CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

256B.01 POLICY.

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

History: *Ex1967 c 16 s 1*

256B.011 POLICY FOR CHILDBIRTH AND ABORTION FUNDING.

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

History: *1978 c 508 s 1*

256B.02 DEFINITIONS.

Subdivision 1. [Repealed, 1987 c 363 s 14]

Subd. 2. [Repealed, 1987 c 363 s 14]

Subd. 3. [Repealed, 1987 c 363 s 14]

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

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

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

Subd. 7. "Vendor of medical care" means any person or persons furnishing, within the scope of the vendor's respective license, any or all of the following goods or services: medical, surgical, hospital, optical, visual, dental and nursing services; drugs and medical supplies; appliances; laboratory, diagnostic, and therapeutic services; nursing home and convalescent care; screening and health assessment services provided by public health nurses as defined in section 145A.02, subdivision 18; health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided; and such other medical services or supplies provided or prescribed by persons authorized by state law to give such services and supplies. The term includes, but is not limited to, directors and officers of corporations or members of partnerships who, either individually or jointly with another or others, have the legal control, supervision, or responsibility of submitting claims for reimbursement to the medical assistance program. The term only includes directors and officers of corporations who personally receive a portion of the distributed assets upon liquidation or dissolution, and their liability is limited to the portion of the claim that bears the same proportion to the total claim as their share of the distributed assets bears to the total distributed assets.

Subd. 8. **Medical assistance; medical care.** "Medical assistance" or "medical care" means payment of part or all of the cost of the care and services identified in section 256B.0625, for eligible individuals whose income and resources are insufficient to meet all of this cost.

Subd. 8a. [Renumbered 256B.0625 subd 1]

Subd. 8b. [Renumbered 256B.0625 subd 2]

Subd. 8c. [Renumbered 256B.0625 subd 3]

Subd. 8d. [Renumbered 256B.0625 subd 4]

Subd. 8e. [Renumbered 256B.0625 subd 5]

Subd. 8f. [Renumbered 256B.0625 subd 6]

Subd. 8g. [Renumbered 256B.0625 subd 7]

Subd. 8h. [Renumbered 256B.0625 subd 8]
Subd. 8i. [Renumbered 256B.0625 subd 9]
Subd. 8j. [Renumbered 256B.0625 subd 10]
Subd. 8k. [Renumbered 256B.0625 subd 11]
Subd. 8l. [Renumbered 256B.0625 subd 12]
Subd. 8m. [Renumbered 256B.0625 subd 13]
Subd. 8n. [Renumbered 256B.0625 subd 14]
Subd. 8o. [Renumbered 256B.0625 subd 15]
Subd. 8p. [Renumbered 256B.0625 subd 16]
Subd. 8q. [Renumbered 256B.0625 subd 17]
Subd. 8r. [Renumbered 256B.0625 subd 18]
Subd. 8s. [Renumbered 256B.0625 subd 19]
Subd. 8t. [Renumbered 256B.0625 subd 20]
Subd. 8u. [Renumbered 256B.0625 subd 21]
Subd. 8v. [Renumbered 256B.0625 subd 22]
Subd. 8w. [Renumbered 256B.0625 subd 23]
Subd. 8x. [Renumbered 256B.0625 subd 24]
Subd. 8y. [Renumbered 256B.0625 subd 25]

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

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

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

Subd. 12. "Third party payer" means a person, entity, or agency or government program that has a probable obligation to pay all or part of the costs of a medical assistance recipient's health services.

Subd. 13. **Prepaid health plan.** "Prepaid health plan" means a vendor who receives a capitation payment and assumes financial risk for the provision of medical assistance services under a contract with the commissioner.

History: *Ex1967 c 16 s 2; 1969 c 395 s 1; 1973 c 717 s 17; 1975 c 247 s 9; 1975 c 384 s 1; 1975 c 437 art 2 s 3; 1976 c 173 s 56; 1976 c 236 s 1; 1976 c 312 s 1; 1978 c 508 s 2; 1978 c 560 s 10; 1981 c 360 art 2 s 26,54; 1Sp1981 c 2 s 12; 1Sp1981 c 4 art 4 s 22; 3Sp1981 c 2 art 1 s 31; 1982 c 562 s 2; 1983 c 151 s 1,2; 1983 c 312 art 1 s 27; art 5 s 10; art 9 s 4; 1984 c 654 art 5 s 58; 1985 c 21 s 52-54; 1985 c 49 s 41; 1985 c 252 s 19,20; 1Sp1985 c 3 s 19; 1986 c 394 s 17; 1986 c 444; 1987 c 370 art 1 s 3; art 2 s 4; 1987 c 374 s 1; 1987 c 309 s 24; 1987 c 403 art 2 s 73,74; art 5 s 16; 1988 c 689 art 2 s 141,268*

256B.03 PAYMENTS TO VENDORS.

Subdivision 1. **General limit.** All payments for medical assistance hereunder must be made to the vendor. The maximum payment for new vendors enrolled in the medical assistance program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

Subd. 2. **Limit on annual increase to long-term care providers.** Notwithstanding the provisions of sections 256B.421 to 256B.48, Laws 1981, chapter 360, article II, section 2, or any other provision of chapter 360, and rules promulgated under those sections, rates paid to a skilled nursing facility or an intermediate care facility, including boarding care facilities and supervised living facilities, except state owned and operated facilities, for rate years beginning during the biennium ending June 30, 1983, shall not exceed by more than ten percent the final rate allowed to the facility for the preceding

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

The commissioner shall not increase the percentage for investment allowances.

History: *Ex1967 c 16 s 3; 1981 c 360 art 2 s 27,54; 1Sp1981 c 2 s 13; 1Sp1981 c 4 art 4 s 22; 3Sp1982 c 1 art 2 s 4; 1983 c 312 art 1 s 27; 1987 c 384 art 2 s 63; 1987 c 403 art 2 s 75*

256B.031 PREPAID HEALTH PLANS.

Subdivision 1. **Contracts.** The commissioner may contract with health insurers licensed and operating under chapters 60A and 62A, nonprofit health service plans licensed and operating under chapter 62C, health maintenance organizations licensed and operating under chapter 62D, and vendors of medical care and organizations participating in prepaid programs under section 256D.03, subdivision 4, clause (b), to provide medical services to medical assistance recipients. Notwithstanding any other law, health insurers may enter into contracts with the commissioner under this section. As a condition of the contract, health insurers and health service plan corporations must agree to comply with the requirements of section 62D.04, subdivision 1, clauses (a), (b), (c), (d), and (f), and provide a complaint procedure that satisfies the requirements of section 62D.11. Nothing in this section permits health insurers not licensed as health maintenance organizations under chapter 62D to offer a prepaid health plan as defined in section 256B.02, subdivision 12, to persons other than those receiving medical assistance or general assistance medical care under this section. Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16B.19, subdivisions 5 and 6. Contracts must specify the services that are included in the per capita rate. Contracts must specify those services that are to be eligible for risk sharing between the prepaid health plan and the state. Contracts must also state that payment must be made within 60 days after the month of coverage.

Subd. 2. **Services.** State contracts for these services must assure recipients of at least the comprehensive health services defined in sections 256B.02, subdivision 8, and 256B.0625, except services defined in section 256B.0625, subdivisions 2, 5, 18, and 19, and except services defined as chemical dependency services and mental health services.

Contracts under this section must include provision for assessing pregnant women to determine their risk of poor pregnancy outcome. Contracts must also include provision for treatment of women found to be at risk of poor pregnancy outcome.

Subd. 3. **Information required.** Prepaid health plans under contract must provide information to the commissioner according to the contract specifications. The information must include, at a minimum, the number of people receiving services, the number of encounters, the types of services received, evidence of an operating quality assurance program, and information about the use of and actual recoveries of available third-party resources. A plan under contract to provide services in a county must provide the county agency with the most current listing of the health care providers whose services are covered by the plan.

Subd. 4. **Prepaid health plan rates.** For payments made during calendar year 1988, the monthly maximum allowable rate established by the commissioner of human services for payment to prepaid health plans must not exceed 90 percent of the projected average monthly per capita fee-for-service medical assistance costs for state fiscal year 1988 for recipients of aid to families with dependent children. The base year for projecting the average monthly per capita fee-for-service medical assistance costs is state fiscal year 1986. A maximum allowable per capita rate must be established collectively for Anoka, Carver, Dakota, Hennepin, Ramsey, St. Louis, Scott, and Washington counties. A separate maximum allowable per capita rate must be established collectively for

all other counties. The maximum allowable per capita rate may be adjusted to reflect utilization differences among eligible classes of recipients. For payments made during calendar year 1989, the maximum allowable rate must be calculated in the same way as 1988 rates, except the base year is state fiscal year 1987. For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates. Rates established for prepaid health plans must be based on the services that the prepaid health plan provides under contract with the commissioner.

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.

Subd. 6. **Ombudsman.** The commissioner shall designate an ombudsman to advocate for persons required to enroll in prepaid health plans under this section. The ombudsman shall advocate for recipients enrolled in prepaid health plans through complaint and appeal procedures and ensure that necessary medical services are provided

either by the prepaid health plan directly or by referral to appropriate social services. At the time of enrollment in a prepaid health plan, the local agency shall inform recipients about the ombudsman program and their right to a resolution of a complaint by the prepaid health plan if they experience a problem with the plan or its providers.

Subd. 7. **Services pending appeal.** If the recipient appeals in writing to the state agency on or before the tenth day after the decision of the prepaid health plan to reduce, suspend, or terminate services which the recipient had been receiving, and the treating physician or another plan physician orders the services to be continued at the previous level, the prepaid health plan must continue to provide services at a level equal to the level ordered by the plan's physician until the state agency renders its decision.

Subd. 8. **Case management.** The commissioner shall prepare a report to the legislature by January 1988, that describes the issues involved in successfully implementing a case management system in counties where the commissioner has fewer than two prepaid health plans under contract to provide health care services to eligible classes of recipients. In the report the commissioner shall address which health care providers could be case managers, the responsibilities of the case manager, the assumption of risk by the case manager, the services to be provided either directly or by referral, reimbursement concerns, federal waivers that may be required, and other issues that may affect the quality and cost of care under such a system.

Subd. 9. **Prepayment coordinator.** The local agency shall designate a prepayment coordinator to assist the state agency in implementing this section, section 256B.69, and section 256D.03, subdivision 4. Assistance must include educating recipients about available health care options, enrolling recipients under subdivision 5, providing necessary eligibility and enrollment information to health plans and the state agency, and coordinating complaints and appeals with the ombudsman established in subdivision 6.

Subd. 10. **Impact on public or teaching hospitals and community clinics.** (a) Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program, provided the terms of participation in the program are competitive with the terms of other participants.

(b) Prepaid health plans serving counties with a nonprofit community clinic or community health services agency must contract with the clinic or agency to provide services to clients who choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other health plan providers for the same or similar services.

History: *1987 c 403 art 2 s 76; 1988 c 689 art 2 s 142,268; 1989 c 282 art 3 s 40*

256B.035 MANAGED CARE.

The commissioner of human services may contract with public or private entities for health care services for medical assistance and general assistance medical care recipients identified by the commissioner as inappropriately using health care services. The commissioner may enter into risk-based and non-risk-based contracts. Contracts may be for the full range of health services, or a portion thereof, for medical assistance and general assistance medical care populations to determine the effectiveness of various provider reimbursement and care delivery mechanisms. The commissioner may seek necessary federal waivers and implement projects when approval of the waivers is obtained from the Health Care Financing Administration of the United States Department of Health and Human Services.

History: *1990 c 568 art 3 s 20*

256B.04 DUTIES OF STATE AGENCY.

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

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

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

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

Subd. 5. The state agency within 60 days after the close of each fiscal year, shall prepare and print for the fiscal year a report that includes a full account of the operations and expenditure of funds under this chapter, a full account of the activities undertaken in accordance with subdivision 10, adequate and complete statistics divided by counties about all medical assistance provided in accordance with this chapter, and any other information it may deem advisable.

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

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

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

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

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

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

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

The rules shall provide:

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

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

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

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

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

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

Subd. 14. **Competitive bidding.** 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.

Subd. 15. **Utilization review.** (1) Establish on a statewide basis a new program to safeguard against unnecessary or inappropriate use of medical assistance services, against excess payments, against unnecessary or inappropriate hospital admissions or lengths of stay, and against underutilization of services in prepaid health plans, long-term care facilities or any health care delivery system subject to fixed rate reimbursement. In implementing the program, the state agency shall utilize both prepayment and

postpayment review systems to determine if utilization is reasonable and necessary. The determination of whether services are reasonable and necessary shall be made by the commissioner in consultation with a professional services advisory group or health care consultant appointed by the commissioner.

(2) Contracts entered into for purposes of meeting the requirements of this subdivision shall not be subject to the set-aside provisions of chapter 16B.

(3) A recipient aggrieved by the commissioner's termination of services or denial of future services may appeal pursuant to section 256.045. A vendor aggrieved by the commissioner's determination that services provided were not reasonable or necessary may appeal pursuant to the contested case procedures of chapter 14. To appeal, the vendor shall notify the commissioner in writing within 30 days of receiving the commissioner's notice. The appeal request shall specify each disputed item, the reason for the dispute, an estimate of the dollar amount involved for each disputed item, the computation that the vendor believes is correct, the authority in statute or rule upon which the vendor relies for each disputed item, the name and address of the person or firm with whom contacts may be made regarding the appeal, and other information required by the commissioner.

(4) The commissioner may select providers to provide case management services to recipients who use health care services inappropriately or to recipients who are eligible for other managed care projects. The providers shall be selected based upon criteria that may include a comparison with a peer group of providers related to the quality, quantity, or cost of health care services delivered or a review of sanctions previously imposed by health care services programs or the provider's professional licensing board.

Subd. 16. **Personal care services.** (a) The commissioner shall adopt permanent rules to implement, administer, and operate personal care services. The rules must incorporate the standards and requirements adopted by the commissioner of health under section 144A.45 which are applicable to the provision of personal care. Limits on the extent of personal care services that may be provided to an individual must be based on the cost-effectiveness of the services in relation to the costs of inpatient hospital care, nursing home care, and other available types of care. The rules must provide, at a minimum:

(1) that agencies be selected to contract with or employ and train staff to provide and supervise the provision of personal care services;

(2) that agencies employ or contract with a qualified applicant that a qualified recipient proposes to the agency as the recipient's choice of assistant;

(3) that agencies bill the medical assistance program for a personal care service by a personal care assistant and supervision by the registered nurse supervising the personal care assistant;

(4) that agencies establish a grievance mechanism; and

(5) that agencies have a quality assurance program.

(b) For personal care assistants under contract with an agency under paragraph (a), the provision of training and supervision by the agency does not create an employment relationship. The commissioner may waive the requirement for the provision of personal care services through an agency in a particular county, when there are less than two agencies providing services in that county.

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: *Ex1967 c 16 s 4; 1976 c 273 s 1-3; 1977 c 185 s 1; 1977 c 347 s 39,40; 1978 c 560 s 11; Ex1979 c 1 s 46; 1980 c 349 s 3,4; 1982 c 640 s 3; 1983 c 312 art 5 s 11,12; 1984 c 640 s 32; 1985 c 248 s 70; 1Sp1985 c 9 art 2 s 37; 1986 c 444; 1987 c 378 s 15; 1987 c 403 art 2 s 77,78; 1988 c 532 s 13; 1989 c 282 art 3 s 41,42; 1990 c 568 art 3 s 21,22*

256B.041 CENTRALIZED DISBURSEMENT OF MEDICAL ASSISTANCE PAYMENTS.

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

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

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

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

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

The county shall advance 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.

Beginning July 1, 1991, the state will reimburse counties according to the payment schedule in section 256.025 for the county share of local agency expenditures under this subdivision from January 1, 1991, on. Payment to counties under this subdivision is subject to the provisions of section 256.017.

Subd. 6. The commissioners of human services and administration may contract with any agency of government or any corporation for providing all or a portion of the services for carrying out the provisions of this section. Local welfare agencies may pay vendors of transportation for nonemergency medical care when so authorized by rule of the commissioner of human services.

Subd. 7. Federal funds available for administrative purposes shall be distributed between the state and the county on the same basis that reimbursements are earned, except as provided for under section 256.017.

History: *1973 c 717 s 2; 1975 c 437 art 2 s 4; 1978 c 560 s 12; 1983 c 312 art 5 s 13,14; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1988 c 719 art 8 s 11,12; 1989 c 277 art 2 s 7; 1Sp1989 c 1 art 16 s 6*

256B.042 THIRD PARTY LIABILITY.

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

Subd. 2. **Lien enforcement.** The state agency may perfect and enforce its lien by following the procedures set forth in sections 514.69, 514.70 and 514.71, and its verified lien statement shall be filed with the appropriate court administrator in the county of financial responsibility. The verified lien statement shall contain the following: the name and address of the person to whom medical care was furnished, the date of injury, the name and address of the vendor or vendors furnishing medical care, the dates of the service, the amount claimed to be due for the care, and, to the best of the state agency's knowledge, the names and addresses of all persons, firms, or corporations claimed to be liable for damages arising from the injuries. This section shall not affect the priority of any attorney's lien. The state agency is not subject to any limitations period referred to in section 514.69 or 514.71 and has one year from the date notice is received by it under subdivision 4, paragraph (c), or one year from the date medical bills are first paid by the state agency, whichever is later, to file its verified lien statement. The state agency may commence an action to enforce the lien within one year of (1) the date the notice required by subdivision 4, paragraph (c), is received or (2) the date the recipient's cause of action is concluded by judgment, award, settlement, or otherwise, whichever is later.

Subd. 3. The attorney general, or the appropriate county attorney acting at the direction of the attorney general, shall represent the state agency to enforce the lien created under this section or, if no action has been brought, may initiate and prosecute an independent action on behalf of the state agency against a person, firm, or corporation that may be liable to the person to whom the care was furnished.

Subd. 4. **Notice.** The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable to pay part or all of the cost of medical care when the state agency has paid or become liable for the cost of that care. Notice must be given as follows:

(a) Applicants for medical assistance shall notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A person who is a party to a claim upon which the state agency may be entitled to a lien under this section shall notify the state agency of its potential lien claim before filing a claim, commencing an action, or negotiating a settlement.

Notice given to the local agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Subd. 5. **Costs deducted.** Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has filed its lien, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of medical assistance paid to or on behalf of the person as a result of the injury must be deducted next, and paid to the state agency. The rest must be paid to the medical assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and other collection costs.

History: *1975 c 247 s 6; 1976 c 236 s 2; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1987 c 370 art 2 s 5-8; 1988 c 689 art 2 s 143*

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).

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

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

Subd. 4. [Repealed, 1987 c 403 art 2 s 164]

History: *Ex1967 c 16 s 5; 1971 c 961 s 28; 1982 c 640 s 4; 1984 c 580 s 3; 1984 c 654 art 5 s 58; 1988 c 719 art 8 s 13; 1989 c 89 s 10*

256B.055 ELIGIBILITY CATEGORIES.

Subdivision 1. **Children eligible for subsidized adoption assistance.** Medical assistance may be paid for a child eligible for or receiving adoption assistance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676 under Minnesota Statutes, section 259.40 or 259.431.

Subd. 2. **Subsidized foster children.** Medical assistance may be paid for a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676.

Subd. 3. **AFDC families.** Medical assistance may be paid for a person who is eligible for or receiving, or who would be eligible for, except for excess income or assets, public assistance under the aid to families with dependent children program.

Subd. 4. **Recipients of Minnesota supplemental aid.** Medical assistance may be paid for a person who is receiving public assistance under the Minnesota supplemental aid program.

Subd. 5. **Pregnant women; dependent unborn child.** Medical assistance may be paid for a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse, who meets the other eligibility criteria of this section and who would be categorically eligible for assistance under the aid to families with dependent children program if the child had been born and was living with the woman. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid for a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse, who meets the other eligibility criteria of this section and whose unborn child would be eligible as a needy child under subdivision 10 if born and living with the woman. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

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 or, who would meet those requirements except for excess income or assets, and who meets the other eligibility requirements of this section.

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. [Repealed, 1990 c 568 art 3 s 104]

Subd. 9. **Children.** Medical assistance may be paid for a person who is under 21 years of age and in need of medical care that neither the person nor the person's relatives responsible under sections 256B.01 to 256B.26 are financially able to provide.

Subd. 10. **Infants.** Medical assistance may be paid for an infant less than one year of age born on or after October 1, 1984, whose mother was eligible at the time of birth and who remains in the mother's household. Eligibility under this subdivision is concurrent with the mother's and does not depend on the father's income except as the income affects the mother's eligibility.

Subd. 11. **Elderly hospital inpatients.** Medical assistance may be paid for a person who is residing in a hospital for treatment of mental disease or tuberculosis and is 65 years of age or older and without means sufficient to pay the per capita hospital charge.

Subd. 12. **Disabled children.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing in a medical institution, and who requires a level of care provided in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for persons with mental retardation or related conditions, for whom home care is appropriate, provided that the cost to medical assistance for home care services is not more than the amount that medical assistance would pay for appropriate institutional care.

(b) For purposes of this subdivision, "hospital" means an acute care institution as defined in section 144.696, subdivision 3, licensed pursuant to sections 144.50 to 144.58, which is appropriate if a person is technology dependent or has a chronic health condition which requires frequent intervention by a health care professional to avoid death.

(c) For purposes of this subdivision, "skilled nursing facility" and "intermediate care facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse.

(d) For purposes of this subdivision, "intermediate care facility for the mentally retarded" or "ICF/MR" means a program licensed to provide services to persons with mental retardation under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota department of health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with mental retardation or persons with related conditions who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs.

(e) For purposes of this subdivision, a person "requires a level of care provided in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for persons with mental retardation or related conditions" if the person requires 24-hour supervision because the person exhibits suicidal or homicidal ideation or behavior, psychosomatic disorders or somatopsychic disorders that may become life threatening, severe socially unacceptable behavior associated with psychiatric disorder, psychosis or severe developmental problems requiring continuous skilled observation, or disabling symptoms that do not respond to office-centered outpatient treatment.

History: *Ex1967 c 16 s 6; 1969 c 841 s 1; 1973 c 717 s 18; 1974 c 525 s 1,2; 1975 c 247 s 10; 1976 c 236 s 3; 1977 c 448 s 6; 1978 c 760 s 1; 1979 c 309 s 4; 1980 c 509 s 106; 1980 c 527 s 1; 1981 c 360 art 2 s 28; 1Sp1981 c 2 s 14; 3Sp1981 c 2 art 1 s 32; 3Sp1981 c 3 s 17; 1982 c 553 s 6; 1982 c 640 s 5; 1983 c 312 art 5 s 15; 1984 c 422 s 1; 1984 c 534 s 22; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1985 c 252 s 21; 1986 c 444; 1Sp1986 c 1 art 8 s 5; 1987 c 403 art 2 s 79,80; 1988 c 689 art 2 s 144,145,268; 1989 c 282 art 3 s 43,44; 1990 c 568 art 3 s 23-27*

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

Subdivision 1. **Residency.** To be eligible for medical assistance, a person must reside in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota in accordance with the rules of the state agency.

Subd. 1a. **Income and assets generally.** Unless specifically required by state law or rule or federal law or regulation, the methodologies used in counting income and assets to determine eligibility for medical assistance shall be as follows: (a) for persons whose eligibility category is based on blindness, disability, or age of 65 or more years, the methodologies for the supplemental security income program shall be used; and (b) for families and children, which includes all other eligibility categories, the methodologies for the aid to families with dependent children program under section 256.73 shall be used. For these purposes, a "methodology" does not include an asset or income standard, budgeting or accounting method, or method of determining effective dates.

Subd. 2. **Homestead.** To be eligible for medical assistance, a person must not own, individually or together with the person's spouse, real property other than the homestead. For the purposes of this section, "homestead" means the house owned and occupied by the applicant or recipient as a primary place of residence, together with the contiguous land upon which it is situated. The homestead shall continue to be excluded for persons residing in a long-term care facility if it is used as a primary residence by one of the following individuals:

(a) the spouse;

(b) a child under age 21;

(c) a child of any age who is blind or permanently and totally disabled as defined in the supplemental security income program;

(d) a sibling who has equity interest in the home and who resided in the home for at least one year immediately before the date of the person's admission to the facility; or

(e) a child of any age, or, subject to federal approval, a grandchild of any age, who resided in the home for at least two years immediately before the date of the person's admission to the facility, and who provided care to the person that permitted the person to reside at home rather than in an institution.

The homestead is also excluded for the first six calendar months of the person's stay in the long-term care facility. The person's equity in the homestead must be reduced to an amount within limits or excluded on another basis if the person remains in the long-term care facility for a period longer than six months. Real estate not used as a home may not be retained unless the property is not salable, the equity is $6,000 or less and the income produced by the property is at least six percent of the equity, or the excess real property is exempted for a period of nine months if there is a good faith effort to sell the property and a legally binding agreement is signed to repay the amount of assistance issued during that nine months.

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) Insurance settlements to repair or replace damaged, destroyed, or stolen property are considered to the same extent as in the related cash assistance programs.

(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 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. 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.

Subd. 6. **Assignment of benefits.** To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's spouse from any third person liable for the costs of medical care for the person, the spouse, and children. The state agency shall require from any applicant or recipient of medical assistance the assignment of any rights to medical support and third party payments. Persons must cooperate with the state in establishing pater-

nity and obtaining third party payments. By signing an application for medical assistance, a person assigns to the department of human services all rights the person may have to medical support or payments for medical expenses from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third party payments. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant is determined eligible for and receives medical assistance benefits. The application must contain a statement explaining this assignment. Any assignment shall not be effective as to benefits paid or provided under automobile accident coverage and private health care coverage prior to notification of the assignment by the person or organization providing the benefits.

Subd. 7. **Period of eligibility.** Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. A redetermination of eligibility must occur every 12 months.

History: *Ex1967 c 16 s 6; 1969 c 841 s 1; 1973 c 717 s 18; 1974 c 525 s 1,2; 1975 c 247 s 10; 1976 c 236 s 3; 1977 c 448 s 6; 1978 c 760 s 1; 1979 c 309 s 4; 1980 c 509 s 106; 1980 c 527 s 1; 1981 c 360 art 2 s 28; 1Sp1981 c 2 s 14; 3Sp1981 c 2 art 1 s 32; 3Sp1981 c 3 s 17; 1982 c 553 s 6; 1982 c 640 s 5; 1983 c 312 art 5 s 15; 1984 c 422 s 1; 1984 c 534 s 22; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1985 c 252 s 21; 1986 c 444; 1Sp1986 c 1 art 8 s 5; 1987 c 403 art 2 s 79,80; 1988 c 689 art 2 s 144,145,268; 1989 c 282 art 3 s 45-47; 1989 c 332 s 1; 1990 c 568 art 3 s 28-32*

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 who has written verification of a positive pregnancy test from a physician or licensed registered nurse, 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 five years of age in a family whose countable income is less than 133 percent of the federal poverty guidelines for the same family size, is eligible for medical assistance. A child six through seven years of age, who was born after September 30, 1983, 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 recipi-

ent 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.

Subd. 4. **Qualified working disabled adults.** A person who is entitled to Medicare Part A benefits under section 1818A of the Social Security Act; whose income does not exceed 200 percent of the federal poverty guidelines for the applicable family size; whose nonexempt assets do not exceed twice the maximum amount allowable under the supplemental security income program, according to family size; and who is not otherwise eligible for medical assistance, is eligible for medical assistance reimbursement of the Medicare Part A premium. 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. 5. **Disabled adult children.** A person who is at least 18 years old, who was eligible for supplemental security income benefits on the basis of blindness or disability, who became disabled or blind before he or she reached the age of 22, and who lost eligibility as a result of becoming entitled to a child's insurance benefits on or after July 1, 1987, under section 202(d) of the Social Security Act, or because of an increase in those benefits effective on or after July 1, 1987, is eligible for medical assistance as long as he or she would be entitled to supplemental security income in the absence of child's insurance benefits or increases in those benefits.

History: *1989 c 282 art 3 s 48; 1990 c 568 art 3 s 33-36*

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 allowance for children under age 18 which, together with the net income of the children, would provide income equal to the medical assistance standard for a family size that includes only the minor children. This deduction applies only if the children do not live with the community spouse and only if the children resided with the institutionalized person immediately prior to admission;

(6) 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

(7) 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 (6), "other family member" means a person who resides with the community spouse and who is a minor or dependent child, dependent parent, or dependent sibling of either spouse. "Dependent" means a person who could be claimed as a dependent for federal income tax purposes under the Internal Revenue Code.

(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; 1990 c 568 art 3 s 37*

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. A substitution under this paragraph may be made only if the assets of the couple have been arranged so that the maximum amount of income-producing assets, at the maximum rate of return, are available to the community spouse under the community spouse asset allowance. The maximum rate of return is the average rate of return available from the financial institution holding the asset, or a rate determined by the commissioner to be reasonable according to community standards, if the asset is not held by a financial institution.

(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) An institutionalized spouse may be found eligible for medical assistance even though assets in excess of the allowable amount are found to be available under paragraph (a) if the assets are owned jointly or individually by the community spouse, and the institutionalized spouse cannot use those assets to pay for the cost of care without the consent of the community spouse, and if: (i) the institutionalized spouse assigns to the commissioner the right to support from the community spouse under section 256B.14, subdivision 2; (ii) the institutionalized spouse lacks the ability to execute an assignment due to a physical or mental impairment; or (iii) the denial of eligibility would cause an imminent threat to the institutionalized spouse's health and well-being.

(c) 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, unless the institutionalized spouse has been found eligible under clause (b).

(d) 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; 1990 c 568 art 3 s 38,39*

256B.0595 PROHIBITIONS ON TRANSFER; EXCEPTIONS.

Subdivision 1. **Prohibited transfers.** If a person or the person's spouse 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 before or any time after the date of institutionalization if the person has been determined eligible for medical assistance, or within 30 months before or any time after 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. If the transfer was not reported to the local agency at the time of application, and the applicant received long-term care services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. 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 who has made, or whose spouse has made a transfer prohibited by subdivision 1, is not ineligible for long-term care services if one of the following conditions applies:

(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; 1990 c 568 art 3 s 40-42*

256B.06 ELIGIBILITY; MIGRANT WORKERS; CITIZENSHIP.

Subdivision 1. [Renumbered 256B.055 subd 1]

Subd. 1a. [Renumbered 256B.055 subd 2]

Subd. 1b. [Renumbered 256B.055 subd 3]
Subd. 1c. [Renumbered 256B.055 subd 4]
Subd. 1d. [Renumbered 256B.055 subd 5]
Subd. 1e. [Renumbered 256B.055 subd 6]
Subd. 1f. [Renumbered 256B.055 subd 7]
Subd. 1g. [Renumbered 256B.055 subd 8]
Subd. 1h. [Renumbered 256B.055 subd 9]
Subd. 1i. [Renumbered 256B.055 subd 10]
Subd. 1j. [Renumbered 256B.055 subd 11]
Subd. 1k. [Renumbered 256B.056 subd 1]
Subd. 1l. [Renumbered 256B.056 subd 2]
Subd. 1m. [Renumbered 256B.056 subd 3]
Subd. 1n. [Renumbered 256B.056 subd 4]
Subd. 1o. [Renumbered 256B.056 subd 5]
Subd. 1p. [Renumbered 256B.056 subd 6]
Subd. 1q. [Renumbered 256B.055 subd 12]
Subd. 1r. [Renumbered 256B.056 subd 7]
Subd. 2. [Repealed, 1974 c 525 s 3]

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

Subd. 4. **Citizenship requirements.** Eligibility for medical assistance is limited to citizens of the United States and aliens lawfully admitted for permanent residence or otherwise permanently residing in the United States under the color of law. Aliens who are seeking legalization under the Immigration Reform and Control Act of 1986, Public Law Number 99-603, who are under age 18, over age 65, blind, disabled, or Cuban or Haitian, and who meet the eligibility requirements of medical assistance under subdivision 1 and section 256B.17 are eligible to receive medical assistance. Pregnant women who are aliens seeking legalization under the Immigration Reform and Control Act of 1986, Public Law Number 99-603, and who meet the eligibility requirements of medical assistance under subdivision 1 are eligible for payment of care and services through the period of pregnancy and six weeks postpartum. Payment shall also be made for care and services that are furnished to an alien, regardless of immigration status, who otherwise meets the eligibility requirements of this section if such care and services are necessary for the treatment of an emergency medical condition. For purposes of this subdivision, the term "emergency medical condition" means a medical condition, including labor and delivery, that if not immediately treated could cause a person physical or mental disability, continuation of severe pain, or death.

History: *Ex1967 c 16 s 6; 1969 c 841 s 1; 1973 c 717 s 18; 1974 c 525 s 1,2; 1975 c 247 s 10; 1976 c 236 s 3; 1977 c 448 s 6; 1978 c 760 s 1; 1979 c 309 s 4; 1980 c 509 s 106; 1980 c 527 s 1; 1981 c 360 art 2 s 28; 1Sp1981 c 2 s 14; 3Sp1981 c 2 art 1 s 32; 3Sp1981 c 3 s 17; 1982 c 553 s 6; 1982 c 640 s 5; 1983 c 312 art 5 s 15; 1984 c 422 s 1; 1984 c 534 s 22; 1984 c 654 art 5 s 58; 1985 c 248 s 70; 1985 c 252 s 21; 1986 c 444; 1Sp1986 c 1 art 8 s 5; 1987 c 403 art 2 s 79,80; 1988 c 689 art 2 s 144,145,268*

256B.061 ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS.

If any individual has been determined to be eligible for medical assistance, it will be made available for care and services included under the plan and furnished in or after the third month before the month in which the individual made application for such assistance, if such individual was, or upon application would have been, eligible for medical assistance at the time the care and services were furnished. The commissioner may limit, restrict, or suspend the eligibility of an individual for up to one year

upon that individual's conviction of a criminal offense related to application for or receipt of medical assistance benefits.

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

256B.062 CONTINUED ELIGIBILITY.

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: *1973 c 717 s 4; 1981 c 231 s 1; 1Sp1985 c 9 art 2 s 38; 1989 c 282 art 3 s 53*

256B.0625 COVERED SERVICES.

Subdivision 1. **Inpatient hospital services.** Medical assistance covers inpatient hospital services. A second medical opinion is required prior to reimbursement for elective surgeries requiring a second opinion. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion prior to reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and the criteria and standards are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether a second medical opinion is required, made in accordance with rules governing that decision, is not subject to administrative appeal.

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, unless (a) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (b) the health care financing administration approves the necessary state plan amendments; (c) the patient was screened as provided in section 256B.091; (d) the patient no longer requires acute care services; and (e) no nursing home beds are available within 25 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

Subd. 3. **Physicians' services.** Medical assistance covers physicians' services.

Subd. 4. **Outpatient and clinic services.** Medical assistance covers outpatient hospital or physician-directed clinic services. The physician-directed clinic staff shall include at least two physicians and all services shall be provided under the direct supervision of a physician. Hospital outpatient departments are subject to the same limitations and reimbursements as other enrolled vendors for all services, except initial triage, emergency services, and services not provided or immediately available in clinics, physicians' offices, or by other enrolled providers. A second medical opinion is required

before reimbursement for elective surgeries requiring a second opinion. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion before reimbursement and the criteria and standards for deciding whether an elective surgery should require a second surgical opinion. The list and the criteria and standards are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether a second medical opinion is required, made in accordance with rules governing that decision, is not subject to administrative appeal. "Emergency services" means those medical services required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death or are necessary to alleviate severe pain. Neither the hospital, its employees, nor any physician or dentist, shall be liable in any action arising out of a determination not to render emergency services or care if reasonable care is exercised in determining the condition of the person, or in determining the appropriateness of the facilities, or the qualifications and availability of personnel to render these services consistent with this section.

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services, as defined in rules adopted by the commissioner pursuant to section 256B.04, subdivision 2, and provided by a community mental health center as defined in section 245.62, subdivision 2.

Subd. 6. **Home health care.** Medical assistance covers home health care services.

Subd. 7. **Private duty nursing.** Medical assistance covers private duty nursing services.

Subd. 8. **Physical therapy.** Medical assistance covers physical therapy and related services.

Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy and related services.

Subd. 9. **Dental services.** Medical assistance covers dental services. Dental services include, with prior authorization, fixed cast metal restorations that are cost-effective for persons who cannot use removable dentures because of their medical condition.

Subd. 10. **Laboratory and X-ray services.** Medical assistance covers laboratory and X-ray services.

Subd. 11. **Nurse anesthetist services.** Medical assistance covers nurse anesthetist services.

Subd. 12. **Eyeglasses, dentures, and prosthetic devices.** Medical assistance covers eyeglasses, dentures, and prosthetic devices if prescribed by a licensed practitioner.

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 legend drug 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. Over-the-counter medications must be dispensed in the manufacturer's unopened package. 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.

Subd. 14. **Diagnostic, screening, and preventive services.** Medical assistance covers diagnostic, screening, and preventive services. "Preventive services" include services related to pregnancy, including services for those conditions which may complicate a pregnancy and which may be available to a pregnant woman determined to be at risk of poor pregnancy outcome. Preventive services available to a woman at risk of poor pregnancy outcome may differ in an amount, duration, or scope from those available to other individuals eligible for medical assistance.

Subd. 15. **Health plan premiums.** Medical assistance covers health care prepayment plan premiums and insurance premiums if paid directly to a vendor and supple-

mentary medical insurance benefits under Title XVIII of the Social Security Act. For purposes of obtaining Medicare part B, expenditures may be made even if federal funding is not available.

Subd. 16. **Abortion services.** Medical assistance covers abortion services, but only if one of the following conditions is met:

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

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

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

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.

Subd. 18. **Bus or taxicab transportation.** To the extent authorized by rule of the state agency, medical assistance covers costs of bus or taxicab transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care.

Subd. 19. **Personal care assistants.** Medical assistance covers personal care assistant services provided by an individual, not a relative, who is qualified to provide the services, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a registered nurse. Payments to personal care assistants shall be adjusted annually to reflect changes in the cost of living or of providing services by the average annual adjustment granted to vendors such as nursing homes and home health agencies.

Subd. 20. **Mental illness case management.** To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness.

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

Subd. 22. **Hospice care.** Medical assistance covers hospice care services under Public Law Number 99-272, section 9505, to the extent authorized by rule.

Subd. 23. **Day treatment services.** Medical assistance covers day treatment services as specified in sections 245.462, subdivision 8, and 245.471, subdivision 3, that are provided under contract with the county board.

Subd. 24. **Other medical or remedial care.** Medical assistance covers any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law, except licensed chemical dependency treatment programs or primary treatment or extended care treatment units in hospitals that are covered under Laws 1986, chapter 394, sections 8 to 20. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but

payment must be made under Laws 1986, chapter 394, sections 8 to 20. The commissioner shall publish in the State Register a list of elective surgeries that require a second medical opinion before medical assistance reimbursement, and the criteria and standards for deciding whether an elective surgery should require a second medical opinion. The list and criteria and standards are not subject to the requirements of sections 14.01 to 14.69.

Subd. 25. **Second opinion or prior authorization required.** The commissioner shall publish in the State Register a list of health services that require prior authorization, as well as the criteria and standards used to select health services on the list. The list and the criteria and standards used to formulate it are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision whether prior authorization is required for a health service or a second medical opinion is required for an elective surgery is not subject to administrative appeal.

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.

Subd. 28. **Certified pediatric or family nurse practitioner services.** Medical assistance covers services performed by a certified pediatric nurse practitioner or a certified family nurse practitioner in independent practice, if the services are otherwise covered under this chapter as a physician service, and if the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171.

Subd. 29. **Public health nursing clinic services.** Medical assistance covers the services of a certified public health nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171.

Subd. 30. **Other clinic services.** Medical assistance covers rural health clinic, federally qualified health center, and nonprofit community health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

History: *Ex1967 c 16 s 2; 1969 c 395 s 1; 1973 c 717 s 17; 1975 c 247 s 9; 1975 c 384 s 1; 1975 c 437 art 2 s 3; 1976 c 173 s 56; 1976 c 236 s 1; 1976 c 312 s 1; 1978 c 508 s 2; 1978 c 560 s 10; 1981 c 360 art 2 s 26,54; 1Sp1981 c 2 s 12; 1Sp1981 c 4 art 4 s 22; 3Sp1981 c 2 art 1 s 31; 1982 c 562 s 2; 1983 c 151 s 1,2; 1983 c 312 art 1 s 27; art 5 s 10; art 9 s 4; 1984 c 654 art 5 s 58; 1985 c 21 s 52-54; 1985 c 49 s 41; 1985 c 252 s 19,20; 1Sp1985 c 3 s 19; 1986 c 394 s 17; 1986 c 444; 1987 c 370 art 1 s 3; art 2 s 4; 1987 c 374 s 1; 1987 c 309 s 24; 1987 c 403 art 2 s 73,74; art 5 s 16; 1988 c 689 art 2 s 141,268; 1989 c 282 art 3 s 54-58; 1990 c 422 s 10; 1990 c 568 art 3 s 43-50,104*

256B.0627 COVERED SERVICE; HOME CARE SERVICES.

Subdivision 1. **Definition.** "Home care services" means a medically necessary health service that is ordered by a physician and documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days. Home care services include personal care and nursing supervision of personal care services which is reviewed and revised as medically necessary by the physician at least once every 365 days. Home care services are provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility.

Subd. 2. **Services covered.** Home care services covered under this section include:

(1) nursing services;

(2) private duty nursing services;

(3) home health aide services;

(4) personal care services; and

(5) nursing supervision of personal care services.

Subd. 3. **Private duty nursing services; who may provide.** Private duty nursing services may be provided by a registered nurse or licensed practical nurse who is not the recipient's spouse, legal guardian, or parent of a minor child.

Subd. 4. **Personal care services.** (a) Personal care services may be provided by a qualified individual who is not the recipient's spouse, legal guardian, or parent of a minor child.

(b) The personal care services that are eligible for payment are the following:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) range of motion exercises;

(4) respiratory assistance;

(5) transfers;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is normally self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with food, nutrition, and diet activities;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) services provided for the recipient's personal health and safety;

(15) helping the recipient to complete daily living skills such as personal and oral hygiene and medication schedules; and

(16) incidental household services that are an integral part of a personal care service described in clauses (1) to (15).

(c) The personal care services that are not eligible for payment are the following:

(1) personal care services that are not in the plan of care developed by the supervising registered nurse in consultation with the personal care assistants and the recipient or family of the recipient;

(2) services that are not supervised by the registered nurse;

(3) services provided bv the recipient's spouse, legal guardian, or parent of a minor child;

(4) sterile procedures; and

(5) injections of fluids into veins, muscles, or skin.

Subd. 5. **Limitation on payments.** Medical assistance payments for home care services shall be limited according to paragraphs (a) to (e).

(a) **Exemption from payment limitations.** The level, or the number of hours or vis-

its of a specific service, of home health care services to a recipient that began before and is continued without increase on or after December 1987, shall be exempt from the payment limitations of this section, as long as the services are medically necessary.

(b) **Level I home care.** For all new cases after December 1987, medically necessary home care services up to $800 may be provided in a calendar month.

If the services in the recipient's home care plan will exceed the $800 threshold for 30 days or less, the medically necessary services may be provided.

(c) **Level II home care.** If the services in the recipient's home care plan exceed $800 for more than 30 days, a public health nurse from the local preadmission screening team shall determine the recipient's maximum level of home care according to this paragraph.

(1) The public health nurse from the local preadmission screening team shall base the determination of the recipient's maximum level of care on the need and eligibility of the recipient for one of the following placements:

(i) residential facility for persons with mental retardation or related conditions operated under section 256B.501;

(ii) inpatient hospital care for a ventilator-dependent recipient. "Ventilator dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to or has been dependent for at least 30 consecutive days; or

(iii) all other recipients not appropriate for one of the above placements.

(2) If the recipient is eligible under clause (1)(i), the monthly medical assistance reimbursement for home care services shall not exceed the total monthly statewide average payment rate for residential facilities for children or adults with mental retardation or related conditions as appropriate for the recipient's age and level of self-preservation as determined according to Minnesota Rules, parts 9553.0010 to 9553.0080.

(3) If the recipient is eligible under clause (1)(ii), the monthly medical assistance reimbursement for home care services shall not exceed the monthly cost of care at the highest cost hospital designated as a long-term hospital under the Medicare program. For purposes of this clause, home care services means all services provided in the home that would be included in the payment for care at the long-term hospital.

(4) If the recipient is not eligible under either clause (1)(i) or (1)(ii), the monthly medical assistance reimbursement for home care services shall not exceed the total monthly statewide average payment for the case mix classification most appropriate to the recipient. The case mix classification is established under section 256B.431.

(5) The determination of the recipient's maximum level of home care by the public health nurse is called a home care cost assessment. The home care cost assessment must be requested by the home care provider before the end of the first 30 days of provided service and must be conducted by the public health nurse within ten working days following request.

(6) A home care provider shall request a new home care cost assessment when the needs of the individual have changed enough to require that a revised care plan be implemented that will increase costs beyond what was approved by the previous home care cost assessment and the change is anticipated to last for more than 30 days. The home care provider must request the home care cost assessment before the end of the first 30 days of provided service. Whenever a home care cost assessment is completed, the public health nurse that completes the home care cost assessment, in consultation with the home care provider, shall determine the time period for which a home care cost assessment shall remain valid. If the recipient continues to require home care services beyond the limited duration of the home care cost assessment, the home care provider must request a reassessment through the home care cost assessment process described above. Under no circumstances shall a home care cost assessment be valid for more than 12 months.

(7) Reimbursement for the home care cost assessment shall be made through the Medicaid administrative authority. The state shall pay the nonfederal share.

(d) **Level III home care.** If the home care provider determines that the recipient's needs exceed the amount approved for the appropriate level of care as determined in paragraph (c), the home care provider may refer the case to the department for a level III determination. Based on the client needs, physician orders, diagnosis, condition, and plan of care, the department may give prior approval for care that exceeds level II described in paragraph (c). The amount approved shall not exceed the maximum cost for the appropriate level of care as determined in paragraph (c), clause (1), which will be the maximum ICF/MR rate for intermediate care facilities for persons with mental retardation or related conditions, or the maximum nursing home case mix payment, or the highest hospital cost for the state.

The department has 30 days from receipt of the request to complete the level III determination, during which time it may approve the higher level while reviewing the case.

Case reviews or approval of home care services in levels II and III may result in assignment of a case manager.

(e) **Prior approval required in foster care setting.** Any home care service provided in an adult or child foster care setting must receive prior approval by the department.

Subd. 6. **Recovery of excessive payments.** The commissioner shall seek monetary recovery from providers of payments made for services which exceed the limits established in this section.

History: *1990 c 568 art 3 s 51*

256B.0629 ADVISORY COMMITTEE ON ORGAN AND TISSUE TRANSPLANTS.

Subdivision 1. **Creation and membership.** By July 1, 1990, the commissioner shall appoint and convene a 12-member advisory committee to provide advice and recommendations to the commissioner concerning the eligibility of organ and tissue transplant procedures for reimbursement by medical assistance and general assistance medical care. The committee must include representatives of the transplant provider community, hospitals, patient recipient groups or organizations, the department of human services, the department of finance, and the department of health, at least one representative of a health plan regulated under chapter 62A, 62C, or 62D, and persons with expertise in ethics, law, and economics. The terms and removal of members shall be governed by section 15.059. Members shall not receive per diems but shall be compensated for expenses. The advisory committee does not expire as provided in section 15.059, subdivision 6.

Subd. 2. **Function and objectives.** The advisory committee shall meet at least twice a year. The committee's activities include, but are not limited to:

(1) collection of information on the efficacy and experience of various forms of transplantation not approved by Medicare;

(2) collection of information from Minnesota transplant providers on available services, success rates, and the current status of transplant activity in the state;

(3) development of guidelines for determining when and under what conditions organ and tissue transplants not approved by Medicare should be eligible for reimbursement by medical assistance and general assistance medical care;

(4) providing recommendations, at least annually, to the commissioner on: (i) organ and tissue transplant procedures, beyond those approved by Medicare, that should also be eligible for reimbursement under medical assistance and general assistance medical care; and (ii) which transplant centers should be eligible for reimbursement from medical assistance and general assistance medical care.

Subd. 3. **Annual report.** The advisory committee shall present an annual report to the commissioner and the chairs of the health and human services appropriations divisions of the house appropriations committee and the senate finance committee by January 1 of each year on the findings and recommendations of the committee.

Subd. 4. **Responsibilities of the commissioner.** The commissioner shall periodically:

(1) Recommend to the legislature criteria governing the eligibility of organ and tissue transplant procedures for reimbursement from medical assistance and general assistance medical care. Procedures approved by Medicare are automatically eligible for medical assistance and general assistance medical care reimbursement. Additional procedures are eligible for reimbursement only upon approval by the legislature. Only procedures recommended by the task force and the commissioner may be considered by the legislature.

(2) Recommend to the legislature criteria for certifying transplant centers within and outside of Minnesota where Minnesotans receiving medical assistance and general assistance medical care may obtain transplants. Additional centers may be certified only upon approval of the legislature. Only centers recommended by the task force and the commissioner may be considered by the legislature.

History: *1990 c 568 art 3 s 52*

256B.063 COST SHARING.

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

History: *1973 c 717 s 5*

256B.064 INELIGIBLE PROVIDER.

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

Subd. 1a. **Grounds for monetary recovery and sanctions against vendors.** The commissioner may seek monetary recovery and impose sanctions against vendors of medical care for any of the following: fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; a pattern of presentment of false or duplicate claims or claims for services not medically necessary; a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; suspension or termination as a Medicare vendor; and refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients. The determination of services not medically necessary may be made by the commissioner in consultation with a peer advisory task force appointed by the commissioner on the recommendation of appropriate professional organizations. The task force expires as provided in section 15.059, subdivision 5.

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

Subd. 1c. The commissioner may obtain monetary recovery for the conduct described in subdivision 1a by the following methods: assessing and recovering money erroneously paid and debiting from future payments any money erroneously paid, except that patterns need not be proven as a precondition to monetary recovery for false claims, duplicate claims, claims for services not medically necessary, or false statements. The commissioner may charge interest on money to be recovered if the recovery is to be made by installment payments or debits. The interest charged shall be the rate established by the commissioner of revenue under section 270.75.

Subd. 2. The commissioner shall determine monetary amounts to be recovered and the sanction to be imposed upon a vendor of medical care for conduct described

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

History: *1973 c 717 s 6; 1976 c 188 s 1; 1980 c 349 s 5,6; 1982 c 424 s 130; 1983 c 312 art 5 s 17; 1987 c 370 art 1 s 4; 1987 c 403 art 2 s 81; 1988 c 629 s 52*

256B.0641 RECOVERY OF OVERPAYMENTS.

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

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

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

Subd. 2. **Overpayments to prior owners.** The current owner of a nursing home, boarding care home, or intermediate care facility for persons with mental retardation or a related condition is liable for the overpayment amount owed by a former owner for any facility sold, transferred, or reorganized after May 15, 1987. Within 12 months of a written request by the current owner, the commissioner shall conduct a field audit of the facility for the auditable rate years during which the former owner owned the facility and issue a report of the field audit within 15 months of the written request. Nothing in this subdivision limits the liability of a former owner.

History: *1Sp1985 c 9 art 2 s 39; 1987 c 133 s 1*

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.0643 VENDOR REQUEST FOR CONTESTED CASE PROCEEDING.

Unless otherwise provided by law, a vendor of medical care, as defined in section 256B.02, subdivision 7, must use this procedure to request a contested case, as defined in section 14.02, subdivision 3. A request for a contested case must be filed with the commissioner in writing within 60 days after the date the notification of an action or determination was mailed. The appeal request must specify:

(1) each disputed action or item;

(2) the reason for the dispute;

(3) an estimate of the dollar amount involved, if any, for each disputed item;

(4) the computation or other disposition that the appealing party believes is correct;

(5) the authority in statute or rule upon which the appealing party relies for each disputed item;

(6) the name and address of the person or firm with whom contacts may be made regarding the appeal; and

(7) other information required by the commissioner. Nothing in this section shall be construed to create a right to an administrative appeal or contested case proceeding.

History: *1990 c 568 art 3 s 53*

256B.065 SOCIAL SECURITY AMENDMENTS.

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

History: *1973 c 717 s 7*

256B.07 [Repealed, 1987 c 403 art 2 s 164]

256B.08 APPLICATION.

Subdivision 1. **Application process.** An applicant for medical assistance, or a person acting in the applicant's behalf, shall file an application with a local agency in the manner and form prescribed by the state agency. When a married applicant resides in a nursing home or applies for medical assistance for nursing home services, the local agency shall consider an application on behalf of the applicant's spouse only upon specific request of the applicant or upon specific request of the spouse and separate filing of an application.

Subd. 2. **Expedited review for pregnant women.** A pregnant woman who may be eligible for assistance under section 256B.055, subdivision 1, must receive an appointment for eligibility determination no later than five working days from the date of her request for assistance from the local agency. The local agency shall expedite processing her application for assistance and shall make a determination of eligibility on a completed application no later than ten working days following the applicant's initial appointment. The local agency shall assist the applicant to provide all necessary information and documentation in order to process the application within the time period required under this subdivision. The state agency shall provide for the placement of applications for medical assistance in eligible provider offices, community health offices, and Women, Infants and Children (WIC) program sites.

History: *Ex1967 c 16 s 8; 1Sp1981 c 2 s 15; 1986 c 444; 1988 c 689 art 2 s 146,268*

256B.09 INVESTIGATIONS.

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

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

256B.091 NURSING HOME PREADMISSION SCREENING PROGRAM.

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

use of available federal and state funds and establish the broadest program possible within the appropriation available.

Subd. 2. **Screening teams; establishment.** Each county agency designated by the commissioner of human services to participate in the program shall contract with the community health board organized under sections 145A.09 to 145A.13 or other public or nonprofit agency to establish a screening team to assess the health and social needs of all applicants prior to admission to a nursing home or a boarding care home licensed under section 144A.02 or sections 144.50 to 144.56, that is certified for medical assistance as a skilled nursing facility, intermediate care facility level I, or intermediate care facility level II. Each local screening team shall be composed of a public health nurse as defined in section 145A.02, subdivision 18, from the local public health nursing service and a social worker from the local community welfare agency. Each screening team shall have a physician available for consultation and shall utilize individuals' attending physicians' physical assessment forms, if any, in assessing needs. The individual's physician shall be included on the screening team if the physician chooses to participate. If a person who has been screened must be reassessed for purposes of assigning a case mix classification because admission to a nursing home occurs later than the time allowed by rule following the initial screening and assessment, the reassessment may be completed by the public health nurse member of the screening team. If the individual is being discharged from an acute care facility, a discharge planner from that facility may be present, at the facility's request, during the screening team's assessment of the individual and may participate in discussions but not in making the screening team's recommendations under subdivision 3, clause (e). If the assessment procedure or screening team recommendation results in a delay of the individual's discharge from the acute care facility, the facility shall not be denied medical assistance reimbursement or incur any other financial or regulatory penalty of the medical assistance program that would otherwise be caused by the individual's extended length of stay; 50 percent of the cost of this reimbursement or financial or regulatory penalty shall be paid by the state and 50 percent shall be paid by the county. Other personnel as deemed appropriate by the county agency may be included on the team. The county agency may contract with an acute care facility to have the facility's discharge planners perform the functions of a screening team with regard to individuals discharged from the facility and in those cases the discharge planners may participate in making recommendations under subdivision 3, clause (e). No member of a screening team shall have a direct or indirect financial or self-serving interest in a nursing home or noninstitutional referral such that it would not be possible for the member to consider each case objectively.

Individuals not eligible for medical assistance who are being transferred from a hospital to a nursing home or boarding care home may be screened by only one member of the screening team in consultation with the other member. The interagency board for quality assurance, with the participation of members of screening teams, shall identify other circumstances when it would be appropriate for only one member of a screening team to conduct the nursing home preadmission screenings. The committee shall report its recommendations to the legislature in January, 1987.

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

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

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

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

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

(e) Recommendations for individuals screened regarding:

(1) Nursing home 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.

Subd. 4. **Screening of persons.** Prior to nursing home or boarding care home admission, screening teams shall assess the needs of all applicants, except (1) patients transferred from other certified nursing homes or boarding care homes; (2) patients who, having entered acute care facilities from nursing homes or boarding care homes, are returning to a nursing home or boarding care home; (3) individuals who are screened by another state within three months before admission to a Minnesota nursing home; (4) individuals whose length of stay is expected to be 30 days or less based on a physician's certification, if the facility notifies the screening team upon admission and provides an update to the screening team on the 30th day after admission; (5) individuals who have a contractual right to have their nursing home care paid for indefinitely by the veteran's administration; or (6) persons entering a facility conducted by and for the adherents of a recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing. The total screening cost for each county for applicants and residents of nursing homes who request a screening must be paid monthly by nursing homes and boarding care homes participating in the medical assistance program in the county. The monthly amount to be paid by each nursing home and boarding care home for fiscal year 1991 must be determined by dividing the county's estimate of the total annual cost of screenings allowed in the county for the following rate year by 12 to determine the monthly cost estimate and allocating the monthly cost estimate to each nursing home and boarding care home based on the number of licensed beds in the nursing home or boarding care home. The rate allowed for a screening where two team members are present shall be the actual costs up to $195. The rate allowed for a screening where only one team member is present shall be the actual costs up to $117. The commissioner shall establish by rulemaking an annual adjustment of the state maximum screening rate. The monthly cost estimate for each nursing home or boarding care home must be submitted to the nursing home or boarding care home and the state by the county no later than February 15 of each year for inclusion in the nursing home's or boarding care home's payment rate on the following rate year. The commissioner shall include the reported annual estimated cost of screenings for each nursing home or boarding care home as an operating cost of that nursing home in accordance with section 256B.431, subdivision 2b, clause (g). If in more than ten percent of the total number of screenings performed by a county in a fiscal year for all individuals regardless of payment source, the screening timelines were not met because a county was late in screening the individual, the county is solely responsible for paying the cost of those delayed screenings that exceed ten percent. Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility. Any other interested person may be screened under this subdivision if the person pays a fee for the screening based upon a sliding fee scale determined by the commissioner.

Subd. 5. **Appeals.** Appeals from the screening team's recommendation shall be made pursuant to the procedures set forth in section 256.045, subdivisions 2 and 3.

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

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

(a) The cost effectiveness of the program;

(b) The unmet needs in the community;

(c) Similar screening activities in the counties;

(d) Methods to improve the program.

Subd. 8. **Alternative care grants.** (a) The commissioner shall provide funds to counties participating in the program to pay costs of providing alternative care to individuals screened under subdivision 4 and nursing home or boarding care home residents who request a screening.

(b) Prior to July of each year, the commissioner shall allocate state funds available for alternative care grants to each local agency.

(c) For fiscal year 1991 only, the appropriation shall be distributed as specified in paragraphs (1) and (2).

(1) Sufficient state funds shall be set aside for payment for unreimbursed services provided prior to April 1, 1990, as billed by each county by June 1, 1990.

(2) The remainder of the state funds available for alternative care grants must be allocated to each county in the same proportion as each county's share of the actual payments made plus claims submitted for services rendered in the base year. The base year for each county shall be either fiscal year 1989 or calendar year 1989, whichever period contains a larger total dollar amount of payments plus claims submitted for each county. To be counted in the allocation process, claims must be submitted by June 1, 1990. This allocation will include the state share for medical assistance recipients as well as the state share for those who would be eligible within 180 days after nursing home admission. No reallocation between counties will be made. The county agency shall not be reimbursed for services which exceed the county allocation. To receive reimbursement for persons who are eligible within 180 days, the county must submit invoices within 90 days following the month of service. The number of medical assistance waiver recipients which each county may serve is allocated according to the number of open medical assistance waiver cases on July 1, 1990. Additional recipients may be served with the approval of the commissioner. These additional recipients must be served within the county's allocation.

(d) The alternative care grant appropriation for fiscal years 1992 and beyond shall

cover only individuals who would be eligible for medical assistance within 180 days after admission to a nursing home. The commissioner shall allocate state funds available for alternative care grants to each county agency. The allocation must be made as follows: the state funds available for alternative care grants, up to the amount of the previous year's allocation increased by the percentage for rates in Minnesota Rules, part 9505.2490, must be allocated to each county in the same proportion as the previous year's allocation. If the appropriation is less than the previous year's allocation plus inflation, it shall be prorated according to the county's share of the formula. Any funds appropriated in excess of the previous year's allocation plus inflation shall be allocated to county agencies by methodologies that target funds for programs designed to reduce premature nursing home placements and promote cost-effective alternatives to increasing nursing home beds and nursing home utilization. The additional allocation to counties will become part of the allocation base. The commissioner shall appoint a work group including county and senior representatives to assist in developing criteria for allocating funds which may include identifying special target populations, geographic areas, or projects. No reallocation between counties shall be made. The county agency shall not be reimbursed for services which exceed the county allocation. To receive reimbursement, the county must submit invoices within 90 days following the date of service. The number of medical assistance waiver recipients which a county may serve must be allocated according to the number of open medical assistance waiver cases on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

(e) The commissioner is directed to conduct a review of the preadmission screening program and alternative care grant program including screening requirements, screening reimbursement, program effectiveness, eligibility criteria for alternative care, accessibility to services, copayment and sliding fee issues, county utilization, rates for services, the payment system, funding and forecasting issues, administrative requirements, incentives for innovation, improved consistency with the community assistance for disabled individuals program and medical assistance home care services, and the allocation formula. In conducting this review, special attention should be given to ways to increase sliding fee collections and reduce or minimize administrative and program requirements and associated county costs. The commissioner shall appoint a work group including county and senior citizen representatives to assist in the program review. The commissioner must present a report on the findings of the review and recommendations for change to the legislature by February 15, 1991.

(f) Payment is available under this subdivision only for individuals (1) for whom the screening team would recommend nursing home or boarding care home admission, or continued stay if alternative care were not available; (2) who are receiving medical assistance or who would be eligible for medical assistance within 180 days of admission to a nursing home; (3) who need services that are not available at that time in the county through other public assistance; and (4) who are age 65 or older.

(g) The commissioner shall establish by rule, in accordance with chapter 14, procedures for determining limits on the rates for payment of approved services, including screenings, and submittal and approval of a biennial county plan for the administration of the preadmission screening and alternative care grants program.

(h) Grants may be used for payment of costs of providing care-related supplies, equipment, and the following services: adult foster care, adult day care, home health aide, homemaker, personal care, case management, and respite care. These services must be provided by a licensed health care provider, a home health service eligible for reimbursement under Titles XVIII and XIX of the federal Social Security Act, or by persons employed by or contracted with by the county board or the local welfare agency.

(i) The county agency shall ensure that a plan of care is established for each individual in accordance with subdivision 3, clause (e)(2), and that a client's service needs and eligibility is reassessed at least every six months. The plan shall include any services prescribed by the individual's attending physician as necessary and follow up services

as necessary. The county agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program and shall provide documentation in each individual's plan of care and to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private. The county agency shall document to the commissioner that the agency made reasonable efforts to inform potential providers of the anticipated need for services under the alternative care grants program, including a minimum of 14 days written advance notice of the opportunity to be selected as a service provider and an annual public meeting with providers to explain and review the criteria for selection, and that the agency allowed potential providers an opportunity to be selected to contract with the county board. Grants to counties under this subdivision are subject to audit by the commissioner for fiscal and utilization control.

(j) The county must select providers for contracts or agreements using the following criteria and other criteria established by the county:

(1) the need for the particular services offered by the provider;

(2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;

(3) the geographic area to be served;

(4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;

(5) rates for each service and unit of service exclusive of county administrative costs;

(6) evaluation of services previously delivered by the provider; and

(7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

(k) The county must evaluate its own agency services under the criteria established for other providers. The county shall provide a written statement of the reasons for not selecting providers.

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

(m) The commissioner shall apply for a waiver for federal financial participation to expand the availability of services under this subdivision. Waivered services provided to medical assistance recipients must comply with the same criteria as defined in this section and in the approved waiver. Reimbursement for the medical assistance recipients shall be made from the regular medical assistance account. The commissioner shall provide grants to counties from the nonfederal share, unless the commissioner obtains a federal waiver for medical assistance payments, of medical assistance appropriations. A county agency may use grant money to supplement but not supplant services available through other public assistance or service programs and shall not use grant money to establish new programs for which public money is available through sources other than grants provided under this subdivision. A county agency shall not use grant money to provide care under this subdivision to an individual if the anticipated cost of providing this care would exceed the average payment, as determined by the commissioner, for the level of care that the recipient would receive if placed in a nursing home or boarding care home. The nonfederal share may be used to pay up to 90 percent of the start-up and service delivery costs of providing care under this subdivision. The state share of the nonfederal portion of costs shall be 90 percent and the county share shall be ten percent. Each county agency that receives a grant shall pay

ten percent of the costs for persons who are eligible for the services but who are not yet eligible for medical assistance.

(n) Beginning July 1, 1991, the state will reimburse counties according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision from January 1, 1991, on, for individuals who are receiving medical assistance.

(o) Beginning July 1, 1991, the state will reimburse counties, up to the limit of state appropriations, according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision from January 1, 1991, on, for individuals who would be eligible for medical assistance within 180 days of admission to a nursing home.

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

Subd. 9. **Rules.** The commissioner of human services shall promulgate emergency rules and permanent rules to implement the provisions of subdivisions 6 and 8 and permanent rules to implement the provisions of subdivisions 2 and 4.

History: *1980 c 575 s 1; 1981 c 360 art 2 s 29; 1982 c 424 s 130; 1982 c 455 s 1-5; 1983 c 199 s 6-9; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1Sp1985 c 3 s 20-24; 1986 c 420 s 7-10; 1Sp1986 c 3 art 1 s 28; 1987 c 299 s 20-24; 1987 c 309 s 24; 1988 c 689 art 2 s 147; 1988 c 719 art 8 s 14; 1989 c 282 art 3 s 60; 1Sp1989 c 1 art 16 s 7; 1990 c 568 art 3 s 54-56*

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

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

Subd. 1a. **Case management services.** Case management services are limited to diagnosis, assessment of the individual's service needs, development of an individual service plan, specification of methods for providing services, and the evaluation and monitoring of the services identified in the plan.

Subd. 1b. **Individual service plan.** The individual service plan must:

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

(2) identify goals and objectives for the client,

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

(4) identify the need for an habilitation component of the plan, and

(5) identify and coordinate methodologies to carry out the goals and objectives.

Subd. 1c. **Fiscal limitations.** Subdivision 1 shall not be construed as requiring expenditure of money not available to county agencies for services to persons with, or who might have, mental retardation or related conditions, except for:

(1) services specifically required by federal law or state statute such as case management and day training and habilitation services; and

(2) services identified in the person's individual service plan as services that the county will provide until the person's individual service plan is amended.

Subd. 1d. **County requirements.** Before a county denies, reduces, or terminates a service to an individual due to fiscal limitations, the county agency must show that money is not available for services to persons with mental retardation or related conditions and that good faith efforts have been made to identify needs and obtain available funds. The county agency must show this by documenting that the following actions have been taken:

(1) the county case manager has identified the person's service needs and the actions that will be taken to develop or obtain those services in the person's individual service plan and action that will be taken to prevent abuse or neglect as defined in sections 626.556, subdivision 2, paragraphs (a), (c), and (d), and 626.557, subdivision 2, paragraphs (d) and (e);

(2) prior to the admission of a person to a regional treatment center program for persons with developmental disabilities, the county agency made efforts to secure community-based alternatives. If these alternatives were rejected in favor of a regional treatment center placement, the county agency must also document the reasons why they were rejected; and

(3) the county agency has made a request for state funds or new capacity for services to meet the individual's unmet needs, since those needs have been identified in the person's individual service plan.

Subd. 1e. **County waiting list.** The county agency shall maintain a waiting list of persons with developmental disabilities specifying the services needed but not provided.

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

Subd. 3. **Termination of services.** County agency case managers, under rules of the commissioner, shall authorize and terminate services of community and state hospital providers in accordance with individual service plans. Medical assistance services not needed shall not be authorized by county agencies nor funded by the commissioner.

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

Subd. 5. **Federal waivers.** The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 to 1396p, as amended through December 31, 1987, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a state hospital or a community intermediate care facility for persons with mental retardation or related conditions. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 to 1396p, as amended through December 31, 1987, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services that would have been provided without the waivered services.

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

Subd. 7. **Screening teams established.** (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) Effective July 1, 1991, 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.

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

History: *1983 c 312 art 9 s 5; 1984 c 640 s 32; 1985 c 21 s 55; 1Sp1985 c 9 art 2 s 40-45; 1987 c 305 s 2; 1988 c 689 art 2 s 148,149; 1989 c 282 art 3 s 61; art 6 s 29,30; 1990 c 568 art 3 s 57-61; 1990 c 599 s 1*

256B.093 SERVICES FOR PERSONS WITH BRAIN INJURIES.

Subdivision 1. **State coordinator.** The commissioner of human services shall desig-

nate 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.10 [Repealed, 1976 c 131 s 2]

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

256B.12 LEGAL REPRESENTATION.

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

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

256B.121 TREBLE DAMAGES.

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

History: *1976 c 188 s 4*

256B.13 SUBPOENAS.

Each county agency and the state agency shall have the power to issue subpoenas for witnesses and compel their attendance and the production of papers and writing; and officers and employees designated by any county agency or the state agency may administer oaths and examine witnesses under oath in connection with any application or proceedings hereunder.

History: *Ex1967 c 16 s 13*

256B.14 RELATIVE'S RESPONSIBILITY.

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

Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to determine the ability of responsible relatives to contribute partial or complete payment or repayment of medical assistance furnished to recipients for whom they are responsible. These rules shall not require payment or 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 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 payment or 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.

Subd. 3. **Community spouse contribution.** The community spouse of an institutionalized person who receives medical assistance under section 256B.059, subdivision 5, paragraph (b), has an obligation to pay for the cost of care equal to the dollar value of assets considered available under section 256B.059, subdivision 5.

Subd. 4. **Appeals.** A responsible relative may appeal the determination of an obligation to make a contribution under this section according to section 256.045.

History: *Ex1967 c 16 s 14; 1973 c 725 s 46; 1977 c 448 s 7; 1982 c 640 s 6; 1983 c 312 art 5 s 19; 1984 c 530 s 4; 1986 c 444; 1988 c 689 art 2 s 150,268; 1989 c 282 art 3 s 63; 1990 c 568 art 3 s 62*

NOTE: Subdivision 2, as amended by Laws 1988, chapter 689, article 2, section 150, is effective upon receiving approval of the health care financing administration. See Laws 1988, chapter 689, article 2, section 270, subdivision 7.

256B.15 CLAIMS AGAINST ESTATES.

Subdivision 1. **Estates subject to claims.** If a person receives any medical assistance hereunder, on the person's death, if single, or on the death of the survivor of a married couple, either or both of whom received medical assistance, the total amount paid for medical assistance rendered for the person and spouse shall be filed as a claim against the estate of the person or the estate of the surviving spouse in the court having jurisdiction to probate the estate.

A claim shall be filed if medical assistance was rendered for either or both persons under one of the following circumstances:

(a) the person was over 65 years of age; or

(b) the person resided in a medical institution for six months or longer and, at the time of institutionalization or application for medical assistance, whichever is later, the person could not have reasonably been expected to be discharged and returned home, as certified in writing by the person's treating physician. For purposes of this section only, a "medical institution" means a skilled nursing facility, intermediate care facility, intermediate care facility for persons with mental retardation, nursing facility, or inpatient hospital.

The claim shall be considered an expense of the last illness of the decedent for the purpose of section 524.3-805. Any statute of limitations that purports to limit any county agency or the state agency, or both, to recover for medical assistance granted hereunder shall not apply to any claim made hereunder for reimbursement for any medical assistance granted hereunder. Counties are entitled to one-half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort.

Subd. 2. **Limitations on claims.** The claim shall include only the total amount of medical assistance rendered after age 65 or during a period of institutionalization described in subdivision 1, clause (b), and shall not include interest. A claim against the estate of a surviving spouse who did not receive medical assistance, for medical assistance rendered for the predeceased spouse, is limited to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage.

Subd. 3. **Minor, blind, or disabled children.** If a decedent who was single, or who was the surviving spouse of a married couple, is survived by a child who is under age 21 or blind or permanently and totally disabled according to the supplemental security income program criteria, no claim shall be filed against the estate.

Subd. 4. **Other survivors.** If the decedent who was single or the surviving spouse

of a married couple is survived by one of the following persons, a claim exists against the estate in an amount not to exceed the value of the nonhomestead property included in the estate:

(a) a sibling who resided in the decedent medical assistance recipient's home at least one year before the decedent's institutionalization and continuously since the date of institutionalization; or

(b) a son or daughter or, subject to federal approval, a grandchild, who resided in the decedent medical assistance recipient's home for at least two years immediately before the parent's institutionalization and continuously since the date of institutionalization, and who establishes by a preponderance of the evidence that he or she provided care to the parent or grandparent who received medical assistance, the care was provided before institutionalization, and the care permitted the parent to reside at home rather than in an institution.

History: *Ex1967 c 16 s 15; 1981 c 360 art 1 s 22; 1Sp1981 c 4 art 1 s 126; 1986 c 444; 1987 c 403 art 2 s 82; 1988 c 719 art 8 s 15; 1990 c 568 art 3 s 63*

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

256B.17 [Repealed, 1989 c 282 art 3 s 98; 1990 c 568 art 3 s 95,96]

256B.18 METHODS OF ADMINISTRATION.

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

History: *Ex1967 c 16 s 18*

256B.19 DIVISION OF COST.

Subdivision 1. **Division of cost.** The cost of medical assistance paid by each county of financial responsibility shall be borne as follows: Ninety percent of the expense of assistance not paid by federal funds available for that purpose shall be paid by the state and ten percent shall be paid by the county of financial responsibility.

For counties that participate in a Medicaid demonstration project under sections 256B.69 and 256B.71, the division of the nonfederal share of medical assistance expenses for payments made to prepaid health plans or for payments made to health maintenance organizations in the form of prepaid capitation payments, this division of medical assistance expenses shall be 95 percent by the state and five percent by the county of financial responsibility.

Beginning July 1, 1991, the state will reimburse counties according to the payment schedule in section 256.025 for the county share of costs incurred under this subdivision from January 1, 1991, on. Payment to counties under this subdivision is subject to the provisions of section 256.017.

In counties where prepaid health plans are under contract to the commissioner to provide services to medical assistance recipients, the cost of court ordered treatment ordered without consulting the prepaid health plan that does not include diagnostic evaluation, recommendation, and referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

Subd. 2. **Distribution of federal funds.** Federal funds available for administrative purposes shall be distributed between the state and the county in the same proportion that expenditures were made, except as provided for in section 256.017.

Subd. 2a. **Division of costs.** Beginning July 1, 1991, the state shall reimburse counties according to the payment schedule in section 256.025 for the nonfederal share of

costs incurred for medical assistance common carrier transportation and related travel expenses provided for medical purposes to medical assistance recipients from January 1, 1991, on. For purposes of this subdivision, transportation shall have the meaning given it in Code of Federal Regulations, title 42, section 440.170(a), as amended through October 1, 1987, and travel expenses shall have the meaning given in Code of Federal Regulations, title 42, section 440.170(a)(3), as amended through October 1, 1987.

The county shall ensure that only the least costly, most appropriate transportation and travel expenses are used. The state may enter into volume purchase contracts, or use a competitive bidding process, whenever feasible, to minimize the costs of transportation services. If the state has entered into a volume purchase contract or used the competitive bidding procedures of chapter 16B to arrange for transportation services, the county may be required to use such arrangements to be eligible for state reimbursement of the 50 percent county share of medical assistance common carrier transportation and related travel expenses provided for medical purposes.

Subd. 2b. **Pilot project reimbursement.** In counties where a pilot or demonstration project is operated under the medical assistance program, the state may pay 100 percent of the administrative costs for the pilot or demonstration project after June 30, 1990. Reimbursement for these costs is subject to section 256.025.

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

History: *Ex1967 c 16 s 19; 1971 c 547 s 1; 1975 c 437 art 2 s 7; 1982 c 640 s 7; 1983 c 312 art 9 s 6; 1984 c 534 s 24; 1Sp1985 c 9 art 2 s 46; 1986 c 444; 1987 c 403 art 2 s 85; 1988 c 719 art 8 s 16,17; 1Sp1989 c 1 art 16 s 8,9; 1990 c 568 art 3 s 64*

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: *Ex1967 c 16 s 20; 1973 c 492 s 14; 1986 c 444; 1989 c 89 s 11*

256B.21 CHANGE OF RESIDENCE.

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

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

256B.22 COMPLIANCE WITH SOCIAL SECURITY ACT.

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

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

256B.23 USE OF FEDERAL FUNDS.

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

History: *Ex1967 c 16 s 23*

256B.24 PROHIBITIONS.

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

History: *Ex1967 c 16 s 24*

256B.25 PAYMENTS TO CERTIFIED FACILITIES.

Subdivision 1. Payments may not be made hereunder for care in any private or public institution, including but not limited to hospitals and nursing homes, unless licensed by an appropriate licensing authority of this state, any other state, or a Canadian province and if applicable, certified by an appropriate authority under United States Code, title 42, sections 1396-1396p.

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

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

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

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

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

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

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: *Ex1967 c 16 s 25; 1969 c 395 s 2; 1984 c 641 s 13; 1984 c 654 art 5 s 58; 1985 c 248 s 69; 1989 c 282 art 3 s 64*

256B.26 AGREEMENTS WITH OTHER STATE DEPARTMENTS.

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

History: *Ex1967 c 16 s 26; 1984 c 654 art 5 s 58*

256B.27 MEDICAL ASSISTANCE; COST REPORTS.

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

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

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

Subd. 3. The commissioner of human services, with the written consent of the recipient, on file with the local welfare agency, shall be allowed access to all personal medical records of medical assistance recipients solely for the purposes of investigating whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which is duplicative, erroneous, or false in whole or in part, or which results in the vendor obtaining greater compensation than the vendor is legally entitled to; or (b) the medical care was medically necessary. The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records. The determination of provision of services not medically necessary shall be made by the commissioner. The commissioner may consult with an advisory task force of vendors the commissioner may appoint, on the recommendation of appropriate professional organizations. The task force expires as provided in section 15.059, subdivision 6. Notwithstanding any other law to the con-

trary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of human services pursuant to this section.

Subd. 4. **Authorization of commissioner to examine records.** A person determined to be eligible for medical assistance shall be deemed to have authorized the commissioner of human services in writing to examine, for the investigative purposes identified in subdivision 3, all personal medical records developed while receiving medical assistance.

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

History: *1971 c 961 s 24; 1976 c 188 s 3; 1977 c 326 s 11; 1980 c 349 s 7,8; 1981 c 311 s 39; 1982 c 476 s 1; 1982 c 545 s 24; 1982 c 640 s 8; 1983 c 312 art 5 s 25,26; 1984 c 654 art 5 s 58; 1986 c 444; 1987 c 370 art 1 s 5,6; 1988 c 629 s 53*

256B.30 HEALTH CARE FACILITY REPORT.

Every facility required to be licensed under the provisions of sections 144.50 to 144.58, or 144A.02, shall provide annually to the commissioner of human services the reports as may be required under law and under rules adopted by the commissioner of human services under the administrative procedure act. The rules shall provide for the submission of a full and complete financial report of a facility's operations including:

(1) An annual statement of income and expenditures;

(2) A complete statement of fees and charges;

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

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

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

256B.31 CONTINUED HOSPITAL CARE FOR LONG-TERM POLIO PATIENT.

A medical assistance recipient who has been a polio patient in an acute care hospital for a period of not less than 25 consecutive years is eligible to continue receiving hospital care, whether or not the care is medically necessary for purposes of federal reimbursement. The cost of continued hospital care not reimbursable by the federal government must be paid with state money allocated for the medical assistance program. The rate paid to the hospital is the rate per day established using Medicare principles for the hospital's fiscal year ending December 31, 1981, adjusted each year by the annual hospital cost index established under section 256.969, subdivision 1, or by other limits in effect at the time of the adjustment. This section does not prohibit a voluntary move to another living arrangement by a recipient whose care is reimbursed under this section.

History: *1988 c 689 art 2 s 152*

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

Subdivision 1. **Personal needs allowance.** (a) Notwithstanding any law to the contrary, welfare allowances for clothing and personal needs for individuals receiving medical assistance while residing in any skilled nursing home, intermediate care facility, or medical institution including recipients of supplemental security income, in this state shall not be less than $45 per month from all sources. When benefit amounts for social security or supplemental security income recipients are increased pursuant to United States Code, title 42, sections 415(i) and 1382f, the commissioner shall, effective in the month in which the increase takes effect, increase by the same percentage to the nearest whole dollar the clothing and personal needs allowance for individuals receiving medical assistance while residing in any skilled nursing home, medical institution, or intermediate care facility. The commissioner shall provide timely notice to local agencies, providers, and recipients of increases under this provision.

(b) The personal needs allowance may be paid as part of the Minnesota supplemental aid program, notwithstanding the provisions of section 256D.37, subdivision 2, and payments to recipients of Minnesota supplemental aid may be made once each three months covering liabilities that accrued during the preceding three months.

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

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

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

Subd. 5. The nursing home may transfer the personal allowance to someone other than the recipient only when the recipient or the recipient's guardian or conservator designates that person in writing to receive or expend funds on behalf of the recipient and that person certifies in writing that the allowance is spent for the well-being of the recipient. Persons, other than the recipient, in possession of the personal allowance, may use the allowance only for the well-being of the recipient. Any person, other than the recipient, who, with intent to defraud, uses the personal needs allowance for purposes other than the well-being of the recipient shall be guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3, clauses (2), (3)(a) and (c), (4), and (5). To prosecute under this subdivision, the attorney general or the appropriate county attorney, acting independently or at the direction of the attorney general, may institute a criminal action. A nursing home that transfers personal needs allowance funds to a person other than the recipient in good faith and in compliance with this section shall not be held liable under this subdivision.

Subd. 6. In addition to the remedies otherwise provided by law, any person injured by a violation of any of the provisions of this section, may bring a civil action and recover damages, together with costs and disbursements, including costs of investigation and reasonable attorney's fees, and receive other equitable relief as determined by the court.

History: *1974 c 575 s 15; 1977 c 271 s 1,2; 1980 c 563 s 1; 1982 c 476 s 2; 1984 c 534 s 25; 1984 c 654 art 5 s 58; 1986 c 444; 1987 c 254 s 7; 1987 c 403 art 2 s 86,87; 1988 c 689 art 2 s 153; 1990 c 566 s 7*

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

In addition to the personal allowance established in section 256B.35, any recipient of medical assistance with a handicap, mental retardation, or a related condition, con-

fined in a skilled nursing home or intermediate care facility shall also be permitted a special personal allowance drawn solely from earnings from any productive employment under an individual plan of rehabilitation. This special personal allowance shall not exceed (1) the limits set therefor by the commissioner, or (2) the amount of disregarded income the individual would have retained as a recipient of aid to the disabled benefits in December, 1973, whichever amount is lower.

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

256B.37 PRIVATE INSURANCE POLICIES, CAUSES OF ACTION.

Subdivision 1. **Subrogation.** Upon furnishing medical assistance to any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of medical assistance, the state agency shall be subrogated, to the extent of the cost of medical care furnished, to any rights the person may have under the terms of the coverage or under the cause of action.

The right of subrogation created in this section includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

Subd. 2. **Civil action for recovery.** To recover under this section, the attorney general, or the appropriate county attorney, acting upon direction from the attorney general, may institute or join a civil action to enforce the subrogation rights established under this section.

Subd. 3. **Notice.** The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the cost of medical care when the state agency has paid or become liable for the cost of care. Notice must be given as follows:

(a) Applicants for medical assistance shall notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement.

Notice given to the local agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Subd. 4. **Recovery.** Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of medical assistance paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency. The rest must be paid to the medical assistance recipient or other plaintiff. The plaintiff, however, must receive at least one-third of the net recovery after attorney fees and collection costs.

Subd. 5. **Private benefits to be used first.** Private accident and health care coverage for medical services is primary coverage and must be exhausted before medical assistance is paid. When a person who is otherwise eligible for medical assistance has private accident or health care coverage, including a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent. Supplemental payment may be made by medical assistance, but the combined total amount paid must not exceed the amount payable under medical assistance in the absence of other coverage. Medical assistance must not make supplemental payment for covered services rendered by a vendor who participates or contracts with a health coverage plan if the plan requires the vendor to accept the plan's payment as payment in full.

Subd. 6. **Parent's or obligee's health plan.** When a parent or a person with an obli-

gation of support has enrolled in a prepaid health care plan under section 518.171, subdivision 1, the commissioner of human services shall limit the recipient of medical assistance to the benefits payable under that prepaid health care plan to the extent that services available under medical assistance are also available under the prepaid health care plan.

History: *1975 c 247 s 7; 1987 c 370 art 2 s 9-14; 1987 c 403 art 3 s 26*

256B.39 AVOIDANCE OF DUPLICATE PAYMENTS.

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

History: *1975 c 247 s 8*

256B.40 SUBSIDY FOR ABORTIONS PROHIBITED.

No medical assistance funds of this state or any agency, county, municipality or any other subdivision thereof and no federal funds passing through the state treasury or the state agency shall be authorized or paid pursuant to this chapter to any person or entity for or in connection with any abortion that is not eligible for funding pursuant to sections 256B.02, subdivision 8, and 256B.0625.

History: *1978 c 508 s 3; 1988 c 689 art 2 s 268*

NURSING HOME RATES

256B.41 INTENT.

Subdivision 1. **Authority.** The commissioner shall establish, by rule, procedures for determining rates for care of residents of nursing homes which qualify as vendors of medical assistance, and for implementing the provisions of this section and sections 256B.421, 256B.431, 256B.47, 256B.48, 256B.50, and 256B.502. The procedures shall be based on methods and standards that the commissioner finds are adequate to provide for the costs that must be incurred for the care of residents in efficiently and economically operated nursing homes and shall specify the costs that are allowable for establishing payment rates through medical assistance.

Subd. 2. **Federal requirements.** If any provision of this section and sections 256B.421, 256B.431, 256B.47, 256B.48, 256B.50, and 256B.502, is determined by the United States government to be in conflict with existing or future requirements of the United States government with respect to federal participation in medical assistance, the federal requirements shall prevail.

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

History: *1976 c 282 s 1; 1983 c 199 s 10; 1Sp1985 c 9 art 2 s 47*

256B.411 COMPLIANCE WITH STATE STATUTES.

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

Subd. 2. **Requirements.** No medical assistance payments shall be made to any nursing home unless the nursing home is certified to participate in the medical assistance program under title XIX of the federal Social Security Act and has in effect a provider agreement with the commissioner meeting the requirements of state and federal statutes and rules. No medical assistance payments shall be made to any nursing home unless the nursing home complies with all requirements of Minnesota Statutes including, but not limited to, this chapter and rules adopted under it that govern participation in the program. This section applies whether the nursing home participates fully in the

medical assistance program or is withdrawing from the medical assistance program. No future payments may be made to any nursing home which has withdrawn or is withdrawing from the medical assistance program except as provided in section 256B.48, subdivision 1a; provided, however, that payments may also be made under a court order entered on or before June 7, 1985, unless the court order is reversed on appeal.

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

256B.42 [Repealed, 1983 c 199 s 19]

256B.421 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this section and sections 256B.41, 256B.411, 256B.431, 256B.433, 256B.47, 256B.48, 256B.50, and 256B.502, the following terms and phrases shall have the meaning given to them.

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

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

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

Subd. 5. **General and administrative costs.** "General and administrative costs" means all allowable costs for administering the facility, including but not limited to: salaries of administrators, assistant administrators, accounting personnel, data processing personnel, and all clerical personnel; board of directors fees; business office functions and supplies; travel, except as necessary for training programs for nursing personnel and dieticians required to maintain licensure, certification, or professional standards requirements; telephone and telegraph; advertising; membership dues and subscriptions; postage; insurance, except as included as a fringe benefit under subdivision 14; professional services such as legal, accounting and data processing services; central or home office costs; management fees; management consultants; employee training, for any top management personnel and for other than direct resident care related personnel; and business meetings and seminars.

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

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

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

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

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

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

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

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

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

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

History: *1983 c 199 s 11; 1984 c 641 s 14-16; 1984 c 654 art 5 s 58; 1985 c 267 s 2; 1Sp1985 c 3 s 26; 1Sp1985 c 9 art 2 s 49; 1987 c 403 art 2 s 88; 1989 c 282 art 3 s 65*

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

256B.431 RATE DETERMINATION.

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

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

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

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

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

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

(4) 15 percent for convalescent and nursing care units attached to hospitals for the rate year beginning July 1, 1984, of the expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administration.

Subd. 2a. **Operating costs, 1983-1984.** For the rate year beginning July 1, 1983, and ending June 30, 1984, the prospective operating cost payment rate for each nursing home shall be determined by the commissioner based on the allowed historical operating costs as reported in the most recent cost report received by December 31, 1982 and audited by March 1, 1983, and may be subsequently adjusted to reflect the costs allowed. To determine the allowed historical operating cost, the commissioner shall update the historical per diem shown in those cost reports to June 30, 1983, using a nine percent annual rate of increase after applying the general and administrative cost limitation described in subdivision 2. The commissioner shall calculate the 60th percentile of actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1.

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

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

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

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

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

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

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

(c) The commissioner shall analyze and evaluate each nursing home's cost report

of allowable operating costs incurred by the nursing home during the reporting year immediately preceding the rate year for which the payment rate becomes effective.

(d) The commissioner shall establish limits on actual allowable historical operating cost per diems based on cost reports of allowable operating costs for the reporting year that begins October 1, 1983, taking into consideration relevant factors including resident needs, geographic location, size of the nursing home, and the costs that must be incurred for the care of residents in an efficiently and economically operated nursing home. In developing the geographic groups for purposes of reimbursement under this section, the commissioner shall ensure that nursing homes in any county contiguous to the Minneapolis-St. Paul seven-county metropolitan area are included in the same geographic group. The limits established by the commissioner shall not be less, in the aggregate, than the 60th percentile of total actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year. For rate years beginning on or after July 1, 1989, facilities located in geographic group I as described in Minnesota Rules, part 9549.0052, on January 1, 1989, 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 effi-

ciency 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 nonprofit 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.

Subd. 2c. **Operating costs after July 1, 1986.** For rate years beginning on or after July 1, 1986, the commissioner may allow a one time adjustment to historical operating costs of a nursing home that has been found by the commissioner of health to be significantly below care related minimum standards appropriate to the mix of resident needs in that nursing home when it is determined by the commissioners of health and human services that the nursing home is unable to meet minimum standards through reallocation of nursing home costs and efficiency incentives or allowances. In developing procedures to allow adjustments, the commissioner shall specify the terms and conditions governing any additional payments made to a nursing home as a result of the adjustment. The commissioner shall establish procedures to recover amounts paid under this subdivision, in whole or in part, and to adjust current and future rates, for nursing homes that fail to use the adjustment to satisfy care related minimum standards.

Subd. 2d. If an annual cost report or field audit indicates that expenditures for direct resident care have been reduced in amounts large enough to indicate a possible detrimental effect on the quality of care, the commissioner shall notify the commissioner of health and the interagency board for quality assurance. If a field audit reveals

that unallowable expenditures have been included in the nursing home's historical operating costs, the commissioner shall disallow the expenditures and recover the entire overpayment. The commissioner shall establish, by rule, procedures for assessing an interest charge at the rate determined for unpaid taxes or penalties under section 270.75 on any outstanding balance resulting from an overpayment or underpayment.

Subd. 2e. **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.

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

Subd. 2g. **Required consultants.** Costs considered general and administrative costs under section 256B.421 must be included in general and administrative costs in total, without direct or indirect allocation to other cost categories. In a nursing home of 60 or fewer beds, part of an administrator's salary may be allocated to other cost categories to the extent justified in records kept by the nursing home. Central or home office costs representing services of required consultants in areas including, but not limited to, dietary, pharmacy, social services, or activities may be allocated to the appropriate

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

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

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

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

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

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

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

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

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

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

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

Subd. 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.

Subd. 2l. **Inflation adjustments after July 1, 1990.** For rate years beginning on or after July 1, 1990, the forecasted composite price index for a nursing home's allowable operating cost per diems shall be determined using Data Resources, Inc., forecast for change in the Nursing Home Market Basket. The commissioner of human services shall use the indices as forecasted by Data Resources, Inc., in the fourth quarter of the calendar year preceding the rate year.

Subd. 3. **Property-related costs, 1983-1985.** (a) For rate years beginning July 1, 1983 and July 1, 1984, property-related costs shall be reimbursed to each nursing home at the level recognized in the most recent cost report received by December 31, 1982, and audited by March 1, 1983, and may be subsequently adjusted to reflect the costs recognized in the final rate for that cost report, adjusted for rate limitations in effect before May 23, 1983. Effective for rate years beginning on or after July 1, 1988, a rate limitation ratio that is based on historical limitations resulting from the application of the regional maximum rate, private-pay rate, or ten percent cap on rate increases, must not be less than .90. Property-related costs include: depreciation, interest, earnings or investment allowance, lease, or rental payments. No adjustments shall be made as a result of sales or reorganizations of provider entities.

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

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

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

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

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

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

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

Subd. 3b. **Depreciation recapture.** The sale of a nursing home which occurred on or after July 1, 1987, shall result in depreciation recapture payments to be paid by the buyer to the commissioner within 60 days of the department's notification if the sale price exceeds the nursing home's allowable historical cost of capital assets including land recognized by the commissioner at the time of the sale reduced by accumulated depreciation. The gross recapture amount shall be the lesser of the actual gain on the sale or actual depreciation recognized for the purpose of calculating medical assistance payment rates from the latter of the date of previous sale or November 1, 1972, through the date of the sale. The gross recapture amount shall be allocated to each reporting year from the latter of the date of previous sale or November 1, 1972, through the date of the sale in the same ratio as depreciation amounts recognized for the purpose of calculating medical assistance payment rates. The amount allocated to each reporting year

shall be divided by the total actual resident days in that reporting year, thereby determining a cost-per-resident day. The recapture amount shall be the cost-per-resident day for each reporting year times the actual medical assistance resident days for the corresponding rate year following each reporting year. No payment of depreciation recapture shall be assessed with respect to a portion of a rate year beginning after June 30, 1985, in which the property-related payment rate was based on the nursing home's rental value. The recapture amount shall be reduced by one percent for each month of continuous ownership since the previous date of sale of the nursing home up to a maximum of 100 months. For the purpose of this subdivision, the sale of a nursing home means the sale or transfer of a nursing home's capital assets or capital stock or the redemption of ownership interests by members of a partnership. In the case of a sale or transfer of a nursing home in which the new operator leases depreciable equipment used in the nursing home business from the prior operator, or an affiliate of the prior operator, the net present value of the lease shall be added to the transaction price for the purpose of determining the actual gain on the sale. In the case of a partial sale of a nursing home, the provisions of this subdivision will be applied proportionately to sales or accumulations of sales that exceed 20 percent of a nursing home's capital assets or capital stock. Depreciation recapture payments resulting from the sale of a nursing home which occurred before July 1, 1985, shall be calculated in accordance with reimbursement regulations in effect on the date of the sale.

Subd. 3c. **Plant and maintenance costs.** For the rate years beginning on or after July 1, 1987, the commissioner shall allow as an expense in the reporting year of occurrence the lesser of the actual allowable plant and maintenance costs for supplies, minor equipment, equipment repairs, building repairs, purchased services and service contracts, except for arms-length service contracts whose primary purpose is supervision, or $325 per licensed bed.

Subd. 3d. **Betterments and additions.** Notwithstanding any contrary provision of this chapter, or a rule adopted under this chapter, a nursing home that commenced construction on a betterment and addition costing $700,000 or more prior to the expiration of Minnesota Rules, 12 MCAR 2.05001 to 2.05016 (Temporary)(1983) shall have its property-related payment rate step-up as a result of the betterment and addition calculated as set forth in 12 MCAR 2.05011.B.3 in the case of betterments, and 12 MCAR 2.05011.D in the case of additions. For purposes of this subdivision, the terms "betterment" and "addition" have the meaning set forth in 12 MCAR 2.05002 and the term "commenced construction" has the meaning set forth in section 144A.071, subdivision 3.

Subd. 3e. **Hospital-attached convalescent and nursing care facilities.** If a nonprofit or community-operated hospital and attached convalescent and nursing care facility suspend operation of the hospital, the surviving nursing care facility must be allowed to continue its status as a hospital-attached convalescent and nursing care facility for reimbursement purposes in three subsequent rate years.

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. 3h. **Special property rate.** Notwithstanding contrary provisions of chapter 256B or rules adopted under it, for rate years beginning July 1, 1990, a nursing home under lease from 1968 until 1983 with a lessee or related party having an option to purchase the nursing home, which option was subsequently exercised, shall be allowed debt and interest costs incurred by the lessee or related party on indebtedness created when the option to purchase was exercised before the end of the 1983 calendar year. The nursing home must demonstrate 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.

Subd. 3i. **Property costs for the rate year beginning July 1, 1990.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item H, the commissioner shall determine property-related payment rates for nursing homes for the rate year beginning July 1, 1990, as follows:

(a) The property-related payment rate for a nursing home that qualifies under subdivision 3g is the greater of the rate determined under that subdivision or the rate determined under paragraph (c), (d), or (e), whichever is applicable.

(b) Nursing homes shall be grouped according to the type of property-related payment rate the commissioner determined for the rate year beginning July 1, 1989. A nursing home whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item A (full rental reimbursement), shall be considered group A. A nursing home whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item B (phase-down to full rental reimbursement), shall be considered group B. A nursing home whose property-related payment rate was determined under Minnesota Rules, part 9549.0060, subpart 13, item C or D (phase-up to full rental reimbursement), shall be considered group C.

(c) For the rate year beginning July 1, 1990, a group A nursing home shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(d) For the rate year beginning July 1, 1990, a Group B nursing home shall receive the greater of 87 percent of the property-related payment rate in effect on July 1, 1989; or the rental per diem rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section in effect on July 1, 1990; or the sum of 100 percent of the nursing home's allowable principal and interest expense, plus its equipment allowance multiplied by the resident days for the reporting year ending September 30, 1989, 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); except that the nursing home's property-related payment rate must not exceed its property-related payment rate in effect on July 1, 1989.

(e) For the rate year beginning July 1, 1990, a group C nursing home shall receive its property-related payment rate determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, except the rate must not exceed the lesser of its property-related payment rate determined for the rate year beginning July 1, 1989, multiplied by 116 percent or its rental per diem rate determined effective July 1, 1990.

(f) The property-related payment rate for a nursing home that qualifies for a rate adjustment under Minnesota Rules, part 9549.0060, subpart 13, item G (special reappraisals), shall have the property-related payment rate determined in paragraphs (a) to (e) adjusted according to the provisions in that rule.

(g) Except as provided in subdivision 4, paragraph (f), and subdivision 11, a nursing home that has a change in ownership or a reorganization of provider entity is subject to the provisions of Minnesota Rules, part 9549.0060, subpart 13, item F.

Subd. 3j. **Property rate adjustment for required improvements.** The commissioner shall add an adjustment to the property-related payment rate of a certified, freestanding boarding care home reflecting the costs incurred by that nursing home to install a communications system in every room and hallway handrails, as required under the 1987 federal Omnibus Budget Reconciliation Act, Public Law Number 100-203. The property-related payment rate increase is only available if, and to the extent that, the nursing home's existing property-related payment rate, minus the nursing home's allowable principal and interest costs and equipment allowance, is not sufficient to cover the costs of the required improvements. Each nursing home eligible for the adjustment shall submit to the commissioner a detailed estimate of the cost increases the facility will incur to meet the new physical plant requirements. Ten percent of the amount of the costs that are determined by the commissioner to be reasonable for the nursing home to meet the new requirements, divided by resident days, must be added to the nursing home's property-related payment rate. The adjustment shall be added to the property-related payment rate determined under subdivision 3i. The resulting recalculated property-related payment rate is effective October 1, 1990, or 60 days after a nursing home submits its detailed cost estimate, whichever occurs later.

The adjustment is only available to a certified, freestanding boarding care home that cannot meet the requirements of Public Law Number 100-203 for communications systems and handrails as demonstrated to the satisfaction of the commissioner of health. When the commissioner of human services establishes that it is not cost-effective to upgrade an eligible certified, freestanding boarding care home to the new standards, the commissioner of human services may exclude the certified freestanding boarding care home if it is either an institution for mental disease or a certified, freestanding boarding care 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.

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 con-

ditions 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.

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

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

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 adjustment 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.

(d) Notwithstanding the provisions of paragraph (a), clause (3), if an eligible nursing home has less than 61 licensed beds, the director of nurses' compensated hours must be excluded from the computation of compensated hours for professional nurses and registered nurses in paragraph (a), clauses (1) and (2). The commissioner shall recompute the one-time nursing staff adjustment to the payment rate using the data from the cost report for the reporting year ending September 30, 1989, and the adjustment computed under this paragraph shall replace the adjustment previously computed under this subdivision effective October 1, 1990, and shall be effective for the period October 1, 1990, to June 30, 1992.

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.

Subd. 11. **Special property rate setting procedures for certain nursing homes.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item H, to the contrary, for the rate year beginning July 1, 1990, a nursing home leased prior to January 1, 1986, and currently subject to adverse licensure action under section 144A.04, subdivision 4, paragraph (a), or section 144A.11, subdivision 2, and whose ownership changes prior to July 1, 1990, shall be allowed a property-related payment equal to the lesser of its current lease obligation divided by its capacity days as determined in Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), or the frozen property-related payment rate in effect for the rate year beginning July 1, 1989. For rate years beginning on or after July 1, 1991, the property-related payment rate shall be its rental rate computed using the previous owner's allowable principal and interest expense as allowed by the department prior to that prior owner's sale and lease-back transaction of December 1985.

History: *1983 c 199 s 12; 1984 c 640 s 32; 1984 c 641 s 17-20,22; 1984 c 654 art 5 s 58; 1984 c 655 art 1 s 40,41; 1985 c 248 s 40,69; 1985 c 267 s 3; 1Sp1985 c 3 s 25,27-29,31; 1986 c 316 s 2; 1987 c 403 art 2 s 89; art 4 s 6-11; 1988 c 689 art 2 s 154-161; 1988 c 719 art 19 s 9; 1989 c 12 s 1,2; 1989 c 282 art 3 s 66-78; 1990 c 568 art 3 s 65-72*

256B.432 LONG-TERM CARE FACILITIES; CENTRAL, AFFILIATED, OR CORPORATE OFFICE COSTS.

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

(a) "Management agreement" means an agreement in which one or more of the following criteria exist:

(1) the central, affiliated, or corporate office has or is authorized to assume day-to-day operational control of the long-term care facility for any six-month period within a 24-month period. "Day-to-day operational control" means that the central, affiliated, or corporate office has the authority to require, mandate, direct, or compel the employees of the long-term care facility to perform or refrain from performing certain acts, or to supplant or take the place of the top management of the long-term care facility. "Day-to-day operational control" includes the authority to hire or terminate employees or to provide an employee of the central, affiliated, or corporate office to serve as administrator of the long-term care facility;

(2) the central, affiliated, or corporate office performs or is authorized to perform two or more of the following: the execution of contracts; authorization of purchase orders; signature authority for checks, notes, or other financial instruments; requiring the long-term care facility to use the group or volume purchasing services of the central, affiliated, or corporate office; or the authority to make annual capital expenditures for the long-term care facility exceeding $50,000, or $500 per licensed bed, whichever is less, without first securing the approval of the long-term care facility board of directors;

(3) the central, affiliated, or corporate office becomes or is required to become the licensee under applicable state law;

(4) the agreement provides that the compensation for services provided under the agreement is directly related to any profits made by the long-term care facility; or

(5) the long-term care facility entering into the agreement is governed by a governing body that meets fewer than four times a year, that does not publish notice of its meetings, or that does not keep formal records of its proceedings.

(b) "Consulting agreement" means any agreement the purpose of which is for a central, affiliated, or corporate office to advise, counsel, recommend, or suggest to the owner or operator of the nonrelated long-term care facility measures and methods for improving the operations of the long-term care facility.

(c) "Long-term care facility" means a nursing home whose medical assistance rates are determined according to section 256B.431 or an intermediate care facility for persons with mental retardation and related conditions whose medical assistance rates are determined according to section 256B.501.

Subd. 2. **Effective date.** For rate years beginning on or after July 1, 1990, the central, affiliated, or corporate office cost allocations in subdivisions 3 to 6 must be used when determining medical assistance rates under sections 256B.431 and 256B.501.

Subd. 3. **Allocation; direct identification of costs of long-term care facilities; management agreement.** All costs that can be directly identified with a specific long-term care facility that is a related organization to the central, affiliated, or corporate office, or that is controlled by the central, affiliated, or corporate office under a management agreement, must be allocated to that long-term care facility.

Subd. 4. **Allocation; direct identification of costs to other activities.** All costs that can be directly identified with any other activity or function not described in subdivision 3 must be allocated to that activity or function.

Subd. 5. **Allocation of remaining costs; allocation ratio.** (a) After the costs that can be directly identified according to subdivisions 3 and 4 have been allocated, the remaining central, affiliated, or corporate office costs must be allocated between the long-term care facility operations and the other activities or facilities unrelated to the long-term care facility operations based on the ratio of expenses.

(b) For purposes of allocating these remaining central, affiliated, or corporate office costs, the numerator for the allocation ratio shall be determined as follows:

(1) for long-term care facilities that are related organizations or are controlled by a central, affiliated, or corporate office under a management agreement, the numerator of the allocation ratio shall be equal to the sum of the total costs incurred by each related organization or controlled long-term care facility;

(2) for a central, affiliated, or corporate office providing goods or services to related organizations that are not long-term care facilities, the numerator of the allocation ratio shall be equal to the sum of the total costs incurred by the non-long-term care related organizations;

(3) for a central, affiliated, or corporate office providing goods or services to unrelated long-term care facilities under a consulting agreement, the numerator of the allocation ratio shall be equal to the greater of directly identified central, affiliated, or corporate costs or the contracted amount; or

(4) for business activities that involve the providing of goods or services to unrelated parties which are not long-term care facilities, the numerator of the allocation ratio shall be equal to the greater of directly identified costs or revenues generated by the activity or function.

(c) The denominator for the allocation ratio is the sum of the numerators in paragraph (b), clauses (1) to (4).

Subd. 6. **Cost allocation between long-term care facilities.** (a) Those long-term care operations that have long-term care facilities both in Minnesota and outside of Minnesota must allocate the long-term care operation's central, affiliated, or corporate office costs identified in subdivision 5 to Minnesota based on the ratio of total resident days in Minnesota long-term care facilities to the total resident days in all facilities.

(b) The Minnesota long-term care operation's central, affiliated, or corporate office costs identified in paragraph (a) must be allocated to each Minnesota long-term care facility on the basis of resident days.

History: *1990 c 568 art 3 s 73*

256B.433 ANCILLARY SERVICES.

Subdivision 1. **Setting payment; monitoring use of therapy services.** The commissioner shall promulgate rules pursuant to the administrative procedure act to set the amount and method of payment for ancillary materials and services provided to recipients residing in nursing homes. Payment for materials and services may be made to either the nursing home in the operating cost per diem, to the vendor of ancillary services pursuant to Minnesota Rules, parts 9500.0750 to 9500.1080 or to a nursing home pursuant to Minnesota Rules, parts 9500.0750 to 9500.1080. Payment for the same or similar service to a recipient shall not be made to both the nursing home and the vendor. The commissioner shall ensure the avoidance of double payments through audits and adjustments to the nursing home's annual cost report as required by section 256B.47, and that charges and arrangements for ancillary materials and services are cost effective and as would be incurred by a prudent and cost-conscious buyer. Therapy services provided to a recipient must be medically necessary and appropriate to the medical condition of the recipient. If the vendor, nursing home, or ordering physician cannot provide adequate medical necessity justification, as determined by the commissioner, in consultation with an advisory task force that meets the requirements of section 256B.064, subdivision 1a, the commissioner may recover or disallow the payment for the services and may require prior authorization for therapy services as a condition of payment or may impose administrative sanctions to limit the vendor, nursing home, or ordering physician's participation in the medical assistance program. If the provider number of a nursing home is used to bill services provided by a vendor of therapy services that is not related to the nursing home by ownership, control, affiliation, or employment status, no withholding of payment shall be imposed against the nursing home for services not medically necessary except for funds due the unrelated vendor of therapy services as provided in subdivision 3, paragraph (c). For the purpose of this subdivision, no monetary recovery may be imposed against the nursing home for funds paid to the unrelated vendor of therapy services as provided in subdivision 3, paragraph (c), for services not medically necessary.

Subd. 2. **Certification that treatment is appropriate.** The physical therapist, occupational therapist, speech therapist, or audiologist who provides or supervises the provision of therapy services, other than an initial evaluation, to a medical assistance recipient must certify in writing that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient every 30 days. The therapist's statement of certification must be maintained in the recipient's medical record together with the specific orders by the physician and the treatment plan. If the recipient's medical record does not include these documents, the commissioner may recover or disallow the payment for such services. If the therapist determines that the therapy's nature, scope, duration, or intensity is not appropriate to the medical condition of the recipient, the therapist must provide a statement to that effect in writing to the nursing home for inclusion in the recipient's medical record. The commissioner shall utilize a peer review program that meets the requirements of section 256B.064, subdivision 1a, to make recommendations regarding the medical necessity of services provided.

Subd. 3. **Separate billings for therapy services.** Until new procedures are developed under subdivision 4, payment for therapy services provided to nursing home residents that are billed separate from nursing home's payment rate or according to Minnesota Rules, parts 9500.0750 to 9500.1080, shall be subject to the following requirements:

(a) The practitioner invoice must include, in a format specified by the commissioner, the provider number of the nursing home where the medical assistance recipient resides regardless of the service setting.

(b) Nursing homes that are related by ownership, control, affiliation, or employment status to the vendor of therapy services shall report, in a format specified by the commissioner, the revenues received during the reporting year for therapy services provided to residents of the nursing home. For rate years beginning on or after July 1, 1988, the commissioner shall offset the revenues received during the reporting year for therapy services provided to residents of the nursing home to the total payment rate of the

nursing home by dividing the amount of offset by the nursing home's actual resident days. Except as specified in paragraphs (d) and (f), the amount of offset shall be the revenue in excess of 108 percent of the cost removed from the cost report resulting from the requirement of the commissioner to ensure the avoidance of double payments as determined by section 256B.47. In establishing a new base period for the purpose of setting operating cost payment rate limits and rates, the commissioner shall not include the revenues offset in accordance with this section.

(c) For rate years beginning on or after July 1, 1987, nursing homes shall limit charges in total to vendors of therapy services for renting space, equipment, or obtaining other services during the rate year to 108 percent of the annualized cost removed from the reporting year cost report resulting from the requirement of the commissioner to ensure the avoidance of double payments as determined by section 256B.47. If the arrangement for therapy services is changed so that a nursing home is subject to this paragraph instead of paragraph (b), the cost that is used to determine rent must be adjusted to exclude the annualized costs for therapy services that are not provided in the rate year. The maximum charges to the vendors shall be based on the commissioner's determination of annualized cost and may be subsequently adjusted upon resolution of appeals.

(d) The commissioner shall require reporting of all revenues relating to the provision of therapy services and shall establish a therapy cost, as determined by section 256B.47, to revenue ratio for the reporting year ending in 1986. For subsequent reporting years, the ratio may increase five percentage points in total until a new base year is established under paragraph (e). Increases in excess of five percentage points may be allowed if adequate justification is provided to and accepted by the commissioner. Unless an exception is allowed by the commissioner, the amount of offset in paragraph (b) is the greater of the amount determined in paragraph (b) or the amount of offset that is imputed based on one minus the lesser of (1) the actual reporting year ratio or (2) the base reporting year ratio increased by five percentage points, multiplied by the revenues.

(e) The commissioner may establish a new reporting year base for determining the cost to revenue ratio.

(f) If the arrangement for therapy services is changed so that a nursing home is subject to the provisions of paragraph (b) instead of paragraph (c), an average cost to revenue ratio based on the ratios of nursing homes that are subject to the provisions of paragraph (b) shall be imputed for paragraph (d).

(g) This section does not allow unrelated nursing homes to reorganize related organization therapy services and provide services among themselves to avoid offsetting revenues. Nursing homes that are found to be in violation of this provision shall be subject to the penalty requirements of section 256B.48, subdivision 1, paragraph (f).

Subd. 4. **Advisory committee.** The commissioner shall convene an advisory task force consisting of nursing home consumers, therapists from each discipline, and representatives of the nursing home industry. The commissioner, in consultation with the advisory committee, shall study alternative methods of payment for therapy services provided to nursing home residents and report to the legislature by February 1, 1989. The task force expires as provided in section 15.059, subdivision 6.

History: *1983 c 199 s 18; 1985 c 248 s 69; 1987 c 403 art 2 s 90; 1988 c 629 s 54,55; 1988 c 689 art 2 s 162*

256B.44 Subdivision 1. [Repealed, 1983 c 199 s 19]
Subd. 2. [Repealed, 1979 c 336 s 18; 1983 c 199 s 19]
Subd. 3. [Repealed, 1983 c 199 s 19]

256B.45 [Repealed, 1983 c 199 s 19]

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

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

Subdivision 1. **Nonallowable costs.** The following costs shall not be recognized as allowable: (1) political contributions; (2) salaries or expenses of a lobbyist, as defined in section 10A.01, subdivision 11, for lobbying activities; (3) advertising designed to encourage potential residents to select a particular nursing home; (4) assessments levied by the commissioner of health for uncorrected violations; (5) legal and related expenses for unsuccessful challenges to decisions by governmental agencies; (6) memberships in sports, health or similar social clubs or organizations; (7) costs incurred for activities directly related to influencing employees with respect to unionization; and (8) direct and indirect costs of providing services which are billed separately from the nursing home's payment rate or pursuant to Minnesota Rules, parts 9500.0750 to 9500.1080. The commissioner shall by rule exclude the costs of any other items not directly related to the provision of resident care.

Subd. 2. **Notice to residents.** No increase in nursing home rates for private paying residents shall be effective unless the nursing home notifies the resident or person responsible for payment of the increase in writing 30 days before the increase takes effect.

A nursing home may adjust its rates without giving the notice required by this subdivision when the purpose of the rate adjustment is to reflect a necessary change in the level of care provided to a resident. If the state fails to set rates as required by section 256B.431, the time required for giving notice is decreased by the number of days by which the state was late in setting the rates.

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.

Subd. 4. **Allocation of costs; hospital-attached facilities.** To ensure the avoidance of double payments as required by section 256B.433, the direct and indirect reporting year costs of providing therapy services to residents of a hospital-attached nursing home, when the services are billed separately from the nursing home's 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 based on the Medicare step-down as prepared in accordance with instructions provided by the commissioner.

History: *1976 c 282 s 7; 1977 c 305 s 45; 1977 c 326 s 15,16; 1979 c 35 s 1; 1980 c 570 s 2; 1982 c 424 s 130; 1983 c 199 s 13; 1987 c 403 art 2 s 91-93; 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.

Subd. 1a. **Termination.** If a nursing home terminates its participation in the medical assistance program, whether voluntarily or involuntarily, the commissioner may

authorize the nursing home to receive continued medical assistance reimbursement only on a temporary basis until medical assistance residents can be relocated to nursing homes participating in the medical assistance program.

Subd. 1b. **Exception.** Notwithstanding any agreement between a nursing home and the department of human services or the provisions of this section or section 256B.411, other than subdivision 1a, the commissioner may authorize continued medical assistance payments to a nursing home which ceased intake of medical assistance recipients prior to July 1, 1983, and which charges private paying residents rates that exceed those permitted by subdivision 1, paragraph (a), for (i) residents who resided in the nursing home before July 1, 1983, or (ii) residents for whom the commissioner or any predecessors of the commissioner granted a permanent individual waiver prior to October 1, 1983. Nursing homes seeking continued medical assistance payments under this subdivision shall make the reports required under subdivision 2, except that on or after December 31, 1985, the financial statements required need not be audited by or contain the opinion of a certified public accountant or licensed public accountant, but need only be reviewed by a certified public accountant or licensed public accountant. In the event that the state is determined by the federal government to be no longer eligible for the federal share of medical assistance payments made to a nursing home under this subdivision, the commissioner may cease medical assistance payments, under this subdivision, to that nursing home.

Subd. 1c. **Case mix rate for provider with addendum to provider agreement.** A nursing home with an addendum to its provider agreement effective beginning July 1, 1983, or September 24, 1985, shall have its payment rates established by the commissioner under this subdivision. To save medical assistance resources, for rate years beginning after July 1, 1991, the provider's payment rates shall be the payment rates established by the commissioner July 1, 1990, multiplied by a 12-month inflation factor based on the forecasted inflation between the midpoints of rate years using the inflation index applied by the commissioner to other nursing homes.

The provider and the department of health shall complete case mix assessments under Minnesota Rules, chapter 4656, and parts 9549.0058 and 9549.0059, on only those residents receiving medical assistance. The commissioner of health may audit and verify the limited provider assessments at any time.

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

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

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

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

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

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

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

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

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

Subd. 3. **Incomplete or inaccurate reports.** The commissioner may reject any annual cost report filed by a nursing home pursuant to this chapter if the commissioner determines that the report or the information required in subdivision 2, clause (a) has been filed in a form that is incomplete or inaccurate. In the event that a report is rejected pursuant to this subdivision, the commissioner shall reduce the reimbursement rate to a nursing home to 80 percent of its most recently established rate until the information is completely and accurately filed.

Subd. 4. **Extensions.** The commissioner may grant a 15-day extension of the reporting deadline to a nursing home for good cause. To receive such an extension, a nursing home shall submit a written request by December 1. The commissioner will notify the nursing home of the decision by December 15.

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

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

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

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

(d) use any combination of the foregoing actions.

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

(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) **After September 30, 1990.** After September 30, 1990, 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) **Conflict with Medicare distinct part requirements.** At the request of a facility,

the commissioner of human services may reduce the 50 percent Medicare participation requirement in paragraphs (c) and (d) to no less than 20 percent if the commissioner of health determines that, due to the facility's physical plant configuration, the facility cannot satisfy Medicare distinct part requirements at the 50 percent certification level. To receive a reduction in the participation requirement, a facility must demonstrate that the reduction will not adversely affect access of Medicare-eligible residents to Medicare-certified beds.

(f) **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.

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

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

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: *1976 c 282 s 8; 1977 c 309 s 1; 1977 c 326 s 17; 1978 c 674 s 28; 1983 c 199 s 14; 1984 c 640 s 32; 1984 c 641 s 23; 1Sp1985 c 3 s 31; 1Sp1985 c 9 art 2 s 50-52; 1986 c 420 s 11,12; 1986 c 444; 1987 c 364 s 1; 1987 c 403 art 2 s 94; 1989 c 282 art 3 s 80-82; 1990 c 568 art 3 s 74,75; 1990 c 599 s 2*

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

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

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

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

Subd. 3. **Continued services for persons over age 65.** Persons who are found eligible for services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they meet all other eligibility factors.

History: *1984 c 640 s 32; 1984 c 654 art 5 s 24,58; 1990 c 568 art 3 s 76*

256B.491 WAIVERED SERVICES.

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

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

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

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

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

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

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

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

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

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

256B.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 or managing agent. In this case, the commissioner and the receiver or managing agent 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; 1990 c 568 art 3 s 77*

256B.50 APPEALS.

Subdivision 1. **Scope.** A provider may appeal from a determination of a payment rate established pursuant to this chapter and reimbursement rules of the commissioner if the appeal, if successful, would result in a change to the provider's payment rate or to the calculation of maximum charges to therapy vendors as provided by section 256B.433, subdivision 3. Appeals must be filed in accordance with procedures in this section. This section does not apply to a request from a resident or nursing home for reconsideration of the classification of a resident under section 144.0722.

Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Determination of a payment rate" means the process by which the commissioner establishes the payment rate paid to a provider pursuant to this chapter, including determinations made in desk audit, field audit, or pursuant to an amendment filed by the provider.

(b) "Provider" means a nursing home as defined in section 256B.421, subdivision 7, or a facility as defined in section 256B.501, subdivision 1.

(c) "Reimbursement rules" means Minnesota Rules, parts 9510.0010 to 9510.0480, 9510.0500 to 9510.0890, and rules adopted by the commissioner pursuant to sections 256B.41 and 256B.501, subdivision 3.

Subd. 1b. **Filing an appeal.** To appeal, the provider shall file with the commissioner a written notice of appeal; the appeal must be received by the commissioner within 60 days of the date the determination of the payment rate was mailed. The notice of appeal must specify each disputed item; the reason for the dispute; the total dollar amount in dispute for each separate disallowance, allocation, or adjustment of each cost item or part of a cost item; the computation that the provider believes is correct; the authority in statute or rule upon which the provider relies for each disputed item; the name and address of the person or firm with whom contacts may be made regarding the appeal; and other information required by the commissioner.

Subd. 1c. **Contested case procedures.** Except as provided in subdivision 2, the appeal must be heard by an administrative law judge according to sections 14.48 to 14.56. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect. Regardless of any rate appeal, the rate established must be the rate paid and must remain in effect until final resolution of the appeal or subsequent desk or field audit adjustment, notwithstanding any provision of law or rule to the contrary. To challenge the validity of rules established by the commissioner pursuant to this section and sections 256B.41, 256B.421, 256B.431, 256B.47, 256B.48, 256B.501, and 256B.502, a provider shall comply with section 14.44.

Subd. 1d. **Expedited appeal review process.** (a) Within 120 days of the date an appeal is due according to subdivision 1b, the department shall review an appealed adjustment equal to or less than $100 annually per licensed bed of the provider, make a determination concerning the adjustment, and notify the provider of the determination. Except as allowed in paragraph (g), this review does not apply to an appeal of an adjustment made to, or proposed on, an amount already paid to the provider. In this subdivision, an adjustment is each separate disallowance, allocation, or adjustment of a cost item or part of a cost item as submitted by a provider according to forms required by the commissioner.

(b) For an item on which the provider disagrees with the results of the determina-

tion of the department made under paragraph (a), the provider may, within 60 days of the date of the review notice, file with the office of administrative hearings and the department its written argument and documents, information, or affidavits in support of its appeal. If the provider fails to make a submission in accordance with this paragraph, the department's determinations on the disputed items must be upheld.

(c) Within 60 days of the date the department received the provider's submission under paragraph (b), the department may file with the office of administrative hearings and serve upon the provider its written argument and documents, information, and affidavits in support of its determination. If the department fails to make a submission in accordance with this paragraph, the administrative law judge shall proceed pursuant to paragraph (d) based on the provider's submission.

(d) Upon receipt by the office of administrative hearings of the department's submission made under paragraph (c) or upon the expiration of the 60-day filing period, whichever is earlier, the chief administrative law judge shall assign the matter to an administrative law judge. The administrative law judge shall consider the submissions of the parties and all relevant rules, statutes, and case law. The administrative law judge may request additional argument from the parties if it is deemed necessary to reach a final decision, but shall not allow witnesses to be presented or discovery to be made in the proceeding. Within 60 days of receipt by the office of administrative hearings of the department's submission or the expiration of the 60-day filing period in paragraph (c), whichever is earlier, the administrative law judge shall make a final decision on the items in issue, and shall notify the provider and the department by first-class mail of the decision on each item. The decision of the administrative law judge is the final administrative decision, is not appealable, and does not create legal precedent, except that the department may make an adjustment contrary to the decision of the administrative law judge based upon a subsequent cost report amendment or field audit that reveals information relating to the adjustment that was not known to the department at the time of the final decision.

(e) For a disputed item otherwise subject to the review set forth in this subdivision, the department and the provider may mutually agree to bypass the expedited review process and proceed to a contested case hearing at any time prior to the time for the department's submission under paragraph (c).

(f) When the department determines that the appeals of two or more providers otherwise subject to the review set forth in this subdivision present the same or substantially the same adjustment, the department may remove the disputed items from the review in this subdivision, and the disputed items shall proceed in accordance with subdivision 1c. The department's decision to remove the appealed adjustments to contested case proceeding is final and is not reviewable.

(g) For a disputed item otherwise subject to the review in this subdivision, the department or a provider may petition the chief administrative law judge to issue an order allowing the petitioning party to bypass the expedited review process. If the petition is granted, the disputed item must proceed in accordance with subdivision 1c. In making the determination, the chief administrative law judge shall consider the potential impact and precedential and monetary value of the disputed item. A petition for removal to contested case hearing must be filed with the chief administrative law judge and the opposing party on or before the date on which its submission is due under paragraph (b) or (c). Within 20 days of receipt of the petition, the opposing party may submit its argument opposing the petition. Within 20 days of receipt of the argument opposing the petition, or if no argument is received, within 20 days of the date on which the argument was due, the chief administrative law judge shall issue a decision granting or denying the petition. If the petition is denied, the petitioning party has 60 days from the date of the denial to make a submission under paragraph (b) or (c).

(h) The department and a provider may mutually agree to use the procedures set forth in this subdivision for any disputed item not otherwise subject to this subdivision.

(i) Nothing shall prevent either party from making its submissions and arguments under this subdivision through a person who is not an attorney.

(j) This subdivision applies to all appeals for rate years beginning after June 30, 1988.

Subd. 1e. **Attorney's fees and costs.** (a) Notwithstanding section 3.762, paragraph (a), for an issue appealed under subdivision 1, the prevailing party in a contested case proceeding or, if appealed, in subsequent judicial review, must be awarded reasonable attorney's fees and costs incurred in litigating the appeal, if the prevailing party shows that the position of the opposing party was not substantially justified. The procedures for awarding fees and costs set forth in section 3.764 must be followed in determining the prevailing party's fees and costs except as otherwise provided in this subdivision. For purposes of this subdivision, "costs" means subpoena fees and mileage, transcript costs, court reporter fees, witness fees, postage and delivery costs, photocopying and printing costs, amounts charged the commissioner by the office of administrative hearings, and direct administrative costs of the department; and "substantially justified" means that a position had a reasonable basis in law and fact, based on the totality of the circumstances prior to and during the contested case proceeding and subsequent review.

(b) When an award is made to the department under this subdivision, attorney fees must be calculated at the cost to the department. When an award is made to a provider under this subdivision, attorney fees must be calculated at the rate charged to the provider except that attorney fees awarded must be the lesser of the attorney's normal hourly fee or $100 per hour.

(c) In contested case proceedings involving more than one issue, the administrative law judge shall determine what portion of each party's attorney fees and costs is related to the issue or issues on which it prevailed and for which it is entitled to an award. In making that determination, the administrative law judge shall consider the amount of time spent on each issue, the precedential value of the issue, the complexity of the issue, and other factors deemed appropriate by the administrative law judge.

(d) When the department prevails on an issue involving more than one provider, the administrative law judge shall allocate the total amount of any award for attorney fees and costs among the providers. In determining the allocation, the administrative law judge shall consider each provider's monetary interest in the issue and other factors deemed appropriate by the administrative law judge.

(e) Attorney fees and costs awarded to the department for proceedings under this subdivision must not be reported or treated as allowable costs on the provider's cost report.

(f) Fees and costs awarded to a provider for proceedings under this subdivision must be reimbursed to them by reporting the amount of fees and costs awarded as allowable costs on the provider's cost report for the reporting year in which they were awarded. Fees and costs reported pursuant to this subdivision must be included in the general and administrative cost category but are not subject to either the general and administrative or other operating cost limits.

(g) If the provider fails to pay the awarded attorney fees and costs within 120 days of the final decision on the award of attorney fees and costs, the department may collect the amount due through any method available to it for the collection of medical assistance overpayments to providers. Interest charges must be assessed on balances outstanding after 120 days of the final decision on the award of attorney fees and costs. The annual interest rate charged must be the rate charged by the commissioner of revenue for late payment of taxes that is in effect on the 121st day after the final decision on the award of attorney fees and costs.

(h) Amounts collected by the commissioner pursuant to this subdivision must be deemed to be recoveries pursuant to section 256.01, subdivision 2, clause 15.

(i) This subdivision applies to all contested case proceedings set on for hearing by the commissioner on or after April 29, 1988, regardless of the date the appeal was filed.

Subd. 1f. **Legal and related expenses.** Legal and related expenses for unresolved challenges to decisions by governmental agencies shall be separately identified and

explained on the provider's cost report for each year in which the expenses are incurred. When the challenge is resolved in favor of the governmental agency, the provider shall notify the department of the extent to which its challenge was unsuccessful or the cost report filed for the reporting year in which the challenge was resolved. In addition, the provider shall inform the department of the years in which it claimed legal and related expenses and the amount of the expenses claimed in each year relating to the unsuccessful challenge. The department shall reduce the provider's medical assistance rate in the subsequent rate year by the total amount claimed by the provider for legal and related expenses incurred in an unsuccessful challenge to a decision by a governmental agency.

Subd. 1g. **Appeal supplement.** (a) For an appeal filed with the commissioner regarding payment rates calculated pursuant to Minnesota Rules, parts 9510.0010 to 9510.0480, or parts 9510.0500 to 9510.0890, or prior provisions of these rules, that was not subject to the provisions of this section or section 256B.501, subdivision 3, at the time it was filed, the appellant must file an appeal supplement. The appeal supplement must be filed no later than December 31, 1988, and must specify each disputed item, the reason for the dispute, an estimate of the dollar amount involved for each disputed item, the computation that the provider believes is correct, the authority in statute or rule upon which the provider relies for each disputed item, the name and address of the person or firm with whom contacts may be made regarding the appeal, and any other information required by the commissioner. Failure to file the appeal supplement is jurisdictional and the commissioner may accordingly dismiss the appeal, and the rate established by the commissioner shall take effect.

(b) Filing of an appeal supplement must not be construed to correct any legal defect in the original appeal.

(c) An appeal for which an appeal supplement is filed pursuant to this subdivision must be set on for a contested case hearing, made part of the expedited appeal process with the agreement of both the provider and the department, or otherwise resolved by December 31, 1989.

Subd. 2. **Appraised value.** (a) A nursing home may appeal the determination of its appraised value, as determined by the commissioner pursuant to section 256B.431 and rules established thereunder. A written notice of appeal concerning the appraised value of a nursing home's real estate as established by an appraisal conducted after July 1, 1986, must be filed with the commissioner within 60 days of the date the determination was made and shall state the appraised value the nursing home believes is correct for the building, land improvements, and attached equipment and the name and address of the firm with whom contacts may be made regarding the appeal. The appeal request shall include a separate appraisal report prepared by an independent appraiser of real estate which supports the total appraised value claimed by the nursing home. The appraisal report shall be based on an on-site inspection of the nursing home's real estate using the depreciated replacement cost method, must be in a form comparable to that used in the commissioner's appraisal, and must pertain to the same time period covered by the appealed appraisal. The appraisal report shall include information related to the training, experience, and qualifications of the appraiser who conducted and prepared the appraisal report for the nursing home.

(b) A nursing home which has filed an appeal request prior to the effective date of Laws 1987, chapter 403, concerning the appraised value of its real estate as established by an appraisal conducted before July 1, 1986, must submit to the commissioner the information described under paragraph (a) within 60 days of the effective date of Laws 1987, chapter 403, in order to preserve the appeal.

(c) An appeal request which has been filed pursuant to the provisions of paragraph (a) or (b) shall be finally resolved through an agreement entered into by and between the commissioner and the nursing home or by the determination of an independent appraiser based upon an on-site inspection of the nursing home's real estate using the depreciated replacement cost method, in a form comparable to that used in the commissioner's appraisal, and pertaining to the same time period covered by the appealed appraisal. The appraiser shall be selected by the commissioner and the nursing home

by alternately striking names from a list of appraisers approved for state contracts by the commissioner of administration. The appraiser shall make assurances to the satisfaction of the commissioner and the nursing home that the appraiser is experienced in the use of the depreciated cost method of appraisals and that the appraiser is free of any personal, political, or economic conflict of interest that may impair the ability to function in a fair and objective manner. The commissioner shall pay costs of the appraiser through a negotiated rate for services of the appraiser.

(d) The decision of the appraiser is final and is not appealable. Exclusive jurisdiction for appeals of the appraised value of nursing homes lies with the procedures set out in this subdivision. No court of law shall possess subject matter jurisdiction to hear appeals of appraised value determinations of nursing homes.

History: *1983 c 199 s 15; 1984 c 640 s 32; 1984 c 641 s 21; 1985 c 248 s 69; 1Sp1985 c 3 s 32; 1987 c 403 art 4 s 12; 1988 c 689 art 2 s 163-168; 1990 c 568 art 3 s 78,79*

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

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

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

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

(c) "Waivered service" means home or community-based service authorized under United States Code, title 42, section 1396n(c), as amended through December 31, 1987, and defined in the Minnesota state plan for the provision of medical assistance services. Waivered services include, at a minimum, case management, family training and support, developmental training homes, supervised living arrangements, semi-independent living services, respite care, and training and habilitation services.

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

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

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

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

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

(d) incentives to reward accumulation of equity;

(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.

Subd. 3a. **Interim rates.** For rate years beginning October 1, 1988, and October 1, 1989, the commissioner shall establish an interim program operating cost payment rate for care of residents in intermediate care facilities for persons with mental retardation.

(a) For the rate year beginning October 1, 1988, the interim program operating cost payment rate is the greater of the facility's 1987 reporting year allowable program operating costs per resident day increased by the composite forecasted index in subdivision 3c, or the facility's January 1, 1988, program operating cost payment rate increased by the composite forecasted index in subdivision 3c, except that the composite forecasted index is established based on the midpoint of the period January 1, 1988, to September 30, 1988, to the midpoint of the following rate year.

(b) For the rate year beginning October 1, 1989, the interim program operating cost payment rate is the greater of the facility's 1988 reporting year allowable program operating costs per resident day increased by the composite forecasted index in subdivision 3c, or the facility's October 1, 1988, program operating cost payment rate increased by the composite forecasted index in subdivision 3c, except that the composite forecasted index is established based on the midpoint of the rate year beginning October 1, 1988, to the midpoint of the following rate year.

Subd. 3b. **Settle-up of costs.** The facility's program operating costs are subject to a retroactive settle-up for the 1988 and 1989 reporting years, determined by the following method:

(a) If a facility's program operating costs, including one-time adjustment program operating costs for the facility's 1988 or 1989 reporting year, are less than 98 percent of the facility's total program operating cost payments for facilities with 20 or fewer licensed beds, or less than 99 percent of the facility's total program operating cost payments for facilities with more than 20 licensed beds, then the facility must repay the difference to the state according to the desk audit adjustment procedures in Minnesota Rules, part 9553.0041, subpart 13, items B to E. For the purpose of determining the retroactive settle-up amounts, the facility's total program operating cost payments must be computed by multiplying the facility's program operating cost payment rates, including one-time program operating cost adjustment rates for those reporting years, by the prorated resident days,that correspond to those program operating cost payment rates paid during those reporting years.

(b) If a facility's program operating costs, including one-time adjustment program operating costs for the facility's 1989 reporting year are between 102 and 105 percent of the amount computed by multiplying the facility's program operating cost payment rates, including one-time program operating cost adjustment rates for those reporting years, by the prorated resident days that correspond to those program operating cost payment rates paid during that reporting year, the state must repay the difference to

the facility according to the desk audit adjustment procedures in Minnesota Rules, part 9553.0041, subpart 13, items B to E.

A facility's retroactive settle-up must be calculated by October 1, 1990.

Subd. 3c. **Composite forecasted index.** For rate years beginning on or after October 1, 1988, the commissioner shall establish a statewide composite forecasted index to take into account economic trends and conditions between the midpoint of the facility's reporting year and the midpoint of the rate year following the reporting year. The statewide composite index must incorporate the forecast by Data Resources, Inc. of increases in the average hourly earnings of nursing and personal care workers indexed in Standard Industrial Code 805 in "Employment and Earnings," published by the Bureau of Labor Statistics, United States Department of Labor. This portion of the index must be weighted annually by the proportion of total allowable salaries and wages to the total allowable operating costs in the program, maintenance, and administrative operating cost categories for all facilities.

For adjustments to the other operating costs in the program, maintenance, and administrative operating cost categories, the statewide index must incorporate the Data Resources, Inc. forecast for increases in the national CPI-U. This portion of the index must be weighted annually by the proportion of total allowable other operating costs to the total allowable operating costs in the program, maintenance, and administrative operating cost categories for all facilities. The commissioner shall use the indices as forecasted by Data Resources, Inc., in the fourth quarter of the reporting year.

For rate years beginning on or after October 1, 1990, the commissioner shall index a facility's allowable operating costs in the program, maintenance, and administrative operating cost categories by using Data Resources, Inc., forecast for change in the Consumer Price Index-All Items (U.S. city average) (CPI-U). The commissioner shall use the indices as forecasted by Data Resources, Inc., in the first quarter of the calendar year in which the rate year begins.

Subd. 3d. **Limits on administrative operating costs.** For the rate year beginning October 1, 1989, the administrative operating cost per bed limit shall be calculated according to paragraphs (a) to (d).

(a) The commissioner shall classify a facility into one of two groups based on the number of licensed beds reported on the facility's cost report. Group one includes facilities with more than 20 licensed beds. Group two includes facilities with 20 or fewer licensed beds.

(b) The commissioner shall determine the allowable administrative historical operating cost per licensed bed for each facility in the two groups by dividing the allowable administrative historical operating cost in each facility by the number of licensed beds in each facility.

(c) The commissioner shall establish the administrative cost per licensed bed limit by multiplying the median of the array of allowable administrative historical operating costs per licensed bed for each group by the percentage that establishes the limit at the 75th percentile of the array of each group.

(d) For the rate year beginning October 1, 1989, the maximum allowable administrative historical operating cost shall be the facility's allowable administrative historical operating cost or the amount in paragraph (c) multiplied by the facility's licensed beds, whichever is less.

Subd. 3e. **Increase in limits.** For rate years beginning on or after October 1, 1990, the commissioner shall increase the administrative cost per licensed bed limit in subdivision 3d, paragraph (c), and the maintenance operating cost limit in Minnesota Rules, part 9553.0050, subpart 1, item A, subitem (2), by multiplying the administrative operating cost per bed limit and the maintenance operating cost limit by the forecasted index in subdivision 3c except that the index shall be based on the 12 months between the midpoints of the two preceding reporting years.

Subd. 3f. **Rate adjustments.** For rate years beginning October 1, 1989, the commissioner may develop a method to adjust facility rates to meet new licensing or certifica-

tion standards or regulations adopted by the state or federal government that result in significant cost increases. The commissioner may also consider establishing separate administrative cost limits based on other factors including difficulty of care of residents and licensure classification.

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.

Subd. 3h. **Waiving interest charges.** The commissioner may waive interest charges on overpayments incurred by intermediate care facilities for persons with mental retardation and related conditions for the period October 1, 1987, to February 29, 1988, if the overpayments resulted from the continuation of the desk audit rate in effect on September 30, 1987, through the period.

Subd. 3i. **Scope.** Subdivisions 3a to 3h do not apply to facilities whose payment rates are governed by Minnesota Rules, part 9553.0075.

Subd. 3j. **Rules.** The commissioner shall adopt rules to implement this section. The commissioner shall consult with provider groups, advocates, and legislators to develop these rules.

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.

Subd. 4. **Waivered services.** In establishing rates for waivered services the commis-

sioner shall consider the need for flexibility in the provision of those services to meet individual needs identified by the screening team.

Subd. 5. [Repealed, 1987 c 403 art 5 s 22]

Subd. 6. [Repealed, 1987 c 403 art 5 s 22]

Subd. 7. [Repealed, 1987 c 403 art 5 s 22]

Subd. 8. **Payment for persons with special needs.** The commissioner shall establish by December 31, 1983, procedures to be followed by the counties to seek authorization from the commissioner for medical assistance reimbursement for very dependent persons with special needs in an amount in excess of the rates allowed pursuant to subdivisions 2 and 4, including rates established under section 252.46 when they apply to services provided to residents of intermediate care facilities for persons with mental retardation or related conditions, and procedures to be followed for rate limitation exemptions for intermediate care facilities for persons with mental retardation or related conditions. No excess payment or limitation exemption shall be authorized unless the need for the service is documented in the individual service plan of the person or persons to be served, the type and duration of the services needed are stated, and there is a basis for estimated cost of the services.

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

Subd. 9. [Repealed, 1987 c 403 art 5 s 22]

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

Subd. 11. **Investment per bed limits, interest expense limitations, and arms-length leases.** (a) The provisions of Minnesota Rules, part 9553.0075, except as modified under this subdivision, shall apply to newly constructed or established facilities that are certified for medical assistance on or after May 1, 1990.

(b) For purposes of establishing payment rates under this subdivision and Minnesota Rules, parts 9553.0010 to 9553.0080, the term "newly constructed or newly established" means a facility (1) for which a need determination has been approved by the commissioner under sections 252.28 and 252.291; (2) whose program is newly licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, and certified under Code of Federal Regulations, title 42, section 442.400, et seq.; and (3) that is part of a proposal that meets the requirements of section 252.291, subdivision 2, paragraph (2). The term does not include a facility for which a need determination was granted solely for other reasons such as the relocation of a facility; a change in the facility's name, program, number of beds, type of beds, or ownership; or the sale of a facility, unless the relocation of a facility to one or more service sites is the result of a closure of a facility under section 252.292, in which case clause (3) shall not apply. The term does include a facility that converts more than 50 percent of its licensed beds from class A to class B residential or class B institutional to serve persons discharged from state regional treatment centers on or after May 1, 1990, in which case clause (3) does not apply.

(c) Newly constructed or newly established facilities that are certified for medical assistance on or after May 1, 1990, shall be allowed the capital asset investment per bed limits as provided in clauses (1) to (4).

(1) The 1990 calendar year investment per bed limit for a facility's land must not exceed $5,700 per bed for newly constructed or newly established facilities in Hennepin, Ramsey, Anoka, Washington, Dakota, Scott, Carver, Chisago, Isanti, Wright, Benton, Sherburne, Stearns, St. Louis, Clay, and Olmsted counties, and must not exceed $3,000 per bed for newly constructed or newly established facilities in other counties.

(2) The 1990 calendar year investment per bed limit for a facility's depreciable capital assets must not exceed $44,800 for class B residential beds, and $45,200 for class B institutional beds.

(3) The investment per bed limit in clause (2) must not be used in determining the three-year average percentage increase adjustment in Minnesota Rules, part 9553.0060, subpart 1, item C, subitem (4), for facilities that were newly constructed or newly established before May 1, 1990.

(4) The investment per bed limits in clause (2) shall be adjusted annually beginning January 1, 1991, and each January 1 following, as provided in Minnesota Rules, part 9553.0060, subpart 1, item C, subitem (2).

(d) A newly constructed or newly established facility's interest expense limitation as provided for in Minnesota Rules, part 9553.0060, subpart 3, item F, on capital debt for capital assets acquired during the interim or settle-up period, shall be increased by 2.5 percentage points for each full .25 percentage points that the facility's interest rate on its mortgage is below the maximum interest rate as established in Minnesota Rules, part 9553.0060, subpart 2, item A, subitem (2). For all following rate periods, the interest expense limitation on capital debt in Minnesota Rules, part 9553.0060, subpart 3, item F, shall apply to the facility's capital assets acquired, leased, or constructed after the interim or settle-up period. If a newly constructed or newly established facility is acquired by the state, the limitations of this paragraph and Minnesota Rules, part 9553.0060, subpart 3, item F, shall not apply.

(e) If a newly constructed or newly established facility is leased with an arms-length lease as provided for in Minnesota Rules, part 9553.0060, subpart 7, the lease agreement shall be subject to the following conditions:

(1) the term of the lease, including option periods, must not be less than 20 years;

(2) the maximum interest rate used in determining the present value of the lease must not exceed the lesser of the interest rate limitation in Minnesota Rules, part 9553.0060, subpart 2, item A, subitem (2), or 16 percent; and

(3) the residual value used in determining the net present value of the lease must be established using the provisions of Minnesota Rules, part 9553.0060.

(f) All leases of the physical plant of an intermediate care facility for the mentally retarded shall contain a clause that requires the owner to give the commissioner notice of any requests or orders to vacate the premises 90 days before such vacation of the premises is to take place. In the case of unlawful detainer actions, the owner shall notify the commissioner within three days of notice of an unlawful detainer action being served upon the tenant. The only exception to this notice requirement is in the case of emergencies where immediate vacation of the premises is necessary to assure the safety and welfare of the residents. In such an emergency situation, the owner shall give the commissioner notice of the request to vacate at the time the owner of the property is aware that the vacating of the premises is necessary. This section applies to all leases entered into after July 1, 1990. Rentals set in leases entered into after that date that do not contain this clause are not allowable costs for purposes of medical assistance reimbursement.

(g) A newly constructed or newly established facility's preopening costs are subject to the provisions of Minnesota Rules, part 9553.0035, subpart 12, and must be limited to only those costs incurred during one of the following periods, whichever is shorter:

(1) between the date the commissioner approves the facility's need determination and 30 days before the date the facility is certified for medical assistance; or

(2) the 12-month period immediately preceding the 30 days before the date the facility is certified for medical assistance.

History: *1983 c 312 art 9 s 7; 1984 c 640 s 32; 1984 c 654 art 5 s 25,58; 1985 c 21 s 57; 1986 c 420 s 13; 1987 c 403 art 5 s 17-19; 1988 c 689 art 2 s 169-180; 1989 c 282 art 3 s 84-86; 1990 c 568 art 3 s 80-82*

256B.502 EMERGENCY AND PERMANENT RULES; REPORT.

The commissioners of health and human services shall promulgate emergency and permanent rules necessary to implement Laws 1983, chapter 199, except as otherwise indicated in accordance with sections 14.01 to 14.38. Emergency rules promulgated by

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

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

256B.503 RULES.

To implement Laws 1983, chapter 312, article 9, sections 1 to 7, the commissioner shall promulgate emergency and permanent rules in accordance with sections 14.01 to 14.38. Rules adopted to implement Laws 1983, chapter 312, article 9, section 5, must (a) be in accord with the provisions of Minnesota Statutes, chapter 256E, (b) set standards for case management which include, encourage and enable flexible administration, (c) require the county boards to develop individualized procedures governing case management activities, (d) consider criteria promulgated under section 256B.092, subdivision 3, and the federal waiver plan, (e) identify cost implications to the state and to county boards, and (f) require the screening teams to make recommendations to the county case manager for development of the individual service plan.

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

History: *1983 c 312 art 9 s 8; 1984 c 640 s 32; 1Sp1985 c 9 art 2 s 53*

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

Subdivision 1. A legislative commission is created

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *1976 c 312 s 2; 1984 c 654 art 5 s 58*

DENTAL CARE FOR SENIOR CITIZENS

256B.56 PURPOSE.

The purpose of the pilot dental program is to determine the need for and the feasibility of establishing a statewide dental program for eligible senior citizens, the optimal methods of providing dental service, whether the provision of dental services causes the general health of the participants to be improved and whether the provision of dental services to the eligible senior citizens provides comparable benefits to society as if provided to others.

History: *1976 c 305 s 1*

256B.57 PILOT PROGRAMS; ESTABLISHMENT.

The commissioner of human services, hereinafter the commissioner, shall establish two pilot programs to provide dental care to senior citizens. One pilot program shall be established in the metropolitan area, composed of Hennepin, Ramsey, Anoka, Washington, Dakota, Scott, and Carver counties; and one pilot program shall be estab-

lished in an area selected by the commissioner and located outside of the seven metropolitan counties.

History: *1976 c 305 s 2; 1984 c 654 art 5 s 58*

256B.58 ADMINISTRATION.

The pilot programs shall be administered by the commissioner. The commissioner may employ staff to administer the programs. The cost of the staff shall be met solely by funds authorized to be spent for administering the programs.

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

256B.59 SERVICE CONTRACTS; REVIEW.

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

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

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

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

256B.60 ELIGIBILITY FOR BENEFITS.

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

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

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

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

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

History: *1976 c 305 s 5*

256B.61 SERVICES AND PAYMENT.

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

(a) routine examinations,

(b) X-rays,

(c) emergency treatment for relief of pain,

(d) restorative services,

(e) oral surgery, including preoperative and postoperative care,

(f) surgical and nonsurgical periodontics,

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

(h) prosthetics.

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

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

History: *1976 c 305 s 6*

256B.62 FINANCIAL REQUIREMENTS.

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

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

History: *1976 c 305 s 7*

256B.63 OUTSIDE FUNDING.

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

History: *1976 c 305 s 8*

256B.64 ATTENDANTS TO VENTILATOR-DEPENDENT RECIPIENTS.

A ventilator-dependent recipient of medical assistance who has been receiving the services of a private duty nurse or personal care assistant in the recipient's home may continue to have a private duty nurse or personal care assistant present upon admission to a hospital licensed under chapter 144. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient. The personal care assistant or private duty nurse may offer nonbinding advice to the health care professionals in charge of the ventilator-dependent patient's care and treatment on matters pertaining to the comfort and safety of the patient. After the 120 hour transition period, an assessment may be made by the ventilator-dependent patient, the attending physician, and the patient's primary care nurse to determine whether continued services of communicator or interpreter for the patient by the private duty nurse or personal care assistant are necessary and appropriate for the patient's needs. If continued service is necessary and appropriate, the physician must certify this need to the commissioner of human services in order for payments to continue. The commissioner may adopt rules necessary to implement this section. Reimbursement under this section must be at the payment rate and in a manner consistent with the payment rate and manner used in reimbursing these providers for home care services for the ventilator-dependent recipient under the medical assistance program.

History: *1988 c 689 art 2 s 181*

256B.69 PREPAYMENT DEMONSTRATION PROJECT.

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

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

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

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

(c) "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06.

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

Subd. 3. **Geographic area.** The commissioner shall designate the geographic areas in which eligible individuals may be included in the medical assistance prepayment programs.

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 pro-

vider 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.

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

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees;

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

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

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

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

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

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

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

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

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

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

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: *1983 c 312 art 5 s 27; 1984 c 654 art 5 s 58; 1987 c 403 art 2 s 95-101; 1988 c 689 art 2 s 182,183,268; 1989 c 209 art 1 s 23; 1989 c 282 art 3 s 87-90; 1990 c 426 art 1 s 29; 1990 c 568 art 3 s 83,84*

256B.70 DEMONSTRATION PROJECT WAIVER.

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

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

256B.71 SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION.

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

Subd. 2. **Case management.** Each participating provider approved by the commissioner shall serve as case manager for recipients enrolled in its plan. The participating provider shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure that appropriate health care is delivered to enrollees.

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

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

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

History: *1983 c 295 s 1; 1984 c 654 art 5 s 58; 1986 c 444; 1988 c 689 art 2 s 268*

256B.72 RIGHT OF APPEAL.

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

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

DEMONSTRATION PROJECT FOR UNINSURED LOW-INCOME PERSONS

256B.73 DEMONSTRATION PROJECT FOR UNINSURED LOW-INCOME PERSONS.

Subdivision 1. **Purpose.** The purpose of the demonstration project is to determine the need for and the feasibility of establishing a statewide program of medical insurance for uninsured low-income persons.

Subd. 2. **Establishment: geographic area.** The commissioner of human services shall cooperate with a local coalition to establish a demonstration project to provide low cost medical insurance to uninsured low-income persons in Cook, Crow Wing, Lake, St. Louis, Carlton, Aitkin, Pine, Itasca, and Koochiching counties except an individual county may be excluded as determined by the county board of commissioners. The coalition shall work with the commissioners of human services, commerce, and health and potential demonstration providers as well as other public and private organizations to determine program design, including enrollee eligibility requirements, benefits, and participation.

Subd. 3. **Definitions.** For the purposes of this section, the following terms have the meanings given:

(1) "coalition" means an organization comprised of members representative of small business, health care providers, county social service departments, health consumer groups, and the health industry, established to serve the purposes of this demonstration;

(2) "demonstration provider" means a corporation regulated under chapter 62A, 62C, or 62D;

(3) "individual provider" means a medical provider under contract to the demonstration provider to provide medical care to enrollees; and

(4) "enrollee" means a person eligible to receive coverage according to subdivision 4.

Subd. 4. **Enrollee eligibility requirements.** To be eligible for participation in the demonstration project, an enrollee must:

(1) not be eligible for Medicare, medical assistance, or general assistance medical care; and

(2) have no medical insurance or health benefits plan available through employment or other means that would provide coverage for the same medical services as provided by this demonstration.

Subd. 5. **Enrollee benefits.** (a) Eligible persons enrolled by a demonstration provider shall receive a health services benefit package that includes health services which the enrollees might reasonably require to be maintained in good health, including emergency care, inpatient hospital and physician care, outpatient health services, and preventive health services.

(b) Services related to chemical dependency, mental illness, vision care, dental care, and other benefits may be excluded or limited upon approval by the commissioners. The coalition may petition the commissioner of commerce or health, whichever is appropriate, for waivers that allow these benefits to be excluded or limited.

(c) The commissioners, the coalition, and demonstration providers shall work together to design a package of benefits or packages of benefits that can be provided to enrollees for an affordable monthly premium.

Subd. 6. **Enrollee participation.** The demonstration provider may terminate the coverage for an enrollee who has not made payment within the first ten calendar days of the month for which coverage is being purchased. The termination for nonpayment shall be retroactive to the first day of the month for which no payment has been made by the enrollee. The coalition will assure that participants receive adequate information about the demonstration nature of the project. The coalition will assist enrollees with finding alternative coverage at the conclusion of the demonstration project.

Subd. 7. **Contract with coalition.** The commissioner of human services shall contract with the coalition to administer and direct the demonstration project and to select and retain the demonstration provider for the duration of the project. This contract shall be for 24 months with an option to renew for no more than 12 months. This contract may be canceled without cause by the commissioner upon 90 days' written notice to the coalition or by the coalition with 90 days' written notice to the commissioner. The commissioner shall assure the cooperation of the county human services or social services staff in all counties participating in the project.

Subd. 8. **Medical assistance and general assistance medical care coordination.** To assure enrollees of uninterrupted delivery of health care services, the commissioner may pay the premium to the demonstration provider for persons who become eligible for medical assistance or general assistance medical care. To determine eligibility for medical assistance, any medical expenses for eligible services incurred by the demonstration provider shall be considered as evidence of satisfying the medical expense requirements of section 256B.056, subdivisions 4 and 5. To determine eligibility for general assistance medical care, any medical expenses for eligible services incurred by the demonstration provider shall be considered as evidence of satisfying the medical expense requirements of section 256D.03, subdivision 3.

Subd. 9. **Waiver required.** No part of the demonstration project shall become operational until any required waivers of appropriate federal regulations are obtained from the health care financing administration.

Subd. 10. [Repealed, 1988 c 689 art 2 s 269]

History: *1987 c 337 s 123; 1988 c 689 art 2 s 184,268; 1990 c 454 s 1; 1990 c 568 art 3 s 85*