CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

256B.031 PREPAID HEALTH PLANS.

[For text of subds 1 to 4, see M.S.1988]

Subd. 5. **Free choice limited.** (a) The commissioner may require recipients of aid to families with dependent children to enroll in a prepaid health plan and receive services from or through the prepaid health plan, with the following exceptions:

(1) recipients who are refugees and whose health services are reimbursed 100 percent by the federal government; and

(2) recipients who are placed in a foster home or facility. If placement occurs before the seventh day prior to the end of any month, the recipient will be disenrolled from the recipient's prepaid health plan effective the first day of the following month. If placement occurs after the seventh day before the end of any month, that recipient will be disenrolled from the prepaid health plan on the first day of the second month following placement. The prepaid health plan must provide all services set forth in subdivision 2 during the interim period.

Enrollment in a prepaid health plan is mandatory only when recipients have a choice of at least two prepaid health plans.

(b) Recipients who become eligible on or after December 1, 1987, must choose a health plan within 30 days of the date eligibility is determined. At the time of application, the local agency shall ask the recipient whether the recipient has a primary health care provider. If the recipient has not chosen a health plan within 30 days but has provided the local agency with the name of a primary health care provider, the local agency shall determine whether the provider participates in a prepaid health plan available to the recipient and, if so, the local agency shall select that plan on the recipient's behalf. If the recipient has not provided the name of a primary health care provider who participates in an available prepaid health plan, commissioner shall randomly assign the recipient to a health plan.

(c) If possible, the local agency shall ask whether the recipient has a primary health care provider and the procedures under paragraph (b) shall apply. If a recipient does not choose a prepaid health plan by this date, the commissioner shall randomly assign the recipient to a health plan.

(d) The commissioner shall request a waiver from the federal Health Care Financing Administration to limit a recipient's ability to change health plans to once every

six or 12 months. If such a waiver is obtained, each recipient must be enrolled in the health plan for a minimum of six or 12 months. A recipient may change health plans once within the first 60 days after initial enrollment.

(e) Women who are receiving medical assistance due to pregnancy and later become eligible for aid to families with dependent children are not required to choose a prepaid health plan until 60 days postpartum. An infant born as a result of that pregnancy must be enrolled in a prepaid health plan at the same time as the mother.

(f) If third-party coverage is available to a recipient through enrollment in a prepaid health plan through employment, through coverage by the former spouse, or if a duty of support has been imposed by law, order, decree, or judgment of a court under section 518.551, the obligee or recipient shall participate in the prepaid health plan in which the obligee has enrolled provided that the commissioner has contracted with the plan.

[For text of subds 6 to 10, see M.S.1988]

History: *1989 c 282 art 3 s 40*

256B.04 DUTIES OF STATE AGENCY.

[For text of subds 1 to 13, see M.S.1988]

Subd. 14. **Competitive bidding.** When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16B, to provide items under the medical assistance program including but not limited to the following:

(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;

(5) special transportation services; and

(6) drugs.

[For text of subds 15 and 16, see M.S.1988]

Subd. 17. **Prenatal care outreach.** (a) The commissioner of human services shall award a grant to an eligible organization to conduct a statewide media campaign promoting early prenatal care. The goals of the campaign are to increase public awareness of the importance of early and continuous prenatal care and to inform the public about public and private funds available for prenatal care.

(b) In order to receive a grant under this section, an applicant must:

(1) have experience conducting prenatal care outreach;

(2) have an established statewide constituency or service area; and

(3) demonstrate an ability to accomplish the purposes in this subdivision.

(c) Money received under this subdivision may be used for purchase of materials

and supplies, staff fees and salaries, consulting fees, and other goods and services necessary to accomplish the goals of the campaign. Money may not be used for capital expenditures.

History: *1989 c 282 art 3 s 41,42*

256B.041 CENTRALIZED DISBURSEMENT OF MEDICAL ASSISTANCE PAYMENTS.

[For text of subds 1 to 4, see M.S.1988]

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. Effective January 1, 1990, the state rate of participation shall be determined as a percentage that equals the difference between 100 percent and the percentage rate of federal financial participation.

For the period from January 1 to June 30, the county shall advance ten percent of that portion of medical assistance costs not met by federal funds, 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. Subsequent to July 1 of each year, the state agency shall reimburse the county agency for the funds expended during the January 1 to June 30 period, except as provided for in section 256.017. For the period from July 1 to December 31, payments will be made by the state agency, except as provided for in section 256.017, and the county agency will be advised of the amounts paid monthly.

[For text of subds 6 and 7, see M.S.1988]

History: *1989 c 277 art 2 s 7*

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 the commissioner of human services as specified in section 256.01, 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 under section 256.01, subdivision 2, paragraph (17).

[For text of subds 2 and 3, see M.S.1988]

History: *1989 c 89 s 10*

256B.055 ELIGIBILITY CATEGORIES.

[For text of subds 1 to 6, see M.S.1988]

Subd. 7. **Aged, blind, or disabled persons.** Medical assistance may be paid for a person who meets the categorical eligibility requirements of the supplemental security income program and the other eligibility requirements of this section. The methodology for calculating income must be the same methodology used for calculating income for the supplemental security income program except as specified otherwise by state or federal law, rule, or regulation.

Effective February 1, 1989, and to the extent allowed by federal law the commissioner shall deduct state and federal income taxes and federal insurance contributions act payments withheld from the individual's earned income in determining eligibility under this subdivision.

Subd. 8. **Medically needy persons with excess income or assets.** Medical assistance

may be paid for a person who, except for the amount of income or assets, 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. However, in the case of families and children, the methodology for calculating assets shall be as specified in section 256.73, subdivision 2, except that the exclusion for an automobile shall be as in subdivision 3, clause (g), as long as acceptable to the health care financing administration, and the methodology for calculating deductions from earnings for child care and work expenses shall be as specified in section 256.74, subdivision 1.

[For text of subds 9 to 12, see M.S.1988]

History: *1989 c 282 art 3 s 43,44*

256B.056 ELIGIBILITY; RESIDENCY; RESOURCES; INCOME.

[For text of subds 1 and 2, see M.S.1988]

Subd. 3. **Asset limitations.** To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members (husband and wife, or parent and child), the household must not own more than $6,000 in 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. The value of the items in paragraphs (a) to (i) are not considered in determining medical assistance eligibility.

(a) The homestead is not considered.

(b) Household goods and personal effects are not considered.

(c) Personal property used as a regular abode by the applicant or recipient is not considered.

(d) A lot in a burial plot for each member of the household is not considered.

(e) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.

(f) For a period of six months, insurance settlements to repair or replace damaged, destroyed, or stolen property are not considered.

(g) One motor vehicle that is 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 that is used primarily for the person's benefit is not considered.

To be excluded, the vehicle must have a market value of less than $4,500; be necessary to obtain medically necessary health services; be necessary for employment; be modified for operation by or transportation of a handicapped person; or be necessary to perform essential daily tasks because of climate, terrain, distance, or similar factors. The equity value of other motor vehicles is counted against the asset limit.

(h) Life insurance policies and assets designated as burial expenses, according to the standards and restrictions of the supplemental security income (SSI) program.

(i) Other items which may be excluded by federal law are not considered.

Subd. 3a. **Asset limitations for veterans.** (a) Notwithstanding subdivision 3, the income and asset limitations for a veteran who is otherwise eligible for medical assistance are the income and asset limitations established by the board of directors of the Minnesota nursing homes for veterans applying for admission to a veterans home. The provisions concerning transfers of property in section 256B.17 do not apply to a veteran. For purposes of this subdivision, "veteran" has the meaning given in section 197.447.

(b) Paragraph (a) is effective only to the extent allowed by federal medical assistance laws and regulations and only if the federal health care financing agency approves the necessary amendments to the state medical assistance plan. The commissioner shall seek waivers of federal requirements to the extent necessary to implement paragraph (a).

Subd. 4. **Income.** To be eligible for medical assistance, a person must not have, or anticipate receiving, semiannual income in excess of 120 percent of the income standards by family size used in the aid to families with dependent children program, except that families and children may have an income up to 133-1/3 percent of the AFDC income standard. 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 Numbers 94-566, section 503; 99-272; and 99-509.

Subd. 5. **Excess income.** A person who has excess income is eligible for medical assistance if the person has expenses for medical care that are more than the amount of the person's excess income, computed by deducting incurred medical expenses from the excess income to reduce the excess to the income standard specified in subdivision 4. The person shall elect to have the medical expenses deducted at the beginning of a one-month budget period or at the beginning of a six-month budget period. The commissioner shall seek applicable waivers from the Secretary of Health and Human Services to allow persons eligible for assistance on a spend-down basis under this subdivision to elect to pay the monthly spend-down amount to the local agency in order to maintain eligibility on a continuous basis for medical assistance and to simplify payment to health care providers. If the local agency has not received payment of the spend-down amount by the 15th day of the month, the recipient is ineligible for this option for the following month. The commissioner may seek a waiver of the requirement of the Social Security Act that all requirements be uniform statewide, to phase in this option over a six-month period.

[For text of subds 6 and 7, see M.S.1988]

History: *1989 c 282 art 3 s 45-47; 1989 c 332 s 1*

NOTE: Subdivision 4, as amended by Laws 1989, chapter 282, article 3, section 46, is effective July 1, 1990. See Laws 1989, chapter 282, article 3, section 99.

256B.057 ELIGIBILITY; INCOME AND ASSET LIMITATIONS FOR SPECIAL CATEGORIES.

Subdivision 1. **Pregnant women and infants.** An infant less than one year of age or a pregnant woman, as certified in writing by a physician or nurse midwife, is eligible for medical assistance if countable family income is equal to or less than 185 percent of the federal poverty guideline for the same family size. Eligibility for a pregnant woman or infant less than one year of age under this subdivision must be determined without regard to asset standards established in section 256B.056, subdivision 3. Adjustments in the income limits due to annual changes in the federal poverty guidelines shall be implemented the first day of July following publication of the changes.

Subd. 2. **Children.** A child one through seven years of age in a family whose countable income is less than 100 percent of the federal poverty guidelines for the same family size is eligible for medical assistance. Eligibility for children under this subdivision must be determined without regard to asset standards established in section 256B.056, subdivision 3. Adjustments in the income limits due to annual changes in the federal poverty guidelines shall be implemented the first day of July following publication of the changes.

Subd. 3. **Qualified Medicare beneficiaries.** A person who is entitled to Part A Medicare benefits, whose income is equal to or less than 85 percent of the federal poverty guidelines, and whose assets are no more than twice the asset limit used to determine eligibility for the supplemental security income program, is eligible for medical assistance reimbursement of Part A and Part B premiums, Part A and Part B

coinsurance and deductibles, and cost-effective premiums for enrollment with a health maintenance organization or a competitive medical plan under section 1876 of the Social Security Act. The income limit shall be increased to 90 percent of the federal poverty guidelines on January 1, 1990; to 95 percent on January 1, 1991; and to 100 percent on January 1, 1992. Reimbursement of the Medicare coinsurance and deductibles, when added to the amount paid by Medicare, must not exceed the total rate the provider would have received for the same service or services if the person were a medical assistance recipient with Medicare coverage. Adjustments in the income limits due to annual changes in the federal poverty guidelines shall be implemented the first day of July following publication of the changes.

History: *1989 c 282 art 3 s 48*

256B.0575 AVAILABILITY OF INCOME FOR INSTITUTIONALIZED PERSONS.

When an institutionalized person is determined eligible for medical assistance, the income that exceeds the deductions in paragraphs (a) and (b) must be applied to the cost of institutional care.

(a) The following amounts must be deducted from the institutionalized person's income in the following order:

(1) the personal needs allowance under section 256B.35;

(2) the personal allowance for disabled individuals under section 256B.36;

(3) if the institutionalized person has a legally-appointed guardian or conservator, five percent of the recipient's gross monthly income up to $100 as reimbursement for guardianship or conservatorship services;

(4) a monthly income allowance determined under section 256B.058, subdivision 2, but only to the extent income of the institutionalized spouse is made available to the community spouse;

(5) a monthly family allowance for other family members, equal to one-third of the difference between 122 percent of the federal poverty guidelines and the monthly income for that family member; and

(6) amounts for reasonable expenses incurred for necessary medical or remedial care for the institutionalized spouse that are not medical assistance covered expenses and that are not subject to payment by a third party.

For purposes of clause (5), family member includes only minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse if the sibling resides with the community spouse.

(b) Income shall be allocated to an institutionalized person for a period of up to three calendar months, in an amount equal to the medical assistance standard for a family size of one if:

(1) a physician certifies that the person is expected to reside in the long-term care facility for three calendar months or less;

(2) if the person has expenses of maintaining a residence in the community; and

(3) if one of the following circumstances apply:

(i) the person was not living together with a spouse or a family member as defined in paragraph (a) when the person entered a long-term care facility; or

(ii) the person and the person's spouse become institutionalized on the same date, in which case the allocation shall be applied to the income of one of the spouses.

For purposes of this paragraph, a person is determined to be residing in a licensed nursing home, regional treatment center, or medical institution if the person is expected to remain for a period of one full calendar month or more.

History: *1989 c 282 art 3 s 49*

256B.058 TREATMENT OF INCOME OF INSTITUTIONALIZED SPOUSE.

Subdivision 1. **Income not available.** The income described in subdivisions 2 and 3 shall be deducted from an institutionalized spouse's monthly income and is not considered available for payment of the monthly costs of an institutionalized person in the institution after the person has been determined eligible for medical assistance.

Subd. 2. **Monthly income allowance for community spouse.** (a) For an institutionalized spouse with a spouse residing in the community, monthly income may be allocated to the community spouse as a monthly income allowance for the community spouse. Beginning with the first full calendar month the institutionalized spouse is in the institution, the monthly income allowance is not considered available to the institutionalized spouse for monthly payment of costs of care in the institution as long as the income is made available to the community spouse.

(b) The monthly income allowance is the amount by which the community spouse's monthly maintenance needs allowance under paragraphs (c) and (d) exceeds the amount of monthly income otherwise available to the community spouse.

(c) The community spouse's monthly maintenance needs allowance is the lesser of $1,500 or 122 percent of the monthly federal poverty guideline for a family of two plus an excess shelter allowance. The excess shelter allowance is for the amount of shelter expenses that exceed 30 percent of 122 percent of the federal poverty guideline line for a family of two. Shelter expenses are the community spouse's expenses for rent, mortgage payments including principal and interest, taxes, insurance, required maintenance charges for a cooperative or condominium that is the community spouse's principal residence, and the standard utility allowance under section 5(e) of the federal Food Stamp Act of 1977. If the community spouse has a required maintenance charge for a cooperative or condominium, the standard utility allowance must be reduced by the amount of utility expenses included in the required maintenance charge.

If the community or institutionalized spouse establishes that the community spouse needs income greater than the monthly maintenance needs allowance determined in this paragraph due to exceptional circumstances resulting in significant financial duress, the monthly maintenance needs allowance may be increased to an amount that provides needed additional income.

(d) The percentage of the federal poverty guideline used to determine the monthly maintenance needs allowance in paragraph (c) is increased to 133 percent on July 1, 1991, and to 150 percent on July 1, 1992. Adjustments in the income limits due to annual changes in the federal poverty guidelines shall be implemented the first day of July following publication of the annual changes. The $1,500 maximum must be adjusted January 1, 1990, and every January 1 after that by the same percentage increase in the consumer price index for all urban consumers (all items; United States city average) between the two previous Septembers.

(e) If a court has entered an order against an institutionalized spouse for monthly income for support of the community spouse, the community spouse's monthly income allowance under this subdivision shall not be less than the amount of the monthly income ordered.

Subd. 3. **Family allowance.** (a) A family allowance determined under paragraph (b) is not considered available to the institutionalized spouse for monthly payment of costs of care in the institution.

(b) The family allowance is equal to one-third of the amount by which 122 percent of the monthly federal poverty guideline for a family of two exceeds the monthly income for that family member.

(c) For purposes of this subdivision, the term family member only includes a minor or dependent child, dependent parent, or dependent sibling of the institutionalized or community spouse if the sibling resides with the community spouse.

(d) The percentage of the federal poverty guideline used to determine the family allowance in paragraph (b) is increased to 133 percent on July 1, 1991, and to 150 percent on July 1, 1992. Adjustments in the income limits due to annual changes in

the federal poverty guidelines shall be implemented the first day of July following publication of the annual changes.

Subd. 4. **Treatment of income.** (a) No income of the community spouse will be considered available to an eligible institutionalized spouse, beginning the first full calendar month of institutionalization, except as provided in this subdivision.

(b) In determining the income of an institutionalized spouse or community spouse, after the institutionalized spouse has been determined eligible for medical assistance, the following rules apply.

(1) For income that is not from a trust, availability is determined according to items (i) to (v), unless the instrument providing the income otherwise specifically provides:

(i) if payment is made solely in the name of one spouse, the income is considered available only to that spouse;

(ii) if payment is made in the names of both spouses, one-half of the income is considered available to each;

(iii) if payment is made in the names of one or both spouses together with one or more other persons, the income is considered available to each spouse according to the spouse's interest, or one-half of the joint interest is considered available to each spouse if each spouse's interest is not specified;

(iv) if there is no instrument that establishes ownership, one-half of the income is considered available to each spouse; and

(v) either spouse may rebut the determination of availability of income by showing by a preponderance of the evidence that ownership interests are different than provided above.

(2) For income from a trust, income is considered available to each spouse as provided in the trust. If the trust does not specify an amount available to either or both spouses, availability will be determined according to items (i) to (iii):

(i) if payment of income is made only to one spouse, the income is considered available only to that spouse;

(ii) if payment of income is made to both spouses, one-half is considered available to each; and

(iii) if payment is made to either or both spouses and one or more other persons, the income is considered available to each spouse in proportion to each spouse's interest, or if no such interest is specified, one-half of the joint interest is considered available to each spouse.

History: *1989 c 282 art 3 s 50*

256B.059 TREATMENT OF ASSETS WHEN A SPOUSE IS INSTITUTIONALIZED.

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Community spouse" means the spouse of an institutionalized person.

(c) "Spousal share" means one-half of the total value of all assets, to the extent that either the institutionalized spouse or the community spouse had an ownership interest at the time of institutionalization.

(d) "Assets otherwise available to the community spouse" means assets individually or jointly owned by the community spouse, other than assets excluded by subdivision 5, paragraph (c).

(e) "Community spouse asset allowance" is the value of assets that can be transferred under subdivision 3.

Subd. 2. **Assessment of spousal share.** At the beginning of a continuous period of institutionalization of a person, at the request of either the institutionalized spouse or the community spouse, or upon application for medical assistance, the total value of

assets in which either the institutionalized spouse or the community spouse had an interest at the time of institutionalization shall be assessed and documented and the spousal share shall be assessed and documented.

Subd. 3. **Community spouse asset allowance.** (a) An institutionalized spouse may transfer assets to the community spouse solely for the benefit of the community spouse. Except for increased amounts allowable under subdivision 4, the maximum amount of assets allowed to be transferred is the amount which, when added to the assets otherwise available to the community spouse, is the greater of:

(1) $12,000;

(2) the lesser of the spousal share or $60,000; or

(3) the amount required by court order to be paid to the community spouse.

If the assets available to the community spouse are already at the limit permissible under this section, or the higher limit attributable to increases under subdivision 4, no assets may be transferred from the institutionalized spouse to the community spouse. The transfer must be made as soon as practicable after the date the institutionalized spouse is determined eligible for medical assistance, or within the amount of time needed for any court order required for the transfer. On January 1, 1990, and every January 1 thereafter, the $12,000 and $60,000 limits shall be adjusted by the same percentage change in the consumer price index for all urban consumers (all items; United States city average) between the two previous Septembers. These adjustments shall also be applied to the $12,000 and $60,000 limits in subdivision 5.

Subd. 4. **Increased community spouse asset allowance; when allowed.** (a) If either the institutionalized spouse or community spouse establishes that the community spouse asset allowance under subdivision 3 (in relation to the amount of income generated by such an allowance) is not sufficient to raise the community spouse's income to the minimum monthly maintenance needs allowance in section 256B.058, subdivision 2, paragraph (c), there shall be substituted for the amount allowed to be transferred an amount sufficient, when combined with the monthly income otherwise available to the spouse, to provide the minimum monthly maintenance needs allowance.

(b) The community spouse asset allowance under subdivision 3 can be increased by court order or hearing that complies with the requirements of United States Code, title 42, section 1924.

Subd. 5. **Asset availability.** (a) At the time of application for medical assistance benefits, assets considered available to the institutionalized spouse shall be the total value of all assets in which either spouse has an ownership interest, reduced by the greater of:

(1) $12,000; or

(2) the lesser of the spousal share or $60,000; or

(3) the amount required by court order to be paid to the community spouse. If the community spouse asset allowance has been increased under subdivision 4, then the assets considered available to the institutionalized spouse under this subdivision shall be further reduced by the value of additional amounts allowed under subdivision 4.

(b) After the month in which the institutionalized spouse is determined eligible for medical assistance, during the continuous period of institutionalization, no assets of the community spouse are considered available to the institutionalized spouse.

(c) For purposes of this section, assets do not include assets excluded under section 256B.056, without regard to the limitations on total value in that section.

History: *1989 c 282 art 3 s 51*

256B.0595 PROHIBITIONS ON TRANSFER; EXCEPTIONS.

Subdivision 1. **Prohibited transfers.** If an institutionalized person has given away, sold, or disposed of, for less than fair market value, any asset or interest therein, except

assets other than the homestead that are excluded under section 256B.056, subdivision 3, within 30 months of the date of institutionalization if the person has been determined eligible for medical assistance, or within 30 months of the date of the first approved application for medical assistance if the person has not yet been determined eligible for medical assistance, the person is ineligible for long-term care services for the period of time determined under subdivision 2. For purposes of this section, long-term care services include nursing facility services, and home and community-based services provided pursuant to section 256B.491. For purposes of this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person who is an inpatient in a nursing facility, or who is receiving home and community-based services under section 256B.491.

Subd. 2. **Period of ineligibility.** For any uncompensated transfer, the number of months of ineligibility for long-term care services shall be the lesser of 30 months, or the uncompensated transfer amount divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

Subd. 3. **Homestead exception to transfer prohibition.** (a) An institutionalized person is not ineligible for long-term care services due to a transfer of assets for less than fair market value if the asset transferred was a homestead and:

(1) title to the homestead was transferred to the individual's

(i) spouse;

(ii) child who is under age 21;

(iii) blind or permanently and totally disabled child as defined in the supplemental security income program;

(iv) sibling who has equity interest in the home and who was residing in the home for a period of at least one year immediately before the date of the individual's admission to the facility; or

(v) son or daughter who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the facility, and who provided care to the individual that permitted the individual to reside at home rather than in an institution or facility;

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

(3) 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.

(b) When a waiver is granted under paragraph (a), clause (3), a cause of action exists against the person to whom the homestead was transferred for that portion of long-term care services granted within 30 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 local agency responsible for providing medical assistance under chapter 256G.

Subd. 4. **Other exceptions to transfer prohibition.** An institutionalized person receiving medical assistance on the date of institutionalization who has transferred assets for less than fair market value within the 30 months immediately before the date of institutionalization or an institutionalized person who was not receiving medical assistance on the date of institutionalization and who has transferred assets for less than fair market value within 30 months immediately before the month of application is not ineligible for long-term care services if one of the following conditions apply:

(1) the assets were transferred to the community spouse, as defined in section 256B.059; or

(2) the institutionalized spouse, prior to being institutionalized, transferred assets to his or her spouse, provided that the spouse to whom the assets were transferred does not then transfer those assets to another person for less than fair market value. (At the time when one spouse is institutionalized, assets must be allocated between the spouses as provided under section 256B.059); or

(3) the assets were transferred to the individual's child who is blind or permanently and totally disabled as determined in the supplemental security income program; or

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

(5) the local agency determines that denial of eligibility for long-term care services would work an undue hardship and grants a waiver of excess assets. When a waiver is granted, a cause of action exists against the person to whom the assets were transferred for that portion of long-term care services granted within 30 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 local agency responsible for providing medical assistance under this chapter.

History: *1989 c 282 art 3 s 52*

256B.062 CONTINUED ELIGIBILITY.

Medical assistance may be paid for persons who received aid to families with dependent children in at least three of the six months preceding the month in which the person became ineligible for aid to families with dependent children, if the ineligibility was due to an increase in hours of employment or employment income or due to the loss of an earned income disregard. A person who is eligible for extended medical assistance is entitled to six months of assistance without reapplication, unless the assistance unit ceases to include a dependent child. For a person under 21 years of age, medical assistance may not be discontinued within the six-month period of extended eligibility until it has been determined that the person is not otherwise eligible for medical assistance. Medical assistance may be continued for an additional six months if the person meets all requirements for the additional six months, according to Title XIX of the Social Security Act, as amended by section 303 of the Family Support Act of 1988, Public Law Number 100-485.

History: *1989 c 282 art 3 s 53*

NOTE: This section, as amended by Laws 1989, chapter 282, article 3, section 53, is effective April 1, 1990, for families who become ineligible for AFDC on or after that date. See Laws 1989, chapter 282, article 3, section 99.

256B.0625 COVERED SERVICES.

[For text of subd 1, see M.S.1988]

Subd. 2. **Skilled and intermediate nursing care.** Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, 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.

[For text of subds 3 to 12, see M.S.1988]

Subd. 13. **Drugs.** (a) Medical assistance covers drugs if prescribed by a licensed practitioner. The commissioner shall designate a formulary committee to advise the commissioner on the names of drugs for which payment is 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, and vitamins for children under the age of seven and pregnant or nursing women; 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.

(b) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee established by the commissioner, the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee or the usual and customary price charged to the public. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug may be estimated by the commissioner. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the administrative procedure act. An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. 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. Implementation of any change in the fixed dispensing fee that

has not been subject to the administrative procedure act is limited to not more than 180 days, unless, during that time, the commissioner initiates rulemaking through the administrative procedure act.

[For text of subds 14 to 16, see M.S.1988]

Subd. 17. **Transportation costs.** (a) Medical assistance covers 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 subdivision, a person who is incapable of transport by taxicab or bus shall be considered to be nonambulatory.

(b) Special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, provided to nonambulatory persons who do not need a wheelchair lift van or stretcher-equipped vehicle, may be reimbursed at a lower rate than special transportation provided to persons who need a wheelchair lift van or stretcher-equipped vehicle.

[For text of subds 18 to 20, see M.S.1988]

Subd. 21. [Repealed, 1989 c 282 art 3 s 98]

[For text of subds 22 to 25, see M.S.1988]

Subd. 26. **Special education services.** Medical assistance covers medical services identified in a recipient's individualized education plan and covered under the medical assistance state plan. The services may be provided by a Minnesota school district that is enrolled as a medical assistance provider or its subcontractor, and only if the services meet all the requirements otherwise applicable if the service had been provided by a provider other than a school district, in the following areas: medical necessity, physician's orders, documentation, personnel qualifications, and prior authorization requirements. Medical assistance coverage for medically necessary services provided under other subdivisions in this section may not be denied solely on the basis that the same or similar services are covered under this subdivision.

Subd. 27. **Organ and tissue transplants.** Medical assistance coverage for organ and tissue transplant procedures is limited to those procedures covered by the Medicare program, provided those procedures comply with all applicable laws, rules, and regulations governing (1) coverage by the Medicare program, (2) federal financial participation by the Medicaid program, and (3) coverage by the Minnesota medical assistance program.

History: *1989 c 282 art 3 s 54-58*

NOTE: Subdivision 2, as amended by Laws 1989, chapter 282, article 3, section 54, is effective July 1, 1990. See Laws 1989, chapter 282, article 3, section 99.

256B.0642 FEDERAL FINANCIAL PARTICIPATION.

The commissioner may, in the aggregate, prospectively reduce payment rates for medical assistance providers receiving federal funds to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare limitations.

History: *1989 c 282 art 3 s 59*

256B.091 NURSING HOME PREADMISSION SCREENING PROGRAM.

[For text of subds 1 and 2, see M.S.1988]

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 or boarding care 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) Assessment of active treatment needs:

(1) in cooperation with a qualified mental health professional for persons with a primary or secondary diagnosis of mental illness; and

(2) in cooperation with a qualified mental retardation professional for persons with a primary or secondary diagnosis of mental retardation or related conditions.

For purposes of this subdivision, a qualified mental retardation professional must meet the standards for a qualified mental retardation professional in Code of Federal Regulations, title 42, section 483.430;

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

(h) Preparation of reports which may be required by the commissioner of human services.

[For text of subds 4 to 9, see M.S.1988]

History: *1989 c 282 art 3 s 60*

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

[For text of subds 1 to 6, see M.S.1988]

Subd. 7. **Screening teams established.** (a) 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 date that the assessment is completed or within 60 working days of a request for service by a person with mental retardation or related conditions, whichever is the earlier, 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, and a qualified mental retardation professional, as defined in the Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988. The case manager may also act as the qualified mental retardation professional if the case manager meets the federal definition. County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for the public guardianship representation required by the screening or individual service and habilitation planning process. The contract shall be limited to public guardianship representation for the screening and individual service and habilitation planning activities. The contract shall require compliance with the commissioner's instructions and may be for paid or voluntary services. 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.

(b) In addition to the requirements of paragraph (a), the following conditions apply to the discharge of persons with mental retardation or a related condition from a regional treatment center:

(1) For a person under public guardianship, at least two weeks prior to each screening team meeting the case manager must notify in writing parents, near relatives, and the ombudsman established under section 245.92 or a designee, and invite them to attend. The notice to parents and near relatives must include: (i) notice of the provisions of section 252A.03, subdivision 4, regarding assistance to persons interested in assuming private guardianship; (ii) notice of the rights of parents and near relatives to object to a proposed discharge by requesting a review as provided in clause (7); and (iii) information about advocacy services available to assist parents and near relatives of persons with mental retardation or related conditions. In the case of an emergency screening meeting, the notice must be provided as far in advance as practicable.

(2) Prior to the discharge, a screening must be conducted under subdivision 8 and a plan developed under subdivision 1a. For a person under public guardianship, the county shall encourage parents and near relatives to participate in the screening team meeting. The screening team shall consider the opinions of parents and near relatives in making its recommendations. The screening team shall determine that the services outlined in the plan are available in the community before recommending a discharge. The case manager shall provide a copy of the plan to the person, legal representative, parents, near relatives, the ombudsman established under section 245.92, and the protection and advocacy system established under United States Code, title 42, section 6042, at least 30 days prior to the date the proposed discharge is to occur. The information provided to parents and near relatives must include notice of the rights of parents and near relatives to object to a proposed discharge by requesting a review as provided in clause (7). If a discharge occurs, the case manager and a staff person from the regional treatment center from which the person was discharged must conduct a monitoring visit as required in Minnesota Rules, part 9525.0115, within 90 days of discharge and provide an evaluation within 15 days of the visit to the person, legal representative, parents, near relatives, ombudsman, and the protection and advocacy system established under United States Code, title 42, section 6042.

(3) In order for a discharge or transfer from a regional treatment center to be approved, the concurrence of a majority of the screening team members is required. The screening team shall determine that the services outlined in the discharge plan are available and accessible in the community before the person is discharged. The recommendation of the screening team cannot be changed except by subsequent action of the team and is binding on the county and on the commissioner. If the commissioner or the county determines that the decision of the screening team is not in the best interests of the person, the commissioner or the county may seek judicial review of the screening team recommendation. A person or legal representative may appeal under section 256.045, subdivision 3 or 4a.

(4) For persons who have overriding health care needs or behaviors that cause injury to self or others, or cause damage to property that is an immediate threat to the physical safety of the person or others, the following additional conditions must be met:

(i) For a person with overriding health care needs, either a registered nurse or a licensed physician shall review the proposed community services to assure that the medical needs of the person have been planned for adequately. For purposes of this paragraph, "overriding health care needs" means a medical condition that requires daily clinical monitoring by a licensed registered nurse.

(ii) For a person with behaviors that cause injury to self or others, or cause damage to property that is an immediate threat to the physical safety of the person or others, a qualified mental retardation professional, as defined in paragraph (a), shall review the proposed community services to assure that the behavioral needs of the person have

been planned for adequately. The qualified mental retardation professional must have at least one year of experience in the areas of assessment, planning, implementation, and monitoring of individual habilitation plans that have used behavior intervention techniques.

(5) No person with mental retardation or a related condition may be discharged from a regional treatment center before an appropriate community placement is available to receive the person.

(6) A resident of a regional treatment center may not be discharged to a community intermediate care facility with a licensed capacity of more than 15 beds. Effective July 1, 1993, a resident of a regional treatment center may not be discharged to a community intermediate care facility with a licensed capacity of more than ten beds.

(7) If the person, legal representative, parent, or near relative of the person proposed to be discharged from a regional treatment center objects to the proposed discharge, the individual who objects to the discharge may request a review under section 256.045, subdivision 4a, and may request reimbursement as allowed under section 256.045. The person must not be transferred from a regional treatment center while a review or appeal is pending. Within 30 days of the request for a review, the local agency shall conduct a conciliation conference and inform the individual who requested the review in writing of the action the local agency plans to take. The conciliation conference must be conducted in a manner consistent with section 256.045, subdivision 4a. A person, legal representative, parent, or near relative of the person proposed to be discharged who is not satisfied with the results of the conciliation conference may submit to the commissioner a written request for a hearing before a state human services referee under section 256.045, subdivision 4a. The person, legal representative, parent, or near relative of the person proposed to be discharged may appeal the order to the district court of the county responsible for furnishing assistance by serving a written copy of a notice of appeal on the commissioner and any adverse party of record within 30 days after the day the commissioner issued the order and by filing the original notice and proof of service with the court administrator of the district court. Judicial review must proceed under section 256.045, subdivisions 7 to 10. For a person under public guardianship, the ombudsman established under section 245.92 may object to a proposed discharge by requesting a review or hearing or by appealing to district court as provided in this clause. The person must not be transferred from a regional treatment center while a conciliation conference or appeal of the discharge is pending.

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 appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's 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 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) regional treatment center placement; or (5) a home and community-based alternative to community residential placement or state hospital placement;

(g) evaluate the availability, location, and quality of the services listed in paragraph (f), including the impact of placement alternatives on the client's ability to maintain or improve existing patterns of contact and involvement with parents and other family members;

(h) identify the cost implications of recommendations in paragraph (f);

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

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

[For text of subd 9, see M.S.1988]

History: *1989 c 282 art 3 s 61; art 6 s 29,30*

256B.093 SERVICES FOR PERSONS WITH BRAIN INJURIES.

Subdivision 1. **State coordinator.** The commissioner of human services shall designate a full-time position within the long-term care management division of the department of human services to supervise and coordinate services for persons with brain injuries.

Subd. 2. **Eligibility.** The commissioner may contract with qualified agencies or persons to provide case management services to medical assistance recipients who are at risk of institutionalization and meet one of the following criteria:

(a) The person has a brain injury.

(b) The person is receiving home care services or is in an institution and has a discharge plan requiring the provision of home care services and meets one of the following criteria:

(1) the person suffers from a brain abnormality or degenerative brain disease resulting in significant destruction of brain tissue and loss of brain function that requires extensive services over an extended period of time;

(2) the person is unable to direct the person's own care;

(3) the person has medical home care costs that exceed thresholds established by the commissioner under Minnesota Rules, parts 9505.0170 to 9505.0475;

(4) the person is eligible for medical assistance under the option for certain disabled children in section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA);

(5) the person receives home care from two or more providers who are unable to effectively coordinate the services; or

(6) the person has received or will receive home care services for longer than six months.

Subd. 3. **Case management duties.** The department shall fund the case management contracts using medical assistance administrative funds. The contractor must:

(1) assess the person's individual needs for services required to prevent institutionalization;

(2) assure that a care plan that meets the person's needs is developed by the appropriate agency or individual;

(3) assist the person in obtaining services necessary to allow the person to remain in the community;

(4) coordinate home care services with other medical assistance services under section 256B.0625;

(5) assure cost effectiveness of medical assistance services;

(6) make recommendations to the commissioner on the approval or denial of the use of medical assistance funds to pay for home care services when home care services exceed thresholds established by the commissioner under Minnesota Rules, parts 9505.0170 to 9505.0475;

(7) assist the person with problems related to the provision of home care services;

(8) assure the quality of home care services; and

(9) reassess the person's need for and level of home care services at a frequency determined by the commissioner.

Subd. 4. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Brain injury" means a sudden insult or damage to the brain or its coverings, not of a degenerative nature. The insult or damage may produce an altered state of consciousness or a decrease in mental, cognitive, behavioral, or physical functioning resulting in partial or total disability.

(b) "Home care services" means medical assistance home care services defined under section 256B.0625, subdivisions 6, 7, and 19.

History: *1989 c 282 art 3 s 62*

256B.14 RELATIVE'S RESPONSIBILITY.

Subdivision 1. **In general.** Subject to the provisions of sections 256B.055, 256B.056, and 256B.06, responsible relative means the parent of a minor recipient of medical assistance.

Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to determine the ability of responsible relatives to contribute partial or complete repayment of medical assistance furnished to recipients for whom they are responsible. These rules shall not require repayment when payment would cause undue hardship to the responsible relative or 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 or under section 134 of the Tax Equity and Fiscal Responsibility Act of 1982, United States Code, title 42, section 1396a(e)(3), 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: *1989 c 282 art 3 s 63*

256B.17 [Repealed, 1989 c 282 art 3 s 98]

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 and reports shall be presented to the state agency by the respective counties as required under section 256.01, subdivision 2, paragraph (17). 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: *1989 c 89 s 11*

256B.25 PAYMENTS TO CERTIFIED FACILITIES.

[For text of subds 1 to 3, see M.S.1988]

Subd. 4. **Payment during suspended admissions.** A nursing home or boarding care home that has received a notice to suspend admissions under section 144A.10, subdivision 4a, shall be ineligible to receive payment for admissions that occur during the effective dates of the suspension. Upon termination of the suspension by the commissioner of health, payments may be made for eligible persons, beginning with the day after the suspension ends.

History: *1989 c 282 art 3 s 64*

256B.32 FACILITY FEE FOR OUTPATIENT HOSPITAL EMERGENCY ROOM AND CLINIC VISITS.

The commissioner shall establish a facility fee payment mechanism that will pay a facility fee to all enrolled outpatient hospitals for each emergency room or outpatient clinic visit provided on or after July 1, 1989. This payment mechanism may not result in an overall increase in outpatient payment rates. This section does not apply to federally mandated maximum payment limits, department approved program packages, or services billed using a nonoutpatient hospital provider number.

History: *1989 c 285 s 4*

256B.421 DEFINITIONS.

[For text of subds 1 to 13, see M.S.1988]

Subd. 14. **Fringe benefits.** "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, except for public employee retirement act contributions, and uniform allowances.

[For text of subd 15, see M.S.1988]

History: *1989 c 282 art 3 s 65*

256B.431 RATE DETERMINATION.

[For text of subds 1 to 2a, see M.S.1988]

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. For rate years beginning on or after July 1, 1987, or until the new base period is established, facilities located in geographic group I as described in Minnesota Rules, part 9549.0052 (Emergency), on January 1, 1987, may choose to have the commissioner apply either the care related limits or the other operating cost limits calculated for facilities located in geographic group II, or both, if either of the limits calculated for the group II facilities is higher. The efficiency incentive for geographic group I nursing homes must be calculated based on geographic group I limits. The phase-in must be established utilizing the chosen limits. For purposes of these exceptions to the geographic grouping requirements, the definitions in Minnesota Rules, parts 9549.0050 to 9549.0059 (Emergency), and 9549.0010 to 9549.0080, apply. 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 or payments in lieu of real estate tax of each nursing home as an operating cost of that nursing home. Allowable costs under this subdivision for payments made by a non-profit nursing home that are in lieu of real estate taxes shall not exceed the amount which the nursing home would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes. For rate years beginning on or after July 1, 1987, the reported actual real estate tax liability or payments in lieu of real estate tax of nursing homes shall be adjusted to include an amount equal to one-half of the dollar change in real estate taxes from the prior year. 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. For rate years beginning on or after July 1, 1989, the commissioner shall include a nursing home's reported public employee retirement act contribution for the reporting year as apportioned to the care-related operating cost categories and other operating cost categories multiplied by the appropriate composite index or indices established pursuant to paragraph (e) as costs under this paragraph. Total adjusted real estate tax liability, payments in lieu of real estate tax, actual special assessments paid, the indexed public employee retirement act contribution, 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 care-related operating cost limits 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), unless otherwise indicated in this paragraph.

(h) For rate years beginning on or after July 1, 1987, the commissioner shall adjust the rates of a nursing home that meets the criteria for the special dietary needs of its residents as specified in section 144A.071, subdivision 3, clause (c), and the requirements in section 31.651. The adjustment for raw food cost shall be the difference between the nursing home's allowable historical raw food cost per diem and 115 percent of the median historical allowable raw food cost per diem of the corresponding geographic group.

The rate adjustment shall be reduced by the applicable phase-in percentage as provided under subdivision 2h.

[For text of subds 2c and 2d, see M.S.1988]

Subd. 2e. **Contracts for services for ventilator dependent persons.** The commissioner may contract with a nursing home eligible to receive medical assistance payments to provide services to a ventilator dependent person identified by the commissioner according to criteria developed by the commissioner, including:

(1) nursing home care has been recommended for the person by a preadmission screening team;

(2) the person has been assessed at case mix classification K;

(3) the person has been hospitalized for at least six months and no longer requires inpatient acute care hospital services; and

(4) the commissioner has determined that necessary services for the person cannot be provided under existing nursing home rates.

The commissioner may issue a request for proposals to provide services to a ventilator dependent person to nursing homes eligible to receive medical assistance payments and shall select nursing homes from among respondents according to criteria developed by the commissioner, including:

(1) the cost effectiveness and appropriateness of services;

(2) the nursing home's compliance with federal and state licensing and certification standards; and

(3) the proximity of the nursing home to a ventilator dependent person identified by the commissioner who requires nursing home placement.

The commissioner may negotiate an adjustment to the operating cost payment rate for a nursing home selected by the commissioner from among respondents to the request for proposals. The negotiated adjustment must reflect only the actual additional cost of meeting the specialized care needs of a ventilator dependent person identified by the commissioner for whom necessary services cannot be provided under existing nursing home rates and which are not otherwise covered under Minnesota Rules, parts 9549.0010 to 9549.0080 or 9505.0170 to 9505.0475. The negotiated payment rate must not exceed 200 percent of the highest multiple bedroom payment rate for a Minnesota nursing home, as initially established by the commissioner for the rate year for case mix classification K. The negotiated adjustment shall not affect the payment rate charged to private paying residents under the provisions of section 256B.48, subdivision 1. The negotiated adjustment 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.

[For text of subds 2f to 2h, see M.S.1988]

Subd. 2i. **Operating costs after July 1, 1988.** (a) **Other operating cost limits.** For the rate year beginning July 1, 1988, the commissioner shall increase the other operating cost limits established in Minnesota Rules, part 9549.0055, subpart 2, item E, to 110 percent of the median of the array of allowable historical other operating cost per diems and index these limits as in Minnesota Rules, part 9549.0056, subparts 3 and 4. The limits must be established in accordance with subdivision 2b, paragraph (d). For rate years beginning on or after July 1, 1989, the adjusted other operating cost limits must be indexed as in Minnesota Rules, part 9549.0056, subparts 3 and 4.

(b) **Care-related operating cost limits.** For the rate year beginning July 1, 1988, the commissioner shall increase the care-related operating cost limits established in Minnesota Rules, part 9549.0055, subpart 2, items A and B, to 125 percent of the median of the array of the allowable historical case mix operating cost standardized per diems and the allowable historical other care-related operating cost per diems and index those limits as in Minnesota Rules, part 9549.0056, subparts 1 and 2. The limits must be established in accordance with subdivision 2b, paragraph (d). For rate years beginning on or after July 1, 1989, the adjusted care-related limits must be indexed as in Minnesota Rules, part 9549.0056, subparts 1 and 2.

(c) **Salary adjustment per diem.** For the rate period October 1, 1988, to June 30, 1990, the commissioner shall add the appropriate salary adjustment per diem calculated in clause (1) or (2) to the total operating cost payment rate of each nursing home. The salary adjustment per diem for each nursing home must be determined as follows:

(1) for each nursing home that reports salaries for registered nurses, licensed practical nurses, and aides, orderlies and attendants separately, the commissioner shall determine the salary adjustment per diem by multiplying the total salaries, payroll taxes, and fringe benefits allowed in each operating cost category, except management fees and administrator and central office salaries and the related payroll taxes and fringe benefits, by 3.5 percent and then dividing the resulting amount by the nursing home's actual resident days; and

(2) for each nursing home that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the salary adjustment per diem is the weighted average salary adjustment per diem increase determined under clause (1).

Each nursing home that receives a salary adjustment per diem pursuant to this subdivision shall adjust nursing home employee salaries by a minimum of the amount determined in clause (1) or (2). The commissioner shall review allowable salary costs, including payroll taxes and fringe benefits, for the reporting year ending September 30, 1989, to determine whether or not each nursing home complied with this requirement. The commissioner shall report the extent to which each nursing home complied with the legislative commission on long-term care by August 1, 1990.

(d) **New base year.** The commissioner shall establish new base years for both the reporting year ending September 30, 1989, and the reporting year ending September 30, 1990. In establishing new base years, the commissioner must take into account:

(1) statutory changes made in geographic groups;

(2) redefinitions of cost categories; and

(3) reclassification, pass-through, or exemption of certain costs such as public employee retirement act contributions.

Subd. 2j. **Hospital-attached nursing home status.** (a) For the purpose of setting rates under Minnesota Rules, parts 9549.0010 to 9549.0080, for rate years beginning after June 30, 1989, a hospital-attached nursing home means a nursing home recognized by the federal Medicare program to be a hospital-based nursing facility for purposes of being subject to higher cost limits accorded hospital-based nursing facilities under the Medicare program, or, prior to June 30, 1983, was classified as a hospital-attached nursing home under Minnesota Rules, parts 9510.0010 to 9510.0480, provided that the nursing home's cost report filed under Minnesota Rules, parts 9549.0010 to 9549.0080, shall use the same cost allocation principles and methods used in the reports filed for the Medicare program.

(b) For rate years beginning after June 30, 1989, a nursing home and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year or the nine-month period following the nursing home's reporting year, shall be considered a hospital-attached nursing home for purposes of setting payment rates under Minnesota Rules, parts 9549.0010 to 9549.0080, for the rate year following the reporting year or the nine-month period in which the facility made its Medicare application. The nursing home must file its cost report or an amended cost report for that reporting year before the following rate year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital-based nursing facility status been granted to the nursing home. For each subsequent rate year, the nursing home must meet the definition requirements in paragraph (a). If the nursing home is denied hospital-based nursing facility status under the Medicare program, the nursing home's payment rates for the rate years the nursing home was considered to be a hospital-attached nursing home pursuant to this paragraph shall be recalculated treating the nursing home as a non-hospital-attached nursing home.

Subd. 2k. **Operating costs after July 1, 1989.** For rate years beginning on or after July 1, 1989, a nursing home that is exempt under subdivision 2b, paragraph (d), clause (2); whose total number of licensed beds are licensed under Minnesota Rules, parts 9570.2000 to 9570.3600; and that maintains an average length of stay of less than 365 days during each reporting year, is limited to 140 percent of the other-operating-cost limit for hospital-attached nursing homes as established by Minnesota Rules, part 9549.0055, subpart 2, item E, subitem (2), as modified by subdivision 2i, paragraph (a). For purposes of this subdivision, the nursing home's average length of stay must be computed by dividing the nursing home's actual resident days for the reporting year by the nursing home's total discharges for that reporting year.

[For text of subd 3, see M.S.1988]

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 movable 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.

(d) For rate years beginning on or after July 1, 1987, a nursing home which has reduced licensed bed capacity after January 1, 1986, shall be allowed to:

(1) aggregate the applicable investment per bed limits based on the number of beds licensed prior to the reduction; and

(2) establish capacity days for each rate year following the licensure reduction based on the number of beds licensed on the previous April 1 if the commissioner is notified of the change by April 4. The notification must include a copy of the delicensure request that has been submitted to the commissioner of health.

(e) Until the rental reimbursement method is fully phased in, a nursing home whose final property-related payment rate is the rental rate shall continue to have its property-related payment rates established based on the rental reimbursement method.

(f) For rate years beginning on or after July 1, 1989, the interest expense that results from a refinancing of a nursing home's demand call loan, when the loan that must be refinanced was incurred before May 22, 1983, is an allowable interest expense if:

(1) the demand call loan or any part of it was in the form of a loan that was callable at the demand of the lender;

(2) the demand call loan or any part of it was called by the lender through no fault of the nursing home;

(3) the demand call loan or any part of it was made by a government agency operating under a statutory or regulatory loan program;

(4) the refinanced debt does not exceed the sum of the allowable remaining balance of the demand call loan at the time of payment on the demand call loan and refinancing costs;

(5) the term of the refinanced debt does not exceed the remaining term of the demand call loan, had the debt not been subject to an on-call payment demand; and

(6) the refinanced debt is not a debt between related organizations as defined in Minnesota Rules, part 9549.0020, subpart 38.

[For text of subds 3b to 3e, see M.S.1988]

Subd. 3f. **Property costs after July 1, 1988.** (a) **Investment per bed limit.** For the rate year beginning July 1, 1988, the replacement-cost-new per bed limit must be $32,571 per licensed bed in multiple bedrooms and $48,857 per licensed bed in a single bedroom. For the rate year beginning July 1, 1989, the replacement-cost-new per bed limit for a single bedroom must be $49,907 adjusted according to Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1990, the replacement-cost-new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1).

(b) **Rental factor.** For the rate year beginning July 1, 1988, the commissioner shall increase the rental factor as established in Minnesota Rules, part 9549.0060, subpart 8, item A, by 6.2 percent rounded to the nearest 100th percent for the purpose of reimbursing nursing homes for soft costs and entrepreneurial profits not included in the cost valuation services used by the state's contracted appraisers. For rate years beginning on or after July 1, 1989, the rental factor is the amount determined under this paragraph for the rate year beginning July 1, 1988.

(c) **Occupancy factor.** For rate years beginning on or after July 1, 1988, in order to determine property-related payment rates under Minnesota Rules, part 9549.0060, for all nursing homes except those whose average length of stay in a skilled level of care within a nursing home is 180 days or less, the commissioner shall use 95 percent of capacity days. For a nursing home whose average length of stay in a skilled level of care within a nursing home is 180 days or less, the commissioner shall use the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

(d) **Equipment allowance.** For rate years beginning on July 1, 1988, and July 1, 1989, the commissioner shall add ten cents per resident per day to each nursing home's property-related payment rate. The ten-cent property-related payment rate increase is not cumulative from rate year to rate year. For the rate year beginning July 1, 1990, the commissioner shall increase each nursing home's equipment allowance as established in Minnesota Rules, part 9549.0060, subpart 10, by ten cents per resident per day. For rate years beginning on or after July 1, 1991, the adjusted equipment allowance must be adjusted annually for inflation as in Minnesota Rules, part 9549.0060, subpart 10, item E.

(e) **Post chapter 199 related-organization debts and interest expense.** For rate years beginning on or after July 1, 1990, Minnesota Rules, part 9549.0060, subpart 5, item E, shall not apply to outstanding related organization debt incurred prior to May 23, 1983, provided that the debt was an allowable debt under Minnesota Rules, parts 9510.0010 to 9510.0480, the debt is subject to repayment through annual principal payments, and the nursing home demonstrates to the commissioner's satisfaction that the interest rate on the debt was less than market interest rates for similar arms-length transactions at the time the debt was incurred. If the debt was incurred due to a sale

between family members, the nursing home must also demonstrate that the seller no longer participates in the management or operation of the nursing home. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) **Building capital allowance for nursing homes with operating leases.** For rate years beginning on or after July 1, 1990, a nursing home with operating lease costs incurred for the nursing home's buildings shall receive its building capital allowance computed in accordance with Minnesota Rules, part 9549.0060, subpart 8.

Subd. 3g. **Property costs after July 1, 1990, for certain facilities.** (a) For rate years beginning on or after July 1, 1990, nursing homes that, on or after January 1, 1976, but prior to January 1, 1987, were newly licensed after new construction, or increased their licensed beds by a minimum of 35 percent through new construction, and whose building capital allowance is less than their allowable annual principal and interest on allowable debt prior to the application of the replacement-cost-new per bed limit and whose remaining weighted average debt amortization schedule as of January 1, 1988, exceeded 15 years, must receive a property-related payment rate equal to the greater of their rental per diem or their annual allowable principal and allowable interest without application of the replacement-cost-new per bed limit, divided by their capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), for the preceding reporting year, plus their equipment allowance. A nursing home that is eligible for a property-related payment rate under this subdivision and whose property-related payment rate in a subsequent rate year is its rental per diem must continue to have its property-related payment rates established for all future rate years based on the rental reimbursement method in Minnesota Rules, part 9549.0060.

The commissioner may require the nursing home to apply for refinancing as a condition of receiving special rate treatment under this subdivision.

(b) If a nursing home is eligible for a property-related payment rate under this subdivision, and the nursing home's debt is refinanced after October 1, 1988, the provisions in paragraphs (1) to (7) also apply to the property-related payment rate for rate years beginning on or after July 1, 1990.

(1) A nursing home's refinancing must not include debts with balloon payments.

(2) If the issuance costs, including issuance costs on the debt refinanced, are financed as part of the refinancing, the historical cost of capital assets limit in Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (6), includes issuance costs that do not exceed seven percent of the debt refinanced, plus the related issuance costs. For purposes of this paragraph, issuance costs means the fees charged by the underwriter, issuer, attorneys, bond raters, appraisers, and trustees, and includes the cost of printing, title insurance, registration tax, and a feasibility study for the refinancing of a nursing home's debt. Issuance costs do not include bond premiums or discounts when bonds are sold at other than their par value, points, or a bond reserve fund. To the extent otherwise allowed under this paragraph, the straight-line amortization of the refinancing issuance costs is not an allowable cost.

(3) The annual principal and interest expense payments and any required annual municipal fees on the nursing home's refinancing replace those of the refinanced debt and, together with annual principal and interest payments on other allowable debts, are allowable costs subject to the limitation on historical cost of capital assets plus issuance costs as limited in paragraph (2), if any.

(4) If the nursing home's refinancing includes zero coupon bonds, the commissioner shall establish a monthly debt service payment schedule based on an annuity that will produce an amount equal to the zero coupon bonds at maturity. The term and interest rate is the term and interest rate of the zero coupon bonds. Any refinancing to repay the zero coupon bonds is not an allowable cost.

(5) The annual amount of annuity payments is added to the nursing home's allowable annual principal and interest payment computed in paragraph (3).

(6) The property-related payment rate is equal to the amount in paragraph (5), divided by the nursing home's capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), for the preceding reporting year plus an equipment allowance.

(7) Except as provided in this subdivision, the provisions of Minnesota Rules, part 9549.0060 apply.

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, but before January 1, 1988, 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 fiscal year beginning on January 1, 1988, the facility's payment rate must be established using the following method: The commissioner shall divide the real estate taxes and special assessments payable as stated in the facility's current property tax statement by actual resident days to compute a real estate tax and special assessment per diem. Next, the prior year's payment rate must be adjusted by the higher of (1) the percentage change in the consumer price index (CPI-U U.S. city

average) as published by the Bureau of Labor Statistics between the previous two Septembers, new series index (1967-100), or (2) 2.5 percent, to determine an adjusted payment rate. The facility's payment rate is the adjusted prior year's payment rate plus the real estate tax and special assessment per diem.

(5) For fiscal years beginning on or after January 1, 1989, the facility's payment rate must be established using the following method: The commissioner shall divide the real estate taxes and special assessments payable as stated in the facility's current property tax statement by actual resident days to compute a real estate tax and special assessment per diem. Next, the prior year's payment rate less the real estate tax and special assessment per diem must be adjusted by the higher of (1) the percentage change in the consumer price index (CPI-U U.S. city average) as published by the Bureau of Labor Statistics between the previous two Septembers, new series index (1967-100), or (2) 2.5 percent, to determine an adjusted payment rate. The facility's payment rate is the adjusted payment rate plus the real estate tax and special assessment per diem.

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

(d) A facility that meets the criteria of paragraph (c) shall submit annual cost reports on forms prescribed by the commissioner.

(e) 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.

(f) For the purposes of Minnesota Rules, part 9549.0060, subpart 13, item F, the following types of transactions shall not be considered a sale or reorganization of a provider entity:

(1) the sale or transfer of a nursing home upon death of an owner;

(2) the sale or transfer of a nursing home due to serious illness or disability of an owner as defined under the social security act;

(3) the sale or transfer of the nursing home upon retirement of an owner at 62 years of age or older;

(4) any transaction in which a partner, owner, or shareholder acquires an interest or share of another partner, owner, or shareholder in a nursing home business provided the acquiring partner, owner, or shareholder has less than 50 percent ownership after the acquisition;

(5) a sale and leaseback to the same licensee which does not constitute a change in facility license;

(6) a transfer of an interest to a trust;

(7) gifts or other transfers for no consideration;

(8) a merger of two or more related organizations;

(9) a transfer of interest in a facility held in receivership;

(10) a change in the legal form of doing business other than a publicly held organization which becomes privately held or vice versa;

(11) the addition of a new partner, owner, or shareholder who owns less than 20 percent of the nursing home or the issuance of stock; or

(12) an involuntary transfer including foreclosure, bankruptcy, or assignment for the benefit of creditors.

Any increase in allowable debt or allowable interest expense or other cost incurred as a result of the foregoing transactions shall be a nonallowable cost for purposes of reimbursement under Minnesota Rules, parts 9549.0010 to 9549.0080.

(g) Upon receiving a recommendation from the commissioner of health for a review of rates under section 144A.15, subdivision 6, the commissioner may grant an adjustment to the nursing home's payment rate. The commissioner shall review the recommendation of the commissioner of health, together with the nursing home's cost report to determine whether or not the deficiency or need can be corrected or met by reallocating nursing home staff, costs, revenues, or other resources including any investments, efficiency incentives, or allowances. If the commissioner determines that the deficiency cannot be corrected or the need cannot be met, the commissioner shall determine the payment rate adjustment by dividing the additional annual costs established during the commissioner's review by the nursing home's actual resident days from the most recent desk-audited cost report. The payment rate adjustment must meet the conditions in section 256B.47, subdivision 2, and shall remain in effect until the receivership under section 144A.15 ends, or until another date the commissioner sets.

Upon the subsequent sale or transfer of the nursing home, the commissioner may recover amounts paid through payment rate adjustments under this paragraph. The buyer or transferee shall repay this amount to the commissioner within 60 days after the commissioner notifies the buyer or transferee of the obligation to repay. The buyer or transferee must also repay the private-pay resident the amount the private-pay resident paid through payment rate adjustment.

[For text of subds 5 and 6, see M.S.1988]

Subd. 7. **One-time adjustment to nursing home payment rates to comply with omnibus budget reconciliation act.** The commissioner shall determine a one-time nursing staff adjustment to the payment rate to adjust payment rates to upgrade certain nursing homes' professional nursing staff complement to meet the minimum standards of 1987 Public Law Number 100-203. The adjustments to the payment rates determined under this subdivision cover cost increases to meet minimum standards for professional nursing staff. For a nursing home to be eligible for the payment rate adjustment, a nursing home must have all of its current licensed beds certified solely for the intermediate level of care. When the commissioner establishes that it is not cost effective to upgrade an eligible nursing home to the new minimum staff standards, the commissioner may exclude the nursing home if it is either an institution for mental disease or a nursing home that would have been determined to be an institution for mental disease, but for the fact that it has 16 or fewer licensed beds.

(a) The increased cost of professional nursing for an eligible nursing home shall be determined according to clauses (1) to (4):

(1) subtract from the number 8760 the compensated hours for professional nurses, both employed and contracted, and, if the result is greater than zero, then multiply the result by $4.55;

(2) subtract from the number 2920 the compensated hours for registered nurses, both employed and contracted, and, if the result is greater than zero, then multiply the result by $9.30;

(3) if an eligible nursing home has less than 61 licensed beds, the director of nurses' compensated hours must be included in the compensated hours for professional nurses in clause (1). If the director of nurses is also a registered nurse, the director of nurses' hours must be included in the compensated hours for registered nurses in clause (2); and

(4) the one-time nursing staff adjustment to the payment rate shall be the sum of clauses (1) and (2) as adjusted by clause (3), if appropriate, and then divided by the nursing home's actual resident days for the reporting year ending September 30, 1988.

(b) The one-time nursing staff adjustment to the payment rate is effective from January 1, 1990, to June 30, 1991.

(c) If a nursing home is granted a waiver to the minimum professional nursing staff standards under Public Law Number 100-203 for either the professional nurse adjust-

ment referred to in clause (1), or the registered nurse adjustment in clause (2), the commissioner must recover the portion of the nursing home's payment rate that relates to a one-time nursing staff adjustment granted under this subdivision. The amount to be recovered shall be based on the type and extent of the waiver granted.

Subd. 8. **One-time per diem rate adjustment for increased costs under the omnibus budget reconciliation act.** For the rate period January 1, 1990, through June 30, 1991, the commissioner shall add 30 cents per resident per day to the nursing home's payment rate. The adjustment must not be paid to freestanding boarding care homes.

Subd. 9. **One-time adjustment for freestanding boarding care homes to cover increased costs under the omnibus budget reconciliation act.** (a) The commissioner shall determine a one-time adjustment to the payment rate of a freestanding boarding care home necessary for that home to comply with the provisions of Public Law Number 100-203 except those requirements outlined in subdivision 7. The adjustment to the payment rate determined under this subdivision covers increased costs for a medical director, nurse aide training for newly hired aides, ongoing in-service training for nurses aides, and other requirements identified by the commissioner that are required because of the Omnibus Budget Reconciliation Act of 1987. These costs will only be reimbursed if they are required in the final regulations pertaining to Public Law Number 100-203.

(b) Each facility eligible for this adjustment shall submit to the commissioner a detailed estimate of the cost increases the facility will incur for these costs.

(c) The costs that are determined by the commissioner to be reasonable and necessary for a freestanding boarding care home to comply with Public Law Number 100-203, except those costs outlined in subdivision 7, must be included in the calculation of the adjustment.

(d) The maximum allowable annual adjustment per bed is $300.

(e) The one-time adjustment is the cost allowed in paragraph (c), subject to the limits in paragraph (d), divided by the nursing home's actual resident days for the reporting year that ended September 30, 1988.

(f) The one-time adjustment determined is effective from January 1, 1990, to June 30, 1991.

Subd. 10. **Appraisal sample stabilization and special reappraisals.** (a) The percentage change in appraised values for nursing homes in the sample used for routine updating of appraised values under Minnesota Rules, part 9549.0060, subpart 2, shall be stabilized by eliminating from the sample of nursing home those appraisals that represent the five highest and the five lowest deviations from those nursing homes' previously established appraised values.

(b) A special reappraisal request must be submitted to the commissioner within 60 days after the project's completion date to be considered eligible for a special reappraisal. If a project has multiple completion dates or involves multiple projects, only projects or parts of projects with completion dates within one year of the completion date associated with a special reappraisal request can be included for the purpose of establishing the nursing home's eligibility for a special reappraisal. A facility which is eligible to request, has requested, or has received a special reappraisal during the calendar year must not be included in the random sample process used to determine the average percentage change in appraised value of nursing homes in the sample.

History: *1989 c 12 s 1,2; 1989 c 282 art 3 s 66-78*

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

[For text of subds 1 and 2, see M.S.1988]

Subd. 3. **Allocation of costs.** To ensure the avoidance of double payments as required by section 256B.433, the direct and indirect reporting year costs of providing residents of nursing homes that are not hospital attached with therapy services that are

billed separately from the nursing home payment rate or according to Minnesota Rules, parts 9500.0750 to 9500.1080, must be determined and deducted from the appropriate cost categories of the annual cost report as follows:

(a) The costs of wages and salaries for employees providing or participating in providing and consultants providing services shall be allocated to the therapy service based on direct identification.

(b) The costs of fringe benefits and payroll taxes relating to the costs in paragraph (a) must be allocated to the therapy service based on direct identification or the ratio of total costs in paragraph (a) to the sum of total allowable salaries and the costs in paragraph (a).

(c) The costs of housekeeping, plant operations and maintenance, real estate taxes, special assessments, and insurance, other than the amounts classified as a fringe benefit, must be allocated to the therapy service based on the ratio of service area square footage to total facility square footage.

(d) The costs of bookkeeping and medical records must be allocated to the therapy service either by the method in paragraph (e) or based on direct identification. Direct identification may be used if adequate documentation is provided to, and accepted by, the commissioner.

(e) The costs of administrators, bookkeeping, and medical records salaries, except as provided in paragraph (d), must be allocated to the therapy service based on the ratio of the total costs in paragraphs (a) to (d) to the sum of total allowable nursing home costs and the costs in paragraphs (a) to (d).

(f) The cost of property must be allocated to the therapy service and removed from the rental per diem, based on the ratio of service area square footage to total facility square footage multiplied by the building capital allowance.

[For text of subd 4, see M.S.1988]

History: *1989 c 282 art 3 s 79*

256B.48 CONDITIONS FOR PARTICIPATION.

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

(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 available to all residents in all areas of the nursing home 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 or refusal to purchase special services. 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; and

(2) engaging in preferential selection from waiting lists based on an applicant's ability to pay privately or an applicant's refusal to pay for a special service.

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 amount based on utilization or service levels or any portion of the vendor's fee to the nursing home except as payment for renting or leasing space or equipment or purchasing support services from the nursing home as limited by section 256B.433. All agreements must be disclosed to the commissioner upon request of the commissioner. Nursing homes and vendors of ancillary services that are found to be in violation of this provision shall each be subject to an action by the state of Minnesota or any of its subdivisions or agencies for treble civil damages on the portion of the fee in excess of that allowed by this provision and section 256B.433. Damages awarded must include three times the excess payments together with costs and disbursements including reasonable attorney's fees or their equivalent.

(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.

[For text of subds 1a to 5, see M.S.1988]

Subd. 6. **Medicare certification.** (a) **Definition.** For purposes of this subdivision, "nursing facility" means a nursing home that is certified as a skilled nursing facility or, after September 30, 1990, a nursing home licensed under chapter 144A that is certified as a nursing facility.

(b) **Full Medicare participation required.** All nursing facilities shall fully 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.

(c) **Until September 30, 1990.** Until September 30, 1990, a nursing facility satisfies the requirements of paragraph (b) if: (1) at least 50 percent of the facility's beds that are licensed under section 144A and certified as skilled nursing beds under the medical assistance program are Medicare certified; or (2) if a nursing facility's beds are licensed under section 144A, and some are medical assistance certified as skilled nursing beds and others are Medical assistance certified as intermediate care facility I beds, at least 50 percent of the facility's total skilled nursing beds and intermediate care facility I beds or 100 percent of its skilled nursing beds, whichever is less, are Medicare certified.

(d) **October 1, 1990, to June 30, 1991.** After September 30, 1990, and until June 30, 1991, a nursing facility satisfies the requirements of paragraph (b) if at least 50 percent of the facility's beds certified as nursing facility beds under the medical assistance program are Medicare certified.

(e) **After June 30, 1991.** After June 30, 1991, a nursing facility satisfies the requirements of paragraph (b) if 100 percent of the facility's beds that are certified as nursing facility beds under the medical assistance program are Medicare certified.

(f) **Prohibited transfers.** A resident in a skilled nursing bed or, after September 30, 1990, a resident in any nursing facility bed, who is eligible for medical assistance and who becomes eligible for Medicare has the right to refuse an intrafacility skilled nursing bed transfer if the commissioner approves the exception request based on written

documentation submitted by a physician that the transfer would create or contribute to a health problem for the resident. A resident who is occupying a skilled nursing bed or, after September 30, 1990, a nursing facility bed certified by the medical assistance and Medicare programs, has the right to refuse a transfer if the resident's bed is needed for a Medicare-eligible patient or private-pay patient and if the commissioner approves the exception based on written documentation submitted by a physician that the transfer would create or contribute to a health problem for the resident.

(g) **Institutions for mental disease.** The commissioner may grant exceptions to the requirements of paragraph (b) for nursing facilities that are designated as institutions for mental disease.

(h) **Notice of rights.** The commissioner shall inform recipients of their rights under this subdivision and section 144.651, subdivision 29.

[For text of subd 7, see M.S.1988]

Subd. 8. **Notification to a spouse.** When a private pay resident who has not yet been screened by the preadmission screening team is admitted to a nursing home or boarding care facility, the nursing home or boarding care facility must notify the resident and the resident's spouse of the following:

(1) their right to retain certain resources under sections 256B.14, subdivision 2, and 256B.17; and

(2) that the federal Medicare hospital insurance benefits program covers posthospital extended care services in a qualified skilled nursing facility for up to 150 days and that there are several limitations on this benefit. The resident and the resident's family must be informed about all mechanisms to appeal limitations imposed under this federal benefit program.

This notice may be included in the nursing home's or boarding care facility's admission agreement and must clearly explain what resources the resident and spouse may retain if the resident applies for medical assistance. The department of human services must notify nursing homes and boarding care facilities of changes in the determination of medical assistance eligibility that relate to resources retained by a resident and the resident's spouse.

The preadmission screening team has primary responsibility for informing all private pay applicants to a nursing home or boarding care facility of the resources the resident and spouse may retain.

History: *1989 c 282 art 3 s 80-82*

256B.495 LONG-TERM CARE RECEIVERSHIP FEES.

Subdivision 1. **Payment of receivership fees.** The commissioner in consultation with the commissioner of health may establish a receivership fee payment that exceeds a long-term care facility payment rate when the commissioner of health determines a long-term care facility is subject to the receivership provisions under section 144A.14 or 144A.15 or the commissioner of human services determines that a facility is subject to the receivership under section 245A.12 or 245A.13. In establishing the receivership fee payment, the commissioner must reduce the receiver's requested receivership fee by amounts that the commissioner determines are included in the long-term care facility's payment rate and that can be used to cover part or all of the receivership fee. Amounts that can be used to reduce the receivership fee shall be determined by reallocating facility staff or costs that were formerly paid by the long-term care facility before the receivership and are no longer required to be paid. The amounts may include any efficiency incentive, allowance, and other amounts not specifically required to be paid for expenditures of the long-term care facility.

If the receivership fee cannot be covered by amounts in the long-term care facility's payment rate, a receivership fee payment shall be set according to paragraphs (a) and (b) and payment shall be according to paragraphs (c) to (e).

(a) The receivership fee per diem shall be determined by dividing the annual

receivership fee payment by the long-term care facility's resident days from the most recent cost report for which the commissioner has established a payment rate or the estimated resident days in the projected receivership fee period.

(b) The receivership fee per diem shall be added to the long-term care facility's payment rate.

(c) Notification of the payment rate increase must meet the requirements of section 256B.47, subdivision 2.

(d) The payment rate in paragraph (b) for a nursing home shall be effective the first day of the month following the receiver's compliance with the notice conditions in paragraph (c). The payment rate in paragraph (b) for an intermediate care facility for the mentally retarded shall be effective on the first day of the rate year in which the receivership fee per diem is determined.

(e) The commissioner may elect to make a lump sum payment of a portion of the receivership fee to the receiver. In this case, the commissioner and the receiver shall agree to a repayment plan. Regardless of whether the commissioner makes a lump sum payment under this paragraph, the provisions of paragraphs (a) to (d) and subdivision 2 also apply.

Subd. 2. **Deduction of receivership fee payments upon termination of receivership.** If the commissioner has established a receivership fee per diem for a long-term care facility in receivership, the commissioner must deduct the receivership fee payments according to paragraphs (a) to (c).

(a) The total receivership fee payments shall be the receivership fee per diem multiplied by the number of resident days for the period of the receivership fee payments. If actual resident days for the receivership fee payment period are not made available within two weeks of the commissioner's written request, the commissioner shall compute the resident days by prorating the facility's resident days based on the number of calendar days from each portion of the long-term care facility's reporting years covered by the receivership period.

(b) The amount determined in paragraph (a) must be divided by the long-term care facility's resident days for the reporting year in which the receivership period ends.

(c) The per diem amount in paragraph (b) shall be subtracted from the long-term care facility's operating cost payment rate for the rate year following the reporting year in which the receivership period ends.

Subd. 3. **Reestablishment of receivership fee payment.** The commissioner of health may request the commissioner to reestablish the receivership fee payment when the original terms of the receivership fee payment have significantly changed with regard to the cost or duration of the receivership agreement. The commissioner, in consultation with the commissioner of health, may reestablish the receivership fee payment when the commissioner determines the cost or duration of the receivership agreement has significantly changed. The provisions of developing a receivership fee payment in subdivisions 1 and 2 apply to the reestablishment process.

History: *1989 c 282 art 3 s 83*

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

[For text of subds 1 and 2, see M.S.1988]

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;

(e) a revaluation on sale between unrelated organizations for a facility that, for at least three years before its use as an intermediate care facility, has been used by the seller as a single family home and been claimed by the seller as a homestead, and was not revalued immediately prior to or upon entering the medical assistance program, provided that the facility revaluation not exceed the amount permitted by the Social Security Act, section 1902(a)(13); and

(f) 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.

[For text of subds 3a to 3f, see M.S.1988]

Subd. 3g. **Assessment of residents.** For rate years beginning on or after October 1, 1990, the commissioner shall establish program operating cost rates for care of residents in facilities that take into consideration service characteristics of residents in those facilities. To establish the service characteristics of residents, the quality assurance and review teams in the department of health shall assess all residents annually beginning January 1, 1989, using a uniform assessment instrument developed by the commissioner. This instrument shall include assessment of the client's behavioral needs, integration into the community, ability to perform activities of daily living, medical and therapeutic needs, and other relevant factors determined by the commissioner. The commissioner may adjust the program operating cost rates of facilities based on a comparison of client service characteristics, resource needs, and costs. The commissioner may adjust a facility's payment rate during the rate year when accumulated changes in the facility's average service units exceed the minimums established in the rules required by subdivision 3j.

[For text of subds 3h to 3j, see M.S.1988]

Subd. 3k. **Experimental project.** The commissioner of human services may conduct and administer experimental projects to determine the effects of competency-based wage adjustments for direct-care staff on the quality of care and active treatment for persons with mental retardation or related conditions. The commissioner shall authorize one project under the following conditions:

(a) One service provider will participate in the project.

(b) The vendor must have an existing competency-based training curriculum and a proposed salary schedule that is coordinated with the training package.

(c) The University of Minnesota affiliated programs must approve the content of the training package and assist the vendor in studying the impact on service delivery and outcomes for residents under a competency-based salary structure. The study and its conclusions must be presented to the commissioner at the conclusion of the project.

(d) The project will last no more than 21 months from its inception.

(e) The project will be funded by Title XIX, medical assistance and the costs incurred shall be allowable program operating costs for future rate years under Minnesota Rules, parts 9553.0010 to 9553.0080. The project's total annual cost must not exceed $49,500. The commissioner shall establish an adjustment to the selected facility's per diem by dividing the $49,500 by the facility's actual resident days for the reporting year ending December 31, 1988. The facility's experimental training project per diem shall be effective on October 1, 1989, and shall remain in effect for the 21-month period ending June 30, 1991.

(f) Only service vendors who have submitted a determination of need pursuant to Minnesota Rules, parts 9525.0015 to 9525.0165, and Minnesota Statutes, section 252.28, requesting the competency-based training program cost increase are eligible. Furthermore, they are only eligible if their determination of need was approved prior to January 1, 1989, and funds were not available to implement the plan.

[For text of subds 4 to 10, see M.S.1988]

History: *1989 c 282 art 3 s 84-86*

256B.69 PREPAYMENT DEMONSTRATION PROJECT.

[For text of subds 1 to 3, see M.S.1988]

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. The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice: (1) persons eligible for medical assistance according to section 256B.055, subdivision 1, or who are in foster placement; (2) persons eligible for medical assistance due to blindness or disability as determined by the social security administration or the state medical review team, unless they are 65 years of age or older; (3) recipients who currently have private coverage through a health maintenance organization; and (4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense. 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. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

Subd. 5. **Prospective per capita payment.** 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. For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

[For text of subds 6 to 10, see M.S.1988]

Subd. 11. **Appeals.** A recipient may appeal to the commissioner a demonstration provider's delay or refusal to provide services, according to section 256.045.

Subd. 12. [Repealed, 1989 c 282 art 3 s 98]

Subd. 13. [Repealed, 1989 c 282 art 3 s 98]

Subd. 14. [Repealed, 1989 c 282 art 3 s 98]

Subd. 15. [Repealed, 1989 c 282 art 3 s 98]

Subd. 16. **Project extension.** Minnesota Rules, parts 9500.1450; 9500.1451; 9500.1452; 9500.1453; 9500.1454; 9500.1455; 9500.1456; 9500.1457; 9500.1458; 9500.1459; 9500.1460; 9500.1461; 9500.1462; 9500.1463; and 9500.1464 are extended until December 31, 1990.

Subd. 17. **Continuation of prepaid medical assistance.** The commissioner may continue the provisions of this section after June 30, 1990, in any or all of the participating counties if necessary federal authority is granted. The commissioner may adopt permanent rules to continue prepaid medical assistance in these areas.

History: *1989 c 209 art 1 s 23; 1989 c 282 art 3 s 87-90*