The participating provider shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in section 256B.02, subdivision 8, in order to ensure that appropriate health care is delivered to enrollees.

Subd. 3. **Enrollment of medical assistance recipients.** Medical assistance recipients may voluntarily enroll in the social health maintenance organization projects. However, once enrolled in a project, the recipient must remain enrolled for a period of six months.

Subd. 4. **Payment for services.** Notwithstanding section 256.966 and chapter 256B, the method of payment utilized for the social health maintenance organization projects shall be the method developed by the commissioner of human services in consultation with local project staff and the federal Department of Health and Human Services, Health Care Financing Administration, Office of Demonstrations. This subdivision applies only to the payment method for the social health maintenance organization projects.

Subd. 5. **Preadmission screening.** Except as applicable to the projects' operation, the provisions of section 256B.091 are waived for the purposes of this section for recipients enrolled with participating providers.

History: *1983 c 295 s 1; 1984 c 654 art 5 s 58; 1986 c 444*

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*