CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

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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 [Repealed, 1987 c 363 s 14]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 [Repealed, 1987 c 363 s 14]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 [Repealed, 1987 c 363 s 14]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 local social service agency 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 subdivision 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 1a.

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.

Subd. 14. **Group health plan.** "Group health plan" means any plan of, or contributed to by, an employer, including a self–insured plan, to provide health care directly or otherwise to the employer's employees, former employees, or the families of the employees or former employees, and includes continuation coverage pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

Subd. 15. **Cost–effective.** "Cost–effective" means that the amount paid by the state for premiums, coinsurance, deductibles, other cost–sharing obligations under a health insurance plan, and other administrative costs is likely to be less than the amount paid for an equivalent set of services paid by medical assistance.

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; 1992 c 464 art 1 s 55; 1992 c 513 art 7 s 31,32; 1994 c 631 s 31

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.

Subd. 3. **American Indian health funding.** Notwithstanding subdivision 1 and sections 256B.0625 and 256D.03, paragraph (f), the commissioner may make payments to federally recognized Indian tribes with a reservation in the state to provide medical assistance to Indians, as defined under federal law, who reside on or near the reservation. The payments may be made in the form of a block grant or other payment mechanism determined in consultation with the tribe. Any alternative payment mechanism agreed upon by the tribes and the commissioner under this subdivision is not dependent upon county agreement but is intended to create a direct payment mechanism between the state and the tribe for the administration of the medical assistance program and for covered services.

For purposes of this subdivision, "Indian tribe" means a tribe, band, or nation, or other organized group or community of Indians that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians and for which a reservation exists as is consistent with Public Law Number 100–485, as amended.

Payments under this subdivision may not result in an increase in expenditures that would not otherwise occur in the medical assistance program under this chapter or the general assistance medical care program under chapter 256D.

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; 1996 c 451 art 5 s 14*

NOTE: Subdivision 3, as added by Laws 1996, chapter 451, article 5, section 14, is effective October 1, 1996, or upon receipt of any necessary federal approval, whichever date is later. Laws 1996, chapter 451, article 5, section 40.

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 pro-

cedure 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 consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology. 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.

Subd. 11. **Limitation on reimbursement to providers not affiliated with a prepaid health plan.** A prepaid health plan may limit any reimbursement it may be required to pay to providers not employed by or under contract with the prepaid health plan to the medical assistance rates for medical assistance enrollees, and the general assistance medical care rates for general assistance medical care enrollees, paid by the commissioner of human services to providers for services to recipients not enrolled in a prepaid health plan.

History: *1987 c 403 art 2 s 76; 1988 c 689 art 2 s 142,268; 1989 c 282 art 3 s 40; 1991 c 292 art 4 s 31,32*

256B.035 MANAGED CARE.

The commissioner of human services may contract with public or private entities or operate a preferred provider program to deliver health care services to medical assistance, general assistance medical care, and MinnesotaCare program recipients. 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; 1992 c 513 art 7 s 33; 1995 c 234 art 8 s 56*

256B.037 PROSPECTIVE PAYMENT OF DENTAL SERVICES.

Subdivision 1. **Contract for dental services.** The commissioner may conduct a demonstration project to contract, on a prospective per capita payment basis, with an organization or organizations licensed under chapter 62C, 62D, or 62N for the provision of all dental care services beginning July 1, 1994, under the medical assistance, general assistance medical care, and MinnesotaCare programs, or when necessary waivers are granted by the secretary of health and human services, whichever occurs later. The commissioner shall identify a geographic area or areas, including both urban and rural areas, where access to dental services has been inadequate, in which to conduct demonstration projects. The commissioner shall seek any federal waivers or approvals necessary to implement this section from the secretary of health and human services.

The commissioner may exclude from participation in the demonstration project any or all groups currently excluded from participation in the prepaid medical assistance program under section 256B.69. Except for persons excluded from participation in the demonstration project, all persons who have been determined eligible for medical assistance, general assistance medical care and, if applicable, MinnesotaCare and reside in the designated geographic areas are required to enroll in a dental plan to receive their dental care services. Except for emergency services or out–of–plan services authorized by the dental plan, recipients must receive their dental services from dental care providers who are part of the dental plan provider network.

The commissioner shall select either multiple dental plans or a single dental plan in a designated area. A dental plan under contract with the department must serve both medical assistance recipients and general assistance medical care recipients in a designated geographic area and may serve MinnesotaCare recipients. The commissioner may limit the number of dental plans with which the department contracts within a designated geographic area, taking into consideration the number of recipients within the designated geographic area; the number of potential dental plan contractors; the size of the provider network offered by dental plans; the dental care services offered by a dental plan; qualifications of dental plan

personnel; accessibility of services to recipients; dental plan assurances of recipient confidentiality; dental plan marketing and enrollment activities; dental plan compliance with this section; dental plan performance under other contracts with the department to serve medical assistance, general assistance medical care, or MinnesotaCare recipients; or any other factors necessary to provide the most economical care consistent with high standards of dental care.

For purposes of this section, "dental plan" means an organization licensed under chapter 62C, 62D, or 62N that contracts with the department to provide covered dental care services to recipients on a prepaid capitation basis. "Emergency services" has the meaning given in section 256B.0625, subdivision 4. "Multiple dental plan area" means a designated area in which more than one dental plan is offered. "Participating provider" means a dentist or dental clinic who is employed by or under contract with a dental plan to provide dental care services to recipients. "Single dental plan area" means a designated area in which only one dental plan is available.

Subd. 1a. **Multiple dental plan areas.** After the department has executed contracts with dental plans to provide covered dental care services in a multiple dental plan area, the department shall:

(1) inform applicants and recipients, in writing, of available dental plans, when written notice of dental plan selection must be submitted to the department, and when dental plan participation begins;

(2) randomly assign to a dental plan recipients who fail to notify the department in writing of their dental plan choice; and

(3) notify recipients, in writing, of their assigned dental plan before the effective date of the recipient's dental plan participation.

Subd. 1b. **Single dental plan areas.** After the department has executed a contract with a dental plan to provide covered dental care services as the sole dental plan in a geographic area, the provisions in paragraphs (a) to (c) apply.

(a) The department shall assure that applicants and recipients are informed, in writing, of participating providers in the dental plan and when dental plan participation begins.

(b) The dental plan may require the recipient to select a specific dentist or dental clinic and may assign to a specific dentist or dental clinic recipients who fail to notify the dental plan of their selection.

(c) The dental plan shall notify recipients in writing of their assigned providers before the effective date of dental plan participation.

Subd. 1c. **Dental choice.** (a) In multiple dental plan areas, recipients may change dental plans once within the first year the recipient participates in a dental plan. After the first year of dental plan participation, recipients may change dental plans during the annual 30–day open enrollment period.

(b) In single dental plan areas, recipients may change their specific dentist or clinic at least once during the first year of dental plan participation. After the first year of dental plan participation, recipients may change their specific dentist or clinic at least once annually. The dental plan shall notify recipients of this change option.

(c) If a dental plan's contract with the department is terminated for any reason, recipients in that dental plan shall select a new dental plan and may change dental plans or a specific dentist or clinic within the first 60 days of participation in the second dental plan.

(d) Recipients may change dental plans or a specific dentist or clinic at any time as follows:

(1) in multiple dental plan areas, if the travel time from the recipient's residence to a general practice dentist is over 30 minutes, the recipient may change dental plans;

(2) in single dental plan areas, if the travel time from the recipient's residence to the recipient's specific dentist or clinic is over 30 minutes, the recipient may change providers; or

(3) if the recipient's dental plan or specific dentist or clinic was incorrectly designated due to department or dental plan error.

(e) Requests for change under this subdivision must be submitted to the department or dental plan in writing. The department or dental plan shall notify recipients whether the request is approved or denied within 30 days after receipt of the written request.

Subd. 2. **Establishment of prepayment rates.** The commissioner shall consult with an independent actuary to establish prepayment rates, but shall retain final authority over the methodology used to establish the rates. The prepayment rates shall not result in payments that exceed the per capita expenditures that would have been made for dental services by the programs under a fee–for–service reimbursement system. The package of dental benefits provided to individuals under this subdivision shall not be less than the package of benefits provided under the medical assistance fee–for–service reimbursement system for dental services.

Subd. 3. **Appeals.** All recipients of services under this section have the right to appeal to the commissioner under section 256.045. A recipient participating in a dental plan may utilize the dental plan's internal complaint procedure but is not required to exhaust the internal complaint procedure before appealing to the commissioner. The appeal rights and procedures in Minnesota Rules, part 9500.1463, apply to recipients who enroll in dental plans.

Subd. 4. **Information required by commissioner.** A contractor shall submit encounter–specific information as required by the commissioner, including, but not limited to, information required for assessing client satisfaction, quality of care, and cost and utilization of services. Dental plans and participating providers must provide the commissioner access to recipient dental records to monitor compliance with the requirements of this section.

Subd. 5. **Other contracts permitted.** Nothing in this section prohibits the commissioner from contracting with an organization for comprehensive health services, including dental services, under section 256B.031, 256B.035, 256B.69, or 256D.03, subdivision 4, paragraph (c).

Subd. 6. **Recipient costs.** A dental plan and its participating providers or nonparticipating providers who provide emergency services or services authorized by the dental plan shall not charge recipients for any costs for covered services.

Subd. 7. **Financial accountability.** A dental plan is accountable to the commissioner for the fiscal management of covered dental care services. The state of Minnesota and recipients shall be held harmless for the payment of obligations incurred by a dental plan if the dental plan or a participating provider becomes insolvent and the department has made the payments due to the dental plan under the contract.

Subd. 8. **Quality improvement.** A dental plan shall have an internal quality improvement system. A dental plan shall permit the commissioner or the commissioner's agents to evaluate the quality, appropriateness, and timeliness of covered dental care services through inspections, site visits, and review of dental records.

Subd. 9. **Third–party liability.** To the extent required under section 62A.046 and Minnesota Rules, part 9506.0080, a dental plan shall coordinate benefits for or recover the cost of dental care services provided recipients who have other dental care coverage. Coordination of benefits includes the dental plan paying applicable copayments or deductibles on behalf of a recipient.

Subd. 10. **Financial capacity.** A dental plan shall demonstrate that its financial risk capacity is acceptable to its participating providers; except, an organization licensed as a health maintenance organization under chapter 62D, a nonprofit health service plan under chapter 62C, or an integrated service network or a community integrated service network under chapter 62N, is not required to demonstrate financial risk capacity beyond the requirements in those chapters for licensure or a certificate of authority.

Subd. 11. **Data privacy.** The contract between the commissioner and the dental plan must specify that the dental plan is an agent of the welfare system and shall have access to welfare data on recipients to the extent necessary to carry out the dental plan's responsibilities under the contract. The dental plan shall comply with chapter 13, the Minnesota government data practices act.

History: *1Sp1993 c 1 art 5 s 27; 1995 c 234 art 6 s 22–33*

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 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) Notwithstanding any contrary language in this paragraph, the commissioner of human services and the commissioner of health shall jointly promulgate rules to be applied to the licensure of personal care services provided under the medical assistance program. The rules shall consider standards for personal care services that are based on the World Institute on Disability's recommendations regarding personal care services. These rules shall at a minimum consider the standards and requirements adopted by the commissioner of health under section 144A.45, which the commissioner of human services determines are applicable to the provision of personal care services, in addition to other standards or modifications which the commissioner of human services determines are appropriate.

The commissioner of human services shall establish an advisory group including personal care consumers and providers to provide advice regarding which standards or modifications should be adopted. The advisory group membership must include not less than 15 members, of which at least 60 percent must be consumers of personal care services and representatives of recipients with various disabilities and diagnoses and ages. At least 51 percent of the members of the advisory group must be recipients of personal care.

The commissioner of human services may contract with the commissioner of health to enforce the jointly promulgated licensure rules for personal care service providers.

Prior to final promulgation of the joint rule the commissioner of human services shall report preliminary findings along with any comments of the advisory group and a plan for monitoring and enforcement by the department of health to the legislature by February 15, 1992.

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) 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 and shall waive the requirement for personal care assistants re-

quired to join an agency for the first time during 1993 when personal care services are provided under a relative hardship waiver under section 256B.0627, subdivision 4, paragraph (b), clause (7), and at least two agencies providing personal care services have refused to employ or contract with the independent personal care assistant.

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.

Subd. 18. **Applications for medical assistance.** The state agency may take applications for medical assistance and conduct eligibility determinations for MinnesotaCare enrollees who are required to apply for medical assistance according to section 256.9353, subdivision 3, paragraph (b).

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; 1991 c 292 art 7 s 8; 1Sp1993 c 1 art 5 s 28; 1995 c 233 art 2 s 56; 1995 c 234 art 6 s 34*

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 sub-

division 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 first received by it under subdivision 4, paragraph (c), even if the notice is untimely, 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. For purposes of this section, "state agency" includes authorized agents of the state agency.

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. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

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; 1Sp1993 c 1 art 5 s 29; 1995 c 207 art 6 s 26*

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 local social services agency 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; 1994 c 631 s 31*

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, and to any child who is not title IV–E eligible but who was determined eligible for adoption assistance under Minnesota Statutes, section 259.67, subdivision 4, clauses (a) to (c), and has a special need for medical or rehabilitative care.

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, whose mother was eligible for and receiving medical assistance at the time of birth and who remains in the mother's household or who is in a family with countable income that is equal to or less than the income standard established under section 256B.057, subdivision 1.

Subd. 10a. **Children.** This subdivision supersedes subdivision 10, as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this subdivision expires and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. Medical assistance may be paid for a child less than two years of age, whose mother was eligible for and receiving medical assistance at the time of birth and who remains in the mother's household or who is in a family with countable income that is equal to or less than the income standard established under section 256B.057, subdivision 1.

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 the child requires a level of care provided in a hospital, nursing 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 under this section is not more than the amount that medical assistance would pay for if the child resides in an institution. After the child is determined to be eligible under this section, the commissioner shall review the child's disability under United States Code, title 42, section 1382c(a) and level of care defined under this section no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. The commissioner's decision on the frequency of continuing review of disability and level of care is not subject to administrative appeal under section 256.045. Nothing in this subdivision shall be construed as affecting other redeterminations of medical assistance eligibility under this chapter and annual cost–effective reviews under this section.

(b) For purposes of this subdivision, "hospital" means an institution as defined in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child requires a level of care provided in a hospital if the child is determined by the commissioner to need an extensive array of health services, including mental health services, for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, who would reside in a hospital or require frequent hospitalization if these services were not provided, and the daily care needs are more complex than a nursing facility level of care.

A child with serious emotional disturbance requires a level of care provided in a hospital if the commissioner determines that the individual requires 24–hour supervision because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become life threatening, recurrent or frequent severe socially unacceptable behavior associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic developmental problems requiring continuous skilled observation, or severe disabling symptoms for which office–centered outpatient treatment is not adequate, and which overall severely impact the individual's ability to function.

(c) For purposes of this subdivision, "nursing 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. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911 and the home care independent rating document under section 256B.0627, subdivision 5, paragraph (f), item (iii), adjusted to address age–appropriate standards for children age 18 and under, pursuant to section 256B.0627, subdivision 5, paragraph (d), clause (2).

(d) For purposes of this subdivision, "intermediate care facility for persons with mental retardation or related conditions" 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. For purposes of this subdivision, a child requires a level of care provided in an ICF/MR if the commissioner finds that the child has mental retardation or a related condition in accordance with section 256B.092, is in need of a 24–hour plan of care and active treatment similar to persons with mental retardation, and there is a reasonable indication that the child will need ICF/MR services.

(e) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24–hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner based on standards developed for the Wisconsin Katie Beckett program published in July 1994.

(f) The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by the parent or guardian, the child's physician or physicians, and other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution to be determined as follows:

(i) for a child who requires a level of care provided in an ICF/MR, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICFs/MR;

(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost–effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and

(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost–effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.

(h) Children eligible for medical assistance services under section 256B.055, subdivision 12, as of June 30, 1995, must be screened according to the criteria in this subdivision prior to January 1, 1996. Children found to be ineligible may not be removed from the program until January 1, 1996.

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; 1991 c 292 art 4 s 33,34; 1Sp1993 c 1 art 5 s 30; 1994 c 631 s 31; 1995 c 207 art 6 s 27; 1995 c 234 art 6 s 35; 1996 c 451 art 2 s 7*

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

Subdivision 1. **Residency.** To be eligible for medical assistance, a person must have resided in Minnesota for at least 30 days, or, if absent from the state, be deemed to be a resident of Minnesota in accordance with the rules of the state agency.

A person who has resided in the state for less than 30 days is considered to be a Minnesota resident if the person:

(1) was born in the state;

(2) has in the past resided in the state for at least 365 consecutive days;

(3) has come to the state to join a close relative, which, for purposes of this subdivision means a parent, grandparent, brother, sister, spouse, or child; or

(4) has come to this state to accept a bona fide offer of employment for which the person is eligible.

A county agency shall waive the 30–day residency requirement in cases of medical emergency or where unusual hardship would result from denial of assistance. The county agency must report to the commissioner within 30 days on any waiver granted under this section. The county shall not deny an application solely because the applicant does not meet at least one of the criteria in this subdivision, but shall continue to process the application and leave the application pending until the residency requirement is met or until eligibility or ineligibility is established.

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 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, except that payments made pursuant to a court order for the support of children shall be excluded from income in an amount not to exceed the difference between the applicable income standard used in the state's medical assistance program for aged, blind, and disabled persons and the applicable income standard used in the state's medical assistance program for families with children. Exclusion of court–ordered child support payments is subject to the condition that if there has been a change in the financial circumstances of the person with the legal obligation to pay support since the support order was entered, the person with the legal obligation to pay support has petitioned for modification of the support order. 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. Effective upon federal approval, in–kind contributions to, and

payments made on behalf of, a recipient, by an obligor, in satisfaction of or in addition to a temporary or permanent order for child support or maintenance, shall be considered income to the recipient. For these purposes, a "methodology" does not include an asset or income standard, or accounting method, or method of determining effective dates.

Subd. 2. **Homestead; exclusion for institutionalized persons.** The homestead shall be excluded for the first six calendar months of a person's stay in a long-term care facility and shall continue to be excluded for as long as the recipient can be reasonably expected to return to the homestead. For purposes of this subdivision, "reasonably expected to return to the homestead" means the recipient's attending physician has certified that the expectation is reasonable, and the recipient can show that the cost of care upon returning home will be met through medical assistance or other sources. 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.

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. 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 assets that are not considered in determining eligibility for medical assistance is the value of those assets that are excluded by the aid to families with dependent children program for families and children, and the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

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

(b) 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.

(c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.

(d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program.

Subd. 3a. [Repealed, 1992 c 513 art 7 s 135]

Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a revocable or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a person or the person's spouse under the terms of which the person receives or could receive payments from the trust principal or income and the trustee has discretion in making payments to the person from the trust principal or income. Notwithstanding that definition, a medical assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before April 7, 1986, solely to benefit a person with mental retardation living in an intermediate care facility for persons with mental retardation; or (3) a trust set up by a person with payments made by the Social Security Administration pursuant to the United States Supreme Court decision in Sullivan v. Zebley, 110 S. Ct. 885 (1990). The maximum amount of payments that a trustee of a medical assistance qualifying trust may make to a person under the terms of the trust is considered to be available assets to the person, without regard to whether

the trustee actually makes the maximum payments to the person and without regard to the purpose for which the medical assistance qualifying trust was established.

(b) Trusts established after August 10, 1993, are treated according to section 13611(b) of the Omnibus Budget Reconciliation Act of 1993 (OBRA), Public Law Number 103–66.

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. Veterans aid and attendance benefits are considered income to the recipient.

Subd. 4a. **Asset verification.** For purposes of verification, the value of a life estate shall be considered not salable unless the owner of the remainder interest intends to purchase the life estate, or the owner of the life estate and the owner of the remainder sell the entire property.

Subd. 4b. **Income verification.** The local agency shall not require a monthly income verification form for a recipient who is a resident of a long–term care facility and who has monthly earned income of $80 or less.

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. Until June 30, 1993, or the date the Medicaid Management Information System (MMIS) upgrade is implemented, whichever occurs last, the commissioner shall allow persons eligible for assistance on a one–month spenddown basis under this subdivision to elect to pay the monthly spenddown amount in advance of the month of eligibility to the local agency in order to maintain eligibility on a continuous basis. If the recipient does not pay the spenddown amount on or before the 10th of the month, the recipient is ineligible for this option for the following month. The local agency must deposit spenddown payments into its treasury and issue a monthly payment to the state agency with the necessary individual account information. The local agency shall code the client eligibility system to indicate that the spenddown obligation has been satisfied for the month paid. The state agency shall convey this information to providers through eligibility cards which list no remaining spenddown obligation. After the implementation of the MMIS upgrade, a recipient electing advance payment must pay the state agency the monthly spenddown amount on or before the 10th of the month in order to be eligible for this option in the following month.

Subd. 5a. **Individuals on fixed income.** Recipients of medical assistance who receive only fixed unearned income, where such income is unvarying in amount and timing of receipt throughout the year, shall report and verify their income annually.

Subd. 5b. **Individuals with low income.** Recipients of medical assistance not residing in a long–term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income on a semiannual basis.

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 paternity 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.

Subd. 8. **Cooperation.** To be eligible for medical assistance, applicants and recipients must cooperate with the state and local agency to identify potentially liable third–party payers and assist the state in obtaining third party payments, unless good cause for noncooperation is determined according to Code of Federal Regulations, title 42, part 433.147. "Cooperation" includes identifying any third party who may be liable for care and services provided under this chapter to the applicant, recipient, or any other family member for whom application is made and providing relevant information to assist the state in pursuing a potentially liable third party. Cooperation also includes providing information about a group health plan for which the person may be eligible and if the plan is determined cost–effective by the state agency and premiums are paid by the local agency or there is no cost to the recipient, they must enroll or remain enrolled with the group. Cost–effective insurance premiums approved for payment by the state agency and paid by the local agency are eligible for reimbursement according to section 256B.19.

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; 1992 c 513 art 7 s 34–38; 1993 c 339 s 13; 1Sp1993 c 1 art 5 s 31; art 6 s 25; 1995 c 207 art 6 s 28,29; 1995 c 248 art 17 s 1–4; 1996 c 451 art 2 s 8,9*

NOTE: The amendment to subdivision 3b by Laws 1995, chapter 207, article 6, section 28, is effective retroactive to August 11, 1993. Laws 1995, chapter 207, article 6, section 125, subdivision 3.

NOTE: Subdivision 5a, as added by Laws 1995, chapter 248, article 17, section 3, ceases to be effective if a federal agency determines that implementation of subdivision 5a would cause a loss of federal funding. Laws 1995, chapter 248, article 17, section 8.

NOTE: The amendment to subdivision 1 by Laws 1996, chapter 451, article 2, section 8, is effective upon federal approval. Laws 1996, chapter 451, article 2, section 62.

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 275 percent of the federal poverty guideline for the same family size. For purposes of this subdivision, "countable family income" means the amount of income considered available using the methodology of the AFDC program, except for the earned income disregard and employment deductions. An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline, up to a maximum of the amount by which the combined total of 185 percent of the federal poverty guideline plus the earned income disregards and deductions of the AFDC program exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than one year of age. 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.

An infant born on or after January 1, 1991, to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical

assistance without redetermination until the child's first birthday, as long as the child remains in the woman's household.

Subd. 1a. **Premiums.** Women and infants who are eligible under subdivision 1 and whose countable family income is equal to or greater than 185 percent of the federal poverty guideline for the same family size shall be required to pay a premium for medical assistance coverage based on a sliding scale as established under section 256.9358.

Subd. 1b. **Pregnant women and infants; expansion.** This subdivision supersedes subdivision 1 as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. An infant less than two years 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 275 percent of the federal poverty guideline for the same family size. For purposes of this subdivision, "countable family income" means the amount of income considered available using the methodology of the AFDC program, except for the earned income disregard and employment deductions. An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline, up to a maximum of the amount by which the combined total of 185 percent of the federal poverty guideline plus the earned income disregards and deductions of the AFDC program exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than two years of age. Eligibility for a pregnant woman or infant less than two years of age under this subdivision must be determined without regard to asset standards established in section 256B.056, subdivision 3.

An infant born on or after January 1, 1991, to a woman who was eligible for and receiving medical assistance on the date of the child's birth shall continue to be eligible for medical assistance without redetermination until the child's second birthday, as long as the child remains in the woman's household.

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 18 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.

Subd. 2a. **No asset test for children and their parents.** Eligibility for medical assistance for a person under age 21, and the person's parents who are eligible under section 256B.055, subdivision 3, and who live in the same household as the person eligible under age 21, must be determined without regard to asset standards established in section 256B.056.

Subd. 2b. **No asset test for children and their parents; expansion.** This subdivision supersedes subdivision 2a as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this subdivision expires and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. Eligibility for medical assistance for a person under age 21, and the person's parents or relative caretakers as defined in the aid to families with dependent children program according to chapter 256, who are eligible under section 256B.055, subdivision 3, and who live in the same household as the person eligible under age 21, must be determined without regard to asset standards established in section 256B.056.

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; and to 100 percent on January 1, 1991. Reimbursement of the Medicare coinsurance and deductibles, when add-

ed to the amount paid by Medicare, must not exceed the total rate the provider would have received for the same service or services if the person were a medical assistance recipient with Medicare coverage. Increases in benefits under Title II of the Social Security Act shall not be counted as income for purposes of this subdivision until the first day of the second full month following publication of the change in the federal poverty guidelines.

Subd. 3a. **Eligibility for payment of Medicare Part B premiums.** A person who would otherwise be eligible as a qualified Medicare beneficiary under subdivision 3, except the person's income is in excess of the limit, is eligible for medical assistance reimbursement of Medicare Part B premiums if the person's income is less than 110 percent of the official federal poverty guidelines for the applicable family size. The income limit shall increase to 120 percent of the official federal poverty guidelines for the applicable family size on January 1, 1995.

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.

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 reaching 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 the person would be entitled to supplemental security income in the absence of child's insurance benefits or increases in those benefits.

Subd. 6. **Disabled widows and widowers.** A person who is at least 50 years old who is entitled to disabled widow's or widower's benefits under United States Code, title 42, section 402(e) or (f), who is not entitled to Medicare Part A, and who received supplemental security income or Minnesota supplemental aid in the month before the month the widow's or widower's benefits began, is eligible for medical assistance as long as the person would be entitled to supplemental security income or Minnesota supplemental aid in the absence of the widow's or widower's benefits.

History: *1986 c 444; 1989 c 282 art 3 s 48; 1990 c 568 art 3 s 33–36; 1991 c 292 art 4 s 35–39; 1992 c 513 art 7 s 39; 1992 c 549 art 4 s 12; 1993 c 345 art 9 s 11–13; 1Sp1993 c 6 s 9; 1995 c 234 art 6 s 36,37*

NOTE: Subdivision 1a, as added by Laws 1993, chapter 345, article 9, section 12, is effective July 1, 1993, or after the effective date of the waiver referred to in Laws 1993, chapter 345, article 9, section 16, whichever is later. Laws 1993, chapter 345, article 9, section 18.

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 or, for a veteran who does not have a spouse or child, or a surviving spouse of a veteran having no child, the amount of an improved pension received from the veteran's administration not exceeding $90 per month;

(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 families and children according to section 256B.056, subdivision 4, 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 to the extent that the deduction is not included in the personal needs allowance under section 256B.35, subdivision 1, as child support garnished under a court order;

(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;

(7) reparations payments made by the Federal Republic of Germany and reparations payments made by the Netherlands for victims of Nazi persecution between 1940 and 1945; and

(8) 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: *1986 c 444; 1989 c 282 art 3 s 49; 1990 c 568 art 3 s 37; 1991 c 292 art 4 s 40; 1Sp1993 c 1 art 5 s 32; 1995 c 207 art 6 s 30; 1996 c 451 art 2 s 10*

NOTE: The amendment to paragraph (a), clause (5), by Laws 1995, chapter 207, article 6, section 30, is effective retroactive to January 1, 1994. Laws 1995, chapter 207, article 6, section 125, subdivision 5.

NOTE: The amendment to this section by Laws 1996, chapter 451, article 2, section 10, is effective upon receipt of federal approval, retroactive to January 1, 1996. Laws 1996, chapter 451, article 2, section 62.

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 spouse.

(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.

(f) "Institutionalized spouse" means a person who is:

(1) in a hospital, nursing facility, or intermediate care facility for persons with mental retardation, or receiving home and community–based services under section 256B.0915 or 256B.49, and is expected to remain in the facility or institution or receive the home and community–based services for at least 30 consecutive days; and

(2) married to a person who is not in a hospital, nursing facility, or intermediate care facility for persons with mental retardation, and is not receiving home and community–based services under section 256B.0915 or 256B.49.

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 the first period of institutionalization of 30 days or more shall be assessed and documented and the spousal share shall be assessed and documented.

Subd. 3. **Community spouse asset allowance.** 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 as follows:

(1) prior to July 1, 1994, the greater of:

(i) $14,148;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse; and

(2) for persons whose date of initial determination of eligibility for medical assistance following their first continuous period of institutionalization occurs on or after July 1, 1994, the greater of:

(i) $20,000;

(ii) the lesser of the spousal share or $70,740; or

(iii) 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, 1994, and every January 1 thereafter, the limits in this subdivision 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 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 1396r–5.

Subd. 5. **Asset availability.** (a) At the time of initial determination of eligibility for medical assistance benefits following the first continuous period of institutionalization, 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 following:

(1) prior to July 1, 1994, the greater of:

(i) $14,148;

(ii) the lesser of the spousal share or $70,740; or

(iii) the amount required by court order to be paid to the community spouse;

(2) for persons whose date of initial determination of eligibility for medical assistance following their first continuous period of institutionalization occurs on or after July 1, 1994, the greater of:

(i) $20,000;

(ii) the lesser of the spousal share or $70,740; or

(iii) 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 3; (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 paragraph (b).

(d) Assets determined to be available to the institutionalized spouse under this section must be used for the health care or personal needs of the institutionalized spouse.

(e) For purposes of this section, assets do not include assets excluded under the supplemental security income program.

History: *1989 c 282 art 3 s 51; 1990 c 568 art 3 s 38,39; 1991 c 199 art 1 s 61; 1992 c 513 art 7 s 40,41; 1Sp1993 c 1 art 5 s 33,34; 1995 c 207 art 6 s 31–33*

256B.0595 PROHIBITIONS ON TRANSFER; EXCEPTIONS.

Subdivision 1. **Prohibited transfers.** (a) For transfers of assets made on or before August 10, 1993, 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 the supplemental security program, 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.

(b) Effective for transfers made after August 10, 1993, a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the supplemental security income program, for the purpose of establishing or maintaining medical assistance eligibility. For purposes of determining eligibility for long–term care services, any transfer of such assets within 36 months before or any time after an institutionalized person applies for medical assistance, or 36 months before or any time after a medical assistance recipient becomes institutionalized, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the person is ineligible for long–term care services for the period of time determined under subdivision 2, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. Notwithstanding the provisions of this paragraph, in the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, any transfers made within 60 months before or any time after an institutionalized person applies for medical assistance and within 60 months before or any time after a medical assistance recipient becomes institutionalized, may be considered.

(c) This section applies to transfers, for less than fair market value, of income or assets, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the person or the person's spouse is entitled but does not receive due to action by the person, the person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse.

(d) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized, written agreement which was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

(e) This section applies to the portion of any asset or interest that a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the person or

spouse while alive, based on estimated life expectancy using the life expectancy tables employed by the supplemental security income program to determine the value of an agreement for services for life. The commissioner may adopt rules reducing life expectancies based on the need for long–term care.

(f) For purposes of this section, long–term care services include services in a nursing facility, services that are eligible for payment according to section 256B.0625, subdivision 2, because they are provided in a swing bed, intermediate care facility for persons with mental retardation, and home and community–based services provided pursuant to sections 256B.0915, 256B.092, and 256B.49. 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 in a swing bed, or intermediate care facility for persons with mental retardation or who is receiving home and community–based services under sections 256B.0915, 256B.092, and 256B.49.

(g) Effective for transfers made on or after July 1, 1995, or upon federal approval, whichever is later, a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, for the purpose of establishing or maintaining medical assistance eligibility. For purposes of determining eligibility for long–term care services, any transfer of such assets within 60 months before, or any time after, an institutionalized person applies for medical assistance, or 60 months before, or any time after, a medical assistance recipient becomes institutionalized, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the person is ineligible for long–term care services for the period of time determined under subdivision 2, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4.

Subd. 1a. **Prohibited transfers.** (a) Notwithstanding any contrary provisions of this section, this subdivision applies to transfers involving recipients of medical assistance that are made on or after April 13, 1996, to the extent permitted by federal law, and to all transfers involving persons who apply for medical assistance on or after April 13, 1996, to the extent permitted by federal law, if the transfer occurred within 72 months before the person applies for medical assistance, except that this subdivision does not apply to transfers made prior to March 1, 1996. A person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, may not give away, sell, dispose of, or reduce ownership or control of any income, asset, or interest therein for less than fair market value for the purpose of establishing or maintaining medical assistance eligibility for the person. For purposes of determining eligibility for medical assistance services, any transfer of such income or assets for less than fair market value within 72 months before or any time after a person applies for medical assistance may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility, and the person is ineligible for medical assistance services for the period of time determined under subdivision 2a, unless the person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3a or 4a.

(b) This section applies to transfers of income or assets for less than fair market value, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the person or the person's spouse is entitled but does not receive due to action by the person, the person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse.

(c) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized, written agreement which was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided.

A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

(d) This section applies to the portion of any income, asset, or interest therein that a person, a person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the person or spouse while alive, based on estimated life expectancy of adults entering long–term care. The commissioner shall adopt rules establishing life expectancies of adults entering long–term care.

Subd. 2. **Period of ineligibility.** (a) For any uncompensated transfer occurring on or before August 10, 1993, 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.

(b) For uncompensated transfers made after August 10, 1993, the number of months of ineligibility for long–term care services shall be the total uncompensated value of the resources transferred 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 except that if one or more uncompensated transfers are made during a period of ineligibility, the total assets transferred during the ineligibility period shall be combined and a penalty period calculated to begin in the month the first uncompensated transfer was made. If the transfer was not reported to the local agency at the time of application, and the applicant received medical assistance 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 medical assistance 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.

(c) If a calculation of a penalty period results in a partial month, payments for long–term care services shall be reduced in an amount equal to the fraction, except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month not included in an existing penalty period does not exceed $500, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.

Subd. 2a. **Period of ineligibility.** (a) Notwithstanding any contrary provisions of this section, this subdivision applies to transfers involving recipients of medical assistance that are made on or after April 13, 1996, to the extent permitted by federal law, and to all transfers involving persons who apply for medical assistance on or after April 13, 1996, to the extent permitted by federal law, regardless of when the transfer occurred, except that this subdivision does not apply to transfers made prior to March 1, 1996. For any uncompensated transfer occurring within 72 months prior to the date of application, at any time after application, or while eligible, the number of months of cumulative ineligibility for medical assistance services shall be the total uncompensated value of the assets and income transferred divided by the statewide average per person nursing facility payment made by the state in effect on the

date of application. The amount used to calculate the average per person payment shall be adjusted each July 1 to reflect average payments for the previous calendar year. For applicants, the period of ineligibility begins with the month in which the person applied for medical assistance and satisfied all other requirements for eligibility, or the month the local agency becomes aware of the transfer, if later. For recipients, the period of ineligibility begins in the month the agency becomes aware of the transfer, except that penalty periods for transfers made during a period of ineligibility as determined under this section shall begin in the month following the existing period of ineligibility. If the transfer was not reported to the local agency at the time of application, and the applicant received medical assistance 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 medical assistance services provided during the period of ineligibility, or for the uncompensated amount of the transfer that was not recovered from the transferor through the implementation of a penalty period under this subdivision, whichever is less. The action may be brought by the state or the local agency responsible for providing medical assistance under chapter 256G. The total uncompensated value is the fair market value of the income or asset at the time it was given away, sold, or disposed of, less the amount of compensation received. No cause of action exists for a transfer, unless:

(1) the transferee knew or should have known that the transfer was being made by a person who was a resident of a long–term care facility or was receiving that level of care in the community at the time of the transfer;

(2) the transferee knew or should have known that the transfer was being made to assist the person to qualify for or retain medical assistance eligibility; or

(3) the transferee actively solicited the transfer with intent to assist the person to qualify for or retain eligibility for medical assistance.

(b) If a calculation of a penalty period results in a partial month, payments for medical assistance services shall be reduced in an amount equal to the fraction, except that in calculating the value of uncompensated transfers, if the total value of all uncompensated transfers made in a month not included in an existing penalty period does not exceed $500, then such transfers shall be disregarded for each month prior to the month of application for or during receipt of medical assistance.

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, as certified by the individual's attending physician, 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 a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well–being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the trans-

ferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision.

(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:

(1) 30 months of a transfer made on or before August 10, 1993;

(2) 60 months if the homestead was transferred after August 10, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law; or

(3) 36 months if transferred in any other manner after August 10, 1993,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under chapter 256G.

Subd. 3a. **Homestead exception to transfer prohibition.** (a) This subdivision applies to transfers involving recipients of medical assistance that are made on or after April 13, 1996, to the extent permitted by federal law, and to all transfers involving persons who apply for medical assistance on or after April 13, 1996, to the extent permitted by federal law, regardless of when the transfer occurred, except that this subdivision does not apply to transfers made prior to March 1, 1996. A person is not ineligible for medical assistance services due to a transfer of assets for less than fair market value as described in subdivision 1a if the asset transferred was a homestead and:

(1) title to the homestead was transferred to the individual's relatives who are residing in the homestead and are 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, as certified by the individual's attending physician, 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 a penalty resulting from a transfer for less than fair market value because denial of eligibility would cause undue hardship for the individual and there exists an imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision.

(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 medical assistance services granted within 72 months of the date the transferor applied for medical assistance and satisfied all other requirements for eligibility, or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall

be brought by the state unless the state delegates this responsibility to 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 individual's spouse or to another for the sole benefit of the spouse; or

(2) the institutionalized spouse, prior to being institutionalized, transferred assets to a 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 a penalty resulting from a transfer for less than fair market value based on an imminent threat to the individual's health and well–being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision. 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:

(i) 30 months of a transfer made on or before August 10, 1993;

(ii) 60 months of a transfer if the assets were transferred after August 30, 1993, to a trust or portion of a trust that is considered a transfer of assets under federal law; or

(iii) 36 months of a transfer if transferred in any other manner after August 10, 1993, or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under this chapter; or

(6) for transfers occurring after August 10, 1993, the assets were transferred by the person or person's spouse: (i) into a trust established solely for the benefit of a son or daughter of any age who is blind or disabled as defined by the Supplemental Security Income program; or (ii) into a trust established solely for the benefit of an individual who is under 65 years of age who is disabled as defined by the Supplemental Security Income program.

Subd. 4a. **Other exceptions to transfer prohibition.** This subdivision applies to transfers involving recipients of medical assistance that are made on or after April 13, 1996, to the extent permitted by federal law, and to all transfers involving persons who apply for medical assistance on or after April 13, 1996, to the extent permitted by federal law, regardless of when the transfer occurred, except that this subdivision does not apply to transfers made prior to March 1, 1996. A person or a person's spouse who has made a transfer prohibited by subdivision 1a is not ineligible for medical assistance services if one of the following conditions applies:

(1) the assets or income were transferred to the individual's spouse or to another for the sole benefit of the spouse, except that after eligibility is established, transfers to a spouse are permitted only to comply with the provisions of section 256B.059; or

(2) the institutionalized spouse, prior to being institutionalized, transferred assets or income to a spouse, provided that the spouse to whom the assets or income were transferred

does not then transfer those assets or income 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 or income were transferred to a trust for the sole benefit of the individual's child who is blind or permanently and totally disabled as determined in the supplemental security income program and the trust reverts to the state upon the disabled child's death to the extent medical assistance has paid for services for the child. This clause applies to a trust established after the commissioner publishes a notice in the State Register that the commissioner has been authorized to implement this clause due to a change in federal law or the approval of a federal waiver; or

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

(5) the local agency determines that denial of eligibility for medical assistance services would work an undue hardship and grants a waiver of a penalty resulting from a transfer for less than fair market value because there exists an imminent threat to the individual's health and well-being. Whenever an applicant or recipient is denied eligibility because of a transfer for less than fair market value, the local agency shall notify the applicant or recipient that the applicant or recipient may request a waiver of the penalty if the denial of eligibility will cause undue hardship. In evaluating a waiver, the local agency shall take into account whether the individual was the victim of financial exploitation, whether the individual has made reasonable efforts to recover the transferred property or resource, and other factors relevant to a determination of hardship. If the local agency does not approve a hardship waiver, the local agency shall issue a written notice to the individual stating the reasons for the denial and the process for appealing the local agency's decision. When a waiver is granted, a cause of action exists against the person to whom the assets were transferred for that portion of medical assistance services granted within 72 months of the date the transferor applied for medical assistance and satisfied all other requirements for eligibility,

or the amount of the uncompensated transfer, whichever is less, together with the costs incurred due to the action. The action shall be brought by the state unless the state delegates this responsibility to the local agency responsible for providing medical assistance under this chapter.

Subd. 5. **Notice of receipt of federal waiver.** In every instance in which a federal waiver that allows the implementation of a provision in this section is granted, the commissioner shall publish notice of receipt of the waiver in the State Register.

Subd. 6. **No bad effect on realty conveyance, encumbrance.** This section does not invalidate or impair the effectiveness of a conveyance or encumbrance of real estate.

Subd. 7. **Notice of rights.** If a period of ineligibility is imposed under subdivision 2 or 2a, the local agency shall inform the applicant or recipient subject to the penalty of the person's rights under section 325F.71, subdivision 2.

History: *1986 c 444; 1989 c 282 art 3 s 52; 1990 c 568 art 3 s 40–42; 1992 c 513 art 7 s 42; 1Sp1993 c 1 art 5 s 35; 1994 c 388 art 1 s 2; 1995 c 207 art 6 s 34–37; 1996 c 451 art 2 s 11–19*

NOTE: The amendments to subdivisions 1, 2, 3, and 4, by Laws 1995, chapter 207, article 6, sections 34 to 37, are effective retroactive to August 11, 1993, except that portion amending subdivision 2, paragraph (c), is effective retroactive to transfers of income or assets made on or after September 1, 1994. Laws 1995, chapter 207, article 6, section 125, subdivision 2, and Laws 1995, chapter 263, section 6.

NOTE: (a) Subdivisions 1a, 2a, 3a, and 4a, as added by Laws 1996, chapter 451, article 2, sections 12, 14, 16, and 18, respectively, are effective the day following final enactment to the extent permitted by federal law. If any provisions of these sections are prohibited by federal law, the provisions shall become effective when federal law is changed to permit their application or a waiver is received. *The commissioner of human services shall notify the revisor of statutes when federal law is enacted or a waiver is received* and publish a notice in the State Register. The commissioner must include the notice in the first State Register published after the effective date of the federal changes.

(b) If, by July 1, 1996, any provisions of the sections mentioned in paragraph (a) are not effective because of prohibitions in federal law, the commissioner shall apply to the federal government for a waiver of those prohibitions, and those provisions shall become effective upon receipt of a federal waiver, notification to the revisor of statutes, and publication of a notice in the State Register to that effect. *If the commissioner applies for a waiver of the lookback period, the commissioner shall seek the longest lookback* period the health care financing administration will approve, not to exceed 72 months. Laws 1996, chapter 451, article 2, section 62.

256B.06 ELIGIBILITY; MIGRANT WORKERS; CITIZENSHIP.

Subdivision 1. [Renumbered 256B.055 subdivision 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 subdivision 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 sections 256B.055 to 256B.062 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, except for organ transplants and related care and services. 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; 1991 c 199 art 2 s 1; 1995 c 207 art 6 s 38*

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 by law; (d) the patient no longer requires acute care services; and (e) no nursing home beds are available within 25 miles of the facility. Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 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. Rates paid for anesthesiology services provided by physicians shall be according to the formula utilized in the Medicare program and shall use a conversion factor "at percentile of calendar year set by legislature."

Subd. 4. **Outpatient and physician–directed 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. "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. 4a. **Second medical opinion for surgery.** Certain surgeries require a second medical opinion to confirm the necessity of the procedure, in order for reimbursement to be made. The commissioner shall publish in the State Register a list of surgeries that require a second medical opinion and the criteria and standards for deciding whether a surgery should require a second medical opinion. The list and the criteria and standards are not subject to the requirements of sections 14.01 to 14.69. The commissioner's decision about whether a second medical opinion is required, made according to rules governing that decision, is not subject to administrative appeal.

Subd. 5. **Community mental health center services.** Medical assistance covers community mental health center services provided by a community mental health center that meets the requirements in paragraphs (a) to (j).

(a) The provider is licensed under Minnesota Rules, parts 9520.0750 to 9520.0870.

(b) The provider provides mental health services under the clinical supervision of a mental health professional who is licensed for independent practice at the doctoral level or by a board–certified psychiatrist or a psychiatrist who is eligible for board certification. Clinical supervision has the meaning given in Minnesota Rules, part 9505.0323, subpart 1, item F.

(c) The provider must be a private nonprofit corporation or a governmental agency and have a community board of directors as specified by section 245.66.

(d) The provider must have a sliding fee scale that meets the requirements in Minnesota Rules, part 9550.0060, and agree to serve within the limits of its capacity all individuals residing in its service delivery area.

(e) At a minimum, the provider must provide the following outpatient mental health services: diagnostic assessment; explanation of findings; family, group, and individual psychotherapy, including crisis intervention psychotherapy services, multiple family group psychotherapy, psychological testing, and medication management. In addition, the provider must provide or be capable of providing upon request of the local mental health authority day treatment services and professional home–based mental health services. The provider must have the capacity to provide such services to specialized populations such as the elderly, families with children, persons who are seriously and persistently mentally ill, and children who are seriously emotionally disturbed.

(f) The provider must be capable of providing the services specified in paragraph (e) to individuals who are diagnosed with both mental illness or emotional disturbance, and chemical dependency, and to individuals dually diagnosed with a mental illness or emotional disturbance and mental retardation or a related condition.

(g) The provider must provide 24–hour emergency care services or demonstrate the capacity to assist recipients in need of such services to access such services on a 24–hour basis.

(h) The provider must have a contract with the local mental health authority to provide one or more of the services specified in paragraph (e).

(i) The provider must agree, upon request of the local mental health authority, to enter into a contract with the county to provide mental health services not reimbursable under the medical assistance program.

(j) The provider may not be enrolled with the medical assistance program as both a hospital and a community mental health center. The community mental health center's administrative, organizational, and financial structure must be separate and distinct from that of the hospital.

Subd. 6. [Repealed, 1991 c 292 art 7 s 26]

Subd. 6a. **Home health services.** Home health services are those services specified in Minnesota Rules, part 9505.0290. Medical assistance covers home health services at a recipient's home residence. Medical assistance does not cover home health services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, unless the program is funded under a home and community–based services waiver or unless the commissioner of human services has prior authorized skilled nurse visits for less than 90 days for a resident at an intermediate care facility for persons with mental retardation, to prevent an admission to a hospital or nursing facility or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the home health services or forgoes the facility per diem for the leave days that home health services are used. Home health services must be provided by a Medicare certified home health agency. All nursing and home health aide services must be provided according to section 256B.0627.

Subd. 7. **Private duty nursing.** Medical assistance covers private duty nursing services in a recipient's home. Recipients who are authorized to receive private duty nursing services in their home may use approved hours outside of the home during hours when normal life activities take them outside of their home and when, without the provision of private duty nursing, their health and safety would be jeopardized. Medical assistance does not cover private duty nursing services for residents of a hospital, nursing facility, intermediate care facility, or a health care facility licensed by the commissioner of health, except as authorized in section 256B.64 for ventilator–dependent recipients in hospitals or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the private duty nursing services or forgoes the facility per diem for the leave days that private duty nursing services are used. Total hours of service and payment allowed for services outside the home cannot exceed that which is otherwise allowed in an in–home setting according to section 256B.0627. All private duty nursing services must be provided according to the limits established under section 256B.0627. Private duty nursing services may not be reimbursed if the nurse is the spouse of the recipient or the parent or foster care provider of a recipient who is under age 18, or the recipient's legal guardian.

Subd. 8. **Physical therapy.** Medical assistance covers physical therapy and related services. Services provided by a physical therapy assistant shall be reimbursed at the same rate as services performed by a physical therapist when the services of the physical therapy assistant are provided under the direction of a physical therapist who is on the premises. Services provided by a physical therapy assistant that are provided under the direction of a physical therapist who is not on the premises shall be reimbursed at 65 percent of the physical therapist rate.

Subd. 8a. **Occupational therapy.** Medical assistance covers occupational therapy and related services. Services provided by an occupational therapy assistant shall be reimbursed at the same rate as services performed by an occupational therapist when the services of the occupational therapy assistant are provided under the direction of the occupational therapist who is on the premises. Services provided by an occupational therapy assistant that are provided under the direction of an occupational therapist who is not on the premises shall be reimbursed at 65 percent of the occupational therapist rate.

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. Rates paid for anesthesiology services provided by certified registered nurse anesthe-

tists shall be according to the formula utilized in the Medicare program and shall use the conversion factor that is used by the Medicare program.

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, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control. The commissioner, after receiving recommendations from professional medical associations and professional pharmacist associations, 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 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 three–year terms and shall serve without compensation. Members may be reappointed once.

(b) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the administrative procedure act, but the formulary committee shall review and comment on the formulary contents. The formulary committee shall review and recommend drugs which require prior authorization. The formulary committee may recommend drugs for prior authorization directly to the commissioner, as long as opportunity for public input is provided. Prior authorization may be requested by the commissioner based on medical and clinical criteria before certain drugs are eligible for payment. Before a drug may be considered for prior authorization at the request of the commissioner:

(1) the drug formulary committee must develop criteria to be used for identifying drugs; the development of these criteria is not subject to the requirements of chapter 14, but the formulary committee shall provide opportunity for public input in developing criteria;

(2) the drug formulary committee must hold a public forum and receive public comment for an additional 15 days; and

(3) the commissioner must provide information to the formulary committee on the impact that placing the drug on prior authorization will have on the quality of patient care and information regarding whether the drug is subject to clinical abuse or misuse. Prior authorization may be required by the commissioner before certain formulary drugs are eligible for payment. The formulary shall not include:

(i) drugs or products for which there is no federal funding;

(ii) over–the–counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, and vitamins for children under the age of seven and pregnant or nursing women;

(iii) any other over–the–counter drug identified by the commissioner, in consultation with the drug formulary committee, 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;

(iv) anorectics; and

(v) drugs for which medical value has not been established.

The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

(c) 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; 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. The pharmacy dispensing fee shall be $3.85. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus nine percent. 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. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30–day supply. 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 – brand necessary" on the prescription as required by section 151.21, subdivision 2.

Subd. 13a. **Drug utilization review board.** A nine–member drug utilization review board is established. The board is comprised of at least three but no more than four licensed physicians actively engaged in the practice of medicine in Minnesota; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. The board shall be staffed by an employee of the department who shall serve as an ex officio nonvoting member of the board. The members of the board shall be appointed by the commissioner and shall serve three–year terms. The members shall be selected from lists submitted by professional associations. The commissioner shall appoint the initial members of the board for terms expiring as follows: three members for terms expiring June 30, 1996; three members for terms expiring June 30, 1997; and three members for terms expiring June 30, 1998. Members may be reappointed once. The board shall annually elect a chair from among the members.

The commissioner shall, with the advice of the board:

(1) implement a medical assistance retrospective and prospective drug utilization review program as required by United States Code, title 42, section 1396r–8(g)(3);

(2) develop and implement the predetermined criteria and practice parameters for appropriate prescribing to be used in retrospective and prospective drug utilization review;

(3) develop, select, implement, and assess interventions for physicians, pharmacists, and patients that are educational and not punitive in nature;

(4) establish a grievance and appeals process for physicians and pharmacists under this section;

(5) publish and disseminate educational information to physicians and pharmacists regarding the board and the review program;

(6) adopt and implement procedures designed to ensure the confidentiality of any information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the review program that identifies individual physicians, pharmacists, or recipients;

(7) establish and implement an ongoing process to (i) receive public comment regarding drug utilization review criteria and standards, and (ii) consider the comments along with other scientific and clinical information in order to revise criteria and standards on a timely basis; and

(8) adopt any rules necessary to carry out this section.

The board may establish advisory committees. The commissioner may contract with appropriate organizations to assist the board in carrying out the board's duties. The commissioner may enter into contracts for services to develop and implement a retrospective and prospective review program.

The board shall report to the commissioner annually on the date the Drug Utilization Review Annual Report is due to the Health Care Financing Administration. This report is to cover the preceding federal fiscal year. The commissioner shall make the report available to the public upon request. The report must include information on the activities of the board and the program; the effectiveness of implemented interventions; administrative costs; and any fiscal impact resulting from the program. An honorarium of $50 per meeting shall be paid to each board member in attendance.

Subd. 13b. **Pharmacy copayment requirements.** A copayment of $1 per prescription shall be required under the medical assistance and general assistance medical care programs according to paragraphs (a) to (d):

(a) A copayment shall not be required of children, pregnant women through the postpartum period, recipients whose only available income is a personal needs allowance in the amount established under section 256B.35 or 256B.36, recipients residing in a setting which receives funding under sections 256I.01 to 256I.06, or institutionalized recipients or, under medical assistance only, from any other persons required to be exempted under federal law;

(b) A copayment shall not be required for family planning services or supplies, psychotropic drugs or emergency services;

(c) A provider may not deny a prescription to a recipient because the recipient is unable to pay the copayment;

(d) A lower copayment shall be collected, under medical assistance only, up to the maximum permitted by federal law, for prescriptions on which federal law prohibits a $1 copayment;

(e) The amount of the copayment under this subdivision shall be subtracted from the payment under subdivision 13; and

(f) This subdivision does not apply to services under the MinnesotaCare program.

Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance covers diagnostic, screening, and preventive services.

(b) "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.

(c) "Screening services" include, but are not limited to, blood lead tests.

Subd. 15. **Health plan premiums and copayments.** Medical assistance covers health care prepayment plan premiums, insurance premiums, and copayments if determined to be cost–effective by the commissioner. For purposes of obtaining Medicare part A and part B, and copayments, 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) Medical assistance covers special transportation, as defined in Minnesota Rules, part 9505.0315, subpart 1, item F, if the provider receives and maintains a current physician's order by the recipient's attending physician certifying that the recipient has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi, other commercial transportation, or private automobile. Special transportation includes driver–assisted service to eligible individuals. Driver–assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs or stretchers in the vehicle. The commissioner shall establish maximum medical assistance reimbursement rates for special transportation services for persons who need a wheelchair lift van or stretcher–equipped vehicle and for those who do not need a wheelchair lift van or stretcher–equipped vehicle. The average of these two rates must not exceed $14 for the base rate and $1.10 per mile. Special transportation 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 the most appropriate and cost–effective form of transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care.

Subd. 18a. **Payment for meals and lodging.** (a) Medical assistance reimbursement for meals for persons traveling to receive medical care may not exceed $5.50 for breakfast, $6.50 for lunch, or $8 for dinner.

(b) Medical assistance reimbursement for lodging for persons traveling to receive medical care may not exceed $50 per day unless prior authorized by the local agency.

(c) Medical assistance direct mileage reimbursement to the eligible person or the eligible person's driver may not exceed 20 cents per mile.

Subd. 19. [Repealed, 1991 c 292 art 7 s 26]

Subd. 19a. **Personal care services.** Medical assistance covers personal care services in a recipient's home. To qualify for personal care services, recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home and when, without the provision of personal care, their health and safety would be jeopardized. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care services in an in–home setting according to section 256B.0627. Medical assistance does not cover personal care services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care services or forgoes the facility per diem for the leave days that personal care services are used. All personal care services must be provided according to section 256B.0627. Personal care services may not be reimbursed if the personal care assistant is the spouse or legal guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Parents of adult recipients, adult children of the recipient or adult siblings of the recipient may be reimbursed for personal care

services if they are not the recipient's legal guardian and are granted a waiver under section 256B.0627.

Subd. 19b. **No automatic adjustment.** For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for home care services. The commissioner of finance shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in reimbursement rates for home care services.

Subd. 19c. **Personal care.** Medical assistance covers personal care services provided by an individual who is qualified to provide the services according to subdivision 19a and section 256B.0627, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a registered nurse.

Subd. 20. **Mental illness case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness or subject to federal approval, children with severe emotional disturbance. Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subpart 6.

(b) In counties where fewer than 50 percent of children estimated to be eligible under medical assistance to receive case management services for children with severe emotional disturbance actually receive these services in state fiscal year 1995, community mental health centers serving those counties, entities meeting program standards in Minnesota Rules, parts 9520.0570 to 9520.0870, and other entities authorized by the commissioner are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subpart 6.

Subd. 20a. **Case management for persons with mental retardation or a related condition.** To the extent defined in the state Medicaid plan, case management service activities for persons with mental retardation or a related condition as defined in section 256B.092, and rules promulgated thereunder, are covered services under medical assistance.

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 245.4871, subdivision 10, 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 chapter 254B. The commissioner shall include chemical dependency services in the state medical assistance plan for federal reporting purposes, but payment must be made under chapter 254B. 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. **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 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 transplant procedures is limited to those procedures covered by the Medicare program; heart–lung transplants for persons with primary pulmonary hypertension and performed at Minnesota transplant centers meeting united network for organ sharing criteria to perform heart–lung transplants; lung transplants using cadaveric donors and performed at Minnesota transplant centers meeting united network for organ sharing criteria to perform lung transplants; pancreas transplants for uremic diabetic recipients of kidney transplants and performed at Minnesota facilities meeting united network for organ sharing criteria to perform pancreas transplants; and allogenic bone marrow transplants for persons with stage III or IV Hodgkin's disease. Transplant procedures must 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. Transplant centers must meet american society of hematology and clinical oncology criteria for bone marrow transplants and be located in Minnesota to receive reimbursement for bone marrow transplants.

Subd. 28. **Certified nurse practitioner services.** Medical assistance covers services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, or a certified geriatric 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 or a registered 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 or registered nurse's license as a registered nurse, as defined in section 148.171.

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, public health clinic services, and the services of a clinic meeting the criteria established in rule by the commissioner. 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.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost–based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the department of health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential

community provider status within the six–month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics. This paragraph takes effect only if the Minnesota health care reform waiver is approved by the federal government, and remains in effect for as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this paragraph expires, and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes.

Subd. 31. **Medical supplies and equipment.** Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the mentally retarded. Reimbursement for wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

Subd. 32. **Nutritional products.** (a) Medical assistance covers nutritional products needed for nutritional supplementation because solid food or nutrients thereof cannot be properly absorbed by the body or needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow's 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. Nutritional products needed for the treatment of a combined allergy to human milk, cow's milk, and soy formula require prior authorization. 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.

(b) The commissioner shall designate a nutritional supplementation products advisory committee to advise the commissioner on nutritional supplementation products for which payment is made. The committee shall consist of nine members, one of whom shall be a physician, one of whom shall be a pharmacist, two of whom shall be registered dietitians, one of whom shall be a public health nurse, one of whom shall be a representative of a home health care agency, one of whom shall be a provider of long–term care services, and two of whom shall be consumers of nutritional supplementation products. Committee members shall serve two–year terms and shall serve without compensation.

(c) The advisory committee shall review and recommend nutritional supplementation products which require prior authorization. The commissioner shall develop procedures for the operation of the advisory committee so that the advisory committee operates in a manner parallel to the drug formulary committee.

Subd. 33. **Child welfare targeted case management.** Medical assistance, subject to federal approval, covers child welfare targeted case management services as defined in section 256B.094 to children under age 21 who have been assessed and determined in accordance with section 256F.095 to be:

(1) at risk of placement or in placement as defined in section 257.071, subdivision 1;

(2) at risk of maltreatment or experiencing maltreatment as defined in section 626.556, subdivision 10e; or

(3) in need of protection or services as defined in section 260.015, subdivision 2a.

Subd. 34. **American Indian health services facilities.** Medical assistance payments to American Indian health services facilities for outpatient medical services billed after June 30, 1990, must be in accordance with the rate published by the United States Assistant Secretary for Health under the authority of United States Code, title 42, sections 248(a) and 249(b). General assistance medical care payments to American Indian health services facilities for the provision of outpatient medical care services billed after June 30, 1990, must be in accor-

dance with the general assistance medical care rates paid for the same services when provided in a facility other than an American Indian health service facility.

Subd. 35. **Family community support services.** Medical assistance covers family community support services as defined in section 245.4871, subdivision 17.

Subd. 36. **Therapeutic support of foster care.** Medical assistance covers therapeutic support of foster care as defined in section 245.4871, subdivision 34.

Subd. 37. **Individualized rehabilitation services.** Medical assistance covers individualized rehabilitation services as defined in section 245.492, subdivision 23, that are provided by a collaborative, county, or an entity under contract with a county through an integrated service system, as described in section 245.4931, that is approved by the state coordinating council, subject to federal approval.

Subd. 38. **Payments for mental health services.** Payments for mental health services covered under the medical assistance program that are provided by masters–prepared mental health professionals shall be 80 percent of the rate paid to doctoral–prepared professionals. Payments for mental health services covered under the medical assistance program that are provided by masters–prepared mental health professionals employed by community mental health centers shall be 100 percent of the rate paid to doctoral–prepared professionals.

Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines within the scope of their licensure, and who are enrolled as a medical assistance provider, must enroll in the pediatric vaccine administration program established by section 13631 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay an $8.50 fee per dose for administration of the vaccine to children eligible for medical assistance. Medical assistance does not pay for vaccines that are available at no cost from the pediatric vaccine administration program.

Subd. 40. **Tuberculosis related services.** (a) For persons infected with tuberculosis, medical assistance covers case management services and direct observation of the intake of drugs prescribed to treat tuberculosis.

(b) "Case management services" means services furnished to assist persons infected with tuberculosis in gaining access to needed medical services. Case management services include at a minimum:

(1) assessing a person's need for medical services to treat tuberculosis;

(2) developing a care plan that addresses the needs identified in clause (1);

(3) assisting the person in accessing medical services identified in the care plan; and

(4) monitoring the person's compliance with the care plan to ensure completion of tuberculosis therapy. Medical assistance covers case management services under this subdivision only if the services are provided by a certified public health nurse who is employed by a community health board as defined in section 145A.02, subdivision 5.

(c) To be covered by medical assistance, direct observation of the intake of drugs prescribed to treat tuberculosis must be provided by a community outreach worker, licensed practical nurse, registered nurse who is trained and supervised by a public health nurse employed by a community health board as defined in section 145A.02, subdivision 5, or a public health nurse employed by a community health board.

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 309 s 24; 1987 c 370 art 1 s 3; art 2 s 4; 1987 c 374 s 1; 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; 1991 c 199 art 2 s 1; 1991 c 292 art 4 s 41–49; art 6 s 45; art 7 s 5,9–11; 1992 c 391 s 1,2; 1992 c 513 art 7 s 43–49; art 9 s 25; 1993 c 246 s 1,2; 1993 c 247 art 4 s 11; 1993 c 345 art 13 s 1; 1Sp1993 c 1 art 3 s 23; art 5 s 36–49; art 7 s 41–44; art 9 s 71; 1Sp1993 c 6 s 10; 1994 c 465 art 3 s 52; 1994 c 625 art 8 s 72; 1995 c 178 art 2 s 26; 1995 c 207 art 6 s 38–51; art 8 s 33; 1995 c 234 art 6 s 38; 1995 c 263 s 10; 1996 c 451 art 2 s 20; art 5 s 15,16*

256B.0626 ESTIMATION OF 50TH PERCENTILE OF PREVAILING CHARGES.

(a) The 50th percentile of the prevailing charge for the base year identified in statute must be estimated by the commissioner in the following situations:

(1) there were less than ten billings in the calendar year specified in legislation governing maximum payment rates;

(2) the service was not available in the calendar year specified in legislation governing maximum payment rates;

(3) the payment amount is the result of a provider appeal;

(4) the procedure code description has changed since the calendar year specified in legislation governing maximum payment rates, and, therefore, the prevailing charge information reflects the same code but a different procedure description; or

(5) the 50th percentile reflects a payment which is grossly inequitable when compared with payment rates for procedures or services which are substantially similar.

(b) When one of the situations identified in paragraph (a) occurs, the commissioner shall use the following methodology to reconstruct a rate comparable to the 50th percentile of the prevailing rate:

(1) refer to information which exists for the first nine billings in the calendar year specified in legislation governing maximum payment rates; or

(2) refer to surrounding or comparable procedure codes; or

(3) refer to the 50th percentile of years subsequent to the calendar year specified in legislation governing maximum payment rates, and reduce that amount by applying an appropriate Consumer Price Index formula; or

(4) refer to relative value indexes; or

(5) refer to reimbursement information from other third parties, such as Medicare.

History: *1Sp1993 c 1 art 5 s 50*

256B.0627 COVERED SERVICE; HOME CARE SERVICES.

Subdivision 1. **Definition.** (a) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. An initial assessment for personal care services is conducted on individuals who are requesting personal care services or for those consumers who have never had a public health nurse assessment. The initial assessment must include: a face–to–face health status assessment and determination of baseline need, collection of initial case data, identification of appropriate services and service plan development, coordination of initial services, referrals and follow–up to appropriate payers and community resources, completion of required reports, obtaining service authorization, and consumer education. A reassessment visit for personal care services is conducted at least annually or when there is a significant change in consumer condition and need for services. The reassessment visit includes a review of initial baseline data, evaluation of service outcomes, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community–based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party.

(b) "Care plan" means a written description of personal care assistant services developed by the agency nurse with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(c) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every 60 days for the provision of home health ser-

vices, or private duty nursing, or at least once every 365 days for personal care. 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 or as specified in section 256B.0625.

(d) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(e) "Personal care assistant" means a person who: (1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school–based job training program or have completed a certified home health aide competency evaluation; (2) is able to effectively communicate with the recipient and personal care provider organization; (3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D; (4) has the ability to, and provides covered personal care services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising registered nurse; (5) is not a consumer of personal care services; and (6) is subject to criminal background checks. An individual who has been convicted of a crime specified in Minnesota Rules, part 4668.0020, subpart 14, or a comparable crime in another jurisdiction is disqualified from being a personal care assistant, unless the individual meets the rehabilitation criteria specified in Minnesota Rules, part 4668.0020, subpart 15.

(f) "Personal care provider organization" means an organization enrolled to provide personal care services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in section 245A.04. This applies to currently enrolled personal care provider organizations and those agencies seeking enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in Minnesota Rules, part 4668.0020, subpart 14, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the rehabilitation criteria specified in Minnesota Rules, part 4668.0020, subpart 15; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the department of human services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

(g) "Responsible party" means an individual residing with a recipient of personal care services who is capable of providing the supportive care necessary to assist the recipient to live in the community, is at least 18 years old, and is not a personal care assistant. Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. Foster care license holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care services in order to obtain the availability of 24–hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

(h) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

(i) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

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

(1) nursing services under section 256B.0625, subdivision 6a;

(2) private duty nursing services under section 256B.0625, subdivision 7;

(3) home health aide services under section 256B.0625, subdivision 6a;

(4) personal care services under section 256B.0625, subdivision 19a;

(5) nursing supervision of personal care services under section 256B.0625, subdivision 19a; and

(6) assessments by county public health nurses for services under section 256B.0625, subdivision 19a.

Subd. 3. [Repealed, 1991 c 292 art 7 s 26]

Subd. 4. **Personal care services.** (a) 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) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

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

(7) turning and positioning;

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

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

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

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months; and

(18) incidental household services that are an integral part of a personal care service described in clauses (1) to (17).

For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention.

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

(1) services not ordered by the physician;

(2) assessments by personal care provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) services provided by parents of adult recipients, adult children or adult siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a part–time or full–time job to provide personal care for the recipient;

(ii) the relative goes from a full–time to a part–time job with less compensation to provide personal care for the recipient;

(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;

(iv) the relative incurs substantial expenses by providing personal care for the recipient; or

(v) because of labor conditions or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

(11) homemaker services that are not an integral part of a personal care services;

(12) home maintenance, or chore services;

(13) services not specified under paragraph (a); and

(14) services not authorized by the commissioner or the commissioner's designee.

Subd. 5. **Limitation on payments.** Medical assistance payments for home care services shall be limited according to this subdivision.

(a) **Limits on services without prior authorization.** A recipient may receive the following home care services during a calendar year:

(1) any initial assessment; and

(2) up to two reassessments per year done to determine a recipient's need for personal care services.

(b) **Prior authorization; exceptions.** All home care services above the limits in paragraph (a) must receive the commissioner's prior authorization, except when:

(1) the home care services were required to treat an emergency medical condition that if not immediately treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories;

(2) the home care services were provided on or after the date on which the recipient's eligibility began, but before the date on which the recipient was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened;

(3) a third–party payor for home care services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. A copy of the notice must be included with the request;

(4) the commissioner has determined that a county or state human services agency has made an error; or

(5) the professional nurse determines an immediate need for up to 40 skilled nursing or home health aide visits per calendar year and submits a request for authorization within 20 working days of the initial service date, and medical assistance is determined to be the appropriate payer.

(c) **Retroactive authorization.** A request for retroactive authorization will be evaluated according to the same criteria applied to prior authorization requests.

(d) **Assessment and service plan.** Assessments under section 256B.0627, subdivision 1, paragraph (a), shall be conducted initially, and at least annually thereafter, in person with the recipient and result in a completed service plan using forms specified by the commissioner. Within 30 days of recipient or responsible party request for home care services, the assessment, the service plan, and other information necessary to determine medical necessity such as diagnostic or testing information, social or medical histories, and hospital or facility discharge summaries shall be submitted to the commissioner. For personal care services:

(1) The amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers.

(2) If the recipient's medical need changes, the recipient's provider may assess the need for a change in service authorization and request the change from the county public health nurse. Within 30 days of the request, the public health nurse will determine whether to request the change in services based upon the provider assessment, or conduct a home visit to assess the need and determine whether the change is appropriate.

(3) To continue to receive personal care services when the recipient displays no significant change, the county public health nurse has the option to review with the commissioner, or the commissioner's designee, the service plan on record and receive authorization for up to an additional 12 months at a time for up to three years.

(e) **Prior authorization.** The commissioner, or the commissioner's designee, shall review the assessment, the service plan, and any additional information that is submitted. The commissioner shall, within 30 days after receiving a complete request, assessment, and service plan, authorize home care services as follows:

(1) **Home health services.** All home health services provided by a licensed nurse or a home health aide must be prior authorized by the commissioner or the commissioner's designee. Prior authorization must be based on medical necessity and cost-effectiveness when compared with other care options. When home health services are used in combination with personal care and private duty nursing, the cost of all home care services shall be considered for cost-effectiveness. The commissioner shall limit nurse and home health aide visits to no more than one visit each per day.

(2) **Personal care services.** (i) All personal care services and registered nurse supervision must be prior authorized by the commissioner or the commissioner's designee except for the assessments established in paragraph (a). The amount of personal care services authorized must be based on the recipient's home care rating. A child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity and the amount of assistance needed is similar to the assistance appropriate for a typical child of the same age. Based on medical necessity, the commissioner may authorize:

(A) up to two times the average number of direct care hours provided in nursing facilities for the recipient's comparable case mix level; or

(B) up to three times the average number of direct care hours provided in nursing facilities for recipients who have complex medical needs or are dependent in at least seven activities of daily living and need physical assistance with eating or have a neurological diagnosis; or

(C) up to 60 percent of the average reimbursement rate, as of July 1, 1991, for care provided in a regional treatment center for recipients who have Level I behavior, plus any inflation adjustment as provided by the legislature for personal care service; or

(D) up to the amount the commissioner would pay, as of July 1, 1991, plus any inflation adjustment provided for home care services, for care provided in a regional treatment center for recipients referred to the commissioner by a regional treatment center preadmission evaluation team. For purposes of this clause, home care services means all services provided in

the home or community that would be included in the payment to a regional treatment center; or

(E) up to the amount medical assistance would reimburse for facility care for recipients referred to the commissioner by a preadmission screening team established under section 256B.0911 or 256B.092; and

(F) a reasonable amount of time for the provision of nursing supervision of personal care services.

(ii) The number of direct care hours shall be determined according to the annual cost report submitted to the department by nursing facilities. The average number of direct care hours, as established by May 1, 1992, shall be calculated and incorporated into the home care limits on July 1, 1992. These limits shall be calculated to the nearest quarter hour.

(iii) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner by the county public health nurse on forms specified by the commissioner. The home care rating shall be a combination of current assessment tools developed under sections 256B.0911 and 256B.501 with an addition for seizure activity that will assess the frequency and severity of seizure activity and with adjustments, additions, and clarifications that are necessary to reflect the needs and conditions of recipients who need home care including children and adults under 65 years of age. The commissioner shall establish these forms and protocols under this section and shall use an advisory group, including representatives of recipients, providers, and counties, for consultation in establishing and revising the forms and protocols.

(iv) A recipient shall qualify as having complex medical needs if the care required is difficult to perform and because of recipient's medical condition requires more time than community–based standards allow or requires more skill than would ordinarily be required and the recipient needs or has one or more of the following:

(A) daily tube feedings;

(B) daily parenteral therapy;

(C) wound or decubiti care;

(D) postural drainage, percussion, nebulizer treatments, suctioning, tracheotomy care, oxygen, mechanical ventilation;

(E) catheterization;

(F) ostomy care;

(G) quadriplegia; or

(H) other comparable medical conditions or treatments the commissioner determines would otherwise require institutional care.

(v) A recipient shall qualify as having Level I behavior if there is reasonable supporting evidence that the recipient exhibits, or that without supervision, observation, or redirection would exhibit, one or more of the following behaviors that cause, or have the potential to cause:

(A) injury to the recipient's own body;

(B) physical injury to other people; or

(C) destruction of property.

(vi) Time authorized for personal care relating to Level I behavior in subclause (v), items (A) to (C), shall be based on the predictability, frequency, and amount of intervention required.

(vii) A recipient shall qualify as having Level II behavior if the recipient exhibits on a daily basis one or more of the following behaviors that interfere with the completion of personal care services under subdivision 4, paragraph (a):

(A) unusual or repetitive habits;

(B) withdrawn behavior; or

(C) offensive behavior.

(viii) A recipient with a home care rating of Level II behavior in subclause (vii), items (A) to (C), shall be rated as comparable to a recipient with complex medical needs under subclause (iv). If a recipient has both complex medical needs and Level II behavior, the home

care rating shall be the next complex category up to the maximum rating under subclause (i), item (B).

(3) **Private duty nursing services.** All private duty nursing services shall be prior authorized by the commissioner or the commissioner's designee. Prior authorization for private duty nursing services shall be based on medical necessity and cost–effectiveness when compared with alternative care options. The commissioner may authorize medically necessary private duty nursing services in quarter–hour units when:

(i) the recipient requires more individual and continuous care than can be provided during a nurse visit; or

(ii) the cares are outside of the scope of services that can be provided by a home health aide or personal care assistant.

The commissioner may authorize:

(A) up to two times the average amount of direct care hours provided in nursing facilities statewide for case mix classification "K" as established by the annual cost report submitted to the department by nursing facilities in May 1992;

(B) private duty nursing in combination with other home care services up to the total cost allowed under clause (2);

(C) up to 16 hours per day if the recipient requires more nursing than the maximum number of direct care hours as established in item (A) and the recipient meets the hospital admission criteria established under Minnesota Rules, parts 9505.0500 to 9505.0540.

The commissioner may authorize up to 16 hours per day of medically necessary private duty nursing services or up to 24 hours per day of medically necessary private duty nursing services until such time as the commissioner is able to make a determination of eligibility for recipients who are cooperatively applying for home care services under the community alternative care program developed under section 256B.49, or until it is determined by the appropriate regulatory agency that a health benefit plan is or is not required to pay for appropriate medically necessary health care services. Recipients or their representatives must cooperatively assist the commissioner in obtaining this determination. Recipients who are eligible for the community alternative care program may not receive more hours of nursing under this section than would otherwise be authorized under section 256B.49.

(4) **Ventilator–dependent recipients.** If the recipient is ventilator–dependent, the monthly medical assistance authorization for home care services shall not exceed what the commissioner would pay for 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. "Ventilator–dependent" means an individual who receives mechanical ventilation for life support at least six hours per day and is expected to be or has been dependent for at least 30 consecutive days.

(f) **Prior authorization; time limits.** The commissioner or the commissioner's designee shall determine the time period for which a prior authorization shall be effective. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. Under no circumstances, other than the exceptions in paragraph (b), shall a prior authorization be valid prior to the date the commissioner receives the request or for more than 12 months. A recipient who appeals a reduction in previously authorized home care services may continue previously authorized services, other than temporary services under paragraph (h), pending an appeal under section 256.045. The commissioner must provide a detailed explanation of why the authorized services are reduced in amount from those requested by the home care provider.

(g) **Approval of home care services.** The commissioner or the commissioner's designee shall determine the medical necessity of home care services, the level of caregiver according to subdivision 2, and the institutional comparison according to this subdivision, the cost–effectiveness of services, and the amount, scope, and duration of home care services reimbursable by medical assistance, based on the assessment, primary payer coverage determination information as required, the service plan, the recipient's age, the cost of services, the recipient's medical condition, and diagnosis or disability. The commissioner may publish additional criteria for determining medical necessity according to section 256B.04.

(h) **Prior authorization requests; temporary services.** The agency nurse, the independently enrolled private duty nurse, or county public health nurse may request a temporary authorization for home care services by telephone. The commissioner may approve a temporary level of home care services based on the assessment, and service or care plan information, and primary payer coverage determination information as required. Authorization for a temporary level of home care services including nurse supervision is limited to the time specified by the commissioner, but shall not exceed 45 days, unless extended because the county public health nurse has not completed the required assessment and service plan, or the commissioner's determination has not been made. The level of services authorized under this provision shall have no bearing on a future prior authorization.

(i) **Prior authorization required in foster care setting.** Home care services provided in an adult or child foster care setting must receive prior authorization by the department according to the limits established in paragraph (a).

The commissioner may not authorize:

(1) home care services that are the responsibility of the foster care provider under the terms of the foster care placement agreement and administrative rules. Requests for home care services for recipients residing in a foster care setting must include the foster care placement agreement and determination of difficulty of care;

(2) personal care services when the foster care license holder is also the personal care provider or personal care assistant unless the recipient can direct the recipient's own care, or case management is provided as required in section 256B.0625, subdivision 19a;

(3) personal care services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided as required in section 256B.0625, subdivision 19a;

(4) home care services when the number of foster care residents is greater than four unless the county responsible for the recipient's foster placement made the placement prior to April 1, 1992, requests that home care services be provided, and case management is provided as required in section 256B.0625, subdivision 19a; or

(5) home care services when combined with foster care payments, other than room and board payments that exceed the total amount that public funds would pay for the recipient's care in a medical institution.

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. This subdivision does not apply to services provided to a recipient at the previously authorized level pending an appeal under section 256.045, subdivision 10.

Subd. 7. **Noncovered home care services.** The following home care services are not eligible for payment under medical assistance:

(1) skilled nurse visits for the sole purpose of supervision of the home health aide;

(2) a skilled nursing visit:

(i) only for the purpose of monitoring medication compliance with an established medication program for a recipient; or

(ii) to administer or assist with medication administration, including injections, prefilling syringes for injections, or oral medication set-up of an adult recipient, when as determined and documented by the registered nurse, the need can be met by an available pharmacy or the recipient is physically and mentally able to self-administer or prefill a medication;

(3) home care services to a recipient who is eligible for covered services including hospice, if elected by the recipient, under the Medicare program or any other insurance held by the recipient;

(4) services to other members of the recipient's household;

(5) a visit made by a skilled nurse solely to train other home health agency workers;

(6) any home care service included in the daily rate of the community-based residential facility where the recipient is residing;

(7) nursing and rehabilitation therapy services that are reasonably accessible to a recipient outside the recipient's place of residence, excluding the assessment, counseling and education, and personal care;

(8) any home health agency service, excluding personal care assistant services and private duty nursing services, which are performed in a place other than the recipient's residence; and

(9) Medicare evaluation or administrative nursing visits on dual–eligible recipients that do not qualify for Medicare visit billing.

History: *1986 c 444; 1990 c 568 art 3 s 51; 1991 c 292 art 7 s 12,25; 1992 c 391 s 3–6; 1992 c 464 art 2 s 1; 1992 c 513 art 7 s 50; 1Sp1993 c 1 art 5 s 51–53; 1995 c 207 art 6 s 52–55; 1996 c 451 art 5 s 17–20*

256B.0628 PRIOR AUTHORIZATION AND REVIEW OF HOME CARE SERVICES.

Subdivision 1. **State coordination.** The commissioner shall supervise the coordination of the prior authorization and review of home care services that are reimbursed by medical assistance.

Subd. 2. **Duties.** (a) The commissioner may contract with or employ qualified registered nurses and necessary support staff, or contract with qualified agencies, to provide home care prior authorization and review services for medical assistance recipients who are receiving home care services.

(b) Reimbursement for the prior authorization function shall be made through the medical assistance administrative authority. The state shall pay the nonfederal share. The functions will be to:

(1) assess the recipient's individual need for services required to be cared for safely in the community;

(2) ensure that a service plan that meets the recipient's needs is developed by the appropriate agency or individual;

(3) ensure cost–effectiveness of medical assistance home care services;

(4) recommend the approval or denial of the use of medical assistance funds to pay for home care services;

(5) reassess the recipient's need for and level of home care services at a frequency determined by the commissioner; and

(6) conduct on–site assessments when determined necessary by the commissioner and recommend changes to care plans that will provide more efficient and appropriate home care.

(c) In addition, the commissioner or the commissioner's designee may:

(1) review service plans and reimbursement data for utilization of services that exceed community–based standards for home care, inappropriate home care services, medical necessity, home care services that do not meet quality of care standards, or unauthorized services and make appropriate referrals within the department or to other appropriate entities based on the findings;

(2) assist the recipient in obtaining services necessary to allow the recipient to remain safely in or return to the community;

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

(4) assist the recipient with problems related to the provision of home care services;

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

(6) assure that all liable third–party payers including Medicare have been used prior to medical assistance for home care services, including but not limited to, home health agency, elected hospice benefit, waivered services, alternative care program services, and personal care services.

(d) For the purposes of this section, "home care services" means medical assistance services defined under section 256B.0625, subdivisions 6a, 7, and 19a.

Subd. 3. **Assessment and prior authorization process for recipients of both home care and home and community–based waivered services for persons with mental re-**

tardation or related conditions. Effective January 1, 1996, for purposes of providing informed choice, coordinating of local planning decisions, and streamlining administrative requirements, the assessment and prior authorization process for persons receiving both home care and home and community–based waivered services for persons with mental retardation or related conditions shall meet the requirements of this section and section 256B.0627 with the following exceptions:

(a) Upon request for home care services and subsequent assessment by the public health nurse under section 256B.0627, the public health nurse shall participate in the screening process, as appropriate, and, if home care services are determined to be necessary, participate in the development of a service plan coordinating the need for home care and home and community–based waivered services with the assigned county case manager, the recipient of services, and the recipient's legal representative, if any.

(b) The public health nurse shall give prior authorization for home care services to the extent that home care services are:

(1) medically necessary;

(2) chosen by the recipient and their legal representative, if any, from the array of home care and home and community–based waivered services available;

(3) coordinated with other services to be received by the recipient as described in the service plan; and

(4) provided within the county's reimbursement limits for home care and home and community–based waivered services for persons with mental retardation or related conditions.

(c) If the public health agency is or may be the provider of home care services to the recipient, the public health agency shall provide the commissioner of human services with a written plan that specifies how the assessment and prior authorization process will be held separate and distinct from the provision of services.

History: *1991 c 292 art 7 s 13; 1Sp1993 c 1 art 5 s 54; 1995 c 207 art 3 s 18; art 6 s 56; 1996 c 451 art 2 s 21*

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 human services finance division of the house health and human services committee and the health care and family services finance division of the senate family services and health care committees 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) Determine 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 if they are recommended by the task force, approved by the commissioner, and published in the State Register.

(2) Determine criteria for certifying transplant centers within and outside of Minnesota where Minnesotans receiving medical assistance and general assistance medical care may obtain transplants. Only centers recommended by the task force and approved by the commissioner may be certified by the commissioner.

History: *1990 c 568 art 3 s 52; 1993 c 4 s 29; 1993 c 339 s 24; 1Sp1993 c 1 art 5 s 55; 1Sp1993 c 6 s 11; 1994 c 529 s 9,10,19*

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. 1d. **Investigative costs.** The commissioner may seek recovery of investigative costs from any vendor of medical care or services who willfully submits a claim for reimbursement for services the vendor knows, or reasonably should have known, is a false representation and which results in the payment of public funds for which the vendor is ineligible. Billing errors deemed to be unintentional, but which result in overcharges, shall not be considered for investigative cost recoupment.

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. Except in the case of a conviction for conduct described in 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.

Upon receipt of a notice that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

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

(5) other information required by the commissioner.

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; 1991 c 292 art 5 s 29; 1992 c 513 art 7 s 51,52*

256B.0641 RECOVERY OF OVERPAYMENTS.

Subdivision 1. **Recovery procedures; sources.** 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;

(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; and

(3) a medical assistance vendor is liable for the overpayment amount owed by a long–term care provider if the vendors or their owners are under common control or ownership.

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.

Subd. 3. **Facility in receivership.** Subdivision 2 does not apply to the change of ownership of a facility to a nonrelated organization while the facility to be sold, transferred or reorganized is in receivership under section 245A.12 or 245A.13, and the commissioner during the receivership has not determined the need to place residents of the facility into a newly constructed or newly established facility. Nothing in this subdivision limits the liability of a former owner.

History: *1Sp1985 c 9 art 2 s 39; 1987 c 133 s 1; 1991 c 292 art 6 s 46; 1995 c 207 art 7 s 22*

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.0644 PARTICIPATION REQUIRED FOR REIMBURSEMENT UNDER OTHER STATE HEALTH CARE PROGRAMS.

A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health maintenance organization, as defined in chapter 62D, must participate as a provider or contractor in the medical assistance program, general assistance medical care program, and MinnesotaCare as a condition of participating as a provider in health insurance plans and programs or contractor for state employees established under section 43A.18, the public employees insurance program under section 43A.316, for health insurance plans offered to local statutory or home rule charter city, county, and school district employees, the workers' compensation system under section 176.135, and insurance plans provided through the Minnesota comprehensive health association under sections 62E.01 to 62E.16. The limitations on insurance plans offered to local government employees shall not be applicable in geographic areas where provider participation is limited by managed care contracts with the department of human services. For providers other than health maintenance organizations, participation in the medical assistance program means that (1) the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients or (2) at least 20 percent of the provider's patients are covered by medical assistance, general assistance medical care, and MinnesotaCare as their primary source of coverage. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall

provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of employee relations shall implement this section through contracts with participating health and dental carriers.

History: *1992 c 549 art 4 s 13; 1993 c 13 art 2 s 7; 1993 c 247 art 4 s 9; 1993 c 339 s 14; 1993 c 345 art 9 s 14; 1995 c 248 art 10 s 16*

256B.0645 PROVIDER PAYMENTS; RETROACTIVE CHANGES IN ELIGIBILITY.

Payment to a provider for a health care service provided to a general assistance medical care recipient who is later determined eligible for medical assistance or MinnesotaCare according to section 256.9367 for the period in which the health care service was provided, shall be considered payment in full, and shall not be adjusted due to the change in eligibility. This section applies to both fee–for–service payments and payments made to health plans on a prepaid capitated basis.

History: *1995 c 234 art 6 s 39*

256B.065 SOCIAL SECURITY AMENDMENTS.

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

History: *1973 c 717 s 7*

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

256B.071 MEDICARE MAXIMIZATION PROGRAM.

Subdivision 1. **Definition.** (a) "Dual entitlees" means recipients eligible for either the medical assistance program or the alternative care program who are also eligible for the federal Medicare program.

(b) For purposes of this section, "home care services" means home health agency services, private duty nursing services, personal care assistant services, waivered services, alternative care program services, hospice services, rehabilitation therapy services, and medical supplies and equipment.

Subd. 2. **Technical assistance to providers.** (a) The commissioner shall establish a technical assistance program to require providers of services and equipment under this section to maximize collections from the federal Medicare program. The technical assistance may include the provision of materials to help providers determine those services and equipment likely to be reimbursed by Medicare. The technical assistance may also include the provision of computer software to providers to assist in this process. The commissioner may expand the technical assistance program to include providers of other services under this chapter.

(b) Any provider of home care services enrolled in the medical assistance program, or county public health nursing agency responsible for personal care assessments, or county case managers for alternative care or medical assistance waiver programs, is required to use the method developed and supplied by the department of human services for determining Medicare coverage for home care equipment and services provided to dual entitlees to ensure appropriate billing of Medicare. The method will be developed in two phases; the first phase is a manual system effective July 1, 1996, and the second phase will automate the manual procedure by expanding the current Medicaid Management Information System (MMIS) effective January 1, 1997. Both methods will determine Medicare coverage for the dates of service and Medicare coverage for home care services, and create an audit trail including reports. Both methods will be linked to prior authorization, therefore, either method must be

used before home care services are authorized and when there is a change of condition affecting medical assistance authorization. The department will conduct periodic reviews of participant performance with the method and upon demonstrating appropriate referral and billing of Medicare, participants may be determined exempt from regular performance audits.

Subd. 3. **Referrals to Medicare certified providers required.** Non–Medicare certified and nonparticipating Medicare certified home care service providers must refer dual eligible recipients to Medicare certified providers when Medicare is determined to be the appropriate payer for supplies and equipment or services. Non–Medicare certified and nonparticipating Medicare certified home care service providers will be terminated from participation in the medical assistance program for failure to make such referrals.

Subd. 4. **Medicare certification requirement.** Medicare certification is required of all medical assistance enrolled home care service providers as defined in subdivision 1 within one year of the date the Minnesota department of health gives notice to the department that initial Medicare surveys will resume.

Subd. 5. **Advisory committee.** The commissioner shall establish an advisory committee comprised of home care services recipients, providers, county public health nurses, home care and county nursing associations, and department of human services staff to make recommendations to the Medicare maximization program. The recommendations shall include: nursing practice issues as they relate to home care services funded by Medicare and medical assistance; and streamlining assessment, prior authorization, and up–front payer determination processes to achieve administrative efficiencies.

History: *1996 c 451 art 2 s 22*

NOTE: Subdivision 3, as added by Laws 1996, chapter 451, article 2, section 22, is effective upon federal approval. Laws 1996, chapter 451, article 2, section 62.

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.

Subd. 3. **Outreach locations.** The local agency must establish locations, other than those used to process applications for cash assistance, to receive and perform initial processing of applications for pregnant women and children who want medical assistance only. At a minimum, these locations must be in federally qualified health centers and in hospitals that receive disproportionate share adjustments under section 256.969, subdivision 8, except that hospitals located outside of this state that receive the disproportionate share adjustment are not included. Initial processing of the application need not include a final determination of eligibility. Local agencies shall designate a person or persons within the agency who will receive the applications taken at an outreach location and the local agency will be responsible for timely determination of eligibility.

History: *Ex1967 c 16 s 8; 1Sp1981 c 2 s 15; 1986 c 444; 1988 c 689 art 2 s 146,268; 1991 c 292 art 4 s 50*

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 [Repealed, 1991 c 292 art 7 s 26]

256B.0911 NURSING FACILITY PREADMISSION SCREENING.

Subdivision 1. **Purpose and goal.** The purpose of the preadmission screening program is to prevent or delay certified nursing facility placements by assessing applicants and residents and offering cost–effective alternatives appropriate for the person's needs. Further, the goal of the program is to contain costs associated with unnecessary certified nursing facility 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 funding available.

Subd. 2. **Persons required to be screened; exemptions.** All applicants to Medicaid certified nursing facilities must be screened prior to admission, regardless of income, assets, or funding sources, except the following:

(1) patients who, having entered acute care facilities from certified nursing facilities, are returning to a certified nursing facility;

(2) residents transferred from other certified nursing facilities located within the state of Minnesota;

(3) individuals who have a contractual right to have their nursing facility care paid for indefinitely by the veteran's administration;

(4) individuals who are enrolled in the Ebenezer/Group Health social health maintenance organization project, or enrolled in a demonstration project under section 256B.69, subdivision 18, at the time of application to a nursing home; or

(5) individuals previously screened and currently being served under the alternative care program or under a home and community–based services waiver authorized under section 1915(c) of the Social Security Act.

Regardless of the exemptions in clauses (2) to (4), persons who have a diagnosis or possible diagnosis of mental illness, mental retardation, or a related condition must be screened before admission unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law Number 101–508.

Before admission to a Medicaid certified nursing home or boarding care home, all persons must be screened and approved for admission through an assessment process. The nursing facility is authorized to conduct case mix assessments which are not conducted by the county public health nurse under Minnesota Rules, part 9549.0059. The designated county agency is responsible for distributing the quality assurance and review form for all new applicants to nursing homes.

Other persons who are not applicants to nursing facilities must be screened if a request is made for a screening.

Subd. 2a. **Screening requirements.** Persons may be screened by telephone or in a face–to–face consultation. The screener will identify each individual's needs according to the following categories: (1) needs no face–to–face screening; (2) needs an immediate face–to–face screening interview; or (3) needs a face–to–face screening interview after admission to a certified nursing facility or after a return home. The screener shall confer with the screening team to ensure that the health and social needs of the individual are assessed. Persons who are not admitted to a Medicaid certified nursing facility must be screened within ten working days after the date of referral. Persons admitted on a nonemergency basis to a Medicaid certi-

fied nursing facility must be screened prior to the certified nursing facility admission. Persons admitted to the Medicaid certified nursing facility from the community on an emergency basis or from an acute care facility on a nonworking day must be screened the first working day after admission and the reason for the emergency admission must be certified by the attending physician in the person's medical record.

Subd. 3. **Persons responsible for conducting the preadmission screening.** (a) A local screening team shall be established by the county board of commissioners. Each local screening team shall consist of screeners who are a social worker and a public health nurse from their respective county agencies. If a county does not have a public health nurse available, it may request approval from the commissioner to assign a county registered nurse with at least one year experience in home care to participate on the team. The screening team members must confer regarding the most appropriate care for each individual screened. Two or more counties may collaborate to establish a joint local screening team or teams.

(b) In assessing a person's needs, screeners shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician shall be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the county agencies.

Subd. 4. **Responsibilities of the county and the screening team.** (a) The county shall:

(1) provide information and education to the general public regarding availability of the preadmission screening program;

(2) accept referrals from individuals, families, human service and health professionals, and hospital and nursing facility personnel;

(3) assess the health, psychological, and social needs of referred individuals and identify services needed to maintain these persons in the least restrictive environments;

(4) determine if the individual screened needs nursing facility level of care;

(5) assess specialized service needs based upon an evaluation by:

(i) a qualified independent mental health professional for persons with a primary or secondary diagnosis of a serious mental illness; and

(ii) a qualified mental retardation professional for persons with a primary or secondary diagnosis of mental retardation or related conditions. For purposes of this clause, 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;

(6) make recommendations for individuals screened regarding cost–effective community services which are available to the individual;

(7) make recommendations for individuals screened regarding nursing home placement when there are no cost–effective community services available;

(8) develop an individual's community care plan and provide follow–up services as needed; and

(9) prepare and submit reports that may be required by the commissioner of human services.

(b) The screener shall document that the most cost–effective alternatives available were offered to the individual or the individual's legal representative. For purposes of this section, "cost–effective alternatives" means community services and living arrangements that cost the same or less than nursing facility care.

(c) Screeners shall adhere to the level of care criteria for admission to a certified nursing facility established under section 144.0721.

(d) For persons who are eligible for medical assistance or who would be eligible within 180 days of admission to a nursing facility and who are admitted to a nursing facility, the nursing facility must include a screener or the case manager in the discharge planning process for those individuals who the team has determined have discharge potential. The screener or the case manager must ensure a smooth transition and follow–up for the individual's return to the community.

Screeners shall cooperate with other public and private agencies in the community, in order to offer a variety of cost–effective services to the disabled and elderly. The screeners

shall encourage the use of volunteers from families, religious organizations, social clubs, and similar civic and service organizations to provide services.

Subd. 5. **Simplification of forms.** The commissioner shall minimize the number of forms required in the preadmission screening process and shall limit the screening document to items necessary for care plan approval, reimbursement, program planning, evaluation, and policy development.

Subd. 6. **Payment for preadmission screening.** (a) The total screening payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for screenings by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility.

(b) Payments for screening activities are available to the county or counties to cover staff salaries and expenses to provide the screening function. The lead agency shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to conduct the preadmission screening activity while meeting the state's long-term care outcomes and objectives as defined in section 256B.0917, subdivision 1. The local agency shall be accountable for meeting local objectives as approved by the commissioner in the CSSA biennial plan.

(c) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(d) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local screening teams.

Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance reimbursement for nursing facilities shall be authorized for a medical assistance recipient only if a preadmission screening has been conducted prior to admission or the local county agency has authorized an exemption. Medical assistance reimbursement for nursing facilities shall not be provided for any recipient who the local screener has determined does not meet the level of care criteria for nursing facility placement or, if indicated, has not had a level II PASARR evaluation completed unless an admission for a recipient with mental illness is approved by the local mental health authority or an admission for a recipient with mental retardation or related condition is approved by the state mental retardation authority. The county preadmission screening team may deny certified nursing facility admission using the level of care criteria established under section 144.0721 and deny medical assistance reimbursement for certified nursing facility care. Persons receiving care in a certified nursing facility or certified boarding care home who are reassessed and no longer meet the level of care criteria for a certified nursing facility or certified boarding care home may no longer remain a resident in the certified nursing facility or certified boarding care home and must be relocated to the community if the persons were admitted on or after July 1, 1996. Persons receiving services under section 256B.0913, subdivisions 1 to 14, or 256B.0915 who are reassessed and found to not meet the level of care criteria for admission to a certified nursing facility or certified boarding care home may no longer receive these services after July 1, 1996. The commissioner shall make a request to the health care financing administration for a waiver allowing screening team approval of Medicaid payments for certified nursing facility care. An individual has a choice and makes the final decision between nursing facility placement and community placement after the screening team's recommendation, except as provided in paragraphs (b) and (c).

(b) The local county mental health authority or the state mental retardation authority under Public Law Numbers 100–203 and 101–508 may prohibit admission to a nursing facility, if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100–203 and 101–508. For purposes of this section, "specialized services" for a person with mental retardation or a related condition means "active treatment" as that term is defined in Code of Federal Regulations, title 42, section 483.440(a)(1).

(c) Upon the receipt by the commissioner of approval by the Secretary of Health and Human Services of the waiver requested under paragraph (a), the local screener shall deny

medical assistance reimbursement for nursing facility care for an individual whose long–term care needs can be met in a community–based setting and whose cost of community–based home care services is less than 75 percent of the average payment for nursing facility care for that individual's case mix classification, and who is either:

(i) a current medical assistance recipient being screened for admission to a nursing facility; or

(ii) an individual who would be eligible for medical assistance within 180 days of entering a nursing facility and who meets a nursing facility level of care.

(d) Appeals from the screening team's recommendation or the county agency's final decision shall be made according to section 256.045, subdivision 3.

Subd. 8. **Advisory committee.** The commissioner shall appoint an advisory committee to advise the commissioner on the preadmission screening program, the alternative care program under section 256B.0913, and the home and community–based services waiver programs for the elderly and the disabled. The advisory committee shall review policies and procedures and provide advice and technical assistance to the commissioner regarding the effectiveness and the efficient administration of the programs. The advisory committee must consist of not more than 22 people appointed by the commissioner and must be comprised of representatives from public agencies, public and private service providers, two representatives of nursing home associations, and consumers from all areas of the state. Members of the advisory committee must not be compensated for service.

Subd. 9. **Case mix assessments.** The nursing facility is authorized to conduct all case mix assessments for persons who have been admitted to the facility prior to a preadmission screening. The county shall conduct the case mix assessment for all persons screened within ten working days prior to admission. The county retains the responsibility of distributing appropriate case mix forms to the nursing facility.

History: *1991 c 292 art 7 s 14; 1992 c 513 art 7 s 53–55; 1Sp1993 c 1 art 5 s 56–61; 1995 c 207 art 6 s 57–61*

NOTE: The amendment to subdivision 7, paragraph (c), by Laws 1993, First Special Session chapter 1, article 5, section 61, was to become effective upon the receipt by the commissioner of human services of the requested waiver from the Secretary of Human Services, for persons screened for admission to a nursing facility on or after the date the waiver was received. See Laws 1993, First Special Session chapter 1, article 5, section 135. However, according to the department of human services, the provisions the waiver would have established were found to be in conflict with other federal regulations and the department of human services withdrew the waiver request.

256B.0912 ALTERNATIVE CARE AND WAIVERED SERVICE PROGRAMS.

Subdivision 1. **Restructuring plan.** By January 1, 1996, the commissioner shall present a plan to the legislature to restructure administration of the alternative care, elderly waiver, and disabled waiver programs. The plan must demonstrate cost neutrality and provide counties with the flexibility, authority, and accountability to administer home and community–based service programs within predetermined fixed budgets. To support this local program administration, the commissioner shall explore options with the health care financing administration to assure flexibility to expand core services within the elderly and disabled waivers as long as cost neutrality is maintained.

Subd. 2. **Waiver program modifications.** The commissioner of human services shall make the following modifications in medical assistance waiver programs, effective for services rendered after June 30, 1995, or, if necessary, after federal approval is granted:

(a) The community alternatives for disabled individuals waiver shall:

(1) if medical supplies and equipment or adaptations are or will be purchased for a waiver services recipient, allow the prorating of costs on a monthly basis throughout the year in which they are purchased. If the monthly cost of a recipient's other waivered services exceeds the monthly limit established in this paragraph, the annual cost of the waivered services shall be determined. In this event, the annual cost of waivered services shall not exceed 12 times the monthly limit calculated in this paragraph;

(2) require client reassessments once every 12 months;

(3) permit the purchase of supplies and equipment costing $150 or less without prior approval of the commissioner of human services. A county is not required to contract with a

provider of supplies and equipment if the monthly cost of supplies and equipment is less than $250; and

(4) allow the implementation of care plans without the approval of the county of financial responsibility when the client receives services from another county.

(b) The traumatic brain injury waiver shall:

(1) require client reassessments once every 12 months;

(2) permit the purchase of supplies and equipment costing $250 or less without having a contract with the supplier; and

(3) allow the implementation of care plans without the approval of the county of financial responsibility when the client receives services from another county.

History: *1995 c 207 art 6 s 62*

256B.0913 ALTERNATIVE CARE PROGRAM.

Subdivision 1. **Purpose and goals.** The purpose of the alternative care program is to provide funding for or access to home and community–based services for frail elderly persons, in order to limit nursing facility placements. The program is designed to support frail elderly persons in their desire to remain in the community as independently and as long as possible and to support informal caregivers in their efforts to provide care for frail elderly people. Further, the goals of the program are:

(1) to contain medical assistance expenditures by providing care in the community at a cost the same or less than nursing facility costs; and

(2) to maintain the moratorium on new construction of nursing home beds.

Subd. 2. **Eligibility for services.** Alternative care services are available to all frail older Minnesotans. This includes:

(1) persons who are receiving medical assistance and served under the medical assistance program or the Medicaid waiver program;

(2) persons who would be eligible for medical assistance within 180 days of admission to a nursing facility and served under subdivisions 4 to 13; and

(3) persons who are paying for their services out–of–pocket.

Subd. 3. **Eligibility for funding for services for medical assistance recipients.** Funding for services for persons who are eligible for medical assistance is available under section 256B.0627, governing home care services, or 256B.0915, governing the Medicaid waiver for home and community–based services.

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been screened by the county screening team or, if previously screened and served under the alternative care program, assessed by the local county social worker or public health nurse;

(2) the person is age 65 or older;

(3) the person would be financially eligible for medical assistance within 180 days of admission to a nursing facility;

(4) the person meets the asset transfer requirements of the medical assistance program;

(5) the screening team would recommend nursing facility admission or continued stay for the person if alternative care services were not available;

(6) the person needs services that are not available at that time in the county through other county, state, or federal funding sources; and

(7) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the statewide average monthly medical assistance payment for nursing facility care at the individual's case mix classification to which the individual would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. If medical supplies and equipment or adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis throughout the year in which they are

purchased. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit calculated in this paragraph.

(b) Individuals who meet the criteria in paragraph (a) and who have been approved for alternative care funding are called 180-day eligible clients.

(c) The statewide average payment for nursing facility care is the statewide average monthly nursing facility rate in effect on July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing facility residents who are age 65 or older and who are medical assistance recipients in the month of March of the previous fiscal year. This monthly limit does not prohibit the 180-day eligible client from paying for additional services needed or desired.

(d) In determining the total costs of alternative care services for one month, the costs of all services funded by the alternative care program, including supplies and equipment, must be included.

(e) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown, unless authorized by the commissioner. A person whose application for medical assistance is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, the county must bill medical assistance from the date the individual was found eligible for services reimbursable under the elderly waiver program.

(f) Alternative care funding is not available for a person who resides in a licensed nursing home or boarding care home, except for case management services which are being provided in support of the discharge planning process.

Subd. 5. **Services covered under alternative care.** (a) Alternative care funding may be used for payment of costs of:

(1) adult foster care;

(2) adult day care;

(3) home health aide;

(4) homemaker services;

(5) personal care;

(6) case management;

(7) respite care;

(8) assisted living;

(9) residential care services;

(10) care-related supplies and equipment;

(11) meals delivered to the home;

(12) transportation;

(13) skilled nursing;

(14) chore services;

(15) companion services;

(16) nutrition services;

(17) training for direct informal caregivers; and

(18) telemedicine devices to monitor recipients in their own homes as an alternative to hospital care, nursing home care, or home visits.

(b) The county agency must ensure that the funds are used only to supplement and not supplant services available through other public assistance or services programs.

(c) Unless specified in statute, the service standards for alternative care services shall be the same as the service standards defined in the elderly waiver. Persons or agencies must be employed by or under a contract with the county agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program.

(d) The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board. The adult foster care daily rate shall be negotiated between the

county agency and the foster care provider. The rate established under this section shall not exceed 75 percent of the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned, and it must allow for other alternative care services to be authorized by the case manager.

(e) Personal care services may be provided by a personal care provider organization. A county agency may contract with a relative of the client to provide personal care services, but must ensure nursing supervision. Covered personal care services defined in section 256B.0627, subdivision 4, must meet applicable standards in Minnesota Rules, part 9505.0335.

(f) A county may use alternative care funds to purchase medical supplies and equipment without prior approval from the commissioner when: (1) there is no other funding source; (2) the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, item A; and (3) the supplies and equipment represent an effective and appropriate use of alternative care funds. A county may use alternative care funds to purchase supplies and equipment from a non–Medicaid certified vendor if the cost for the items is less than that of a Medicaid vendor. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

(g) For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments and are registered with the department of health as providing special services. Residential care services are defined as "supportive services" and "health–related services." "Supportive services" means the provision of up to 24–hour supervision and oversight. Supportive services includes: (1) transportation, when provided by the residential care center only; (2) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature; (3) assisting clients in setting up meetings and appointments; (4) assisting clients in setting up medical and social services; (5) providing assistance with personal laundry, such as carrying the client's laundry to the laundry room. Assistance with personal laundry does not include any laundry, such as bed linen, that is included in the room and board rate. Health–related services are limited to minimal assistance with dressing, grooming, and bathing and providing reminders to residents to take medications that are self–administered or providing storage for medications, if requested. Individuals receiving residential care services cannot receive both personal care services and residential care services.

(h) For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units. Assisted living services are defined as up to 24–hour supervision, and oversight, supportive services as defined in clause (1), individualized home care aide tasks as defined in clause (2), and individualized home management tasks as defined in clause (3) provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

(1) Supportive services include:

(i) socialization, when socialization is part of the plan of care, has specific goals and outcomes established, and is not diversional or recreational in nature;

(ii) assisting clients in setting up meetings and appointments; and

(iii) providing transportation, when provided by the residential center only.

Individuals receiving assisted living services will not receive both assisted living services and homemaking or personal care services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions.

(2) Home care aide tasks means:

(i) preparing modified diets, such as diabetic or low sodium diets;

(ii) reminding residents to take regularly scheduled medications or to perform exercises;

(iii) household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

(iv) household chores when the resident's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

(v) assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the resident is ambulatory, and if the resident has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

(3) Home management tasks means:

(i) housekeeping;

(ii) laundry;

(iii) preparation of regular snacks and meals; and

(iv) shopping.

Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

(i) For the purposes of this section, reimbursement for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency. The rate shall not exceed the nonfederal share of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate of the case mix resident class to which the 180–day eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. For alternative care assisted living projects established under Laws 1988, chapter 689, article 2, section 256, monthly rates may not exceed 65 percent of the greater of either statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate of the case mix resident class to which the 180–day eligible client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The rate may not cover rent and direct food costs.

(j) For purposes of this section, companion services are defined as nonmedical care, supervision and oversight, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands–on medical care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the recipient. This service must be approved by the case manager as part of the care plan. Companion services must be provided by individuals or nonprofit organizations who are under contract with the local agency to provide the service. Any person related to the waiver recipient by blood, marriage or adoption cannot be reimbursed under this service. Persons providing companion services will be monitored by the case manager.

(k) For purposes of this section, training for direct informal caregivers is defined as a classroom or home course of instruction which may include: transfer and lifting skills, nutrition, personal and physical cares, home safety in a home environment, stress reduction and management, behavioral management, long–term care decision making, care coordination and family dynamics. The training is provided to an informal unpaid caregiver of a 180–day eligible client which enables the caregiver to deliver care in a home setting with high levels of quality. The training must be approved by the case manager as part of the individual care plan. Individuals, agencies, and educational facilities which provide caregiver training and education will be monitored by the case manager.

Subd. 6. **Alternative care program administration.** The alternative care program is administered by the county agency. This agency is the lead agency responsible for the local administration of the alternative care program as described in this section. However, it may contract with the public health nursing service to be the lead agency.

Subd. 7. **Case management.** The lead agency shall appoint a social worker from the county agency or a registered nurse from the county public health nursing service of the local board of health to be the case manager for any person receiving services funded by the alternative care program. The case manager must ensure the health and safety of the individual

client and is responsible for the cost–effectiveness of the alternative care individual care plan. The county may allow a case manager to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

Subd. 8. **Requirements for individual care plan.** (a) The case manager shall implement the plan of care for each 180–day eligible client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The county shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The lead 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. The lead agency 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 case manager must give the individual a ten–day written notice of any decrease in or termination of alternative care services.

(b) If the county administering alternative care services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

Subd. 9. **Contracting provisions for providers.** The lead 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 program or waiver programs under sections 256B.0915 and 256B.49, 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. The lead agency shall also document to the commissioner that the agency allowed potential providers an opportunity to be selected to contract with the county agency. Funds reimbursed to counties under this subdivision are subject to audit by the commissioner for fiscal and utilization control.

The lead agency 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.

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.

Subd. 10. **Allocation formula.** (a) The alternative care appropriation for fiscal years 1992 and beyond shall cover only 180–day eligible clients.

(b) Prior to July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2. The allocation for fiscal year 1992 shall be calculated using a base that is adjusted to exclude the medical assistance share of alternative care expenditures. The adjusted base is calculated by mul-

tiplying each county's allocation for fiscal year 1991 by the percentage of county alternative care expenditures for 180–day eligible clients. The percentage is determined based on expenditures for services rendered in fiscal year 1989 or calendar year 1989, whichever is greater.

(c) If the county expenditures for 180–day eligible clients are 95 percent or more of its adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the county expenditures for 180–day eligible clients are less than 95 percent of its adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) For fiscal year 1992 only, a county may receive an increased allocation if annualized service costs for the month of May 1991 for 180–day eligible clients are greater than the allocation otherwise determined. A county may apply for this increase by reporting projected expenditures for May to the commissioner by June 1, 1991. The amount of the allocation may exceed the amount calculated in paragraph (b). The projected expenditures for May must be based on actual 180–day eligible client caseload and the individual cost of clients' care plans. If a county does not report its expenditures for May, the amount in paragraph (c) or (d) shall be used.

(f) Calculations for paragraphs (c) and (d) are to be made as follows: for each county, the determination of expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted by June 1 of that year.

Subd. 11. **Targeted funding.** (a) The purpose of targeted funding is to make additional money available to counties with the greatest need. Targeted funds are not intended to be distributed equitably among all counties, but rather, allocated to those with long–term care strategies that meet state goals.

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus county allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to counties that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) counties that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) counties that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) counties that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) counties that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) Counties that would receive targeted funds according to paragraph (c) must demonstrate to the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall request applications by June 1 each year, for county agencies to apply for targeted funds. The counties selected for targeted funds shall be notified of the amount of their additional funding by August 1 of each year. Targeted funds allocated to a county agency in one year shall be treated as part of the county's base allocation for that year in determining allocations for subsequent years. No reallocations between counties shall be made.

(f) The allocation for each year after fiscal year 1992 shall be determined using the previous fiscal year's allocation, including any targeted funds, as the base and then applying the criteria under subdivision 10, paragraphs (c), (d), and (f), to the current year's expenditures.

Subd. 12. **Client premiums.** (a) A premium is required for all 180-day eligible clients to help pay for the cost of participating in the program. The amount of the premium for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is greater than the medical assistance income standard but less than 150 percent of the federal poverty guideline, and total assets are less than $6,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is greater than 150 percent of the federal poverty guideline, and total assets are less than $6,000, the fee is 25 percent of the cost of alternative care services or the difference between 150 percent of the federal poverty guideline and the client's income less recurring and predictable medical expenses, whichever is less; and

(3) when the alternative care client's total assets are greater than $6,000, the fee is 25 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services except case management shall be included in the estimated costs for the purpose of determining 25 percent of the costs.

The monthly premium shall be calculated based on the cost of the first full month of alternative care services and shall continue unaltered until the next reassessment is completed or at the end of 12 months, whichever comes first. Premiums are due and payable each month alternative care services are received unless the actual cost of the services is less than the premium.

(b) The fee shall be waived by the commissioner when:

(1) a person who is residing in a nursing facility is receiving case management only;

(2) a person is applying for medical assistance;

(3) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(4) a person is a medical assistance recipient, but has been approved for alternative care-funded assisted living services;

(5) a person is found eligible for alternative care, but is not yet receiving alternative care services; or

(6) a person's fee under paragraph (a) is less than $25.

(c) The county agency must collect the premium from the client and forward the amounts collected to the commissioner in the manner and at the times prescribed by the commissioner. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the county with the client's social security number at the time of application. If a client fails or refuses to pay the premium due, the county shall supply the commissioner with the client's social security number and other information the commissioner requires to collect the premium from the client. The commissioner shall collect unpaid premiums using the revenue recapture act in chapter 270A and other methods available to the commissioner. The commissioner may require counties to inform clients of the collection procedures that may be used by the state if a premium is not paid.

(d) The commissioner shall begin to adopt emergency or permanent rules governing client premiums within 30 days after July 1, 1991, including criteria for determining when services to a client must be terminated due to failure to pay a premium.

Subd. 13. **County biennial plan.** The county biennial plan for the preadmission screening program, the alternative care program, waivers for the elderly under section 256B.0915, and waivers for the disabled under section 256B.49, shall be incorporated into the biennial community social services act plan and shall meet the regulations and timelines of that plan. This county biennial plan shall include:

(1) information on the administration of the preadmission screening program;

(2) information on the administration of the home and community–based services waivers for the elderly under section 256B.0915, and for the disabled under section 256B.49; and

(3) information on the administration of the alternative care program.

Subd. 14. **Reimbursement and rate adjustments.** (a) Reimbursement for expenditures for the alternative care services as approved by the client's case manager shall be through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive reimbursement, the county or vendor must submit invoices within 12 months following the date of service. The county agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

(b) If a county collects less than 50 percent of the client premiums due under subdivision 12, the commissioner may withhold up to three percent of the county's final alternative care program allocation determined under subdivisions 10 and 11.

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

(d) For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for alternative care services. The commissioner of finance shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in reimbursement rates for alternative care services based on the forecasted percentage change in the Home Health Agency Market Basket of Operating Costs, for the fiscal year beginning July 1, compared to the previous fiscal year, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc. The forecast to be used is the one published for the calendar quarter beginning January 1, six months prior to the beginning of the fiscal year for which rates are set.

(e) The county shall negotiate individual rates with vendors and may be reimbursed for actual costs up to the greater of the county's current approved rate or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each alternative care service. Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature.

(f) On July 1, 1993, the commissioner shall increase the maximum rate for home delivered meals to $4.50 per meal.

Subd. 15. **Service allowance fund availability.** (a) Effective July 1, 1996, the commissioner may use alternative care funds for services to high function class A persons as defined in section 144.0721, subdivision 3, clause (2). The county alternative care grant allocation will be supplemented with a special allocation amount based on the projected number of eligible high function class A's and computed on the basis of $240 per month per projected eligible person. Individual monthly expenditures under the service allowance option are permitted to be either greater or less than the amount of $240 per month based on individual need. County allocations shall be adjusted periodically based on the actual provision of services to high function class A persons.

(b) Counties shall have the option of providing services, cash service allowances, vouchers, or a combination of these options to high function class A persons defined in section 144.0721, subdivision 3, clause (2). High function class A persons may choose services from among the categories of services listed under subdivision 5, except for case management services.

(c) If the allocation to a county is not sufficient to serve all persons who qualify for alternative care services, the county is not required to provide any alternative care services to a high function class A person but shall establish a waiting list to provide services as funding becomes available.

Subd. 15a. **Reimbursement rate; Anoka county.** Notwithstanding subdivision 14, paragraph (e), effective January 1, 1996, Anoka county's maximum allowed rate for home health aide services per 15–minute unit is $4.39, and its maximum allowed rate for home-

maker services per 15–minute unit is $2.90. Any adjustments in fiscal year 1997 to the maximum allowed rates for home health aide or homemaker services for Anoka county shall be calculated from the maximum rate in effect on January 1, 1996.

Subd. 15b. **Reimbursement rate; Aitkin county.** Notwithstanding subdivision 14, paragraph (e), effective April 1, 1996, Aitkin county's maximum allowed rate for in–home respite care services is $6.62 per 30–minute unit. Any adjustments in fiscal year 1997 to the maximum allowed rate for in–home respite care services for Aitkin county shall be calculated from the maximum rate in effect on April 1, 1996.

Subd. 15c. **Reimbursement rate; Polk and Pennington counties.** Notwithstanding subdivision 14, paragraph (e), effective July 1, 1996, Polk and Pennington counties' maximum allowed rate for homemaker services is $6.18 per 30–minute unit. Any adjustments in fiscal year 1997 to the maximum allowed rate for homemaker services for Polk and Pennington counties shall be calculated from the maximum rate in effect on July 1, 1996.

History: *1991 c 292 art 7 s 15; 1992 c 464 art 2 s 1; 1992 c 513 art 7 s 56–61; 1Sp1993 c 1 art 5 s 62–67; 1Sp1993 c 6 s 12; 1995 c 207 art 6 s 63–69; art 9 s 60; 1995 c 263 s 8; 1996 c 451 art 2 s 23–25; art 4 s 70; art 5 s 21,22*

256B.0915 MEDICAID WAIVER FOR HOME AND COMMUNITY–BASED SERVICES.

Subdivision 1. **Authority.** The commissioner is authorized to apply for a home and community–based services waiver for the elderly, authorized under section 1915(c) of the Social Security Act, in order to obtain federal financial participation to expand the availability of services for persons who are eligible for medical assistance. The commissioner may apply for additional waivers or pursue other federal financial participation which is advantageous to the state for funding home care services for the frail elderly who are eligible for medical assistance. The provision of waivered services to elderly and disabled medical assistance recipients must comply with the criteria approved in the waiver.

Subd. 1a. **Elderly waiver case management services.** Elderly case management services under the home and community–based services waiver for elderly individuals are available from providers meeting qualification requirements and the standards specified in subdivision 1b. Eligible recipients may choose any qualified provider of elderly case management services.

Subd. 1b. **Provider qualifications and standards.** The commissioner must enroll qualified providers of elderly case management services under the home and community–based waiver for the elderly under section 1915(c) of the Social Security Act. The enrollment process shall ensure the provider's ability to meet the qualification requirements and standards in this subdivision and other federal and state requirements of this service. An elderly case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the legal authority for alternative care program administration under section 256B.0913;

(2) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(3) administrative capacity and experience in serving the target population for whom it will provide services and in ensuring quality of services under state and federal requirements;

(4) the legal authority to provide preadmission screening under section 256B.0911, subdivision 4;

(5) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(6) the capacity to document and maintain individual case records under state and federal requirements; and

(7) the county may allow a case manager to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which re-

quire professional judgment including assessments, reassessments, and care plan development.

Subd. 1c. **Case management activities under the state plan.** The commissioner shall seek an amendment to the home and community–based services waiver for the elderly to implement the provisions of subdivisions 1a and 1b. If the commissioner is unable to secure the approval of the secretary of health and human services for the requested waiver amendment by December 31, 1993, the commissioner shall amend the medical assistance state plan to provide that case management provided under the home and community–based services waiver for the elderly is performed by counties as an administrative function for the proper and effective administration of the state medical assistance plan. Notwithstanding section 256.025, subdivision 3, the state shall reimburse counties for the nonfederal share of costs for case management performed as an administrative function under the home and community–based services waiver for the elderly.

Subd. 2. **Spousal impoverishment policies.** The commissioner shall seek to amend the federal waiver and the medical assistance state plan to allow spousal impoverishment criteria as authorized under United States Code, title 42, section 1396r–5, and as implemented in sections 256B.0575, 256B.058, and 256B.059, except that the amendment shall seek to add to the personal needs allowance permitted in section 256B.0575, an amount equivalent to the group residential housing rate as set by section 256I.03, subdivision 5.

Subd. 3. **Limits of cases, rates, reimbursement, and forecasting.** (a) The number of medical assistance waiver recipients that a county may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

(b) The monthly limit for the cost of waivered services to an individual waiver client shall be the statewide average payment rate of the case mix resident class to which the waiver client would be assigned under the medical assistance case mix reimbursement system. If medical supplies and equipment or adaptations are or will be purchased for an elderly waiver services recipient, the costs may be prorated on a monthly basis throughout the year in which they are purchased. If the monthly cost of a recipient's other waivered services exceeds the monthly limit established in this paragraph, the annual cost of the waivered services shall be determined. In this event, the annual cost of waivered services shall not exceed 12 times the monthly limit calculated in this paragraph. The statewide average payment rate is calculated by determining the statewide average monthly nursing home rate, effective July 1 of the fiscal year in which the cost is incurred, less the statewide average monthly income of nursing home residents who are age 65 or older, and who are medical assistance recipients in the month of March of the previous state fiscal year. The annual cost divided by 12 of elderly or disabled waivered services for a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly or disabled waivered services shall not exceed the monthly payment for the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides. The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waivered services, including extended medical supplies and equipment; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

(c) Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the individual care plan.

(d) For both the elderly waiver and the nursing facility disabled waiver, a county may purchase extended supplies and equipment without prior approval from the commissioner when there is no other funding source and the supplies and equipment are specified in the individual's care plan as medically necessary to enable the individual to remain in the community according to the criteria in Minnesota Rules, part 9505.0210, items A and B. A county is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.

(e) For the fiscal year beginning on July 1, 1993, and for subsequent fiscal years, the commissioner of human services shall not provide automatic annual inflation adjustments for home and community–based waivered services. The commissioner of finance shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11, annual adjustments in reimbursement rates for home and community–based waivered services, based on the forecasted percentage change in the Home Health Agency Market Basket of Operating Costs, for the fiscal year beginning July 1, compared to the previous fiscal year, unless otherwise adjusted by statute. The Home Health Agency Market Basket of Operating Costs is published by Data Resources, Inc. The forecast to be used is the one published for the calendar quarter beginning January 1, six months prior to the beginning of the fiscal year for which rates are set. The adult foster care rate shall be considered a difficulty of care payment and shall not include room and board.

(f) The adult foster care daily rate for the elderly and disabled waivers shall be negotiated between the county agency and the foster care provider. The rate established under this section shall not exceed the state average monthly nursing home payment for the case mix classification to which the individual receiving foster care is assigned; the rate must allow for other waiver and medical assistance home care services to be authorized by the case manager.

(g) The assisted living and residential care service rates for elderly and community alternatives for disabled individuals (CADI) waivers shall be made to the vendor as a monthly rate negotiated with the county agency. The rate shall not exceed the nonfederal share of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate of the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. For alternative care assisted living projects established under Laws 1988, chapter 689, article 2, section 256, monthly rates may not exceed 65 percent of the greater of either the statewide or any of the geographic groups' weighted average monthly medical assistance nursing facility payment rate for the case mix resident class to which the elderly or disabled client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059. The rate may not cover direct rent or food costs.

(h) The county shall negotiate individual rates with vendors and may be reimbursed for actual costs up to the greater of the county's current approved rate or 60 percent of the maximum rate in fiscal year 1994 and 65 percent of the maximum rate in fiscal year 1995 for each service within each program.

(i) On July 1, 1993, the commissioner shall increase the maximum rate for home–delivered meals to $4.50 per meal.

(j) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

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

Subd. 3a. **Reimbursement rate; Anoka county.** Notwithstanding subdivision 3, paragraph (h), effective January 1, 1996, Anoka county's maximum allowed rate for home health aide services per 15–minute unit is $4.43, and its maximum allowed rate for homemaker services per 15–minute unit is $2.93. Any adjustments in fiscal year 1997 to the maximum allowed rates for home health aide or homemaker services for Anoka county shall be calculated from the maximum rate in effect on January 1, 1996.

Subd. 3b. **Reimbursement rate; Aitkin county.** Notwithstanding subdivision 3, paragraph (h), effective April 1, 1996, Aitkin county's maximum allowed rate for in–home respite care services is $6.67 per 30–minute unit. Any adjustments in fiscal year 1997 to the maximum allowed rate for in–home respite care services for Aitkin county shall be calculated from the maximum rate in effect on April 1, 1996.

Subd. 3c. **Reimbursement rate; Polk and Pennington counties.** Notwithstanding subdivision 3, paragraph (h), effective July 1, 1996, Polk and Pennington counties' maximum allowed rate for homemaker services is $6.25 per 30–minute unit. Any adjustments in fiscal year 1997 to the maximum allowed rate for homemaker services for Polk and Pennington counties shall be calculated from the maximum rate in effect on July 1, 1996.

Subd. 4. **Termination notice.** The case manager must give the individual a ten–day written notice of any decrease in or termination of waivered services.

Subd. 5. **Reassessments for waiver clients.** A reassessment of a client served under the elderly or disabled waiver must be conducted at least every 12 months and at other times when the case manager determines that there has been significant change in the client's functioning. This may include instances where the client is discharged from the hospital.

Subd. 6. **Implementation of care plan.** If the county administering waivered services is different than the county of financial responsibility, the care plan may be implemented without the approval of the county of financial responsibility.

History: *1991 c 292 art 7 s 16; 1992 c 513 art 7 s 62–64; 1Sp1993 c 1 art 5 s 68–72; 1Sp1993 c 6 s 13; 1995 c 207 art 6 s 70–74; 1995 c 263 s 9; 1996 c 451 art 2 s 26–28; art 5 s 23,24*

256B.0916 EXPANSION OF HOME AND COMMUNITY–BASED SERVICES.

(a) The commissioner shall expand availability of home and community–based services for persons with mental retardation and related conditions to the extent allowed by federal law and regulation and shall assist counties in transferring persons from semi–independent living services to home and community–based services. The commissioner may transfer funds from the state semi–independent living services account available under section 252.275, subdivision 8, and state community social services aids available under section 256E.15 to the medical assistance account to pay for the nonfederal share of nonresidential and residential home and community–based services authorized under section 256B.092 for persons transferring from semi–independent living services.

(b) Upon federal approval, county boards are not responsible for funding semi–independent living services as a social service for those persons who have transferred to the home and community–based waiver program as a result of the expansion under this subdivision. The county responsibility for those persons transferred shall be assumed under section 256B.092. Notwithstanding the provisions of section 252.275, the commissioner shall continue to allocate funds under that section for semi–independent living services and county boards shall continue to fund services under sections 256E.06 and 256E.14 for those persons who cannot access home and community–based services under section 256B.092.

(c) Eighty percent of the state funds made available to the commissioner under section 252.275 as a result of persons transferring from the semi–independent living services program to the home and community–based services program shall be used to fund additional persons in the semi–independent living services program.

History: *1Sp1993 c 1 art 4 s 8*

256B.0917 SENIORS' AGENDA FOR INDEPENDENT LIVING (SAIL) PROJECTS FOR A NEW LONG–TERM CARE STRATEGY.

Subdivision 1. **Purpose, mission, goals, and objectives.** (a) The purpose of implementing seniors' agenda for independent living (SAIL) projects under this section is to demonstrate a new cooperative strategy for the long–term care system in the state of Minnesota.

The projects are part of the initial plan for a 20–year strategy. The mission of the 20–year strategy is to create a new community–based care paradigm for long–term care in Minnesota in order to maximize independence of the older adult population, and to ensure cost–effective use of financial and human resources. The goals for the 20–year strategy are to:

(1) achieve a broad awareness and use of low–cost home care and other residential alternatives to nursing homes;

(2) develop a statewide system of information and assistance to enable easy access to long–term care services;

(3) develop sufficient alternatives to nursing homes to serve the increased number of people needing long–term care;

(4) maintain the moratorium on new construction of nursing home beds and to lower the percentage of elderly persons served in institutional settings; and

(5) build a community–based approach and community commitment to delivering long–term care services for elderly persons in their homes.

(b) The objective for the fiscal years 1994 and 1995 biennial plan is to continue at least four but not more than six projects in anticipation of a statewide program. These projects will continue the process of implementing:

(1) a coordinated planning and administrative process;

(2) a refocused function of the preadmission screening program;

(3) the development of additional home, community, and residential alternatives to nursing homes;

(4) a program to support the informal caregivers for elderly persons;

(5) programs to strengthen the use of volunteers; and

(6) programs to support the building of community commitment to provide long–term care for elderly persons.

This is done in conjunction with an expanded role of the interagency long–term care planning committee as described in section 144A.31. The services offered through these projects will be available to those who have their own funds to pay for services, as well as to persons who are eligible for medical assistance and to persons who are 180–day eligible clients to the extent authorized in this section.

Subd. 2. **Design of SAIL projects; local long–term care coordinating team.** (a) The commissioner of human services in conjunction with the interagency long–term care planning committee's long–range strategic plan shall contract with SAIL projects in four to six counties or groups of counties to demonstrate the feasibility and cost–effectiveness of a local long–term care strategy that is consistent with the state's long–term care goals identified in subdivision 1. The commissioner shall publish a notice in the State Register announcing the availability of project funding and giving instructions for making an application. The instructions for the application shall identify the amount of funding available for project components.

(b) To be selected for the project, a county board or boards must establish a long–term care coordinating team consisting of county social service agencies, public health nursing service agencies, local boards of health, a representative of local nursing home providers, a representative of local home care providers, and the area agencies on aging in a geographic area which is responsible for:

(1) developing a local long–term care strategy consistent with state goals and objectives;

(2) submitting an application to be selected as a project;

(3) coordinating planning for funds to provide services to elderly persons, including funds received under Title III of the Older Americans Act, Community Social Services Act, Title XX of the Social Security Act and the Local Public Health Act; and

(4) ensuring efficient services provision and nonduplication of funding.

(c) The board or boards shall designate a public agency to serve as the lead agency. The lead agency receives and manages the project funds from the state and is responsible for the implementation of the local strategy. If selected as a project, the local long–term care coordinating team must semiannually evaluate the progress of the local long–term care strategy in meeting state measures of performance and results as established in the contract.

(d) Each member of the local coordinating team must indicate its endorsement of the local strategy. The local long–term care coordinating team may include in its membership other units of government which provide funding for services to the frail elderly. The team must cooperate with consumers and other public and private agencies, including nursing homes, in the geographic area in order to develop and offer a variety of cost–effective services to the elderly and their caregivers.

(e) The board or boards shall apply to be selected as a project. If the project is selected, the commissioner of human services shall contract with the lead agency for the project and shall provide additional administrative funds for implementing the provisions of the contract, within the appropriation available for this purpose.

(f) Projects shall be selected according to the following conditions.

No project may be selected unless it demonstrates that:

(i) the objectives of the local project will help to achieve the state's long–term care goals as defined in subdivision 1;

(ii) in the case of a project submitted jointly by several counties, all of the participating counties are contiguous;

(iii) there is a designated local lead agency that is empowered to make contracts with the state and local vendors on behalf of all participants;

(iv) the project proposal demonstrates that the local cooperating agencies have the ability to perform the project as described and that the implementation of the project has a reasonable chance of achieving its objectives;

(v) the project will serve an area that covers at least four counties or contains at least 2,500 persons who are 85 years of age or older, according to the projections of the state demographer or the census if the data is more recent; and

(vi) the local coordinating team documents efforts of cooperation with consumers and other agencies and organizations, both public and private, in planning for service delivery.

Subd. 3. **Local long–term care strategy.** The local long–term care strategy must list performance outcomes and indicators which meet the state's objectives. The local strategy must provide for:

(1) accessible information, assessment, and preadmission screening activities as described in subdivision 4;

(2) an increase in numbers of alternative care clients served under section 256B.0913, including those who are relocated from nursing homes, which results in a reduction of the medical assistance nursing home caseload; and

(3) the development of additional services such as adult family foster care homes; family adult day care; assisted living projects and congregate housing service projects in apartment buildings; expanded home care services for evenings and weekends; expanded volunteer services; and caregiver support and respite care projects.

The county or groups of counties selected for the projects shall be required to comply with federal regulations, alternative care funding policies in section 256B.0913, and the federal waiver programs' policies in section 256B.0915. The requirements for preadmission screening are defined in section 256B.0911, subdivisions 1 to 6. Requirements for an access, screening, and assessment function are defined in subdivision 4. Requirements for the service development and service provision are defined in subdivision 5.

Subd. 4. **Accessible information, screening, and assessment function.** (a) The projects selected by and under contract with the commissioner shall establish an accessible information, screening, and assessment function for persons who need assistance and information regarding long–term care. This accessible information, screening, and assessment activity shall include information and referral, early intervention, follow–up contacts, telephone screening, home visits, assessments, preadmission screening, and relocation case management for the frail elderly and their caregivers in the area served by the county or counties. The purpose is to ensure that information and help is provided to elderly persons and their families in a timely fashion, when they are making decisions about long–term care. These functions may be split among various agencies, but must be coordinated by the local long–term care coordinating team.

(b) Accessible information, screening, and assessment functions shall be reimbursed as follows:

(1) The screenings of all persons entering nursing homes shall be reimbursed as defined in section 256B.0911, subdivision 6; and

(2) Additional state administrative funds shall be available for the access, screening, and assessment activities that are not reimbursed under clause (1). This amount shall not ex-

ceed the amount authorized in the guidelines and in instructions for the application and must be within the amount appropriated for this activity.

(c) Any information and referral functions funded by other sources, such as Title III of the Older Americans Act and Title XX of the Social Security Act and the Community Social Services Act, shall be considered by the local long–term care coordinating team in establishing this function to avoid duplication and to ensure access to information for persons needing help and information regarding long–term care.

(d) The lead agency or the agencies under contract with the lead agency which are responsible for the accessible information, screening, and assessment function must complete the forms and reports required by the commissioner as specified in the contract.

Subd. 5. **Service development and service delivery.** (a) In addition to the access, screening, and assessment activity, each local strategy may include provisions for the following:

(1) the addition of a full–time staff person who is responsible to develop the following services and recruit providers as established in the contract:

(i) additional adult family foster care homes;

(ii) family adult day care providers as defined in section 256B.0919, subdivision 2;

(iii) an assisted living program in an apartment;

(iv) a congregate housing service project in a subsidized housing project; and

(v) the expansion of evening and weekend coverage of home care services as deemed necessary by the local strategic plan;

(2) small incentive grants to new adult family care providers for renovations needed to meet licensure requirements;

(3) a plan to apply for a congregate housing service project as identified in section 256.9751, authorized by the Minnesota board on aging, to the extent that funds are available;

(4) a plan to divert new applicants to nursing homes and to relocate a targeted population from nursing homes, using the individual's own resources or the funding available for services;

(5) one or more caregiver support and respite care projects, as described in subdivision 6; and

(6) one or more living–at–home/block nurse projects, as described in subdivisions 7 to 10.

(b) The expansion of alternative care clients under paragraph (a) shall be accomplished with the funds provided under section 256B.0913, and includes the allocation of targeted funds. The funding for all participating counties must be coordinated by the local long–term care coordinating team and must be part of the local long–term care strategy. Alternative care funds may be transferred from one SAIL county to another within a designated SAIL project area during a fiscal year as authorized by the local long–term care coordinating team and approved by the commissioner. The base allocation used for a future year shall reflect the final transfer. Each county retains responsibility for reimbursement as defined in section 256B.0913, subdivision 12. All other requirements for the alternative care program must be met unless an exception is provided in this section. The commissioner may establish by contract a reimbursement mechanism for alternative care that does not require invoice processing through the Medical Assistance Management Information System (MMIS). The commissioner and local agencies must assure that the same client and reimbursement data is obtained as is available under MMIS.

(c) The administration of these components is the responsibility of the agencies selected by the local coordinating team and under contract with the local lead agency. However, administrative funds for paragraph (a), clauses (2) to (5), and grant funds for paragraph (a), clauses (6) and (7), shall be granted to the local lead agency. The funding available for each component is based on the plan submitted and the amount negotiated in the contract.

Subd. 6. **Caregiver support and respite care projects.** (a) The commissioner shall establish up to 36 projects to expand the respite care network in the state and to support caregivers in their responsibilities for care. The purpose of each project shall be to:

(1) establish a local coordinated network of volunteer and paid respite workers;

(2) coordinate assignment of respite workers to clients and care receivers and assure the health and safety of the client; and

(3) provide training for caregivers and ensure that support groups are available in the community.

(b) The caregiver support and respite care funds shall be available to the four to six local long–term care strategy projects designated in subdivisions 1 to 5.

(c) The commissioner shall publish a notice in the State Register to solicit proposals from public or private nonprofit agencies for the projects not included in the four to six local long–term care strategy projects defined in subdivision 2. A county agency may, alone or in combination with other county agencies, apply for caregiver support and respite care project funds. A public or nonprofit agency within a designated SAIL project area may apply for project funds if the agency has a letter of agreement with the county or counties in which services will be developed, stating the intention of the county or counties to coordinate their activities with the agency requesting a grant.

(d) The commissioner shall select grantees based on the following criteria:

(1) the ability of the proposal to demonstrate need in the area served, as evidenced by a community needs assessment or other demographic data;

(2) the ability of the proposal to clearly describe how the project will achieve the purpose defined in paragraph (b);

(3) the ability of the proposal to reach underserved populations;

(4) the ability of the proposal to demonstrate community commitment to the project, as evidenced by letters of support and cooperation as well as formation of a community task force;

(5) the ability of the proposal to clearly describe the process for recruiting, training, and retraining volunteers; and

(6) the inclusion in the proposal of the plan to promote the project in the community, including outreach to persons needing the services.

(e) Funds for all projects under this subdivision may be used to:

(1) hire a coordinator to develop a coordinated network of volunteer and paid respite care services and assign workers to clients;

(2) recruit and train volunteer providers;

(3) train caregivers;

(4) ensure the development of support groups for caregivers;

(5) advertise the availability of the caregiver support and respite care project; and

(6) purchase equipment to maintain a system of assigning workers to clients.

(f) Project funds may not be used to supplant existing funding sources.

Subd. 7. **Contract.** The commissioner of human services shall execute a contract with an organization experienced in establishing and operating community–based programs that have used the principles listed in subdivision 8, paragraph (b), in order to meet the independent living and health needs of senior citizens aged 65 and over and provide community–based long–term care for senior citizens in their homes. The organization shall:

(1) assist the commissioner in developing criteria for and in awarding grants to establish community–based organizations that will implement living–at–home/block nurse programs throughout the state;

(2) assist the commissioner in awarding grants to enable current living–at–home/block nurse programs to implement the combined living–at–home/block nurse program model;

(3) serve as a state technical assistance center to assist and coordinate the living–at–home/block nurse programs established; and

(4) develop the implementation plan required by subdivision 10.

Subd. 8. **Living–at–home/block nurse program grant.** (a) The commissioner, in cooperation with the organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish or expand up to 15 community–based organizations that will implement living–at–home/block nurse programs that are designed to enable

senior citizens to live as independently as possible in their homes and in their communities. At least seven of the programs must be in counties outside the seven-county metropolitan area. The living-at-home/block nurse program funds shall be available to the four to six SAIL projects established under this section. Nonprofit organizations and units of local government are eligible to apply for grants to establish the community organizations that will implement living-at-home/block nurse programs. In awarding grants, the commissioner shall give preference to nonprofit organizations and units of local government from communities that:

(1) have high nursing home occupancy rates;

(2) have a shortage of health care professionals; and

(3) meet other criteria established by the commissioner, in consultation with the organization under contract.

(b) Grant applicants must also meet the following criteria:

(1) the local community demonstrates a readiness to establish a community model of care, including the formation of a board of directors, advisory committee, or similar group, of which at least two-thirds is comprised of community citizens interested in community-based care for older persons;

(2) the program has sponsorship by a credible, representative organization within the community;

(3) the program has defined specific geographic boundaries and defined its organization, staffing and coordination/delivery of services;

(4) the program demonstrates a team approach to coordination and care, ensuring that the older adult participants, their families, the formal and informal providers are all part of the effort to plan and provide services; and

(5) the program provides assurances that all community resources and funding will be coordinated and that other funding sources will be maximized, including a person's own resources.

(c) Grant applicants must provide a minimum of five percent of total estimated development costs from local community funding. Grants shall be awarded for two-year periods, and the base amount shall not exceed $40,000 per applicant for the grant period. The commissioner, in consultation with the organization under contract, may increase the grant amount for applicants from communities that have socioeconomic characteristics that indicate a higher level of need for development assistance.

(d) Each living-at-home/block nurse program shall be designed by representatives of the communities being served to ensure that the program addresses the specific needs of the community residents. The programs must be designed to:

(1) incorporate the basic community, organizational, and service delivery principles of the living-at-home/block nurse program model;

(2) provide senior citizens with registered nurse directed assessment, provision and coordination of health and personal care services on a sliding fee basis as an alternative to expensive nursing home care;

(3) provide information, support services, homemaking services, counseling, and training for the client and family caregivers;

(4) encourage the development and use of respite care, caregiver support, and in-home support programs, such as adult foster care and in-home adult day care;

(5) encourage neighborhood residents and local organizations to collaborate in meeting the needs of senior citizens in their communities;

(6) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to senior citizens and their caregivers; and

(7) provide coordination and management of formal and informal services to senior citizens and their families using less expensive alternatives.

Subd. 9. **State technical assistance center.** The organization under contract shall be the state technical assistance center to provide orientation and technical assistance, and to coordinate the living-at-home/block nurse programs established. The state resource center shall:

(1) provide communities with criteria in planning and designing their living–at–home/block nurse programs;

(2) provide general orientation and technical assistance to communities who desire to establish living–at–home/block nurse programs;

(3) provide ongoing analysis and data collection of existing and newly established living–at–home/block nurse programs and provide data to the organization performing the independent assessment; and

(4) serve as the living–at–home/block nurse programs' liaison to the legislature and other state agencies.

Subd. 10. **Implementation plan.** The organization under contract shall develop a plan that specifies a strategy for implementing living–at–home/block nurse programs statewide. The plan must also analyze the data collected by the state technical assistance center and describe the effectiveness of services provided by living–at–home/block nurse programs, including the program's impact on acute care costs. The organization shall report to the commissioner of human services and to the legislature by January 1, 1993.

Subd. 11. **SAIL evaluation and expansion.** The commissioner shall evaluate the success of the SAIL projects against the objective stated in subdivision 1, paragraph (b), and recommend to the legislature the continuation or expansion of the long–term care strategy by February 15, 1995.

Subd. 12. **Public awareness campaign.** The commissioner, with assistance from the commissioner of health and with the advice of the long–term care planning committee, shall contract for a public awareness campaign to educate the general public, seniors, consumers, caregivers, and professionals about the aging process, the long–term care system, and alternatives available including alternative care and residential alternatives. Particular emphasis will be given to informing consumers on how to access the alternatives and obtain information on the long–term care system. The commissioner shall pursue the development of new names for preadmission screening, alternative care, foster care, and other services as deemed necessary for the public awareness campaign.

History: *1991 c 292 art 7 s 17; 1992 c 513 art 7 s 65–72; 1Sp1993 c 1 art 5 s 73–79; 1994 c 625 art 8 s 63*

256B.0919 ADULT FOSTER CARE AND FAMILY ADULT DAY CARE.

Subdivision 1. **Adult foster care licensure capacity.** Notwithstanding contrary provisions of the human services licensing act and rules adopted under it, an adult foster care license holder may care for five adults age 60 years or older who do not have serious and persistent mental illness or a developmental disability.

Subd. 2. **Adult foster care; family adult day care.** An adult foster care license holder who is not providing care to persons with serious and persistent mental illness or developmental disabilities may also provide family adult day care for adults age 60 years or older who do not have serious and persistent mental illness or a developmental disability. The maximum combined license capacity for adult foster care and family adult day care is five adults. A separate license is not required to provide family adult day care under this subdivision. Foster care homes providing services to five adults shall not be subject to licensure by the commissioner of health under the provisions of chapter 144, 144A, 157, or any other law requiring facility licensure by the commissioner of health.

Subd. 3. **County certification of persons providing adult foster care to related persons.** A person exempt from licensure under section 245A.03, subdivision 2, who provides adult foster care to a related individual age 65 and older, and who meets the requirements in Minnesota Rules, parts 9555.5105 to 9555.6265, may be certified by the county to provide adult foster care. A person certified by the county to provide adult foster care may be reimbursed for services provided and eligible for funding under sections 256B.0913 and 256B.0915, if the relative would suffer a financial hardship as a result of providing care. For purposes of this subdivision, financial hardship refers to a situation in which a relative incurs a substantial reduction in income as a result of resigning from a full–time job or taking a leave of absence without pay from a full–time job to care for the client.

History: *1986 c 444; 1991 c 292 art 7 s 18; 1992 c 513 art 7 s 73*

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 or arrange for a diagnostic evaluation in order to determine whether the person has or may have mental retardation or has or may have a related condition. If the county of financial responsibility determines that the person has mental retardation or a related condition, the county shall inform the person of case management services available under this section. Except as provided in subdivision 1g or 4b, if a person is diagnosed as having mental retardation or a related condition, the county of financial responsibility shall conduct or arrange for a needs assessment, develop or arrange for an individual service plan, provide or arrange for ongoing case management services at the level identified in the individual service plan, provide or arrange for case management administration, and authorize services identified in the person's individual service plan developed according to subdivision 1b. Diagnostic information, obtained by other providers or agencies, may be used by the county agency in determining eligibility for case management. Nothing in this section shall be construed as requiring: (1) assessment in areas agreed to as unnecessary by the case manager and the person, or the person's legal guardian or conservator, or the parent if the person is a minor, or (2) assessments in areas where there has been a functional assessment completed in the previous 12 months for which the case manager and the person or person's guardian or conservator, or the parent if the person is a minor, agree that further assessment is not necessary. For persons under state guardianship, the case manager shall seek authorization from the public guardianship office for waiving any assessment requirements. Assessments related to health, safety, and protection of the person for the purpose of identifying service type, amount, and frequency or assessments required to authorize services may not be waived. 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.

Subd. 1a. **Case management administration and services.** (a) The administrative functions of case management provided to or arranged for a person include:

(1) intake;

(2) diagnosis;

(3) screening;

(4) service authorization;

(5) review of eligibility for services; and

(6) responding to requests for conciliation conferences and appeals according to section 256.045 made by the person, the person's legal guardian or conservator, or the parent if the person is a minor.

(b) Case management service activities provided to or arranged for a person include:

(1) development of the individual service plan;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options;

(3) assisting the person in the identification of potential providers;

(4) assisting the person to access services;

(5) coordination of services;

(6) evaluation and monitoring of the services identified in the plan; and

(7) annual reviews of service plans.

(c) Case management administration and service activities that are provided to the person with mental retardation or a related condition shall be provided directly by county agencies or under contract.

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

(1) include the results of the assessment information on the person's need for service, including identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(2) identify the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor;

(3) identify long– and short–range goals for the person;

(4) identify specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The individual service plan shall also specify other services the person needs that are not available;

(5) identify the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

(6) identify provider responsibilities to implement and make recommendations for modification to the individual service plan;

(7) include notice of the right to request a conciliation conference or a hearing under section 256.045;

(8) be agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative; and

(9) be reviewed by a health professional if the person has overriding medical needs that impact the delivery of services.

Service planning formats developed for interagency planning such as transition, vocational, and individual family service plans may be substituted for service planning formats developed by county agencies.

Subd. 1c. [Repealed, 1991 c 94 s 25; c 292 art 6 s 47]

Subd. 1d. [Repealed, 1991 c 94 s 25; c 292 art 6 s 47]

Subd. 1e. [Renumbered subd 1f]

Subd. 1e. **Coordination, evaluation, and monitoring of services identified in the individual service plan.** (a) If the individual service plan identifies the need for individual program plans for authorized services, the case manager shall assure that individual program plans are developed by the providers according to clauses (2) to (5). The providers shall assure that the individual program plans:

(1) are developed according to the respective state and federal licensing and certification requirements;

(2) are designed to achieve the goals of the individual service plan;

(3) are consistent with other aspects of the individual service plan;

(4) assure the health and safety of the person; and

(5) are developed with consistent and coordinated approaches to services among the various service providers.

(b) The case manager shall monitor the provision of services:

(1) to assure that the individual service plan is being followed according to paragraph (a);

(2) to identify any changes or modifications that might be needed in the individual service plan, including changes resulting from recommendations of current service providers;

(3) to determine if the person's legal rights are protected, and if not, notify the person's legal guardian or conservator, or the parent if the person is a minor, protection services, or licensing agencies as appropriate; and

(4) to determine if the person, the person's legal guardian or conservator, or the parent if the person is a minor, is satisfied with the services provided.

(c) If the provider fails to develop or carry out the individual program plan according to paragraph (a), the case manager shall notify the person's legal guardian or conservator, or the parent if the person is a minor, the provider, the respective licensing and certification agencies, and the county board where the services are being provided. In addition, the case manager shall identify other steps needed to assure the person receives the services identified in the individual service plan.

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

waiting list shall be used by county agencies to assist them in developing needed services or amending their community social services plan as required in section 256E.09, subdivision 1.

Subd. 1g. **Conditions not requiring development of individual service plan.** Unless otherwise required by federal law, the county agency is not required to complete an individual service plan as defined in subdivision 1b for:

(1) persons whose families are requesting respite care for their family member who resides with them, or whose families are requesting a family support grant and are not requesting purchase or arrangement of habilitative services; and

(2) persons with mental retardation or related conditions, living independently without authorized services or receiving funding for services at a rehabilitation facility as defined in section 268A.01, subdivision 6, and not in need of or requesting additional services.

Subd. 2. **Medical assistance.** To assure quality case management to those persons who are eligible for medical assistance, the commissioner shall, upon request:

(a) provide consultation on the case management process;

(b) assist county agencies in the screening and annual reviews of clients review process to assure that appropriate levels of service are provided to persons;

(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 according to this chapter and rules implementing it.

Subd. 2a. **Medical assistance for case management activities under the state plan Medicaid option.** Upon receipt of federal approval, the commissioner shall make payments to approved vendors of case management services participating in the medical assistance program to reimburse costs for providing case management service activities to medical assistance eligible persons with mental retardation or a related condition, in accordance with the state Medicaid plan and federal requirements and limitations.

Subd. 3. **Authorization and termination of services.** County agency case managers, under rules of the commissioner, shall authorize and terminate services of community and regional treatment center providers according to individual service plans. Services provided to persons with mental retardation or related conditions may only be authorized and terminated by case managers according to (1) rules of the commissioner and (2) the individual service plan as defined in subdivision 1b. Medical assistance services not needed shall not be authorized by county agencies or funded by the commissioner. When purchasing or arranging for unlicensed respite care services for persons with overriding health needs, the county agency shall seek the advice of a health care professional in assessing provider staff training needs and skills necessary to meet the medical needs of the person.

Subd. 4. **Home and community–based services for persons with mental retardation or related conditions.** (a) The commissioner shall make payments to approved vendors participating in the medical assistance program to pay costs of providing home and community–based services, including case management service activities provided as an approved home and community–based service, to medical assistance eligible persons with mental retardation or related conditions who have been screened under subdivision 7 and according to federal requirements. Federal requirements include those services and limitations included in the federally approved application for home and community–based services for persons with mental retardation or related conditions and subsequent amendments.

(b) Effective July 1, 1995, contingent upon federal approval and state appropriations made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8, section 40, the commissioner of human services shall allocate resources to county agencies for home and community–based waivered services for persons with mental retardation or related conditions authorized but not receiving those services as of June 30, 1995, based upon the average resource need of persons with similar functional characteristics. To ensure service continuity for service recipients receiving home and community–based waivered services for persons with mental retardation or related conditions prior to July 1, 1995, the

commissioner shall make available to the county of financial responsibility home and community–based waivered services resources based upon fiscal year 1995 authorized levels.

(c) Home and community–based resources for all recipients shall be managed by the county of financial responsibility within an allowable reimbursement average established for each county. Payments for home and community–based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home and community–based service program. 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. 4a. **Demonstration projects.** The commissioner may waive state rules governing home and community–based services in order to demonstrate other methods of administering these services and to improve efficiency and responsiveness to individual needs of persons with mental retardation or related conditions, notwithstanding section 14.05, subdivision 4. All demonstration projects approved by the commissioner must comply with state laws and federal regulations, must remain within the fiscal limitations of the home and community–based services program for persons with mental retardation or related conditions, and must assure the health and safety of the persons receiving services according to section 256E.08, subdivision 1.

Subd. 4b. **Case management for persons receiving home and community–based services.** Persons authorized for and receiving home and community–based services may select from vendors of case management which have provider agreements with the state to provide home and community–based case management service activities. This subdivision becomes effective July 1, 1992, only if the state agency is unable to secure federal approval for limiting choice of case management vendors to the county of financial responsibility.

Subd. 4c. **Living arrangements based on a 24–hour plan of care.** (a) Notwithstanding the requirements for licensure under Minnesota Rules, part 9525.1860, subpart 6, item D, and upon federal approval of an amendment to the home and community–based services waiver for persons with mental retardation or related conditions, a person receiving home and community–based services may choose to live in their own home without requiring that the living arrangement be licensed under Minnesota Rules, parts 9555.5050 to 9555.6265, provided the following conditions are met:

(1) the person receiving home and community–based services has chosen to live in their own home;

(2) home and community–based services are provided by a qualified vendor who meets the provider standards as approved in the Minnesota home and community–based services waiver plan for persons with mental retardation or related conditions;

(3) the person, or their legal representative, individually or with others has purchased or rents the home and the person's service provider has no financial interest in the home; and

(4) the service planning team, as defined in Minnesota Rules, part 9525.0004, subpart 24, has determined that the planned services, the 24–hour plan of care, and the housing arrangement are appropriate to address the health, safety, and welfare of the person.

(b) The county agency may require safety inspections of the selected housing as part of their determination of the adequacy of the living arrangement.

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 et seq., as amended, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center 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 et seq., as amended, 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 including day training and habilitation 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, and to establish policy and procedures to reduce duplicative efforts and unnecessary paperwork on the part of case managers.

Subd. 7. **Screening teams.** For persons with mental retardation or a related condition, screening teams shall be established which shall evaluate the need for the level of care provided by residential–based habilitation services, residential services, training and habilitation services, and nursing facility services. The evaluation shall address whether home and community–based services are appropriate for persons who are at risk of placement in an intermediate care facility for persons with mental retardation or related conditions, or for whom there is reasonable indication that they might require this level of care. The screening team shall make an evaluation of need within 60 working days of a request for service by a person with mental retardation or related conditions, and within five working days of an emergency admission of a person to an intermediate care facility for persons with mental retardation or related conditions. The screening team shall consist of the case manager for persons with mental retardation or related conditions, the person, the person's legal guardian or conservator, or the parent if the person is a minor, 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 planning process. The contract shall be limited to public guardianship representation for the screening and individual service planning activities. The contract shall require compliance with the commissioner's instructions and may be for paid or voluntary services. For persons determined to have overriding health care needs and are seeking admission to a nursing facility or an ICF/MR, or seeking access to home and community–based waivered services, a registered nurse must be designated as either the case manager or the qualified mental retardation professional. For persons under the jurisdiction of a correctional agency, the case manager must consult with the corrections administrator regarding additional health, safety, and supervision needs. The case manager, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals 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. Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting.

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 person is in need of long–term residential care;

(f) make recommendations regarding placement and payment for: (1) social service or public assistance support, or both, to maintain a person in the person'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 service alternative to community residential placement or regional treatment center placement;

(g) evaluate the availability, location, and quality of the services listed in paragraph (f), including the impact of placement alternatives on the person'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 decisions regarding commitment of persons with mental retardation; and

(j) inform the person and the person's legal guardian or conservator, or the parent if the person is a minor, that appeal may be made to the commissioner pursuant to section 256.045.

Subd. 8a. **County concurrence.** (a) If the county of financial responsibility wishes to place a person in another county for services, the county of financial responsibility shall seek concurrence from the proposed county of service and the placement shall be made cooperatively between the two counties. Arrangements shall be made between the two counties for ongoing social service, including annual reviews of the person's individual service plan. The county where services are provided may not make changes in the person's service plan without approval by the county of financial responsibility.

(b) When a person has been screened and authorized for services in an intermediate care facility for persons with mental retardation or related conditions or for home and community–based services for persons with mental retardation or related conditions, the case manager shall assist that person in identifying a service provider who is able to meet the needs of the person according to the person's individual service plan. If the identified service is to be provided in a county other than the county of financial responsibility, the county of financial responsibility shall request concurrence of the county where the person is requesting to receive the identified services. The county of service may refuse to concur if:

(1) it can demonstrate that the provider is unable to provide the services identified in the person's individual service plan as services that are needed and are to be provided;

(2) in the case of an intermediate care facility for persons with mental retardation or related conditions, there has been no authorization for admission by the admission review team as required in section 256B.0926; or

(3) in the case of home and community–based services for persons with mental retardation or related conditions, the county of service can demonstrate that the prospective provider has failed to substantially comply with the terms of a past contract or has had a prior contract terminated within the last 12 months for failure to provide adequate services, or has received a notice of intent to terminate the contract.

(c) The county of service shall notify the county of financial responsibility of concurrence or refusal to concur no later than 20 working days following receipt of the written request. Unless other mutually acceptable arrangements are made by the involved county agencies, the county of financial responsibility is responsible for costs of social services and the costs associated with the development and maintenance of the placement. The county of service may request that the county of financial responsibility purchase case management services from the county of service or from a contracted provider of case management when the county of financial responsibility is not providing case management as defined in this section and rules adopted under this section, unless other mutually acceptable arrangements are made by the involved county agencies. Standards for payment limits under this section may be established by the commissioner. Financial disputes between counties shall be resolved as provided in section 256G.09.

Subd. 9. **Reimbursement.** Payment for services shall not be provided to a service provider for any person placed in an intermediate care facility for persons with mental retardation or related conditions prior to the person being screened by the screening team. The commissioner shall not deny reimbursement for: (a) a person 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 person admitted to an intermediate care facility for persons with mental retardation or related conditions under emergency circumstances; (c) any eligible person 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 person or the person's legal guardian or conservator, or the parent if the person is a minor, 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 guardian or conservator.

Subd. 10. **Admission of persons to and discharge of persons from regional treatment centers.** (a) Prior to the admission of a person to a regional treatment center program for persons with mental retardation, the case manager shall make efforts to secure community-based alternatives. If these alternatives are rejected by the person, the person's legal guardian or conservator, or the county agency in favor of a regional treatment center placement, the case manager shall document the reasons why the alternatives were rejected.

(b) When discharge of a person from a regional treatment center to a community-based service is proposed, the case manager shall convene the screening team and in addition to members of the team identified in subdivision 7, the case manager shall invite to the meeting the person's parents and near relatives, and the ombudsman established under section 245.92 if the person is under public guardianship. The meeting shall be convened at a time and place that allows for participation of all team members and invited individuals who choose to attend. The notice of the meeting shall inform the person's parents and near relatives about the screening team process, and their right to request a review if they object to the discharge, and shall provide the names and functions of advocacy organizations, and information relating to assistance available to individuals interested in establishing private guardianships under the provisions of section 252A.03. The screening team meeting shall be conducted according to subdivisions 7 and 8. Discharge of the person shall not go forward without consensus of the screening team.

(c) The results of the screening team meeting and individual service plan developed according to subdivision 1b shall be used by the interdisciplinary team assembled in accordance with Code of Federal Regulations, title 42, section 483.440, to evaluate and make recommended modifications to the individual service plan as proposed. The individual service plan shall specify postplacement monitoring to be done by the case manager according to section 253B.15, subdivision 1a.

(d) Notice of the meeting of the interdisciplinary team assembled in accordance with Code of Federal Regulations, title 42, section 483.440, shall be sent to all team members 15 days prior to the meeting, along with a copy of the proposed individual service plan. The case manager shall request that proposed providers visit the person and observe the person's program at the regional treatment center prior to the discharge. Whenever possible, preplacement visits by the person to proposed service sites should also be scheduled in advance of the meeting. Members of the interdisciplinary team assembled for the purpose of discharge planning shall include but not be limited to the case manager, the person, the person's legal guardian or conservator, parents and near relatives, the person's advocate, representatives of proposed community service providers, representatives of the regional treatment center residential and training and habilitation services, a registered nurse if the person has overriding medical needs that impact the delivery of services, and a qualified mental retardation professional specializing in behavior management if the person to be discharged has behaviors that may result in injury to self or others. The case manager may also invite other service providers who have expertise in an area related to specific service needs of the person to be discharged.

(e) The interdisciplinary team shall review the proposed plan to assure that it identifies service needs, availability of services, including support services, and the proposed providers' abilities to meet the service needs identified in the person's individual service plan. The interdisciplinary team shall review the most recent licensing reports of the proposed providers and corrective action taken by the proposed provider, if required. The interdisciplinary team shall review the current individual program plans for the person and agree to an interim individual program plan to be followed for the first 30 days in the person's new living arrangement. The interdisciplinary team may suggest revisions to the service plan, and all team suggestions shall be documented. If the person is to be discharged to a community intermediate care facility for persons with mental retardation or related conditions, the team shall give preference to facilities with a licensed capacity of 15 or fewer beds. Thirty days prior to the date of discharge, the case manager shall send a final copy of the service plan to all invited members of the team, the ombudsman, if the person is under public guardianship, and the advocacy system established under United States Code, title 42, section 6042.

(f) No discharge shall take place until disputes are resolved under section 256.045, subdivision 4a, or until a review by the commissioner is completed upon request of the chief executive officer or program director of the regional treatment center, or the county agency. For persons under public guardianship, the ombudsman may request a review or hearing under section 256.045. Notification schedules required under this subdivision may be waived by members of the team when judged urgent and with agreement of the parents or near relatives participating as members of the interdisciplinary team.

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; 1991 c 292 art 6 s 47; 1992 c 513 art 7 s 74; art 9 s 26,27; 1993 c 339 s 15–19; 1995 c 207 art 3 s 19; art 8 s 34*

256B.0925 [Repealed, 1995 c 186 s 51]

256B.0926 ADMISSION REVIEW TEAM FOR ADMISSIONS TO INTERMEDIATE CARE FACILITIES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS.

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

(b) "Provider" means a provider of community–based intermediate care facility services for persons with mental retardation or related conditions.

(c) "Facility" means a community–based intermediate care facility for persons with mental retardation or related conditions.

(d) "Person" means a person with mental retardation or related conditions who is applying for admission to an intermediate care facility for persons with mental retardation or related conditions.

Subd. 2. **Admission review team; responsibilities; composition.** (a) Before a person is admitted to a facility, an admission review team must assure that the provider can meet the needs of the person as identified in the person's individual service plan required under section 256B.092, subdivision 1.

(b) The admission review team must be assembled pursuant to Code of Federal Regulations, title 42, section 483.440(b)(2). The composition of the admission review team must meet the definition of an interdisciplinary team in Code of Federal Regulations, title 42, section 483.440. In addition, the admission review team must meet any conditions agreed to by the provider and the county where services are to be provided.

(c) The county in which the facility is located may establish an admission review team which includes at least the following:

(1) a qualified mental retardation professional, as defined in Code of Federal Regulations, title 42, section 483.440;

(2) a representative of the county in which the provider is located;

(3) at least one professional representing one of the following professions: nursing, psychology, physical therapy, or occupational therapy; and

(4) a representative of the provider.

If the county in which the facility is located does not establish an admission review team, the provider shall establish a team whose composition meets the definition of an interdisciplinary team in Code of Federal Regulations, title 42, section 483.440. The provider shall invite a representative of the county agency where the facility is located to be a member of the admission review team.

Subd. 3. **Factors to be considered for admission.** (a) The determination of the team to admit a person to the facility must include, but is not limited to, consideration of the following:

(1) the preferences of the person and the person's guardian or family for services of an intermediate care facility for persons with mental retardation or related conditions;

(2) the ability of the provider to meet the needs of the person according to the person's individual service plan and the admission criteria established by the provider;

(3) the availability of a bed in the facility and of nonresidential services required by the person as specified in the person's individual service plan; and

(4) the need of the person for the services in the facility to prevent placement of the person in a more restrictive setting.

(b) When there is more than one qualified person applying for admission to the facility, the admission review team shall determine which applicant shall be offered services first, using the criteria established in this subdivision. The admission review team shall document the factors that resulted in the decision to offer services to one qualified person over another. In cases of emergency, a review of the admission by the admission review team must occur within the first 14 days of placement.

Subd. 4. **Information from provider.** The provider must establish admission criteria based on the level of service that can be provided to persons seeking admission to that facility and must provide the admission review team with the following information:

(1) a copy of the admission and level of care criteria adopted by the provider; and

(2) a written description of the services that are available to the person seeking admission, including day services, professional support services, emergency services, available direct care staffing, supervisory and administrative supports, quality assurance systems, and criteria established by the provider for discharging persons from the facility.

Subd. 5. **Establishment of admission review team; notice to provider.** When a county agency decides to establish admission review teams for the intermediate care facilities for persons with mental retardation or related conditions located in the county, the county agency shall notify the providers of the county agency's intent at least 60 days prior to establishing the teams.

History: *1991 c 292 art 6 s 48*

256B.0928 STATEWIDE CAREGIVER SUPPORT AND RESPITE CARE PROJECT.

(a) The commissioner shall establish and maintain a statewide caregiver support and respite care project. The project shall:

(1) provide information, technical assistance, and training statewide to county agencies and organizations on direct service models of caregiver support and respite care services;

(2) identify and address issues, concerns, and gaps in the statewide network for caregiver support and respite care;

(3) maintain a statewide caregiver support and respite care resource center;

(4) educate caregivers on the availability and use of caregiver and respite care services;

(5) promote and expand caregiver training and support groups using existing networks when possible; and

(6) apply for and manage grants related to caregiver support and respite care.

(b) An advisory committee shall be appointed to advise the caregiver support project on all aspects of the project including the development and implementation of the caregiver support and respite care services projects. The advisory committee shall review procedures and provide advice and technical assistance to the caregiver support project regarding the grant program established under section 256B.0917 and others established for caregivers.

The advisory committee shall consist of not more than 16 people appointed by the commissioner and shall be comprised of representatives from public and private agencies, service providers, and consumers from all areas of the state.

Members of the advisory committee shall not be compensated for service.

History: *1992 c 513 art 7 s 75*

256B.093 SERVICES FOR PERSONS WITH TRAUMATIC BRAIN INJURIES.

Subdivision 1. **State traumatic brain injury program.** The commissioner of human services shall:

(1) maintain a statewide traumatic brain injury program;

(2) supervise and coordinate services and policies for persons with traumatic brain injuries;

(3) contract with qualified agencies or employ staff to provide statewide administrative case management and consultation;

(4) maintain an advisory committee to provide recommendations in reports to the commissioner regarding program and service needs of persons with traumatic brain injuries. The advisory committee shall consist of no less than ten members and no more than 30 members. The commissioner shall appoint all advisory committee members to one– or two–year terms and appoint one member as chair;

(5) investigate the need for the development of rules or statutes for the traumatic brain injury home and community–based services waiver; and (6) investigate present and potential models of service coordination which can be delivered at the local level.

Subd. 2. **Eligibility.** Persons eligible for traumatic brain injury administrative case management and consultation must be eligible medical assistance recipients who have traumatic or certain acquired brain injury and are at risk of institutionalization.

Subd. 3. **Traumatic brain injury program duties.** The department shall fund administrative case management under this subdivision using medical assistance administrative funds. The traumatic brain injury program duties include:

(1) recommending to the commissioner in consultation with the medical review agent according to Minnesota Rules, parts 9505.0500 to 9505.0540, the approval or denial of medical assistance funds to pay for out–of–state placements for traumatic brain injury services and in–state traumatic brain injury services provided by designated Medicare long–term care hospitals;

(2) coordinating the traumatic brain injury home and community–based waiver;

(3) approving traumatic brain injury waiver eligibility or care plans or both;

(4) providing ongoing technical assistance and consultation to county and facility case managers to facilitate care plan development for appropriate, accessible, and cost–effective medical assistance services;

(5) providing technical assistance to promote statewide development of appropriate, accessible, and cost–effective medical assistance services and related policy;

(6) providing training and outreach to facilitate access to appropriate home and community–based services to prevent institutionalization;

(7) facilitating appropriate admissions, continued stay review, discharges, and utilization review for neurobehavioral hospitals and other specialized institutions;

(8) providing technical assistance on the use of prior authorization of home care services and coordination of these services with other medical assistance services;

(9) developing a system for identification of nursing facility and hospital residents with traumatic brain injury to assist in long–term planning for medical assistance services. Factors will include, but are not limited to, number of individuals served, length of stay, services received, and barriers to community placement; and

(10) providing information, referral, and case consultation to access medical assistance services for recipients without a county or facility case manager. Direct access to this assistance may be limited due to the structure of the program.

Subd. 3a. **Traumatic brain injury case management services.** The annual appropriation established under section 171.29, subdivision 2, paragraph (b), clause (5), shall be used for traumatic brain injury program services that include, but are not limited to:

(1) collaborating with counties, providers, and other public and private organizations to expand and strengthen local capacity for delivering needed services and supports, including efforts to increase access to supportive residential housing options;

(2) participating in planning and accessing services not otherwise covered in subdivision 3 to allow individuals to attain and maintain community–based services;

(3) providing information, referral, and case consultation to access health and human services for persons with traumatic brain injury not eligible for medical assistance, though direct access to this assistance may be limited due to the structure of the program; and

(4) collaborating on injury prevention efforts.

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

(a) "Traumatic brain injury" means a sudden insult or damage to the brain or its coverings, not of a degenerative or congenital nature. The insult or damage may produce an altered state of consciousness and may result in a decrease in cognitive, behavioral, emotional, 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 6a, 7, and 19a.

History: *1989 c 282 art 3 s 62; 1991 c 292 art 7 s 19; 1992 c 513 art 7 s 76–78; 1Sp1993 c 1 art 5 s 80,81; 1995 c 207 art 6 s 75–78; 1996 c 451 art 5 s 25*

256B.094 CHILD WELFARE TARGETED CASE MANAGEMENT SERVICES.

Subdivision 1. **Definition.** "Child welfare targeted case management services" means activities that coordinate social and other services designed to help the child under age 21 and the child's family gain access to needed social services, mental health services, habilitative services, educational services, health services, vocational services, recreational services, and related services including, but not limited to, the areas of volunteer services, advocacy, transportation, and legal services. Case management services include developing an individual service plan and assisting the child and the child's family in obtaining needed services through coordination with other agencies and assuring continuity of care. Case managers must assess the delivery, appropriateness, and effectiveness of services on a regular basis.

Subd. 2. **Eligible services.** Services eligible for medical assistance reimbursement include:

(1) assessment of the recipient's need for case management services to gain access to medical, social, educational, and other related services;

(2) development, completion, and regular review of a written individual service plan based on the assessment of need for case management services to ensure access to medical, social, educational, and other related services;

(3) routine contact or other communication with the client, the client's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan, regarding the status of the client, the individual service plan, or the goals for the client, exclusive of transportation of the child;

(4) coordinating referrals for, and the provision of, case management services for the client with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act;

(5) coordinating and monitoring the overall service delivery to ensure quality of services;

(6) monitoring and evaluating services on a regular basis to ensure appropriateness and continued need;

(7) completing and maintaining necessary documentation that supports and verifies the activities in this subdivision;

(8) traveling to conduct a visit with the client or other relevant person necessary to the development or implementation of the goals of the individual service plan; and

(9) coordinating with the medical assistance facility discharge planner in the 30–day period before the client's discharge into the community. This case management service provided to patients or residents in a medical assistance facility is limited to a maximum of two 30–day periods per calendar year.

Subd. 3. **Coordination and provision of services.** (a) In a county where a prepaid medical assistance provider has contracted under section 256B.031 or 256B.69 to provide mental health services, the case management provider shall coordinate with the prepaid provider to ensure that all necessary mental health services required under the contract are provided to recipients of case management services.

(b) When the case management provider determines that a prepaid provider is not providing mental health services as required under the contract, the case management provider shall assist the recipient to appeal the prepaid provider's denial pursuant to section 256.045, and may make other arrangements for provision of the covered services.

(c) The case management provider may bill the provider of prepaid health care services for any mental health services provided to a recipient of case management services which the county arranges for or provides and which are included in the prepaid provider's contract, and which were determined to be medically necessary as a result of an appeal pursuant to section 256.045. The prepaid provider must reimburse the mental health provider, at the prepaid provider's standard rate for that service, for any services delivered under this subdivision.

(d) If the county has not obtained prior authorization for this service, or an appeal results in a determination that the services were not medically necessary, the county may not seek reimbursement from the prepaid provider.

Subd. 4. **Case management provider.** To be eligible to receive medical assistance reimbursement, the case management provider must meet all provider qualification and certification standards under section 256F.10.

Subd. 5. **Case manager.** To provide case management services, a case manager must be employed by and authorized by the case management provider to provide case management services and meet all requirements under section 256F.10.

Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical assistance reimbursement for services under this section shall be made on a monthly basis. Payment is based on face–to–face or telephone contacts between the case manager and the client, client's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan regarding the status of the client, the individual service plan, or the goals for the client. These contacts must meet the minimum standards in clauses (1) and (2):

(1) there must be a face–to–face contact at least once a month except as provided in clause (2); and

(2) for a client placed outside of the county of financial responsibility in an excluded time facility under section 256G.02, subdivision 6, or through the interstate compact on the placement of children, section 257.40, and the placement in either case is more than 60 miles beyond the county boundaries, there must be at least one contact per month and not more than two consecutive months without a face–to–face contact.

(b) The payment rate is established using time study data on activities of provider service staff and reports required under sections 245.482, 256.01, subdivision 2, paragraph (17), and 256E.08, subdivision 8.

Separate payment rates may be established for different groups of providers to maximize reimbursement as determined by the commissioner. The payment rate will be reviewed annually and revised periodically to be consistent with the most recent time study and other data. Payment for services will be made upon submission of a valid claim and verification of proper documentation described in subdivision 7. Federal administrative revenue earned through the time study shall be distributed according to earnings, to counties or groups of counties which have the same payment rate under this subdivision, and to the group of counties which are not certified providers under section 256F.10. The commissioner shall modify the requirements set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.

Subd. 7. **Documentation for case record and claim.** (a) The assessment, case finding, and individual service plan shall be maintained in the individual case record under the data practices act, chapter 13. The individual service plan must be reviewed at least annually and updated as necessary. Each individual case record must maintain documentation of routine, ongoing, contacts and services. Each claim must be supported by written documentation in the individual case record.

(b) Each claim must include:

(1) the name of the recipient;

(2) the date of the service;

(3) the name of the provider agency and the person providing service;

(4) the nature and extent of services; and

(5) the place of the services.

Subd. 8. **Payment limitation.** Services that are not eligible for payment as a child welfare targeted case management service include, but are not limited to:

(1) assessments prior to opening a case;

(2) therapy and treatment services;

(3) legal services, including legal advocacy, for the client;

(4) information and referral services that are part of a county's community social services plan, that are not provided to an eligible recipient;

(5) outreach services including outreach services provided through the community support services program;

(6) services that are not documented as required under subdivision 7 and Minnesota Rules, parts 9505.1800 to 9505.1880;

(7) services that are otherwise eligible for payment on a separate schedule under rules of the department of human services;

(8) services to a client that duplicate the same case management service from another case manager;

(9) case management services provided to patients or residents in a medical assistance facility except as described under subdivision 2, clause (9); and

(10) for children in foster care, group homes, or residential care, payment for case management services is limited to case management services that focus on permanency planning or return to the family home and that do not duplicate the facility's discharge planning services.

History: *1Sp1993 c 1 art 3 s 24*

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. All medical assistance exclusions shall be allowed, and a resource limit of $10,000 for nonexcluded resources shall be implemented. Above these limits, a contribution of one-third of the excess resources shall be required. These rules shall not require 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. 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 150,268,270; 1989 c 282 art 3 s 63; 1990 c 568 art 3 s 62; 1992 c 513 art 7 s 79*

256B.15 CLAIMS AGAINST ESTATES.

Subdivision 1. **Definition.** For purposes of this section, "medical assistance" includes the medical assistance program under this chapter and the general assistance medical care program under chapter 256D, but does not include the alternative care program for nonmedical assistance recipients under section 256B.0913, subdivision 4.

Subd. 1a. **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 55 years of age, and received services under this chapter, excluding alternative care;

(b) the person resided in a medical institution for six months or longer, received services under this chapter excluding alternative care, 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; or

(c) the person received general assistance medical care services under chapter 256D.

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. Notice of the claim shall be given to all heirs and devisees of the decedent whose identity can be ascertained with reasonable diligence. The notice must include procedures and instructions for making an application for a hardship waiver under subdivision 5; time frames for submitting an application and determination; and information regarding appeal rights and procedures. Counties are entitled to one–half of the nonfederal share of medical assistance collections from estates that are directly attributable to county effort.

Subd. 1b. **Claims on the estate of a predeceased spouse.** Upon the death of a spouse who did not receive medical assistance and who predeceases a spouse who did or does receive medical assistance, a claim for the total amount paid for medical assistance rendered for the surviving spouse through the date the deceased spouse died shall be filed against the deceased spouse's estate in the court having jurisdiction to probate the estate. The claim shall be filed if medical assistance was rendered for the surviving spouse under any one of the circumstances in subdivision 1a, clause (a), (b), or (c). Claims under this subdivision shall have the same priority for purposes of section 524.3–805, and the same exceptions with respect to statutes of limitations as claims under subdivision 1a.

Subd. 2. **Limitations on claims.** The claim shall include only the total amount of medical assistance rendered after age 55 or during a period of institutionalization described in subdivision 1a, clause (b), and the total amount of general assistance medical care rendered, and shall not include interest. Claims that have been allowed but not paid shall bear interest according to section 524.3–806, paragraph (d). 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. 2a. **Limitations on claims on the estate of a predeceased spouse.** A claim under subdivision 1b shall include only the total amount of medical assistance rendered after age 55 or during a period of institutionalization described in subdivision 1a, clause (b), and the total amount of general assistance medical care rendered, and shall not include interest. Claims that have been allowed but not paid shall bear interest according to section 524.3–806, paragraph (d). A claim against the estate of a spouse who did not receive medical assistance who predeceases the spouse who did receive medical assistance, for medical assistance rendered for the 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 having provided care to the parent or grandparent who received medical assistance, that the care was provided before institutionalization, and that the care permitted the parent to reside at home rather than in an institution.

Subd. 5. **Undue hardship.** Any person entitled to notice in subdivision 1a has a right to apply for waiver of the claim based upon undue hardship. Any claim pursuant to this section may be fully or partially waived because of undue hardship. Undue hardship does not include action taken by the decedent which divested or diverted assets in order to avoid estate recovery. Any waiver of a claim must benefit the person claiming undue hardship. The commissioner shall have authority to hear claimant appeals, pursuant to section 256.045, when an application for a hardship waiver is denied in whole or part.

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; 1992 c 513 art 7 s 80,81; 1Sp1993 c 1 art 5 s 82,83; 1995 c 207 art 6 s 79–81; 1996 c 451 art 2 s 29,30; art 5 s 26*

NOTE: The amendments to subdivisions 1a and 2 by Laws 1995, chapter 207, article 6, sections 79 and 80, relating only to the age of a medical assistance recipient for purposes of estate claims, are effective for persons who are between the ages of 55 and 64 on or after July 1, 1995, for the total amount of assistance on or after July 1, 1995. See Laws 1995, chapter 207, article 6, section 125, subdivision 1.

NOTE: (a) Subdivisions 1b and 2a were added by Laws 1996, chapter 451, article 2, sections 29 and 30, respectively, and subdivision 5 was repealed by Laws 1996, chapter 451, article 2, section 61, effective the day following final enactment to the extent permitted by federal law. If any provisions of these sections are prohibited by federal law, the provisions shall become effective when federal law is changed to permit their application or a waiver is received. The commissioner of human services shall notify the revisor of statutes when federal law is enacted or a waiver is received and publish a notice in the State Register. The commissioner must include the notice in the first State Register published after the effective date of the federal changes.

(b) If, by July 1, 1996, any provisions of the sections mentioned in paragraph (a) are not effective because of prohibitions in federal law, the commissioner shall apply to the federal government for a waiver of those prohibitions, and those provisions shall become effective upon receipt of a federal waiver, notification to the revisor of statutes, and publication of a notice in the State Register to that effect. If the commissioner applies for a waiver of the lookback period, the commissioner shall seek the longest lookback period the health care financing administration will approve, not to exceed 72 months. Laws 1996, chapter 451, article 2, section 62.

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

256B.17 TRANSFERS OF PROPERTY.

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

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

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

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

Subd. 5. **Excluded resources.** Except for the limitations contained in subdivision 6, a resource which is transferred while otherwise excluded under sections 256B.055, 256B.056, and 256B.06 shall not be considered an available resource for purposes of medical assistance eligibility. This exception shall not apply to applicants for or recipients of general assistance medical care benefits under chapter 256D.

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

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

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

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

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

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

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

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

(b) Either (1) the noninstitutionalized spouse has less than $10,000 in liquid assets, including assets singly owned and 50 percent of assets owned jointly with the institutionalized spouse; or (2) the noninstitutionalized spouse has less than 50 percent of the total value of nonexempt assets owned by both parties, jointly or individually;

(c) The amount transferred, together with the noninstitutionalized spouse's own assets, totals no more than one–half of the total value of the liquid assets of the parties or $10,000 in liquid assets, whichever is greater; and

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

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

History: *Ex1967 c 16 s 17; 1981 c 360 art 2 s 30; 1983 c 312 art 5 s 20–24; 1984 c 534 s 23; 1985 c 252 s 23; 1986 c 444; 1987 c 403 art 2 s 83,84; 1988 c 689 art 2 s 151,268; 1989 c 282 art 3 s 98; 1990 c 568 art 3 s 95,96*

NOTE: Subdivisions 1, 2, 3, 4, 5, 6, and 8 apply to transfers that occurred before July 1, 1988. Subdivision 7 applies to persons institutionalized before October 1, 1989. See Laws 1990, chapter 568, article 3, section 95 and 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 state and county share of medical assistance costs not paid by federal funds shall be as follows:

(1) ninety percent state funds and ten percent county funds, unless otherwise provided below;

(2) beginning January 1, 1992, 50 percent state funds and 50 percent county funds for the cost of placement of severely emotionally disturbed children in regional treatment centers.

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.

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. 1a. **State reimbursement of counties.** 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 subdivision 1 on and after January 1, 1991, except for costs described in subdivision 1, clause (2). Payment to counties under this subdivision is subject to the provisions of section 256.017.

Subd. 1b. **Portion of nonfederal share to be paid by government hospitals.** (a) In addition to the percentage contribution paid by a county under subdivision 1, the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance costs attributable to them. For purposes of this subdivision, "designated governmental unit" means Hennepin county and the University of Minnesota. For purposes of this subdivision, "public hospital" means the Hennepin County Medical Center and the University of Minnesota hospital.

(b) From July 1, 1993 through June 30, 1994, Hennepin county shall on a monthly basis transfer an amount equal to 1.8 percent of the public hospital's net patient revenues, excluding net Medicare revenue to the state Medicaid agency.

(c) Effective July 1, 1994, each of the governmental units designated in paragraph (a) shall on a monthly basis transfer an amount equal to 1.8 percent of the public hospital's net patient revenues, excluding net Medicare revenue, to the state Medicaid agency. The base year for determining this transfer amount shall be established according to section 256.9657, subdivision 4.

(d) These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs, but shall not be subject to payback provisions of section 256.025.

Subd. 1c. **Additional portion of nonfederal share.** In addition to any payment required under subdivision 1b, Hennepin county shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs, but shall not be subject to payback provisions of section 256.025.

Subd. 1d. **Portion of nonfederal share to be paid by certain counties.** In addition to the percentage contribution paid by a county under subdivision 1, the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance cost. For purposes of this subdivision, "designated governmental unit" means the counties of Becker, Beltrami, Clearwater, Cook, Dodge, Hubbard, Itasca, Lake, Pennington, Pipestone, Ramsey, St. Louis, Steele, Todd, Traverse, and Wadena.

Beginning in 1994, each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned and operated by the county, with the county named as licensee, multiplied by $5,723. If two or more counties own and operate a nursing home, the payment shall be prorated. These sums shall be part of the designated governmen-

tal unit's portion of the nonfederal share of medical assistance costs, but shall not be subject to payback provisions of section 256.025.

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. 2c. **Obligation of local agency to investigate and determine eligibility for medical assistance.** (a) When the commissioner receives information that indicates that a general assistance medical care recipient or MinnesotaCare program enrollee may be eligible for medical assistance, the commissioner may notify the appropriate local agency of that fact. The local agency must investigate eligibility for medical assistance and take appropriate action and notify the commissioner of that action within 90 days from the date notice is issued. If the person is eligible for medical assistance, the local agency must find eligibility retroactively to the date on which the person met all eligibility requirements.

(b) When a prepaid health plan under a contract with the state to provide medical assistance services notifies the commissioner that an infant has been or will be born to an enrollee under the contract, the commissioner may notify the appropriate local agency of that fact. The local agency must investigate eligibility for medical assistance for the infant, take appropriate action, and notify the commissioner of that action within 90 days from the date notice is issued. If the infant would have been eligible on the date of birth, the local agency must establish eligibility retroactively to that month.

(c) For general assistance medical care recipients and MinnesotaCare program enrollees, if the local agency fails to comply with paragraph (a), the local agency is responsible for the entire cost of general assistance medical care or MinnesotaCare program services provided from the date the commissioner issues the notice until the date the local agency takes appropriate action on the case and notifies the commissioner of the action. For infants, if the local agency fails to comply with paragraph (b), the commissioner may determine eligibility for medical assistance for the infant for a period of two months, and the local agency shall be responsible for the entire cost of medical assistance services provided for that infant, in addition to a fee of $100 for processing the case. The commissioner shall deduct any obligation incurred under this paragraph from the amount due to the local agency under subdivision 1.

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 men-

tally 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; 1991 c 292 art 4 s 51–53; 1992 c 513 art 7 s 82; 1993 c 13 art 1 s 32; 1Sp1993 c 1 art 5 s 84–86; 1995 c 207 art 6 s 82–84; 1995 c 234 art 8 s 56*

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 de-

fined 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 15 percent of these nursing homes at random or 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 contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of human services pursuant to this section.

Subd. 4. **Authorization of commissioner to examine records.** A person determined to be eligible for medical assistance shall be deemed to have authorized the commissioner of human services in writing to examine, 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; 1995 c 207 art 11 s 6*

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.

(c) The personal needs allowance shall be increased to include income garnished for child support under a court order, up to a maximum of $250 per month but only to the extent that the amount garnished is not deducted as a monthly allowance for children under section 256B.0575, paragraph (a), clause (5).

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; 1996 c 451 art 2 s 31*

NOTE: The amendment to subdivision 1 by Laws 1996, chapter 451, article 2, section 31, is effective upon receipt of federal approval, retroactive to January 1, 1996. Laws 1996, chapter 451, article 2, section 62.

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

In addition to the personal allowance established in section 256B.35, any disabled recipient of medical assistance who is a resident of a nursing facility or intermediate care facility for the mentally retarded, shall also be permitted a special personal allowance drawn solely from earnings from any employment under an individual plan of rehabilitation. This special personal allowance shall consist of the sum of the following amounts, deducted from earnings in the following order:

(1) $80 for the costs of meals and miscellaneous work expenses;

(2) federal insurance contributions act payments withheld from the person's earned income;

(3) actual employment related transportation expenses;

(4) other actual employment related expenses; and

(5) state and federal income taxes withheld from the person's earned income, if the person cannot be claimed as exempt from federal income tax withholding.

The maximum special personal allowance from earnings is the sum of items (1) to (5).

History: *1974 c 575 s 16; 1985 c 21 s 56; 1986 c 444; 1992 c 513 art 7 s 83*

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. A person who is a party to a claim includes the plaintiff, the defendants, and any other party to the cause of action.

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 including Medicare for medical services is primary coverage and must be exhausted before medical assistance is paid for medical services including home health care, personal care assistant services, hospice, or services covered under a Health Care Financing Administration (HCFA) waiver. When a person who is otherwise eligible for medical assistance has private accident or health care coverage, including Medicare or a prepaid health plan, the private health care benefits available to the person must be used first and to the fullest extent.

Subd. 5a. **Supplemental payment by medical assistance.** Medical assistance payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full. Payment for patients that are simultaneously covered by medical assistance and a liable third party other than Medicare will be determined as the lesser of clauses (1) to (3):

(1) the patient liability according to the provider/insurer agreement;

(2) covered charges minus the third party payment amount; or

(3) the medical assistance rate minus the third party payment amount.

A negative difference will not be implemented.

Subd. 6. **Parent's or obligee's health plan.** When a parent or a person with an obligation 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; 1Sp1993 c 1 art 5 s 87–89; 1996 c 451 art 2 s 32*

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 FACILITY RATES

256B.41 INTENT.

Subdivision 1. **Authority.** The commissioner shall establish, by rule, procedures for determining rates for care of residents of nursing facilities which qualify as vendors of medical assistance, and for implementing the provisions of this section and sections 256B.421, 256B.431, 256B.432, 256B.433, 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 facilities 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.432, 256B.433, 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 facility 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; 1992 c 513 art 7 s 84,85,136*

256B.411 COMPLIANCE WITH STATE STATUTES.

Subdivision 1. **Funding.** Subject to exceptions in section 256B.25, subdivision 3, no nursing facility 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 facility unless the nursing facility 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 facility unless the nursing facility 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 facility participates fully in the medical assistance program or is withdrawing from the medical assistance program. No future payments may be made to any nursing facility 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; 1992 c 513 art 7 s 136*

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.432, 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 dietitians 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 facility.** "Nursing facility" 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 dietitians 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 facility 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 facility 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.

Subd. 16. **Capital assets.** "Capital assets," for purposes of section 256B.431, subdivisions 13 to 21, means a nursing facility's buildings, attached fixtures, land improvements,

leasehold improvements, and all additions to or replacements of those assets used directly for resident care.

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; 1992 c 513 art 7 s 86,87,136*

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 facilities 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 facility 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 facility 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 facility 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 facilities 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 facilities 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 facilities grouped by level of care;

(2) for nursing facilities 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 facilities grouped by level of care;

(3) for nursing facilities 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 facilities 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 facility

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 facilities established under subdivision 1.

(a) Within each group, each nursing facility 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 facility 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 facility 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 facility's report of allowable operating costs incurred by the nursing facility 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 facilities established under subdivision 1.

(c) Within each group, each nursing facility 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 facility 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 facility's cost report of allowable operating costs incurred by the nursing facility 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 facility, and the costs that must be incurred for the care of residents in an efficiently and economically operated nursing facility. In developing the geographic groups for purposes of reimbursement under this section, the commissioner shall ensure that nursing facilities 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 facilities 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 calcu-

lated for the group II facilities is higher. The efficiency incentive for geographic group I nursing facilities 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 facility payment rates, the commissioner shall divide the allowable historical operating costs by the actual number of resident days, except that where a nursing facility 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 facilities 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 facilities 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 facilities 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 facility shall receive an operating cost payment rate equal to the sum of the nursing facility'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 facility's historical operating cost in the category increased by the appropriate index established in paragraph (e) for the operating cost category plus an efficiency incentive established pursuant to paragraph (d) or the limit for the operating cost category increased by the same index. If a nursing facility'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 facility as an operating cost of that nursing facility. Allowable costs under this subdivision for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility 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 facilities 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 facility as an operating cost of that nursing facility. For rate years beginning on or after July 1, 1989, the commissioner shall include a nursing facility's reported public employee retirement act contribution for the reporting year as apportioned to the care–related operating cost categories and other operat-

ing 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 facility (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 facility that meets the criteria for the special dietary needs of its residents and the requirements in section 31.651. The adjustment for raw food cost shall be the difference between the nursing facility'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.

(i) For the cost report year ending September 30, 1996, and for all subsequent reporting years, certified nursing facilities must identify, differentiate, and record resident day statistics for residents in case mix classification A who, on or after July 1, 1996, meet the modified level of care criteria in section 144.0721. The resident day statistics shall be separated into case mix classification A–1 for any resident day meeting the high–function class A level of care criteria and case mix classification A–2 for other case mix class A resident days.

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 facility 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 facility when it is determined by the commissioners of health and human services that the nursing facility is unable to meet minimum standards through reallocation of nursing facility 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 facility 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 facilities 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 long–term care planning committee. If a field audit reveals that unallowable expenditures have been included in the nursing facility'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 facility 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 facility 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 facility rates.

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

(1) the cost–effectiveness and appropriateness of services;

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

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

The commissioner may negotiate an adjustment to the operating cost payment rate for a nursing facility 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 facility 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 facility, 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 facilities licensed on June 1, 1983 by the commissioner to provide residential services for the physically handicapped and nursing facilities 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 facilities shall receive their actual allowed historical operating cost per diem increased by six percent. The commissioner shall also apply to these nursing facilities 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 facility 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 facility. 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 facility. 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 facility 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 facility.

(c) The cost in paragraph (a) for each consultant must not be allocated to more than one operating cost category in the nursing facility. If more than one nursing facility is served by a consultant, all nursing facilities 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 facility 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 facility:

(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 facility 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. For the rate period beginning October 1, 1992, and for rate years beginning after June 30, 1993, the amount of the surcharge under section 256.9657, subdivision 1, shall be included in the plant operations and maintenance operating cost category. The surcharge shall be an allowable cost for the purpose of establishing the payment rate.

(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 facility. The salary adjustment per diem for each nursing facility must be determined as follows:

(1) for each nursing facility 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 facility's actual resident days; and

(2) for each nursing facility 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 facility that receives a salary adjustment per diem pursuant to this subdivision shall adjust nursing facility 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 facility complied with this requirement. The commissioner shall

report the extent to which each nursing facility 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.

(e) **New base year.** The commissioner shall establish a new base year for the reporting years ending September 30, 1991, and September 30, 1992. In establishing a new base year, 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.

Subd. 2j. **Hospital-attached nursing facility 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 facility means a nursing facility which meets the requirements of clauses (1) to (3):

(1) the nursing facility is 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 facility under Minnesota Rules, parts 9510.0010 to 9510.0480;

(2) the nursing facility'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 except as provided in clause (3); and

(3) direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

(b) For rate years beginning after June 30, 1989, a nursing facility 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 facility's reporting year, shall be considered a hospital-attached nursing facility 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 facility 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 facility. For each subsequent rate year, the nursing facility must meet the definition requirements in paragraph (a). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility pursuant to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility.

(c) For rate years beginning on or after July 1, 1995, a nursing facility shall be considered a hospital attached nursing facility for purposes of setting payment rates under Minnesota Rules, parts 9549.0010 to 9549.0080 and this section if it meets the requirements of paragraphs (a) and (b), and

(1) the hospital and nursing facility are physically attached or connected by a tunnel or skyway; or

(2) the nursing facility was recognized by the Medicare program as hospital attached as of January 1, 1995, and this status has been maintained continuously.

Subd. 2k. **Operating costs after July 1, 1989.** For rate years beginning on or after July 1, 1989, a nursing facility 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 facilities 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 facility's average length of stay must be computed by dividing the nursing facility's actual resident days for the reporting year by the nursing facility's total discharges for that reporting year.

Subd. 2l. **Inflation adjustments after July 1, 1990.** (a) For rate years beginning on or after July 1, 1990, the forecasted composite price index for a nursing facility'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.

(b) For rate years beginning on or after July 1, 1992, the commissioner shall index the prior year's operating cost limits by the percentage change in the Data Resources, Inc., Nursing Home Market Basket between the midpoint of the current reporting year and the midpoint of the previous reporting year. The commissioner shall use the indices as forecasted by Data Resources, Inc., in the fourth quarter of the calendar year preceding the rate year.

(c) For rate years beginning on or after July 1, 1993, the commissioner shall not provide automatic annual inflation adjustments for nursing facilities. The commissioner of finance shall include annual adjustments in operating costs for nursing facilities as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11.

Subd. 2m. **Nursing facilities specializing in the treatment of Huntington's disease.** For the rate year beginning July 1, 1991, and for the rate period from July 1, 1992, to December 31, 1992, the commissioner shall reimburse nursing facilities that specialize in the treatment of Huntington's disease using the case mix per diem limit that applies to nursing facilities licensed under the department of human services' rules governing residential services for physically handicapped persons to establish rates for up to 35 persons with Huntington's disease. For purposes of this subdivision, a nursing facility specializes in the treatment of Huntington's disease if more than 25 percent of its licensed capacity is used for residents with Huntington's disease.

Subd. 2n. **Efficiency incentive reductions for substandard care.** For rate years beginning on or after July 1, 1991, the efficiency incentive established under subdivision 2b, paragraph (d), shall be reduced or eliminated for nursing facilities determined by the commissioner of health under section 144A.10, subdivision 4, to have uncorrected or repeated violations which create a risk to resident care, safety, or rights, except for uncorrected or repeated violations relating to a facility's physical plant. Upon being notified by the commissioner of health of uncorrected or repeated violations, the commissioner of human services shall require the nursing facility to use efficiency incentive payments to correct the violations. The commissioner of human services shall require the nursing facility to forfeit efficiency incentive payments for failure to correct the violations. Any forfeiture shall be limited to the amount necessary to correct the violation.

Subd. 2o. **Special payment rates for short-stay nursing facilities.** Notwithstanding contrary provisions of this section and rules adopted by the commissioner, for the rate years beginning on or after July 1, 1993, a nursing facility whose average length of stay for the preceding reporting year is (1) less than 180 days; or (2) less than 225 days in a nursing facility with more than 315 licensed beds must be reimbursed for allowable costs up to 125 percent of the total care-related limit and 105 percent of the other-operating-cost limit for hospital-attached nursing facilities. A nursing facility that received the benefit of this limit during the rate year beginning July 1, 1992, continues to receive this rate during the rate year beginning July 1, 1993, even if the facility's average length of stay is more than 180 days in the rate years subsequent to the rate year beginning July 1, 1991. For purposes of this subdivision, a nursing facility shall compute its average length of stay by dividing the nursing facility's ac-

tual resident days for the reporting year by the nursing facility's total resident discharges for that reporting year.

Subd. 2p. **Downsizing of nursing facilities that are institutions for mental disease.** (a) The provisions of this subdivision apply to a nursing facility that is an institution for mental disease and that has less than 23 licensed beds. A nursing facility that meets these conditions may reduce its total number of licensed beds to 16 licensed beds by July 1, 1992, by notifying the commissioner of health of the reduction by April 1, 1992. If the nursing facility elects to reduce its licensed beds to 16, the commissioner of health shall approve that request effective on the date of request.

(b) The commissioner of human services must be notified by the nursing facility of the reduction in licensed beds by April 4, 1992, and that notice must include a copy of the request for reduction submitted to the commissioner of health.

(c) For the rate year beginning July 1, 1992, the commissioner shall establish the operating cost payment rates for a nursing facility that has reduced its licensed bed capacity under this subdivision by taking into account paragraphs (1) and (2).

(1) The commissioner must reduce the nursing facility's nurse's aide, orderly, and attendant salaries account and the food expense account for the reporting year ending September 30, 1991, by 50 percent of the percentage change in licensed beds.

(2) The commissioner shall adjust the nursing facility's resident days and standardized resident days for the reporting year ending September 30, 1991, as in clauses (i) and (ii).

(i) Resident days shall be the lesser of the nursing facility's actual resident days for that reporting year or 5,840.

(ii) Standardized resident days shall be the lesser of the nursing facility's actual standardized resident days or the nursing facility's case mix score for that reporting year times 5,840.

(d) For the rate year beginning July 1, 1993, the commissioner shall establish the operating cost payment rates for a nursing facility that has reduced its licensed bed capacity under this subdivision by taking into account paragraphs (1) and (2).

(1) The commissioner must reduce the nursing facility's account for the nurse's aide, orderly, and attendant salaries, and its account for food expense for the reporting year ending September 30, 1992, by 37.5 percent of the percentage change in licensed beds.

(2) The commissioner shall adjust the nursing facility's resident days and standardized resident days for the reporting year ending September 30, 1992, as in clauses (i) and (ii).

(i) Resident days shall be the lesser of the nursing facility's actual resident days for that reporting year or 5,840.

(ii) Standardized resident days shall be the lesser of the nursing facility's actual standardized resident days or the nursing facility's case mix score for that reporting year times 5,840.

(e) If a nursing facility reduces its total number of licensed beds before June 28, 1991, by notifying the commissioner of health by that date, the dates and computations in this subdivision shall be accelerated by one year.

(f) A nursing facility eligible under this subdivision may use the notification date and the date on which the licensed beds are reduced for purposes of applying the provisions in subdivision 3a, paragraph (d), clause (2).

Subd. 2q. **Negotiated rate cap exemption.** A nursing facility which requests, after January 1991, that its boarding care beds be decertified from participation in the medical assistance program, is not eligible for the exception to the negotiated rate cap in section 256I.05, subdivision 2, paragraph (c), clause (1).

Subd. 2r. **Payment restrictions on leave days.** Effective July 1, 1993, the commissioner shall limit payment for leave days in a nursing facility to 79 percent of that nursing facility's total payment rate for the involved resident.

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 facility 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 facility'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 facility's licensed capacity days for nursing facilities with more than 60 beds and 94 percent of the nursing facility's licensed capacity days for nursing facilities with 60 or fewer beds. For a nursing facility 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 facility's property–related costs by the actual resident days to compute the nursing facility's annual property–related per diem. The commissioner shall promulgate emergency and permanent rules to recapture excess depreciation upon sale of a nursing facility.

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 facility 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 facilities, 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 facilities;

(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 facility 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 facility 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 facility'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 facility;

(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 facility 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 facility'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 facility'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 facility up to a maximum of 100 months. For the purpose of this subdivision, the sale of a nursing facility means the sale or transfer of a nursing facility'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 facility in which the new operator leases depreciable equipment used in the nursing facility 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 facility, the provisions of this subdivision will be applied proportionately to sales or accumulations of sales that exceed 20 percent of a nursing facility's capital assets or capital stock. Depreciation recapture payments resulting from the sale of a nursing facility 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 facility 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 five subsequent rate years. In the fourth year the facility shall receive 60 percent of the difference between the hospital-attached limit and the freestanding nursing facility limit, and in the fifth year the facility shall receive 30 percent of the difference.

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). Beginning January 1, 1991, the replacement-cost-new per bed limits will be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index utilized will be the Bureau of the Census: Composite fixed-weighted price index as published in the Survey of Current Business.

(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 facilities 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 facilities except those whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use 95 percent of capacity days. For a nursing facility whose average length of stay in a skilled level of care within a nursing facility 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 facility'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 facility'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. For the rate period beginning October 1, 1992, the equipment allowance for each nursing facility shall be increased by 28 percent. For rate years beginning after June 30, 1993, the allowance must be adjusted annually for inflation.

(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 facility 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 facility must also demonstrate that the seller no longer participates in the management or operation of the nursing facility. 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 facilities with operating leases.** For rate years beginning on or after July 1, 1990, a nursing facility with operating lease costs incurred for the nursing facility'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 facilities 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 facility 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 facility to apply for refinancing as a condition of receiving special rate treatment under this subdivision.

(b) If a nursing facility is eligible for a property–related payment rate under this subdivision, and the nursing facility'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 facility'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 facility'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 facility'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 facility'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 facility'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 facility'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 this chapter or rules adopted under it, for rate years beginning July 1, 1990, a nursing facility under lease from 1968 until 1983 with a lessee or related party having an option to purchase the nursing facility, 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 facility 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 facilities for the rate year beginning July 1, 1990, as follows:

(a) The property–related payment rate for a nursing facility 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 facilities 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 facility 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 facility 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 facility 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 facility 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 facility 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 facility'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 facility's capacity days as determined under Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c); except that the nursing facility'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 facility 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 facility 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 facility 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 facility 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 facility's existing property–related payment rate, minus the nursing facility's allowable principal and interest costs and equipment allowance, is not sufficient to cover the costs of the required improvements. Each nursing facility 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 facility to meet the new requirements, divided by resident days, must be added to the nursing facility'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 facility 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 facility 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 facility or for the added beds. For newly constructed nursing facilities 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 facilities which provide care under a lesser care level than the level for which the nursing facility is certified.

(b) For the rate years beginning on or after July 1, 1985, a newly constructed nursing facility 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 facility 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 facility. From July 1, 1985, until the total payment rate becomes effective, the commissioner shall make payments to each nursing facility 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 facility upon death of an owner;

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

(3) the sale or transfer of the nursing facility 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 facility 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 facility 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.

Subd. 5. **Adjustments.** When resolution of appeals or on–site field audits of the records of nursing facilities 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. [Repealed, 1991 c 292 art 7 s 26]

Subd. 7. **One–time adjustment to nursing facility 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 facilities' 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 facility to be eligible for the payment rate adjustment, a nursing facility 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 facility to the new minimum staff standards, the commissioner may exclude the nursing facility if it is either an institution for mental disease or a nursing facility 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 facility 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 facility 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 facility'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 facility 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 facility'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 facility 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 facility'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 facility'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. 9a. **One-time adjustment for 21-month factor.** For the rate period beginning October 1, 1992, the 21-month inflation factor for operating costs shall be increased by *seven-tenths of one percent.*

Subd. 10. **Property rate adjustments and construction projects.** A nursing facility's request for a property-related payment rate adjustment and the related supporting documentation of project construction cost information must be submitted to the commissioner within 60 days after the construction project's completion date to be considered eligible for a property-related payment rate adjustment. Construction projects with completion dates within one year of the completion date associated with the property rate adjustment request and phased projects with project completion dates within three years of the last phase of the phased project must be aggregated for purposes of the minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section 144A.071, subdivision 2. "Construction project," "project construction costs," and "phased project" have the meanings given them in Minnesota Rules, part 4655.1110 (Emergency).

Subd. 11. **Special property rate setting procedures for certain nursing facilities.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item H, to the contrary, for the rate year beginning July 1, 1990, a nursing facility 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.

Subd. 12. **Interim property–related payment rates.** For the rate period July 1, 1991, to June 30, 1993, the commissioner shall continue the property–related payment rate in effect on June 30, 1991, for each nursing facility, except as provided in section 256B.431, subdivision 3i, paragraphs (f) and (g), and subdivision 11, except that:

(1) A chain organization consisting of 28 nursing facilities which has a majority of owners beyond the retirement age of 62 and that has a change in ownership or reorganization of provider entity between July 1, 1991, and June 30, 1993, or until the property reimbursement system is changed, shall receive the property–related payment rate in effect at the time of the sale or reorganization. This exception is not effective until the commissioner has received approval of its state plan from the federal government; and

(2) If the property–related payment rate in effect on June 30, 1991, is later adjusted by the commissioner, the property–related payment rate for the rate period July 1, 1991, to July 1, 1993, shall also be adjusted correspondingly.

Subd. 13. **Hold–harmless property–related rates.** (a) Terms used in subdivisions 13 to 21 shall be as defined in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) Except as provided in this subdivision, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property–related rate for a nursing facility shall be the greater of $4 or the property–related payment rate in effect on September 30, 1992. In addition, the incremental increase in the nursing facility's rental rate will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(c) Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item F, a nursing facility that has a sale permitted under subdivision 14 after June 30, 1992, shall receive the property–related payment rate in effect at the time of the sale or reorganization. For rate periods beginning after October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility shall receive, in addition to its property–related payment rate in effect at the time of the sale, the incremental increase allowed under subdivision 14.

(d) For rate years beginning after June 30, 1993, the property–related rate for a nursing facility licensed after July 1, 1989, after relocating its beds from a separate nursing home to a building formerly used as a hospital and sold during the cost reporting year ending September 30, 1991, shall be its property–related rate prior to the sale in addition to the incremental increases provided under this section effective on October 1, 1992, of 29 cents per day, and any incremental increases after October 1, 1992, calculated by using its rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, recognizing the current appraised value of the facility at the new location, and including as allowable debt otherwise allowable debt incurred to remodel the facility in the new location prior to the relocation of beds.

Subd. 14. **Limitations on sales of nursing facilities.** (a) For rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility's property–related payment rate as established under subdivision 13 shall be adjusted by either paragraph (b) or (c) for the sale of the nursing facility, including sales occurring after June 30, 1992, as provided in this subdivision.

(b) If the nursing facility's property–related payment rate under subdivision 13 prior to sale is greater than the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale, the nursing facility's property–related payment rate after sale shall be the greater of its property–related payment rate under subdivision 13 prior to sale or its rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section calculated after sale.

(c) If the nursing facility's property–related payment rate under subdivision 13 prior to sale is equal to or less than the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale, the nursing facility's property–related payment rate after sale shall be the nursing facility's property–related payment rate under subdivision 13 plus the difference between its rental rate calculated under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale and its rental rate calculated under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section calculated after sale.

(d) For purposes of this subdivision, "sale" means the purchase of a nursing facility's capital assets with cash or debt. The term sale does not include a stock purchase of a nursing facility or any of the following transactions:

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

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

(3) gifts or other transfers for no consideration;

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

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

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

(7) a sale, merger, reorganization, or any other transfer of interest between related organizations other than those permitted in this section.

(e) For purposes of this subdivision, "sale" includes the sale or transfer of a nursing facility to a close relative as defined in Minnesota Rules, part 9549.0020, subpart 38, item C, upon the death of an owner, due to serious illness or disability, as defined under the Social Security Act, under United States Code, title 42, section 423(d)(1)(A), or upon retirement of an owner from the business of owning or operating a nursing home at 62 years of age or older. For sales to a close relative allowed under this paragraph, otherwise nonallowable debt resulting from seller financing of all or a portion of the debt resulting from the sale shall be allowed and shall not be subject to Minnesota Rules, part 9549.0060, subpart 5, item E, provided that in addition to existing requirements for allowance of debt and interest, the debt is subject to repayment through annual principal payments and the interest rate on the related organization debt does not exceed three percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation for delivery in 60 days in effect on the day of sale. If at any time, the seller forgives the related organization debt allowed under this paragraph for other than equal amount of payment on that debt, then the buyer shall pay to the state the total revenue received by the nursing facility after the sale attributable to the amount of allowable debt which has been forgiven. Any assignment, sale, or transfer of the debt instrument entered into by the close relatives, either directly or indirectly, which grants to the close relative buyer the right to receive all or a portion of the payments under the debt instrument shall, effective on the date of the transfer, result in the prospective reduction in the corresponding portion of the allowable debt and interest expense. Upon the death of the close relative seller, any remaining balance of the close relative debt must be refinanced and such refinancing shall be subject to the provisions of Minnesota Rules, part 9549.0060, subpart 7, item G. This paragraph shall not apply to sales occurring on or after June 30, 1997.

(f) For purposes of this subdivision, "effective date of sale" means the later of either the date on which legal title to the capital assets is transferred or the date on which closing for the sale occurred.

(g) The effective day for the property-related payment rate determined under this subdivision shall be the first day of the month following the month in which the effective date of sale occurs or October 1, 1992, whichever is later, provided that the notice requirements under section 256B.47, subdivision 2, have been met.

(h) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (3) and (4), and 7, items E and F, the commissioner shall limit the total allowable debt and related interest for sales occurring after June 30, 1992, to the sum of clauses (1) to (3):

(1) the historical cost of capital assets, as of the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the nursing facility's initial historical cost of constructing capital assets;

(2) the average annual capital asset additions after deduction for capital asset deletions, not including depreciations; and

(3) one-half of the allowed inflation on the nursing facility's capital assets. The commissioner shall compute the allowed inflation as described in paragraph (h).

(i) For purposes of computing the amount of allowed inflation, the commissioner must apply the following principles:

(1) the lesser of the Consumer Price Index for all urban consumers or the Dodge Construction Systems Costs for Nursing Homes for any time periods during which both are available must be used. If the Dodge Construction Systems Costs for Nursing Homes becomes unavailable, the commissioner shall substitute the index in subdivision 3f, or such other index as the secretary of the health care financing administration may designate;

(2) the amount of allowed inflation to be applied to the capital assets in paragraph (g), clauses (1) and (2), must be computed separately;

(3) the amount of allowed inflation must be determined on an annual basis, prorated on a monthly basis for partial years and if the initial month of use is not determinable for a capital asset, then one-half of that calendar year shall be used for purposes of prorating;

(4) the amount of allowed inflation to be applied to the capital assets in paragraph (g), clauses (1) and (2), must not exceed 300 percent of the total capital assets in any one of those clauses; and

(5) the allowed inflation must be computed starting with the month following the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the month following the date of the nursing facility's initial occupancy, and ending with the month preceding the effective date of sale.

(j) If the historical cost of a capital asset is not readily available for the date of the nursing facility's most recent previous sale or if there has been no previous sale for the date of the nursing facility's initial occupancy, then the commissioner shall limit the total allowable debt and related interest after sale to the extent recognized by the Medicare intermediary after the sale. For a nursing facility that has no historical capital asset cost data available and does not have allowable debt and interest calculated by the Medicare intermediary, the commissioner shall use the historical cost of capital asset data from the point in time for which capital asset data is recorded in the nursing facility's audited financial statements.

(k) The limitations in this subdivision apply only to debt resulting from a sale of a nursing facility occurring after June 30, 1992, including debt assumed by the purchaser of the nursing facility.

Subd. 15. **Capital repair and replacement cost reporting and rate calculation.** For rate years beginning after June 30, 1993, a nursing facility's capital repair and replacement payment rate shall be established annually as provided in paragraphs (a) to (e).

(a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the costs of any of the following items not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), including cash payment for equity investment and principal and interest expense for debt financing, must be reported in the capital repair and replacement cost category:

(1) wall coverings;

(2) paint;

(3) floor coverings;

(4) window coverings;

(5) roof repair; and

(6) window repair or replacement.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 12, the repair or replacement of a capital asset not included in the equity incentive computations under subdivision 16 or reported as a capital asset addition under subdivision 18, paragraph (b), must be reported under this subdivision when the cost of the item exceeds $500, or in the plant operations and maintenance cost category when the cost of the item is equal to or less than $500.

(c) To compute the capital repair and replacement payment rate, the allowable annual repair and replacement costs for the reporting year must be divided by actual resident days for the reporting year. The annual allowable capital repair and replacement costs shall not exceed $150 per licensed bed. The excess of the allowed capital repair and replacement costs over the capital repair and replacement limit shall be a cost carryover to succeeding cost reporting periods, except that sale of a facility, under subdivision 14, shall terminate the carry-

over of all costs except those incurred in the most recent cost reporting year. The termination of the carryover shall have effect on the capital repair and replacement rate on the same date as provided in subdivision 14, paragraph (f), for the sale. For rate years beginning after June 30, 1994, the capital repair and replacement limit shall be subject to the index provided in subdivision 3f, paragraph (a). For purposes of this subdivision, the number of licensed beds shall be the number used to calculate the nursing facility's capacity days. The capital repair and replacement rate must be added to the nursing facility's total payment rate.

(d) Capital repair and replacement costs under this subdivision shall not be counted as either care–related or other operating costs, nor subject to care–related or other operating limits.

(e) If costs otherwise allowable under this subdivision are incurred as the result of a project approved under the moratorium exception process in section 144A.073, or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of these assets exceeds the lesser of $150,000 or ten percent of the nursing facility's appraised value, these costs must be claimed under subdivision 16 or 17, as appropriate.

Subd. 16. **Major additions and replacements; equity incentive.** For rate years beginning after June 30, 1993, if a nursing facility acquires capital assets in connection with a project approved under the moratorium exception process in section 144A.073 or in connection with an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost of those capital asset additions exceeds the lesser of $150,000 or ten percent of the most recent appraised value, the nursing facility shall be eligible for an equity incentive payment rate as in paragraphs (a) to (d). This computation is separate from the determination of the nursing facility's rental rate. An equity incentive payment rate as computed under this subdivision is limited to one in a 12–month period.

(a) An eligible nursing facility shall receive an equity incentive payment rate equal to the allowable historical cost of the capital asset acquired, minus the allowable debt directly identified to that capital asset, multiplied by the equity incentive factor as described in paragraphs (b) and (c), and divided by the nursing facility's occupancy factor under subdivision 3f, paragraph (c). This amount shall be added to the nursing facility's total payment rate and shall be effective the same day as the incremental increase in paragraph (d) or subdivision 17. The allowable historical cost of the capital assets and the allowable debt shall be determined as provided in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(b) The equity incentive factor shall be determined under clauses (1) to (4):

(1) divide the initial allowable debt in paragraph (a) by the initial historical cost of the capital asset additions referred to in paragraph (a), then cube the quotient,

(2) subtract the amount calculated in clause (1) from the number one,

(3) determine the difference between the rental factor and the lesser of two percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on the first day of the month the debt or cost is incurred, or 16 percent,

(4) multiply the amount calculated in clause (2) by the amount calculated in clause (3).

(c) The equity incentive payment rate shall be limited to the term of the allowable debt in paragraph (a), not greater than 20 years nor less than ten years. If no debt is incurred in acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The sale of a nursing facility under subdivision 14 shall terminate application of the equity incentive payment rate effective on the date provided in subdivision 4, paragraph (f), for the sale.

(d) A nursing facility with an addition to or a renovation of its buildings, attached fixtures, or land improvements meeting the criteria in this subdivision and not receiving the property–related payment rate adjustment in subdivision 17, shall receive the incremental increase in the nursing facility's rental rate as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section. The incremental increase shall be added to the nursing facility's property–related payment rate. The effective date of this incremental increase shall be the first day of the month following the month in which the addition or replacement is completed.

Subd. 17. **Special provisions for moratorium exceptions.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 3, for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility that (1) has completed a construction project approved under section 144A.071, subdivision 4a, clause (m); (2) has completed a construction project approved under section 144A.071, subdivision 4a, and effective after June 30, 1995; or (3) has completed a renovation, replacement, or upgrading project approved under the moratorium exception process in section 144A.073 shall be reimbursed for costs directly identified to that project as provided in subdivision 16 and this subdivision.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (1) and (3), and 7, item D, allowable interest expense on debt shall include:

(1) interest expense on debt related to the cost of purchasing or replacing depreciable equipment, excluding vehicles, not to exceed six percent of the total historical cost of the project; and

(2) interest expense on debt related to financing or refinancing costs, including costs related to points, loan origination fees, financing charges, legal fees, and title searches; and issuance costs including bond discounts, bond counsel, underwriter's counsel, corporate counsel, printing, and financial forecasts. Allowable debt related to items in this clause shall not exceed seven percent of the total historical cost of the project. To the extent these costs are financed, the straight-line amortization of the costs in this clause is not an allowable cost; and

(3) interest on debt incurred for the establishment of a debt reserve fund, net of the interest earned on the debt reserve fund.

(c) Debt incurred for costs under paragraph (b) is not subject to Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (5) or (6).

(d) The incremental increase in a nursing facility's rental rate, determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, resulting from the acquisition of allowable capital assets, and allowable debt and interest expense under this subdivision shall be added to its property-related payment rate and shall be effective on the first day of the month following the month in which the moratorium project was completed.

(e) Notwithstanding subdivision 3f, paragraph (a), for rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the replacement-costs-new per bed limit to be used in Minnesota Rules, part 9549.0060, subpart 4, item B, for a nursing facility that has completed a renovation, replacement, or upgrading project that has been approved under the moratorium exception process in section 144A.073, or that has completed an addition to or replacement of buildings, attached fixtures, or land improvements for which the total historical cost exceeds the lesser of $150,000 or ten percent of the most recent appraised value, must be $47,500 per licensed bed in multiple-bed rooms and $71,250 per licensed bed in a single-bed room. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 1993.

(f) A nursing facility that completes a project identified in this subdivision and, as of April 17, 1992, has not been mailed a rate notice with a special appraisal for a completed project, or completes a project after April 17, 1992, but before September 1, 1992, may elect either to request a special reappraisal with the corresponding adjustment to the property-related payment rate under the laws in effect on June 30, 1992, or to submit their capital asset and debt information after that date and obtain the property-related payment rate adjustment under this section, but not both.

(g) For purposes of this paragraph, a total replacement means the complete replacement of the nursing facility's physical plant through the construction of a new physical plant or the transfer of the nursing facility's license from one physical plant location to another. For total replacement projects completed on or after July 1, 1992, the commissioner shall compute the incremental change in the nursing facility's rental per diem, for rate years beginning on or after July 1, 1995, by replacing its appraised value, including the historical capital asset costs, and the capital debt and interest costs with the new nursing facility's allowable capital asset costs and the related allowable capital debt and interest costs. If the new nursing facility has decreased its licensed capacity, the aggregate investment per bed limit in subdivision 3a,

paragraph (d), shall apply. If the new nursing facility has retained a portion of the original physical plant for nursing facility usage, then a portion of the appraised value prior to the replacement must be retained and included in the calculation of the incremental change in the nursing facility's rental per diem. For purposes of this part, the original nursing facility means the nursing facility prior to the total replacement project. The portion of the appraised value to be retained shall be calculated according to clauses (1) to (3):

(1) The numerator of the allocation ratio shall be the square footage of the area in the original physical plant which is being retained for nursing facility usage.

(2) The denominator of the allocation ratio shall be the total square footage of the original nursing facility physical plant.

(3) Each component of the nursing facility's allowable appraised value prior to the total replacement project shall be multiplied by the allocation ratio developed by dividing clause (1) by clause (2).

In the case of either type of total replacement as authorized under section 144A.071 or 144A.073, the provisions of this subdivision shall also apply. For purposes of the moratorium exception authorized under section 144A.071, subdivision 4a, paragraph (s), if the total replacement involves the renovation and use of an existing health care facility physical plant, the new allowable capital asset costs and related debt and interest costs shall include first the allowable capital asset costs and related debt and interest costs of the renovation, to which shall be added the allowable capital asset costs of the existing physical plant prior to the renovation, and if reported by the facility, the related allowable capital debt and interest costs.

Subd. 18. **Appraisals; updating appraisals, additions, and replacements.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subparts 1 to 3, the appraised value, routine updating of the appraised value, and special reappraisals are subject to this subdivision.

(1) For rate years beginning after June 30, 1993, the commissioner shall permit a nursing facility to appeal its appraisal according to the procedures provided in section 256B.50, subdivision 2. Any reappraisals conducted in connection with that appeal must utilize the comparative-unit method as described in the Marshall Valuation Service published by Marshall-Swift in establishing the nursing facility's depreciated replacement cost.

Nursing facilities electing to appeal their appraised value shall file written notice of appeal with the commissioner of human services before December 30, 1992. The cost of the reappraisal, if any, shall be considered an allowable cost under Minnesota Rules, parts 9549.0040, subpart 9, and 9549.0061.

(2) The redetermination of a nursing facility's appraised value under this paragraph shall have no impact on the rental payment rate determined under subdivision 13 but shall only be used for calculating the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section for rate years beginning after June 30, 1993.

(3) For all rate years after June 30, 1993, the commissioner shall no longer conduct any appraisals under Minnesota Rules, part 9549.0060, for the purpose of determining property-related payment rates.

(b) Notwithstanding Minnesota Rules, part 9549.0060, subpart 2, for rate years beginning after June 30, 1993, the commissioner shall routinely update the appraised value of each nursing facility by adding the cost of capital asset acquisitions to its allowable appraised value.

The commissioner shall also annually index each nursing facility's allowable appraised value by the inflation index referenced in subdivision 3f, paragraph (a), for the purpose of computing the nursing facility's annual rental rate. In annually adjusting the nursing facility's appraised value, the commissioner must not include the historical cost of capital assets acquired during the reporting year in the nursing facility's appraised value.

In addition, the nursing facility's appraised value must be reduced by the historical cost of capital asset disposals or applicable credits such as public grants and insurance proceeds. Capital asset additions and disposals must be reported on the nursing facility's annual cost report in the reporting year of acquisition or disposal. The incremental increase in the nursing facility's rental rate resulting from this annual adjustment as determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section shall be added to the nursing facility's property-related payment rate for the rate year following the reporting year.

Subd. 19. **Refinancing incentive.** (a) A nursing facility that refinances debt after May 30, 1992, in order to save in interest expense payments as determined in clauses (1) to (5) may be eligible for the refinancing incentive under this subdivision. To be eligible for the refinancing incentive, a nursing facility must notify the commissioner in writing of such a refinancing within 60 days following the date on which the refinancing occurs. If the nursing facility meets these conditions, the commissioner shall determine the refinancing incentive as in clauses (1) to (5).

(1) Compute the aggregate amount of interest expense, including amortized issuance and financing costs, remaining on the debt to be refinanced, and divide this amount by the number of years remaining for the term of that debt.

(2) Compute the aggregate amount of interest expense, including amortized issuance and financing costs, for the new debt, and divide this amount by the number of years for the term of that debt.

(3) Subtract the amount in clause (2) from the amount in clause (1), and multiply the amount, if positive, by .5.

(4) The amount in clause (3) shall be divided by the nursing facility's occupancy factor under subdivision 3f, paragraph (c).

(5) The per diem amount in clause (4) shall be deducted from the nursing facility's property–related payment rate for three full rate years following the rate year in which the refinancing occurs. For the fourth full rate year following the rate year in which the refinancing occurs, and each rate year thereafter, the per diem amount in clause (4) shall again be deducted from the nursing facility's property–related payment rate.

(b) An increase in a nursing facility's debt for costs in subdivision 17, paragraph (b), clause (2), including the cost of refinancing the issuance or financing costs of the debt refinanced resulting from refinancing that meets the conditions of this section shall be allowed, notwithstanding Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (6).

(c) The proceeds of refinancing may not be used for the purpose of withdrawing equity from the nursing facility.

(d) Sale of a nursing facility under subdivision 14 shall terminate the payment of the incentive payments under this subdivision effective the date provided in subdivision 14, paragraph (f), for the sale, and the full amount of the refinancing incentive in paragraph (a) shall be implemented.

(e) If a nursing facility eligible under this subdivision fails to notify the commissioner as required, the commissioner shall determine the full amount of the refinancing incentive in paragraph (a), and shall deduct one–half that amount from the nursing facility's property–related payment rate effective the first day of the month following the month in which the refinancing is completed. For the next three full rate years, the commissioner shall deduct one–half the amount in paragraph (a), clause (5). The remaining per diem amount shall be deducted in each rate year thereafter.

(f) The commissioner shall reestablish the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section following the refinancing using the new debt and interest expense information for the purpose of measuring future incremental rental increases.

Subd. 20. **Special property rate setting.** For rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property–related payment rate for a nursing facility approved for total replacement under the moratorium exception process in section 144A.073 through an addition to another nursing facility shall have its property–related rate under subdivision 13 recalculated using the greater of actual resident days or 80 percent of capacity days. This rate shall apply until the nursing facility is replaced or until the moratorium exception authority lapses, whichever is sooner.

Subd. 21. **Indexing thresholds.** Beginning January 1, 1993, and each January 1 thereafter, the commissioner shall annually update the dollar thresholds in subdivisions 15, paragraph (d), 16, and 17, and in section 144A.071, subdivisions 2 and 4a, clauses (b) and (e), by the inflation index referenced in subdivision 3f, paragraph (a).

Subd. 22. **Changes to nursing facility reimbursement.** The nursing facility reimbursement changes in paragraphs (a) to (e) apply to Minnesota Rules, parts 9549.0010 to

9549.0080, and this section, and are effective for rate years beginning on or after July 1, 1993, unless otherwise indicated.

(a) In addition to the approved pension or profit sharing plans allowed by the reimbursement rule, the commissioner shall allow those plans specified in Internal Revenue Code, sections 403(b) and 408(k).

(b) The commissioner shall allow as workers' compensation insurance costs under section 256B.421, subdivision 14, the costs of workers' compensation coverage obtained under the following conditions:

(1) a plan approved by the commissioner of commerce as a Minnesota group or individual self-insurance plan as provided in section 79A.03;

(2) a plan in which:

(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) a related organization to the nursing facility reinsures the workers' compensation coverage purchased, directly or indirectly, by the nursing facility; and

(iii) all of the conditions in clause (4) are met;

(3) a plan in which:

(i) the nursing facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) the insurance premium is calculated retrospectively, including a maximum premium limit, and paid using the paid loss retro method; and

(iii) all of the conditions in clause (4) are met;

(4) additional conditions are:

(i) the costs of the plan are allowable under the federal Medicare program;

(ii) the reserves for the plan are maintained in an account controlled and administered by a person which is not a related organization to the nursing facility;

(iii) the reserves for the plan cannot be used, directly or indirectly, as collateral for debts incurred or other obligations of the nursing facility or related organizations to the nursing facility;

(iv) if the plan provides workers' compensation coverage for non-Minnesota nursing facilities, the plan's cost methodology must be consistent among all nursing facilities covered by the plan, and if reasonable, is allowed notwithstanding any reimbursement laws regarding cost allocation to the contrary;

(v) central, affiliated, corporate, or nursing facility costs related to their administration of the plan are costs which must remain in the nursing facility's administrative cost category and must not be allocated to other cost categories; and

(vi) required security deposits, whether in the form of cash, investments, securities, assets, letters of credit, or in any other form are not allowable costs for purposes of establishing the facilities payment rate.

(5) any costs allowed pursuant to clauses (1) to (3) are subject to the following requirements:

(i) if the nursing facility is sold or otherwise ceases operations, the plan's reserves must be subject to an actuarially based settle-up after 36 months from the date of sale or the date on which operations ceased. The facility's medical assistance portion of the total excess plan reserves must be paid to the state within 30 days following the date on which excess plan reserves are determined;

(ii) any distribution of excess plan reserves made to or withdrawals made by the nursing facility or a related organization are applicable credits and must be used to reduce the nursing facility's workers' compensation insurance costs in the reporting period in which a distribution or withdrawal is received;

(iii) if reimbursement for the plan is sought under the federal Medicare program, and is audited pursuant to the Medicare program, the nursing facility must provide a copy of Medicare's final audit report, including attachments and exhibits, to the commissioner within 30 days of receipt by the nursing facility or any related organization. The commissioner shall

implement the audit findings associated with the plan upon receipt of Medicare's final audit report. The department's authority to implement the audit findings is independent of its authority to conduct a field audit.

(c) In the determination of incremental increases in the nursing facility's rental rate as required in subdivisions 14 to 21, except for a refinancing permitted under subdivision 19, the commissioner must adjust the nursing facility's property-related payment rate for both incremental increases and decreases in recomputations of its rental rate;

(d) A nursing facility's administrative cost limitation must be modified as follows:

(1) if the nursing facility's licensed beds exceed 195 licensed beds, the general and administrative cost category limitation shall be 13 percent;

(2) if the nursing facility's licensed beds are more than 150 licensed beds, but less than 196 licensed beds, the general and administrative cost category limitation shall be 14 percent; or

(3) if the nursing facility's licensed beds is less than 151 licensed beds, the general and administrative cost category limitation shall remain at 15 percent.

(e) The care related operating rate shall be increased by eight cents to reimburse facilities for unfunded federal mandates, including costs related to hepatitis B vaccinations.

Subd. 23. **County nursing home payment adjustments.** (a) Beginning in 1994, the commissioner shall pay a nursing home payment adjustment on May 31 after noon to a county in which is located a nursing home that, as of January 1 of the previous year, was county-owned and operated, with the county named as licensee by the commissioner of health, and had over 40 beds and medical assistance occupancy in excess of 50 percent during the reporting year ending September 30, 1991. The adjustment shall be an amount equal to $16 per calendar day multiplied by the number of beds licensed in the facility as of September 30, 1991.

(b) Payments under paragraph (a) are excluded from medical assistance per diem rate calculations. These payments are required notwithstanding any rule prohibiting medical assistance payments from exceeding payments from private pay residents. A facility receiving a payment under paragraph (a) may not increase charges to private pay residents by an amount equivalent to the per diem amount payments under paragraph (a) would equal if converted to a per diem.

Subd. 24. **Modified efficiency incentive.** Notwithstanding section 256B.74, subdivision 3, for the rate year beginning July 1, 1993, the maximum efficiency incentive is $2.20, and for rate years beginning on or after July 1, 1994, the commissioner shall determine a nursing facility's efficiency incentive by first computing the amount by which the facility's other operating cost limit exceeds its nonadjusted other operating cost per diem for that rate year. The commissioner shall then use the following table to compute the nursing facility's efficiency incentive. Each increment or partial increment the nursing facility's nonadjusted other operating per diem is below its other operating cost limit shall be multiplied by the corresponding percentage for that per diem increment. The sum of each of those computations shall be the nursing facility's efficiency incentive.

Other Operating Cost Per Diem Increment Below Facility Limit	Percentage Applied to Each Per Diem Increment
Less than $0.50	70 percent
$0.50 to less than $0.70	10 percent
$0.70 to less than $0.90	15 percent
$0.90 to less than $1.10	20 percent
$1.10 to less than $1.30	25 percent
$1.30 to less than $1.50	30 percent
$1.50 to less than $1.70	35 percent
$1.70 to less than $1.90	40 percent
$1.90 to less than $2.10	45 percent
$2.10 to less than $2.30	50 percent
$2.30 to less than $2.50	55 percent
$2.50 to less than $2.70	60 percent
$2.70 to less than $2.90	65 percent

$2.90 to less than $3.10	70 percent
$3.10 to less than $3.30	75 percent
$3.30 to less than $3.50	80 percent
$3.50 to less than $3.70	85 percent
$3.70 to less than $3.90	90 percent
$3.90 to less than $4.10	95 percent
$4.10 to less than $4.30	100 percent

The maximum efficiency incentive is $2.44 per resident day.

Subd. 25. **Changes to nursing facility reimbursement beginning July 1, 1995.** The nursing facility reimbursement changes in paragraphs (a) to (h) shall apply in the sequence specified to Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, beginning July 1, 1995.

(a) The eight-cent adjustment to care-related rates in subdivision 22, paragraph (e), shall no longer apply.

(b) For rate years beginning on or after July 1, 1995, the commissioner shall limit a nursing facility's allowable operating per diem for each case mix category for each rate year as in clauses (1) to (3).

(1) For the rate year beginning July 1, 1995, the commissioner shall group nursing facilities into two groups, freestanding and nonfreestanding, within each geographic group, using their operating cost per diem for the case mix A classification. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diem is subject to the hospital attached, short length of stay, or the rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities in each grouping by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem:

(i) is at or below the median minus 1.0 standard deviation of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by six percentage points, or the current reporting year's corresponding allowable operating cost per diem;

(ii) is between minus .5 standard deviation and minus 1.0 standard deviation below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by four percentage points, or the current reporting year's corresponding allowable operating cost per diem; or

(iii) is equal to or above minus .5 standard deviation below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by three percentage points, or the current reporting year's corresponding allowable operating cost per diem.

(2) For the rate year beginning on July 1, 1996, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), increased by one percentage point or the current reporting year's corresponding allowable operating cost per diems; and

(3) For rate years beginning on or after July 1, 1997, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the reporting year prior to the current reporting year's allowable operating cost per diems plus the inflation factor as established in paragraph (f), clause (2), or the current reporting year's corresponding allowable operating cost per diems.

(c) For rate years beginning on July 1, 1995, the commissioner shall limit the allowable operating cost per diems for high cost nursing facilities. After application of the limits in paragraph (b) to each nursing facility's operating cost per diems, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diems are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A operating cost per diems. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by two percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by one percent.

(d) For rate years beginning on or after July 1, 1996, the commissioner shall limit the allowable operating cost per diems for high cost nursing facilities. After application of the limits in paragraph (b) to each nursing facility's operating cost per diems, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diems are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A operating cost per diems. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). In those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by three percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diems by two percent.

(e) For rate years beginning on or after July 1, 1995, the commissioner shall determine a nursing facility's efficiency incentive by first computing the allowable difference, which is the lesser of $4.50 or the amount by which the facility's other operating cost limit exceeds its nonadjusted other operating cost per diem for that rate year. The commissioner shall compute the efficiency incentive by:

(1) subtracting the allowable difference from $4.50 and dividing the result by $4.50;

(2) multiplying 0.20 by the ratio resulting from clause (1), and then;

(3) adding 0.50 to the result from clause (2); and

(4) multiplying the result from clause (3) times the allowable difference.

The nursing facility's efficiency incentive payment shall be the lesser of $2.25 or the product obtained in clause (4).

(f) For rate years beginning on or after July 1, 1995, the forecasted price index for a nursing facility's allowable operating cost per diems shall be determined under clauses (1) to (3) using the change in the Consumer Price Index–All Items (United States city average) (CPI–U) or the change in the Nursing Home Market Basket, both as forecasted by Data Resources Inc., whichever is applicable. The commissioner shall use the indices as forecasted in the fourth quarter of the calendar year preceding the rate year, subject to subdivision 2l, paragraph (c). If, as a result of federal legislative or administrative action, the methodology used to calculate the Consumer Price Index–All Items (United States city average) (CPI–U) changes, the commissioner shall develop a conversion factor or other methodology to convert the CPI–U index factor that results from the new methodology to an index factor that approximates, as closely as possible, the index factor that would have resulted from applica-

tion of the original CPI–U methodology prior to any changes in methodology. The commissioner shall use the conversion factor or other methodology to calculate an adjusted inflation index. The adjusted inflation index must be used to calculate payment rates under this section instead of the CPI–U index specified in paragraph (d). If the commissioner is required to develop an adjusted inflation index, the commissioner shall report to the legislature as part of the next budget submission the fiscal impact of applying this index.

(1) The CPI–U forecasted index for allowable operating cost per diems shall be based on the 21–month period from the midpoint of the nursing facility's reporting year to the midpoint of the rate year following the reporting year.

(2) The Nursing Home Market Basket forecasted index for allowable operating costs and per diem limits shall be based on the 12–month period between the midpoints of the two reporting years preceding the rate year.

(3) For rate years beginning on or after July 1, 1996, the forecasted index for operating cost limits referred to in subdivision 21, paragraph (b), shall be based on the CPI–U for the 12–month period between the midpoints of the two reporting years preceding the rate year.

(g) After applying these provisions for the respective rate years, the commissioner shall index these allowable operating costs per diems by the inflation factor provided for in paragraph (f), clause (1), and add the nursing facility's efficiency incentive as computed in paragraph (e).

(h) A nursing facility licensed for 302 beds on September 30, 1993, that was approved under the moratorium exception process in section 144A.073 for a partial replacement, and completed the replacement project in December 1994, is exempt from paragraphs (b) to (d) for rate years beginning on or after July 1, 1995.

(i) Notwithstanding Laws 1996, chapter 451, article 3, section 11, paragraph (h), for the rate years beginning on July 1, 1996, July 1, 1997, and July 1, 1998, a nursing facility licensed for 40 beds effective May 1, 1992, with a subsequent increase of 20 Medicare/Medicaid certified beds, effective January 26, 1993, in accordance with an increase in licensure is exempt from paragraphs (b) to (d).

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; 1991 c 292 art 4 s 54–60; art 6 s 49,50; art 7 s 25; 1992 c 464 art 1 s 29; 1992 c 513 art 7 s 88–103,136; 1992 c 603 s 19; 1993 c 339 s 20; 1Sp1993 c 1 art 5 s 90–99; 1995 c 207 art 6 s 85,86; art 7 s 23–26; 1996 c 305 art 2 s 48; 1996 c 451 art 3 s 3*

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 nursing 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 nursing facility to perform or refrain from performing certain acts, or to supplant or take the place of the top management of the nursing 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 nursing 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 nursing 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 nursing facility exceeding $50,000,

or $500 per licensed bed, whichever is less, without first securing the approval of the nursing 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 nursing facility; or

(5) the nursing 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 nursing facility measures and methods for improving the operations of the nursing facility.

(c) "Nursing facility" means a nursing facility whose medical assistance rates are determined according to section 256B.431.

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 section 256B.431.

Subd. 3. **Allocation; direct identification of costs of nursing facilities; management agreement.** All costs that can be directly identified with a specific nursing 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 nursing 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 nursing facility operations and the other activities or facilities unrelated to the nursing facility operations based on the ratio of total operating costs.

(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 nursing 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 operating costs incurred by each related organization or controlled nursing facility;

(2) for a central, affiliated, or corporate office providing goods or services to related organizations that are not nursing facilities, the numerator of the allocation ratio shall be equal to the sum of the total operating costs incurred by the nonnursing facility related organizations;

(3) for a central, affiliated, or corporate office providing goods or services to unrelated nursing 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 nursing 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 nursing facilities.** (a) Those nursing operations that have nursing facilities both in Minnesota and comparable facilities outside of Minnesota must allocate the nursing operation's central, affiliated, or corporate office costs identified in subdivision 5 to Minnesota based on the ratio of total resident days in Minnesota nursing facilities to the total resident days in all facilities.

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

Subd. 7. **Receiverships.** This section does not apply to payment rates determined under sections 245A.12, 245A.13, and 256B.495, except that any additional directly identified costs associated with the department of human services' or the department of health's managing agent under a receivership agreement must be allocated to the facility under receivership, and are nonallowable costs to the managing agent on the facility's cost reports.

Subd. 8. **Adequate documentation supporting long–term care facility payrolls.** Beginning July 1, 1993, payroll records supporting compensation costs claimed by long–term care facilities must be supported by affirmative time and attendance records prepared by each individual at intervals of not more than one month. The affirmative time and attendance record must identify the individual's name; the days worked during each pay period; the number of hours worked each day; and the number of hours taken each day by the individual for vacation, sick, and other leave. The affirmative time and attendance record must include a signed verification by the individual and the individual's supervisor, if any, that the entries reported on the record are correct.

History: *1990 c 568 art 3 s 73; 1992 c 513 art 7 s 104,136; 1Sp1993 c 1 art 5 s 100,101; 1995 c 207 art 7 s 27–31; 1996 c 451 art 5 s 27*

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 facilities. Payment for materials and services may be made to either the nursing facility in the operating cost per diem, to the vendor of ancillary services pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475 or to a nursing facility pursuant to Minnesota Rules, parts 9505.0170 to 9505.0475. Payment for the same or similar service to a recipient shall not be made to both the nursing facility and the vendor. The commissioner shall ensure the avoidance of double payments through audits and adjustments to the nursing facility'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 facility, or ordering physician cannot provide adequate medical necessity justification, as determined by the commissioner, 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 facility, or ordering physician's participation in the medical assistance program. If the provider number of a nursing facility is used to bill services provided by a vendor of therapy services that is not related to the nursing facility by ownership, control, affiliation, or employment status, no withholding of payment shall be imposed against the nursing facility 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 facility for funds paid to the unrelated vendor of therapy services as provided in subdivision 3, paragraph (c), for services not medically necessary. For purposes of this section and section 256B.47, therapy includes physical therapy, occupational therapy, speech therapy, audiology, and mental health services that are covered services according to Minnesota Rules, parts 9505.0170 to 9505.0475, and that could be reimbursed separately from the nursing facility per diem.

Subd. 2. **Certification that treatment is appropriate.** The physical therapist, occupational therapist, speech therapist, mental health professional, 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 facility 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 facility residents that are billed separate from nursing facility's payment rate or according to Minnesota Rules, parts 9505.0170 to 9505.0475, 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 facility where the medical assistance recipient resides regardless of the service setting.

(b) Nursing facilities 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 facility. 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 facility to the total payment rate of the nursing facility by dividing the amount of offset by the nursing facility'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. Therapy revenues that are specific to mental health services shall be subject to this paragraph for rate years beginning after June 30, 1993. 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 facilities 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 facility 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. Mental health services shall be subject to this paragraph for rate years beginning after June 30, 1993.

(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 facility is subject to the provisions of paragraph (b) instead of paragraph (c), an average cost to revenue ratio based on the ratios of nursing facilities that are subject to the provisions of paragraph (b) shall be imputed for paragraph (d).

(g) This section does not allow unrelated nursing facilities to reorganize related organization therapy services and provide services among themselves to avoid offsetting revenues. Nursing facilities 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. [Repealed, 1993 c 337 s 20]

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; 1992 c 513 art 7 s 105–107,136; 1993 c 337 s 17*

256B.434 CONTRACTUAL ALTERNATIVE PAYMENT DEMONSTRATION PROJECT FOR NURSING HOMES.

Subdivision 1. **Alternative payment demonstration project established.** The commissioner of human services shall establish a contractual alternative payment demonstration project for paying for nursing facility services under the medical assistance program. A nursing facility may apply to be paid under the contractual alternative payment demonstration project instead of the cost–based payment system established under section 256B.431. A nursing facility electing to use the alternative payment demonstration project must enter into a contract with the commissioner. Payment rates and procedures for facilities electing to use the alternative payment demonstration project are determined and governed by this section and by the terms of the contract. The commissioner may negotiate different contract terms for different nursing facilities.

Subd. 2. **Requests for proposals.** (a) No later than August 1, 1995, the commissioner shall publish in the State Register a request for proposals to provide nursing facility services according to this section. The commissioner shall issue two additional requests for proposals prior to July 1, 1997, based upon a timetable established by the commissioner. The commissioner must respond to all proposals in a timely manner.

(b) The commissioner may reject any proposal if, in the judgment of the commissioner, a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota. The commissioner may accept up to the number of proposals that can be adequately supported with available state resources, as determined by the commissioner, except that the commissioner shall not contract with more than 40 nursing facilities as part of any request for proposals. The commissioner may accept proposals from a single nursing facility or from a group of facilities through a managing entity. The commissioner shall seek to ensure that nursing facilities under contract are located in all geographic areas of the state. The commissioner shall present recommendations to the legislature by February 1, 1996, on the number of nursing facility contracts that may be entered into by the commissioner as a result of a request for proposals.

(c) In issuing the request for proposals, the commissioner may develop reasonable requirements which, in the judgment of the commissioner, are necessary to protect residents or ensure that the contractual alternative payment demonstration project furthers the interest of the state of Minnesota. The request for proposals may include, but need not be limited to, the following:

(1) a requirement that a nursing facility make reasonable efforts to maximize Medicare payments on behalf of eligible residents;

(2) requirements designed to prevent inappropriate or illegal discrimination against residents enrolled in the medical assistance program as compared to private paying residents;

(3) requirements designed to ensure that admissions to a nursing facility are appropriate and that reasonable efforts are made to place residents in home and community–based settings when appropriate;

(4) a requirement to agree to participate in a project to develop data collection systems and outcome–based standards for managed care contracting for long–term care services. Among other requirements specified by the commissioner, each facility entering into a contract may be required to pay an annual fee in an amount determined by the commissioner not to exceed $50 per bed. Revenue generated from the fees is appropriated to the commissioner and must be used to contract with a qualified consultant or contractor to develop data collection systems and outcome–based contracting standards;

(5) a requirement that contractors agree to maintain Medicare cost reports and to submit them to the commissioner upon request or at times specified by the commissioner;

(6) a requirement for demonstrated willingness and ability to develop and maintain data collection and retrieval systems to be used in measuring outcomes; and

(7) a requirement to provide all information and assurances required by the terms and conditions of the federal waiver or federal approval.

(d) In addition to the information and assurances contained in the submitted proposals, the commissioner may consider the following in determining whether to accept or deny a proposal:

(1) the facility's history of compliance with federal and state laws and rules;

(2) whether the facility has a record of excessive licensure fines or sanctions or fraudulent cost reports;

(3) financial history and solvency; and

(4) other factors identified by the commissioner that the commissioner deems relevant to a determination that a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

(e) If the commissioner rejects the proposal of a nursing facility, the commissioner shall provide written notice to the facility of the reason for the rejection, including the factors and evidence upon which the rejection was based.

Subd. 3. **Duration and termination of contracts.** (a) Subject to available resources, the commissioner may begin to execute contracts with nursing facilities November 1, 1995.

(b) All contracts entered into under this section are for a term of four years. Either party may terminate a contract effective July 1 of any year by providing written notice to the other party no later than April 1 of that year. If neither party provides written notice of termination by April 1, the contract is automatically renewed for the next rate year. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

(c) If a nursing facility fails to comply with the terms of a contract, the commissioner shall provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance. If the facility fails to come into compliance or to remain in compliance, the commissioner may terminate the contract. If a contract is terminated, the contract payment remains in effect for the remainder of the rate year in which the contract was terminated, but in all other respects the provisions of this section do not apply to that facility effective the date the contract is terminated. The contract shall contain a provision governing the transition back to the cost–based reimbursement system established under section 256B.431, subdivision 25, and Minnesota Rules, parts 9549.0010 to 9549.0080. A contract entered into under this section may be amended by mutual agreement of the parties.

Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, subdivision 25, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431, subdivision 25.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment. The index for the inflation adjustment must be based on the change in the Consumer Price Index–All Items (United States City average) (CPI–U) forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12–month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

(d) The commissioner may develop additional incentive–based payments of up to five percent above the standard contract rate for achieving outcomes specified in each contract. The incentive system may be implemented for contract rate years beginning on or after July

1, 1996. The specified outcomes must be measurable and must be based on criteria to be developed by the commissioner. The commissioner may establish, for each contract, various levels of achievement within an outcome. After the outcomes have been specified the commissioner shall assign various levels of payment associated with achieving the outcome. Any incentive–based payment cancels if there is a termination of the contract. In establishing the specified outcomes and related criteria the commissioner shall consider the following state policy objectives:

(1) improved cost effectiveness and quality of life as measured by improved clinical outcomes;

(2) successful diversion or discharge to community alternatives;

(3) decreased acute care costs;

(4) improved consumer satisfaction;

(5) the achievement of quality; or

(6) any additional outcomes the commissioner finds desirable.

Subd. 5. **Private pay rates.** (a) Notwithstanding section 256B.48, subdivision 1, paragraph (a), the commissioner shall determine the maximum private pay case mix payment rates for nursing facilities that have entered into an alternative payment demonstration contract under this section as specified in this subdivision. Nothing in this section shall limit the exceptions for private pay rates authorized under section 256B.48, subdivision 1, paragraph (a).

(b) The maximum private pay rate for short–stay private paying residents who are discharged from the facility less than 101 days after admission is an amount equal to the greater of the Medicare payment rate for that facility or the resident's medical assistance case mix payment rate. For the first year of an alternative payment demonstration project contract the commissioner shall establish a maximum private paying rate for short–stay residents that is based on a nursing facility's estimated Medicare payment rate. When actual Medicare final rates are determined, the nursing facility shall retroactively adjust a private paying resident's rates and provide a refund or credit if the amount actually paid by the resident exceeds the amount that would have been paid using Medicare rates.

(c) When a private paying resident is admitted, a nursing facility shall determine, based on the resident's care plan, whether the resident is likely to be discharged less than 101 days after admission. If the resident is likely to be discharged less than 101 days after admission, the nursing facility may charge a short–stay private pay rate up to the maximum specified in paragraph (b). If the resident remains in the facility for longer than 100 days, the facility shall retroactively reduce the resident's payments to the maximum long–term rate specified in subdivision 4 effective from the date of admission and shall reimburse the resident for the overpayment. At the resident's option, the facility may reimburse residents for overpayments by providing a refund or a credit to be applied to future payments, or a combination of both, subject to the facility's right to offset for past–due payments. If the facility determines, based on the care plan, that the resident is likely to remain in the facility for longer than 100 days, the facility shall not charge a private pay rate greater than the maximum rate specified in subdivision 4.

(d) The provisions of paragraphs (b) and (c) do not apply to short–stay residents admitted prior to the effective date of a demonstration project contract.

Subd. 6. **Contract payment rates; appeals.** If an appeal is pending concerning the cost–based payment rates that are the basis for the calculation of the payment rate under the alternative payment demonstration project, the commissioner and the nursing facility may agree on an interim contract rate to be used until the appeal is resolved. When the appeal is resolved, the contract rate must be adjusted retroactively in accordance with the appeal decision.

Subd. 7. **Case mix assessments.** The commissioner may allow a contract facility to develop and implement a case mix assessment using the federal minimum data set resident assessment.

Subd. 8. **Optional higher payments for first 100 days.** The commissioner may include in the contract with a nursing facility under this section a higher rate for the first 100 days after admission than for subsequent days. The rate for the subsequent days must be re-

duced so that the estimated total cost to the medical assistance program will not exceed the estimated cost without the differential payment rates.

Subd. 9. **Managed care contracts for other services.** Beginning July 1, 1995, the commissioner may contract with nursing facilities that have entered into alternative payment demonstration project contracts under this section to provide medical assistance services other than nursing facility care to residents of the facility under a prepaid, managed care payment system. For purposes of contracts entered into under this subdivision, the commissioner may waive one or more of the requirements for payment for ancillary services in section 256B.433. Managed care contracts for other services may be entered into at any time during the duration of a nursing facility's alternative payment demonstration project contract, and the terms of the managed care contracts need not coincide with the terms of the alternative payment demonstration project contract.

Subd. 10. **Exemptions.** (a) To the extent permitted by federal law, (1) a facility that has entered into a contract under this section is not required to file a cost report, as defined in Minnesota Rules, part 9549.0020, subpart 13, for any year after the base year that is the basis for the calculation of the contract payment rate for the first rate year of the alternative payment demonstration project contract; and (2) a facility under contract is not subject to audits of historical costs or revenues, or paybacks or retroactive adjustments based on these costs or revenues, except audits, paybacks, or adjustments relating to the cost report that is the basis for calculation of the first rate year under the contract.

(b) A facility that is under contract with the commissioner under this section is not subject to the moratorium on licensure or certification of new nursing home beds in section 144A.071, unless the project results in a net increase in bed capacity or involves relocation of beds from one site to another. Contract payment rates must not be adjusted to reflect any additional costs that a nursing facility incurs as a result of a construction project undertaken under this paragraph. In addition, as a condition of entering into a contract under this section, a nursing facility must agree that any future medical assistance payments for nursing facility services will not reflect any additional costs attributable to the sale of a nursing facility under this section and to construction undertaken under this paragraph that otherwise would not be authorized under the moratorium in section 144A.073. Nothing in this section prevents a nursing facility participating in the alternative payment demonstration project under this section from seeking approval of an exception to the moratorium through the process established in section 144A.073, and if approved the facility's rates shall be adjusted to reflect the cost of the project.

(c) Notwithstanding section 256B.48, subdivision 6, paragraphs (c), (d), and (e), and pursuant to any terms and conditions contained in the facility's contract, a nursing facility that is under contract with the commissioner under this section is in compliance with section 256B.48, subdivision 6, paragraph (b), if the facility is Medicare certified.

(d) Notwithstanding paragraph (a), if by April 1, 1996, the health care financing administration has not approved a required waiver, or the health care financing administration otherwise requires cost reports to be filed prior to the waiver's approval, the commissioner shall require a cost report for the rate year.

Subd. 11. **Consumer protection.** As a condition of entering into a contract under this section, a nursing facility must agree to establish resident grievance procedures that are similar to those required under section 256.045, subdivision 3. The commissioner may also require nursing facilities to establish expedited grievance procedures to resolve complaints made by short-stay residents. The facility must notify its resident council of its intent to enter into a contract and must consult with the council regarding any changes in operation expected as a result of the contract.

Subd. 12. **Contracts are voluntary.** Participation of nursing facilities in the alternative payment demonstration project is voluntary. The terms and procedures governing the alternative payment demonstration project are determined under this section and through negotiations between the commissioner and nursing facilities that have submitted a letter of intent to participate in the alternative demonstration project. For purposes of developing requests for proposals and contract requirements, and negotiating the terms, conditions, and require-

ments of contracts the commissioner is exempt from the rulemaking requirements in chapter 14.

Subd. 13. **Payment system reform advisory committee.** (a) The commissioner, in consultation with an advisory committee, shall study options for reforming the regulatory and reimbursement system for nursing facilities to reduce the level of regulation, reporting, and procedural requirements, and to provide greater flexibility and incentives to stimulate competition and innovation. The advisory committee shall include, at a minimum, representatives from the long-term care provider community, the department of health, and consumers of long-term care services. The advisory committee sunsets on June 30, 1997. Among other things, the commissioner shall consider the feasibility and desirability of changing from a certification requirement to an accreditation requirement for participation in the medical assistance program, options to encourage early discharge of short-term residents through the provision of intensive therapy, and further modifications needed in rate equalization. The commissioner shall also include detailed recommendations for a permanent managed care payment system to replace the contractual alternative payment demonstration project authorized under this section. The commissioner shall submit a report with findings and recommendations to the legislature by January 15, 1997.

(b) If a permanent managed care payment system has not been enacted into law by July 1, 1997, the commissioner shall develop and implement a transition plan to enable nursing facilities under contract with the commissioner under this section to revert to the cost-based payment system at the expiration of the alternative payment demonstration project. The commissioner shall include in the alternative payment demonstration project contracts entered into under this section a provision to permit an amendment to the contract to be made after July 1, 1997, governing the transition back to the cost-based payment system. The transition plan and contract amendments are not subject to rulemaking requirements.

Subd. 14. **Federal requirements.** The commissioner shall implement the contractual alternative payment demonstration project subject to any required federal waivers or approval and in a manner that is consistent with federal requirements. If a provision of this section is inconsistent with a federal requirement the federal requirement supersedes the inconsistent provision. The commissioner shall seek federal approval and request waivers as necessary to implement this section.

Subd. 15. **External review panel.** The commissioner may establish an external review panel consisting of persons appointed by the commissioner for their expertise on issues relating to nursing facility services, quality, payment systems, and other matters, to advise the commissioner on the development and implementation of the contractual alternative payment demonstration project and to assist the commissioner in assessing the quality of care provided and evaluating a facility's compliance with performance standards specified in a contract. The external review panel must include, among other members, representatives of nursing facilities.

Subd. 16. **Alternative contracts.** The commissioner may also contract with nursing facilities in other ways through requests for proposals, including contracts on a risk or nonrisk basis, with nursing facilities or consortia of nursing facilities, to provide comprehensive long-term care coverage on a premium or capitated basis.

Subd. 17. **Report.** The commissioner shall report to the legislature by January 15, 1997, regarding the impact of the alternative payment demonstration project. In assessing the impact, the commissioner may examine elements of the project including consumer satisfaction, quality of care, adequacy of services, timeliness in the delivery of services, and other elements determined appropriate by the commissioner. In developing this report, the commissioner may involve appropriate consumer advocate groups as needed to assist in monitoring and evaluating changes in a nursing facility's behavior, including the monitoring and evaluation of issues involving resident protection. The report must include recommendations for reimbursement of nursing homes after June 30, 1997, based on experience with the demonstration project.

History: *1995 c 207 art 7 s 32; 1996 c 451 art 5 s 28*

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 facility; (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 facility'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 facility rates for private paying residents shall be effective unless the nursing facility notifies the resident or person responsible for payment of the increase in writing 30 days before the increase takes effect.

A nursing facility 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 facilities that are not hospital attached with therapy services that are billed separately from the nursing facility 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 facility 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 nursing facility's property–related payment rate, based on the ratio of service area square footage to total facility square footage multiplied by the property–related payment rate.

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 facility, when the

services are billed separately from the nursing facility'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; 1992 c 513 art 7 s 136; 1Sp1993 c 1 art 5 s 102*

256B.48 CONDITIONS FOR PARTICIPATION.

Subdivision 1. **Prohibited practices.** A nursing facility 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 facility 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 facility 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 facility in order to comply with licensure or certification standards and that if not provided would result in a deficiency or violation by the nursing facility. 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 facility 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 facility 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 facility 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 facility, 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 facility, or promise to leave all or part of the applicant's estate to the facility.

(c) Requiring any resident of the nursing facility to utilize a vendor of health care services chosen by the nursing facility.

(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 facility, or the applicant's guardian or conservator, that the applicant is neither eligible for nor will seek public assistance for payment of nursing facility 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 facility of financial information of any applicant pursuant to a preadmission screening program established by law shall not raise an inference that the nursing facility 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 facility except as payment for renting or leasing space or equipment or purchasing support services from the nursing facility as limited by section 256B.433. All agreements must be disclosed to the commissioner upon request of the commissioner. Nursing facilities 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 facility with more than 325 beds including at least 150 licensed nursing facility 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 facility 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 facility 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 facility to permit the applicant to withdraw from the facility 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 facility 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 facility to correct the violation. The nursing facility 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 facility 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 facility 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 facility is not eligible for reimbursement for a resident who is eligible for medical assistance, the commissioner may authorize the nursing facility to receive reimbursement on a temporary basis until the resident can be relocated to a participating nursing facility.

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 facility terminates its participation in the medical assistance program, whether voluntarily or involuntarily, the commissioner may authorize the nursing facility to receive continued medical assistance reimbursement only on a temporary basis until medical assistance residents can be relocated to nursing facilities participating in the medical assistance program.

Subd. 1b. **Exception.** Notwithstanding any agreement between a nursing facility 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 facility 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 facility 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 facilities 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 facility under this subdivision, the commissioner may cease medical assistance payments, under this subdivision, to that nursing facility. Between October 1, 1992, and July 1, 1993, a facility governed by this subdivision may elect to resume full participation in the medical assistance program by agreeing to comply with all of the requirements of the medical assistance program, including the rate equalization law in subdivision 1, paragraph (a), and all other requirements established in law or rule, and to resume intake of new medical assistance recipients.

Subd. 1c. **Case mix rate for provider with addendum to provider agreement.** A nursing facility 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 facilities.

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. Beginning with the reporting year which begins October 1, 1992, a nursing facility is no longer required to have a certified audit of its financial statements. The cost of a certified audit shall not be an allowable cost in that reporting year, nor in subsequent reporting years unless the nursing facility submits its certified audited financial statements in the manner otherwise specified in this subdivision. A nursing facility which does not submit a certified audit must submit its working trial balance;

(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.

Both nursing facilities and intermediate care facilities for the mentally retarded must maintain statistical and accounting records in sufficient detail to support information contained in the facility's cost report for at least six years, including the year following the submission of the cost report. For computerized accounting systems, the records must include copies of electronically generated media such as magnetic discs and tapes.

Subd. 3. **Incomplete or inaccurate reports.** The commissioner may reject any annual cost report filed by a nursing facility 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 facility to 80 percent of its most recently established rate until the information is completely and accurately filed. The reinstatement of the total reimbursement rate is retroactive.

Subd. 3a. **Audit adjustments.** If the commissioner requests supporting documentation during an audit for an item of cost reported by a long–term care facility, and the long–term care facility's response does not adequately document the item of cost, the commissioner may make reasoned assumptions considered appropriate in the absence of the requested documentation to reasonably establish a payment rate rather than disallow the entire item of cost. This provision shall not diminish the long–term care facility's appeal rights.

Subd. 4. **Extensions.** The commissioner may grant up to a 15–day extension of the reporting deadline to a nursing facility for good cause. To receive such an extension, a nursing facility shall submit a written request by December 1. The commissioner will notify the nursing facility of the decision by December 15. Between December 1 and December 31, the nursing facility may request a reporting extension for good cause by telephone and followed by a written request.

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

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

(b) terminate the commissioner's agreement with the nursing facility; 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 facility that is certified as a skilled nursing facility or, after September 30, 1990, a nursing facility 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 facility 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 facility or boarding care facility, the nursing facility 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.0575, 256B.058, 256B.059, 256B.0595, and 256B.14, subdivision 2; 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 facility'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 facilities 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 facility or boarding care facility of the resources the resident and spouse may retain.

Subd. 9. **Medical assistance participation for certain facilities.** An agreement entered into between a nursing facility and the commissioner of human services that limits the number of residents that will be reimbursed under the medical assistance program as a condi-

tion of allowing additional beds to be certified under section 144A.071, subdivision 3a, terminates effective October 1, 1992.

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; 1991 c 199 art 2 s 1; 1991 c 292 art 7 s 6; 1992 c 513 art 7 s 108–113,136; 1993 c 339 s 21; 1Sp1993 c 1 art 5 s 103,104*

256B.49 CHRONICALLY ILL CHILDREN AND DISABLED PERSONS; 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. The commissioner shall seek to amend the federal waivers obtained under this section to apply criteria to protect against spousal impoverishment as authorized under United States Code, title 42, section 1396r–5, and as implemented in sections 256B.0575, 256B.058, and 256B.059, except that the amendment shall seek to add to the personal needs allowance permitted in section 256B.0575, an amount equivalent to the group residential housing rate as set by section 256I.03, subdivision 5.

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.

Subd. 4. **Inflation adjustment.** For the biennium ending June 30, 1993, the commissioner of human services shall not provide an annual inflation adjustment for home and community–based waivered services, except as provided in section 256B.491, subdivision 3, and except that the commissioner shall provide an inflation adjustment for the community alternatives for disabled individuals (CADI) and community alternative care (CAC) waivered services programs for the fiscal year beginning July 1, 1991. For fiscal years beginning after June 30, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for home and community–based waivered services. The commissioner of finance shall include, as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11, annual adjustments in reimbursement rates for each home and community–based waivered service program.

Subd. 5. **Provide waiver eligibility for certain chronically ill and certain disabled persons.** Chronically ill or disabled individuals, who are likely to reside in acute care if waiv-

er services were not provided, could be found eligible for services under this section without regard to age.

Subd. 6. **Admission certification.** In determining an individual's eligibility for the community alternative care (CAC) waiver program, and an individual's eligibility for medical assistance under section 256B.055, subdivision 12, paragraph (b), the commissioner may review or contract for review of the individual's medical condition to determine level of care using criteria in Minnesota Rules, parts 9505.0520 to 9505.0540.

For purposes of this subdivision, a person requires long-term care in an inpatient hospital setting if the person has an ongoing condition that is expected to last one year or longer, and would require continuous or frequent hospitalizations during that period, but for the provision of home care services under this section.

Subd. 7. **Persons with developmental disabilities or related conditions.** Individuals who apply for services under the community alternatives for disabled individuals (CADI) waiver program or the traumatic brain injury nursing facility waiver program who have developmental disabilities or related conditions must be screened for the appropriate institutional level of care in accordance with section 256B.092.

Subd. 8. **Case management services.** The county may allow a case manager to delegate certain aspects of the case management activity to another individual employed by the county provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

History: *1984 c 640 s 32; 1984 c 654 art 5 s 24,58; 1990 c 568 art 3 s 76; 1991 c 292 art 4 s 61; 1992 c 513 art 7 s 114; 1Sp1993 c 1 art 5 s 105; 1995 c 207 art 6 s 87–89; 1996 c 451 art 5 s 29–31*

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.

Subd. 3. **Waivered services; salary adjustments.** For the fiscal year beginning July 1, 1991, the commissioner of human services shall increase the statewide reimbursement rates for home and community–based waivered services for persons with developmental disabilities to reflect a three percent increase in salaries, payroll taxes, and fringe benefits of personnel below top management employed by agencies under contract with the county board to provide these services. The specific rate increase made available to county boards shall be calculated based on the estimated portion of the fiscal year 1991 reimbursement rate that is attributable to these costs. County boards shall verify in writing to the commissioner that each waivered service provider has complied with this requirement. If a county board determines that a waivered service provider has not complied with this requirement for a specific contract period, the county board shall reduce the provider's payment rates for the next contract period to reflect the amount of money not spent appropriately. The commissioner shall modify reporting requirements for vendors and counties as necessary to monitor compliance with this provision.

History: *1984 c 641 s 24; 1984 c 654 art 5 s 58; 1991 c 292 art 4 s 62*

256B.495 NURSING FACILITY RECEIVERSHIP FEES.

Subdivision 1. **Payment of receivership fees.** The commissioner in consultation with the commissioner of health may establish a receivership fee that exceeds a nursing facility payment rate when the commissioner of health determines a nursing facility is subject to the receivership provisions under section 144A.14 or 144A.15. In establishing the receivership fee, the commissioner must reduce the receiver's requested receivership fee by amounts that the commissioner determines are included in the nursing 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 nursing 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 nursing facility.

If the receivership fee cannot be covered by amounts in the nursing facility's payment rate, a receivership fee 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 by the nursing 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 nursing 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 facility shall be effective the first day of the month following the receiver's compliance with the notice conditions in paragraph (c).

(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. 1a. **Receivership payment rate adjustment.** Upon receiving a recommendation from the commissioner of health for a review of rates under section 144A.154, 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.

Subd. 2. **Deduction of additional receivership payments upon termination of receivership.** If the commissioner has established a receivership fee per diem for a nursing facility in receivership under subdivision 1 or a payment rate adjustment under subdivision 1a, the commissioner must deduct these receivership payments according to paragraphs (a) to (c).

(a) The total receivership fee payments shall be the receivership per diem plus the payment rate adjustment multiplied by the number of resident days for the period of the receivership. If actual resident days for the receivership 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 nursing facility's reporting years covered by the receivership period.

(b) The amount determined in paragraph (a) must be divided by the nursing 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 nursing facility's operating cost payment rate for the rate year following the reporting year in which the receivership period ends. This provision applies whether or not there is a sale or transfer of the nursing facility, unless the provisions of subdivision 5 apply.

Subd. 3. [Repealed, 1992 c 513 art 8 s 59]

Subd. 4. **Downsizing and closing nursing facilities.** (a) If the nursing facility is subject to a downsizing to closure process during the period of receivership, the commissioner may reestablish the nursing facility's payment rate. The payment rate shall be established based on the nursing facility's budgeted operating costs, the receivership property related costs, and the management fee costs for the receivership period divided by the facility's estimated resident days for the same period. The commissioner of health and the commissioner shall make every effort to first facilitate the transfer of private paying residents to alternate service sites prior to the effective date of the payment rate. The cost limits and the case mix provisions in the rate setting system shall not apply during the portion of the receivership period over which the nursing facility downsizes to closure.

(b) Any payment rate adjustment under this subdivision must meet the conditions in section 256B.47, subdivision 2, and shall remain in effect until the receivership ends, or until another date the commissioner sets.

Subd. 5. **Sale or transfer of a nursing facility in receivership after closure.** (a) Upon the subsequent sale or transfer of a nursing facility in receivership, the commissioner must recover any amounts paid through payment rate adjustments under subdivision 4 which exceed the normal cost of operating the nursing facility. Examples of costs in excess of the normal cost of operating the nursing facility include the managing agent's fee, directly identifiable costs of the managing agent, bonuses paid to employees for their continued employment during the downsizing to closure of the nursing facility, prereceivership expenditures paid by the receiver, additional professional services such as accountants, psychologists, and dietitians, and other similar costs incurred by the receiver to complete receivership. 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.

(b) If a nursing facility with payment rates subject to subdivision 4, paragraph (a), is later sold while the nursing facility is in receivership, the payment rates in effect prior to the receivership shall be the new owner's payment rates. Those payment rates shall continue to be in effect until the rate year following the reporting period ending on September 30 for the new owner. The reporting period shall, whenever possible, be at least five consecutive months. If the reporting period is less than five months but more than three months, the nursing facility's resident days for the last two months of the reporting period must be annualized over the reporting period for the purpose of computing the payment rate for the rate year following the reporting period.

History: *1989 c 282 art 3 s 83; 1990 c 568 art 3 s 77; 1992 c 513 art 7 s 115-119,136*

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 facility 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 facility 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 postmarked or received by the commissioner within 60 days of the date the determination of the payment rate was mailed or personally received by a provider, whichever is earlier. 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. The commissioner shall review an appeal by a nursing facility, if the appeal was sent by certified mail and postmarked prior to August 1, 1991, and would have been received by the commissioner within the 60–day deadline if it had not been delayed due to an error by the postal service.

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 determination of the department made under paragraph (a), the provider may, within 60 days of the date of the review notice, file with both 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 timely submissions 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 an appeal item subject to the review set forth in this subdivision presents the same or substantially the same adjustment presented in another appeal filed pursuant to this chapter, 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 15.472, 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 15.474 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 esti-

mate 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. 1h. **Appeals review project.** (a) The appeals review procedure described in this subdivision is effective for desk audit appeals for rate years beginning between July 1, 1993 and June 30, 1997, and for field audit appeals filed during that time period. For appeals reviewed under this subdivision, subdivision 1c applies only to contested case demands under paragraph (d) and subdivision 1d does not apply.

(b) The commissioner shall review appeals and issue a written determination on each appealed item within one year of the due date of the appeal. Upon mutual agreement, the commissioner and the provider may extend the time for issuing a determination for a specified period. The commissioner shall notify the provider by first class mail of the determination. The determination takes effect 30 days following the date of issuance specified in the determination.

(c) In reviewing the appeal, the commissioner may request additional written or oral information from the provider. The provider has the right to present information by telephone or in person concerning the appeal to the commissioner prior to the issuance of the determination if a conference is requested within six months of the date the appeal was received by the commissioner. Statements made during the review process are not admissible in a contested case hearing under paragraph (d) absent an express stipulation by the parties to the contested case.

(d) For an appeal item on which the provider disagrees with the determination, the provider may file with the commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the commissioner within 30 days of the date of issuance specified in the determination. The commissioner shall refer any contested case demand to the office of the attorney general. When a contested case demand is referred to the office of the attorney general, the contested case procedures described in subdivision 1c apply and the written determination issued by the commissioner is of no effect.

(e) The commissioner has discretion to issue to the provider a proposed resolution for specified appeal items upon a request from the provider filed separately from the notice of appeal. The proposed resolution is final upon written acceptance by the provider within 30 days of the date the proposed resolution was mailed to or personally received by the provider, whichever is earlier.

(f) The commissioner may use the procedures described in this subdivision to resolve appeals filed prior to July 1, 1993.

Subd. 2. **Appraised value.** (a) A nursing facility 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 facility'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 facility 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 facility. The appraisal report shall be based on an on-site inspection of the nursing facility'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 facility. An appeal request shall be deemed timely if it is postmarked or received by the commissioner within the time limits established for filing such appeal requests.

(b) A nursing facility 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 facility or by the determination of an independent appraiser based upon an on-site inspection of the nursing facility'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 facility 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 facility 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 facilities 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 facilities.

Subd. 3. **Time and attendance disputed items.** The commissioner shall settle unresolved appeals by a nursing facility of disallowances or adjustments of compensation costs for rate years beginning prior to June 30, 1994, by recognizing the compensation costs reported by the nursing facility when the appealed disallowances or adjustments were based on a determination of inadequate documentation of time and attendance or equivalent records to support payroll costs. The recognition of costs provided in this subdivision pertains only to appeals of disallowances and adjustments based solely on disputed time and attendance or equivalent records. Appeals of disallowances and adjustments of compensation costs based on other grounds, including misrepresentation of costs or failure to meet the general cost criteria under Minnesota Rules, parts 9549.0010 to 9549.0080, are not governed by this subdivision.

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; 1991 c 292 art 4 s 63; 1992 c 426 s 1; 1992 c 513 art 7 s 120,121,136; 1Sp1993 c 1 art 5 s 106–108*

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. The term does not include a state regional treatment center.

(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. Waiv-

ered 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. 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 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) rule revisions which:

(1) combine the program, maintenance, and administrative operating cost categories, and professional liability and real estate insurance expenses into one general operating cost category;

(2) eliminate the maintenance and administrative operating cost category limits and account for disallowances under the rule existing on July 1, 1995, in the revised rule. If this provision is later invalidated, the total administrative cost disallowance shall be deducted from economical facility payments in clause (3);

(3) establish an economical facility incentive that rewards facilities that provide all appropriate services in a cost-effective manner and penalizes reductions of either direct service wages or standardized hours of care per resident;

(4) establish a best practices award system that is based on outcome measures and that rewards quality, innovation, cost-effectiveness, and staff retention;

(5) establish compensation limits for employees on the basis of full-time employment and the developmentally disabled client base of a provider group or facility. The commissioner may consider the inclusion of hold harmless provisions;

(6) establish overall limits on a high cost facility's general operating costs. The commissioner shall consider groupings of facilities that account for a significant variation in cost. The commissioner may differentiate in the application of these limits between high and very high cost facilities. The limits, once established, shall be indexed for inflation and may be rebased by the commissioner;

(7) utilize the client assessment information obtained from the application of the provisions in subdivision 3g for the revisions in clauses (3), (4), and (6); and

(8) develop cost allocation principles which are based on facility expenses; and

(f) appeals procedures that satisfy the requirements of section 256B.50.

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. **Forecasted index.** 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. For fiscal years beginning after June 30, 1993, the commissioner shall not provide automatic inflation adjustments for intermediate care facilities for persons with mental retardation. The commissioner of finance shall include annual inflation adjustments in operating costs for intermediate care facilities for persons with mental retardation and related conditions as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11. The commissioner shall use the Consumer Price Index–All Items (United States city average) (CPI–U) as forecasted by Data Resources, Inc., to take into account economic trends and conditions for changes in facility allowable historical general operating costs and limits. The forecasted index shall be established for allowable historical general operating costs as follows:

(1) the CPI–U forecasted index for allowable historical general operating costs shall be determined in the first quarter of the calendar year in which the rate year begins and shall be based on the 21–month period from the midpoint of the facility's reporting year to the midpoint of the rate year following the reporting year; and

(2) for rate years beginning on or after October 1, 1995, the CPI–U forecasted index for the overall operating cost limits and for the individual compensation limit shall be determined in the first quarter of the calendar year in which the rate year begins and shall be based

on the 12–month period between the midpoints of the two reporting years preceding the rate year.

Subd. 3d. [Repealed, 1995 c 207 art 7 s 43]

Subd. 3e. [Repealed, 1995 c 207 art 7 s 43]

Subd. 3f. [Repealed, 1995 c 207 art 7 s 43]

Subd. 3g. **Assessment of clients.** (a) To establish the service characteristics of clients, the Minnesota department of health case mix review program shall assess all clients annually. The facility's qualified mental retardation professional (QMRP) with primary responsibility for the client's individual program plan, in conjunction with the interdisciplinary team, shall assess each client who is newly admitted to a facility. This assessment must occur within 30 days from the date of admission during the interdisciplinary team meeting.

(b) All client assessments must be conducted as set forth in the manual, Minnesota ICF/MR Client Assessment Manual, February 1995, hereinafter referred to in this subdivision as the manual. Client assessments completed by the case mix review program and the facility QMRP must be recorded on assessment forms developed by the commissioner of health. The facility QMRP must complete the assessment form, submit it to the case mix review program, and mail a copy to the client's case manager within ten working days following the interdisciplinary team meeting.

(c) The case mix review program shall score assessments according to attachment E of the manual in the assessment domains of personal interaction, independence, and integration, challenging behaviors and preventive practice, activities of daily living, and special treatments. Scores must be based on information from the assessment form. A client's score from each assessment domain shall be used to determine that client's classification.

(d) The commissioner of health shall determine and assign classifications for each client using the procedures specified in attachment F of the manual. The commissioner of health shall assign the client classification within 15 working days after receiving the completed assessment form submitted by the case mix review program team or the facility QMRP. The classification for a newly admitted client is effective retroactive to the date of the client's admission. If a facility QMRP submits an incomplete assessment form, the case mix review program shall inform the facility QMRP of the need to submit additional information necessary for assigning a classification. The facility QMRP must mail the additional information to the case mix review program no later than five working days after receiving the request for the information. If a facility QMRP fails to submit a completed client assessment for a client who is newly admitted to the facility, that client's first assessment in the facility conducted by the case mix review program shall be used to establish a client classification retroactive to the date of the client's admission. Any change in classification due to annual assessment by the case mix review program will be effective on the first day of the month following completion of the case mix review program's annual assessment of all the facility's clients. A client who has resided in the facility less than 30 days must be assessed by the case mix review program during the annual assessment, but must not have a client classification assigned based on the case mix review program's assessment unless the facility QMRP fails to submit a completed client assessment and the client goes on to reside in the facility for more than 30 days.

(e) The facility QMRP may request a reclassification for a client by completing a new client assessment if the facility QMRP believes that the client's status has changed since the case mix review program's annual assessment and that these changes will result in a change in the client's classification. Client assessments for purposes of reclassification will be governed by the following:

(1) The facility QMRP that requests reclassification of a client must provide the case mix review program with evidence to determine a change in the client's classification. Evidence must include photocopies of documentation from the client's record, as specified in the documentation requirements sections of the manual.

(2) A reclassification assessment must occur between the third and the ninth month following the case mix review program's annual assessment of the client. The facility QMRP can request only one reclassification for each client annually.

(3) Any change in classification approved by the case mix review program shall be effective on the first day of the month following the date when the facility QMRP assessed the client for the reclassification.

(4) The case mix review program shall determine reclassification based on the documentation submitted by the facility QMRP. If there is not sufficient information submitted to justify a change to a higher classification, the case mix review program may request additional information necessary to complete a reclassification.

(5) If the facility QMRP does not provide sufficient documentation to support a change in classification, the classification shall remain at the level assessed by the case mix review program at the last inspection of care.

(f) The case mix review program shall conduct desk audits or on–site audits of assessments performed by facility QMRPs. Case mix review program staff shall conduct desk audits of any assessment believed to be inaccurate. The case mix review program may request the facility to submit additional information needed to conduct a desk audit. The facility shall mail the requested information within five working days after receiving the request.

(g) The case mix review program may conduct on–site audits of at least ten percent of the total assessments submitted by facility QMRPs in the previous year and may also conduct special audits if it determines that circumstances exist that could change or affect the validity of assigned classifications. The facility shall grant the case mix review program staff access to the client records during regular business hours for the purpose of conducting an audit. For assessments submitted for new clients, the case mix review program shall consider documentation in the client's record up to and including the date the client was assessed by the facility QMRP. For audits of reclassification assessments, the case mix review program shall consider documentation in the client's record from three months preceding the assessment up to and including the date the client was assessed by the facility QMRP. If the audit reveals that the facility's assessment does not accurately reflect the client's status for the time period and the appropriate supporting documentation cannot be produced by the facility, the case mix review program shall change the classification so that it is consistent with the results of the audit. Any change in client classification that results from an audit must be retroactive to the effective date of the client assessment that was audited. Case mix review program staff shall not discuss preliminary audit findings with the facility's staff. Within 15 working days after completing the audit, the case mix review program shall mail a notice of the results of the audit to the facility.

(h) Requests for reconsideration of client classifications shall be made under section 144.0723 and must be submitted according to section IV of the manual. A reconsideration must be reviewed by case mix review program staff not involved in completing the assessment that established the disputed classification. The reconsideration must be based upon the information provided to the case mix review program. Within 15 working days after receiving the request for reconsideration, the case mix review program shall affirm or modify the original classification. The original classification must be modified if the case mix review program determines that the assessment resulting in the classification did not accurately reflect the status of the client at the time of the assessment. The department of health's decision on reconsiderations is the final administrative decision of the department. The classification assigned by the department of health must be the classification that applies to the client while the request for reconsideration is pending. A change in a classification resulting from a reconsideration must be retroactive to the effective date of the client assessment for which a reconsideration was requested.

(i) The commissioner of human services shall assign weights to each client's classification according to the following table:

Classification	Classification Weight
1S	1.00
1I	1.04
2S	1.36
2I	1.52
3S	1.58
3I	1.68
4S	1.87

4I	2.02
5S	2.09
5I	2.26
6S	2.26
6I	2.52
7S	2.10
7I	2.37
8S	2.26
8I	2.52

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 3e and 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. 3l. **Temporary payment rate provisions.** If an intermediate care facility for persons with mental retardation or related conditions located in Kandiyohi county:

(1) was sold during 1994;

(2) is unable to obtain records necessary to complete the cost report from the former operator at no cost; and

(3) delicensed two beds during that year, then the commissioner shall determine the payment rate for the period May 1, 1995, through September 30, 1996, as provided in paragraphs (a) to (c).

(a) A temporary payment rate shall be paid which is equal to the rate in effect as of April 30, 1995.

(b) The payment rate in paragraph (a) shall be subject to a retroactive downward adjustment based on the provisions in paragraph (c).

(c) The temporary payment rate shall be limited to the lesser of the payment in paragraph (a) or the payment rate calculated based on the facility's cost report for the reporting year January 1, 1995, through December 31, 1995, and the provisions of this section and the reimbursement rules in effect on June 30, 1995, except that the provisions referred to in clauses (1) to (3) shall not apply:

(1) the inflation factor in subdivision 3c;

(2) Minnesota Rules, part 9553.0050, subpart 2, items A to E; and

(3) Minnesota Rules, part 9553.0041, subpart 16.

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

Subd. 4a. **Inclusion of home care costs in waiver rates.** The commissioner shall adjust the limits of the established average daily reimbursement rates for waivered services to include the cost of home care services that may be provided to waivered services recipients. This adjustment must be used to maintain or increase services and shall not be used by county agencies for inflation increases for waivered services vendors. Home care services referenced in this section are those listed in section 256B.0627, subdivision 2. The average daily reimbursement rates established in accordance with the provisions of this subdivision apply only to the combined average, daily costs of waivered and home care services and do not change home care limitations under section 256B.0627. Waivered services recipients receiving home care as of June 30, 1992, shall not have the amount of their services reduced as a result of this section.

Subd. 4b. **Waiver rates and group residential housing rates.** The average daily reimbursement rates established by the commissioner for waivered services shall be adjusted to include the additional costs of services eligible for waiver funding under title XIX of the Social Security Act and for which there is no group residential housing payment available as a result of the payment limitations set forth in section 256I.05, subdivision 10. The adjustment to the waiver rates shall be based on county reports of service costs that are no longer eligible for group residential housing payments. No adjustment shall be made for any amount of reported payments that prior to July 1, 1992, exceeded the group residential housing rate limits established in section 256I.05 and were reimbursed through county funds.

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

Subd. 5a. **Changes to ICF/MR reimbursement.** The reimbursement rule changes in paragraphs (a) to (e) apply to Minnesota Rules, parts 9553.0010 to 9553.0080, and this section, and are effective for rate years beginning on or after October 1, 1993, unless otherwise specified.

(a) The maximum efficiency incentive shall be $1.50 per resident per day.

(b) If a facility's capital debt reduction allowance is greater than 50 cents per resident per day, that facility's capital debt reduction allowance in excess of 50 cents per resident day shall be reduced by 25 percent.

(c) Beginning with the biennial reporting year which begins January 1, 1993, a facility is no longer required to have a certified audit of its financial statements. The cost of a certified audit shall not be an allowable cost in that reporting year, nor in subsequent reporting years unless the facility submits its certified audited financial statements in the manner otherwise specified in this subdivision. A nursing facility which does not submit a certified audit must submit its working trial balance.

(d) In addition to the approved pension or profit sharing plans allowed by the reimbursement rule, the commissioner shall allow those plans specified in Internal Revenue Code, sections 403(b) and 408(k).

(e) The commissioner shall allow as workers' compensation insurance costs under this section, the costs of workers' compensation coverage obtained under the following conditions:

(1) a plan approved by the commissioner of commerce as a Minnesota group or individual self-insurance plan as provided in sections 79A.03;

(2) a plan in which:

(i) the facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) a related organization to the facility reinsures the workers' compensation coverage purchased, directly or indirectly, by the facility; and

(iii) all of the conditions in clause (4) are met;

(3) a plan in which:

(i) the facility, directly or indirectly, purchases workers' compensation coverage in compliance with section 176.181, subdivision 2, from an authorized insurance carrier;

(ii) the insurance premium is calculated retrospectively, including a maximum premium limit, and paid using the paid loss retro method; and

(iii) all of the conditions in clause (4) are met;

(4) additional conditions are:

(i) the reserves for the plan are maintained in an account controlled and administered by a person which is not a related organization to the facility;

(ii) the reserves for the plan cannot be used, directly or indirectly, as collateral for debts incurred or other obligations of the facility or related organizations to the facility;

(iii) if the plan provides workers' compensation coverage for non-Minnesota facilities, the plan's cost methodology must be consistent among all facilities covered by the plan, and if reasonable, is allowed notwithstanding any reimbursement laws regarding cost allocation to the contrary;

(iv) central, affiliated, corporate, or nursing facility costs related to their administration of the plan are costs which must remain in the nursing facility's administrative cost category, and must not be allocated to other cost categories; and

(v) required security deposits, whether in the form of cash, investments, securities, assets, letters of credit, or in any other form are not allowable costs for purposes of establishing the facilities payment rate; and

(5) any costs allowed pursuant to clauses (1) to (3) are subject to the following requirements:

(i) if the facility is sold or otherwise ceases operations, the plan's reserves must be subject to an actuarially based settle-up after 36 months from the date of sale or the date on which operations ceased. The facility's medical assistance portion of the total excess plan reserves must be paid to the state within 30 days following the date on which excess plan reserves are determined;

(ii) any distribution of excess plan reserves made to or withdrawals made by the facility or a related organization are applicable credits and must be used to reduce the facility's workers' compensation insurance costs in the reporting period in which a distribution or withdrawal is received; and

(iii) if the plan is audited pursuant to the Medicare program, the facility must provide a copy of Medicare's final audit report, including attachments and exhibits, to the commissioner within 30 days of receipt by the facility or any related organization. The commissioner shall implement the audit findings associated with the plan upon receipt of Medicare's final audit report. The department's authority to implement the audit findings is independent of its authority to conduct a field audit.

Subd. 5b. **ICF/MR operating cost limitation after September 30, 1995.** (a) For the rate year beginning on October 1, 1995, and for rate years beginning on or after October 1, 1997, the commissioner shall limit the allowable operating cost per diems, as determined under this subdivision and the reimbursement rules, for high cost ICF's/MR. Prior to indexing each facility's operating cost per diems for inflation, the commissioner shall group the facilities into eight groups. The commissioner shall then array all facilities within each grouping by their general operating cost per service unit per diems.

(b) The commissioner shall annually review and adjust the general operating costs incurred by the facility during the reporting year preceding the rate year to determine the facility's allowable historical general operating costs. For this purpose, the term general operating

costs means the facility's allowable operating costs included in the program, maintenance, and administrative operating costs categories, as well as the facility's related payroll taxes and fringe benefits, real estate insurance, and professional liability insurance. A facility's total operating cost payment rate shall be limited according to paragraphs (c) and (d) as follows:

(c) A facility's total operating cost payment rate shall be equal to its allowable historical operating cost per diems for program, maintenance, and administrative cost categories multiplied by the forecasted inflation index in subdivision 3c, clause (1), subject to the limitations in paragraph (d).

(d) For the rate years beginning on or after October 1, 1995, the commissioner shall establish maximum overall general operating cost per service unit limits for facilities according to clauses (1) to (8). Each facility's allowable historical general operating costs and client assessment information obtained from client assessments completed under subdivision 3g for the reporting year ending December 31, 1994 (the base year), shall be used for establishing the overall limits. If a facility's proportion of temporary care resident days to total resident days exceeds 80 percent, the commissioner must exempt that facility from the overall general operating cost per service unit limits in clauses (1) to (8). For this purpose, "temporary care" means care provided by a facility to a client for less than 30 consecutive resident days.

(1) The commissioner shall determine each facility's weighted service units for the reporting year by multiplying its resident days in each client classification level as established in subdivision 3g, paragraph (d), by the corresponding weights for that classification level, as established in subdivision 3g, paragraph (i), and summing the results. For the reporting year ending December 31, 1994, the commissioner shall use the service unit score computed from the client classifications determined by the Minnesota department of health's annual review, including those of clients admitted during that year.

(2) The facility's service unit score is equal to its weighted service units as computed in clause (1), divided by the facility's total resident days excluding temporary care resident days, for the reporting year.

(3) For each facility, the commissioner shall determine the facility's cost per service unit by dividing its allowable historical general operating costs for the reporting year by the facility's service unit score in clause (2) multiplied by its total resident days, or 85 percent of the facility's capacity days times its service unit score in clause (2), if the facility's occupancy is less than 85 percent of licensed capacity. If a facility reports temporary care resident days, the temporary care resident days shall be multiplied by the service unit score in clause (2), and the resulting weighted resident days shall be added to the facility's weighted service units in clause (1) prior to computing the facility's cost per service unit under this clause.

(4) The commissioner shall group facilities based on class A or class B licensure designation, number of licensed beds, and geographic location. For purposes of this grouping, facilities with six beds or less shall be designated as small facilities and facilities with more than six beds shall be designated as large facilities. If a facility has both class A and class B licensed beds, the facility shall be considered a class A facility for this purpose if the number of class A beds is more than half its total number of ICF/MR beds; otherwise the facility shall be considered a class B facility. The metropolitan geographic designation shall include Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. All other Minnesota counties shall be designated as the nonmetropolitan geographic group. These characteristics result in the following eight groupings:

(i) small class A metropolitan;

(ii) large class A metropolitan;

(iii) small class B metropolitan;

(iv) large class B metropolitan;

(v) small class A nonmetropolitan;

(vi) large class A nonmetropolitan;

(vii) small class B nonmetropolitan; and

(viii) large class B nonmetropolitan.

(5) The commissioner shall array facilities within each grouping in clause (4) by each facility's cost per service unit as determined in clause (3).

(6) In each array established under clause (5), facilities with a cost per service unit at or above the median shall be limited to the lesser of: (i) the current reporting year's cost per service unit; or (ii) the prior reporting year's allowable historical general operating cost per service unit plus the inflation factor as established in subdivision 3c, clause (2), increased by three percentage points.

(7) The overall operating cost per service unit limit for each group shall be established as follows:

(i) each array established under clause (5) shall be arrayed again after the application of clause (6);

(ii) in each array established in clause (5), two general operating cost limits shall be determined. The first cost per service unit limit shall be established at 0.5 and less than or equal to 1.0 standard deviation above the median of that array. The second cost per service unit limit shall be established at 1.0 standard deviation above the median of the array; and

(iii) the overall operating cost per service unit limits shall be indexed for inflation annually beginning with the reporting year ending December 31, 1995, using the forecasted inflation index in subdivision 3c, clause (2).

(8) Annually, facilities shall be arrayed using the method described in clauses (5) and (7). Each facility with a cost per service unit at or above its group's first cost per service unit limit, but less than the second cost per service unit limit for that group, shall be limited to 98 percent of its total operating cost per diems then add the forecasted inflation index in subdivision 3c, clause (1). Each facility with a cost per service unit at or above the second cost per service unit limit will be limited to 97 percent of its total operating cost per diems, then add the forecasted inflation index in subdivision 3c, clause (1). Facilities that have undergone a class A to class B conversion since January 1, 1990, are exempt from the limitations in this clause for six years after the completion of the conversion process.

(9) The commissioner may rebase these overall limits, using the method described in this subdivision but no more frequently than once every three years.

(e) For rate years beginning on or after October 1, 1995, the facility's efficiency incentive shall be determined as provided in the reimbursement rule.

(f) The total operating cost payment rate shall be the sum of paragraphs (c) and (e).

(g) For the rate year beginning on October 1, 1996, the commissioner shall exempt a facility from the reductions in this subdivision if the facility is involved in a bed relocation project where more than 25 percent of the facility's beds are transferred to another facility, the relocated beds are six or fewer, there is no change in the total number of ICF/MR beds for the parent organization of the facility, and the relocation is not part of an interim or settle–up rate.

Subd. 5c. **Operating costs after September 30, 1999.** (a) In general, the commissioner shall establish maximum standard rates for the prospective reimbursement of facility costs. The maximum standard rates must take into account the level of reimbursement which is adequate to cover the base–level costs of economically operated facilities. In determining the base–level costs, the commissioner shall consider geographic location, types of facilities (class A or class B), minimum staffing standards, resident assessment under subdivision 3g, and other factors as determined by the commissioner.

(b) The commissioner may also develop additional incentive–based payments which, if achieved for specified outcomes, will be added to the maximum standard rates. The specified outcomes must be measurable and shall be based on criteria to be developed by the commissioner. The commissioner may establish various levels of achievement within an outcome. Once the outcomes are established, the commissioner shall assign various levels of payment associated with achieving the outcome. In establishing the specified outcomes and the related criteria, the commissioner shall consider the following state policy objectives:

(1) resident transitioned into cost–effective community alternatives;

(2) the results of a uniform consumer satisfaction survey;

(3) the achievement of no major licensure or certification deficiencies; or

(4) any other outcomes the commissioner finds desirable. The commissioner may also consider the findings of projects examining services to persons with developmental disabilities, including outcome–based quality assurance methods, and the inclusion of persons with developmental disabilities in managed care alternative service delivery models.

(c) In developing the maximum standard rates and the incentive–based payments, desirable outcomes, and related criteria, the commissioner, in collaboration with the commissioner of health, shall form an advisory committee. The membership of the advisory committee shall include representation from the consumers advocacy groups, facility trade associations, counties, the legislature, and others the commissioners find appropriate.

(d) Beginning July 1, 1998, the commissioner shall collect the data from the facilities, the department of health, or others as necessary to determine the extent to which a facility has met any of the outcomes and related criteria. Payment rates under this subdivision shall be effective October 1, 1999.

(e) The commissioner shall report to the legislature on the progress of the advisory committee by January 31, 1998. By January 15, 1999, the commissioner shall recommend to the legislature legislation which will implement this reimbursement methodology for rate years beginning on or after the proposed effective date of October 1, 1999.

Subd. 5d. **Adjustment for outreach crisis services.** An ICF/MR with crisis services developed under the authority of Laws 1992, chapter 513, article 9, section 40, shall have its operating cost per diem calculated according to paragraphs (a) and (b).

(a) Effective for services rendered from April 1, 1996, to September 30, 1996, and for rate years beginning on or after October 1, 1996, the maintenance limitation in Minnesota Rules, part 9553.0050, subpart 1, item A, subitem (2), shall be calculated to reflect capacity as of October 1, 1992. The maintenance limit shall be the per diem limitation otherwise in effect adjusted by the ratio of licensed capacity days as of October 1, 1992, divided by resident days in the reporting year ending December 31, 1993.

(b) Effective for rate years beginning on or after October 1, 1996, the operating cost per service unit, for purposes of the cost per service unit limit in subdivision 5b, paragraph (d), clauses (7) and (8), shall be calculated after excluding the costs directly identified to the provision of outreach crisis services and a four–bed crisis unit.

(c) The efficiency incentive paid to an ICF/MR shall not be increased as a result of this subdivision.

Subd. 5e. **Rate adjustment for care provided to a medically fragile individual.** Beginning July 1, 1996, the commissioner shall increase reimbursement rates for a facility located in Chisholm and licensed as an intermediate care facility for persons with mental retardation and related conditions since 1972, to cover the cost to the facility for providing 24–hour licensed practical nurse care to a medically fragile individual admitted on March 8, 1996. The commissioner shall include in this higher rate a temporary adjustment to reimburse the facility for costs incurred between March 8, 1996, and June 30, 1996. Once this resident is discharged, the commissioner shall reduce the facility's payment rate by the amount of the cost of the 24–hour licensed practical nurse care.

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 subdivision 2, 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. Rate payments under subdivision 8a are eligible for a rate exception under this subdivision. No excess payment approved by the commissioner after June 30, 1991, shall be authorized unless:

(1) the need for specific level of service is documented in the individual service plan of the person to be served;

(2) the level of service needed can be provided within the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, without a rate exception within 12 months;

(3) staff hours beyond those available under the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, necessary to deliver services do not exceed 1,440 hours within 12 months;

(4) there is a basis for the estimated cost of services;

(5) the provider requesting the exception documents that current per diem rates are insufficient to support needed services;

(6) estimated costs, when added to the costs of current medical assistance–funded residential and day training and habilitation services and calculated as a per diem, do not exceed the per diem established for the regional treatment centers for persons with mental retardation and related conditions on July 1, 1990, indexed annually by the urban consumer price index, all items, as forecasted by Data Resources Inc., for the next fiscal year over the current fiscal year;

(7) any contingencies for an approval as outlined in writing by the commissioner are met; and

(8) any commissioner orders for use of preferred providers are met.

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

The commissioner may terminate the rate exception at any time under any of the conditions outlined in Minnesota Rules, part 9510.1120, subpart 3, for county termination, or by reason of information obtained through program and fiscal audits which indicate the criteria outlined in this subdivision have not been, or are no longer being, met.

The commissioner may approve no more than one rate exception, up to 12 months duration, for an eligible client.

Subd. 8a. **Payment for persons with special needs for crisis intervention services.** State–operated, community–based crisis services provided in accordance with section 252.50, subdivision 7, to a resident of an intermediate care facility for persons with mental retardation (ICF/MR) reimbursed under this section shall be paid by medical assistance in accordance with the paragraphs (a) to (h).

(a) "Crisis services" means the specialized services listed in clauses (1) to (3) provided to prevent the recipient from requiring placement in a more restrictive institutional setting such as an inpatient hospital or regional treatment center and to maintain the recipient in the present community setting.

(1) The crisis services provider shall assess the recipient's behavior and environment to identify factors contributing to the crisis.

(2) The crisis services provider shall develop a recipient–specific intervention plan in coordination with the service planning team and provide recommendations for revisions to the individual service plan if necessary to prevent or minimize the likelihood of future crisis situations. The intervention plan shall include a transition plan to aid the recipient in returning to the community–based ICF/MR if the recipient is receiving residential crisis services.

(3) The crisis services provider shall consult with and provide training and ongoing technical assistance to the recipient's service providers to aid in the implementation of the intervention plan and revisions to the individual service plan.

(b) "Residential crisis services" means crisis services that are provided to a recipient admitted to the crisis services foster care setting because the ICF/MR receiving reimbursement under this section is not able, as determined by the commissioner, to provide the intervention and protection of the recipient and others living with the recipient that is necessary to prevent the recipient from requiring placement in a more restrictive institutional setting.

(c) Crisis services providers must be licensed by the commissioner under section 245A.03 to provide foster care, must exclusively provide short–term crisis intervention, and must not be located in a private residence.

(d) Payment rates are determined annually for each crisis services provider based on cost of care for each provider as defined in section 246.50. Interim payment rates are calcu-

lated on a per diem basis by dividing the projected cost of providing care by the projected number of contact days for the fiscal year, as estimated by the commissioner. Final payment rates are calculated by dividing the actual cost of providing care by the actual number of contact days in the applicable fiscal year.

(e) Payment shall be made for each contact day. "Contact day" means any day in which the crisis services provider has face–to–face contact with the recipient or any of the recipient's medical assistance service providers for the purpose of providing crisis services as defined in paragraph (c).

(f) Payment for residential crisis services is limited to 21 days, unless an additional period is authorized by the commissioner. The additional period may not exceed 21 days.

(g) Payment for crisis services shall be made only for services provided while the ICF/MR receiving reimbursement under this section:

(1) has a shared services agreement with the crisis services provider in effect in accordance with section 246.57;

(2) has reassigned payment for the provision of the crisis services under this subdivision to the commissioner in accordance with Code of Federal Regulations, title 42, section 447.10(e); and

(3) has executed a cooperative agreement with the crisis services provider to implement the intervention plan and revisions to the individual service plan as necessary to prevent or minimize the likelihood of future crisis situations, to maintain the recipient in the present community setting, and to prevent the recipient from requiring a more restrictive institutional setting.

(h) Payment to the ICF/MR receiving reimbursement under this section shall be made for up to 18 therapeutic leave days during which the recipient is receiving residential crisis services, if the ICF/MR is otherwise eligible to receive payment for a therapeutic leave day under Minnesota Rules, part 9505.0415. Payment under this paragraph shall be terminated if the commissioner determines that the ICF/MR is not meeting the terms of the cooperative agreement under paragraph (g) or that the recipient will not return to the ICF/MR.

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

Subd. 10. **Rules.** To implement this section, the commissioner shall promulgate rules in accordance with chapter 14. To implement subdivision 3, the commissioner shall promulgate rules in accordance with sections 14.01 to 14.38.

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) and Minnesota Rules, part 9553.0060, subpart 1, item C, subitem (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), except that the index utilized will be the Bureau of the Census: Composite fixed–weighted price index as published in the Survey of Current Business.

(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 May 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.

(h) The development of any newly constructed or newly established facility as defined in this subdivision and projected to be operational after July 1, 1991, by the commissioner of human services shall be delayed until July 1, 1993, except for those facilities authorized by the commissioner as a result of a closure of a facility according to section 252.292 prior to

January 1, 1991, or those facilities developed as a result of a receivership of a facility according to section 245A.12. This paragraph does not apply to state–operated community facilities authorized in section 252.50.

Subd. 12. **ICF/MR salary adjustments.** For the rate period beginning January 1, 1992, and ending September 30, 1993, the commissioner shall add the appropriate salary adjustment cost per diem calculated in paragraphs (a) to (d) to the total operating cost payment rate of each facility. The salary adjustment cost per diem must be determined as follows:

(a) **Computation and review guidelines.** Except as provided in paragraph (c), a state–operated community service, and any facility whose payment rates are governed by closure agreements, receivership agreements, or Minnesota Rules, part 9553.0075, are not eligible for a salary adjustment otherwise granted under this subdivision. For purposes of the salary adjustment per diem computation and reviews in this subdivision, the term "salary adjustment cost" means the facility's allowable program operating cost category employee training expenses, and the facility's allowable salaries, payroll taxes, and fringe benefits. The term does not include these same salary–related costs for both administrative or central office employees.

For the purpose of determining the amount of salary adjustment to be granted under this subdivision, the commissioner must use the reporting year ending December 31, 1990, as the base year for the salary adjustment per diem computation. For the purpose of both years' salary adjustment cost review, the commissioner must use the facility's salary adjustment cost for the reporting year ending December 31, 1991, as the base year. If the base year and the reporting years subject to review include salary cost reclassifications made by the department, the commissioner must reconcile those differences before completing the salary adjustment per diem review.

(b) **Salary adjustment per diem computation.** For the rate period beginning January 1, 1992, each facility shall receive a salary adjustment cost per diem equal to its salary adjustment costs multiplied by 1–1/2 percent, and then divided by the facility's resident days.

(c) **Adjustments for new facilities.** For newly constructed or newly established facilities, except for state–operated community services, whose payment rates are governed by Minnesota Rules, part 9553.0075, if the settle–up cost report includes a reporting year which is subject to review under this subdivision, the commissioner shall adjust the rule provision governing the maximum settle–up payment rate by increasing the .4166 percent for each full month of the settle–up cost report to .7083. For any subsequent rate period which is authorized for salary adjustments under this subdivision, the commissioner shall compute salary adjustment cost per diems by annualizing the salary adjustment costs for the settle–up cost report period and treat that period as the base year for purposes of reviewing salary adjustment cost per diems.

(d) **Salary adjustment per diem review.** The commissioner shall review the implementation of the salary adjustments on a per diem basis. For reporting years ending December 31, 1992, and December 31, 1993, the commissioner must review and determine the amount of change in salary adjustment costs in both of the above reporting years over the base year after the reporting year ending December 31, 1993. The commissioner must inflate the base year's salary adjustment costs by the cumulative percentage increase granted in paragraph (b), plus three percentage points for each of the two years reviewed. The commissioner must then compare each facility's salary adjustment costs for the reporting year divided by the facility's resident days for both reporting years to the base year's inflated salary adjustment cost divided by the facility's resident days for the base year. If the facility has had a one–time program operating cost adjustment settle–up during any of the reporting years subject to review, the commissioner must remove the per diem effect of the one–time program adjustment before completing the review and per diem comparison.

The review and per diem comparison must be done by the commissioner after the reporting year ending December 31, 1993. If the salary adjustment cost per diem for the reporting years being reviewed is less than the base year's inflated salary adjustment cost per diem, the commissioner must recover the difference within 120 days after the date of written notice. The amount of the recovery shall be equal to the per diem difference multiplied by the facility's resident days in the reporting years being reviewed. Written notice of the amount

subject to recovery must be given by the commissioner following both reporting years reviewed. Interest charges must be assessed by the commissioner after the 120th day of that notice at the same interest rate the commissioner assesses for other balance outstanding.

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; 1991 c 292 art 4 s 64–66; 1992 c 513 art 7 s 122; art 9 s 28,29; 1993 c 339 s 22; 1Sp1993 c 1 art 5 s 109–112; 1995 c 114 s 1; 1995 c 207 art 7 s 33–40; 1996 c 305 art 2 s 49,50; 1996 c 451 art 3 s 4–7*

256B.502 RULES.

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

History: *1983 c 199 s 16; 1984 c 640 s 32; 1984 c 654 art 5 s 58; 1996 c 305 art 2 s 51*

256B.503 RULES.

To implement Laws 1983, chapter 312, article 9, sections 1 to 7, the commissioner shall promulgate 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 rules to implement this section by July 1, 1986.

History: *1983 c 312 art 9 s 8; 1984 c 640 s 32; 1Sp1985 c 9 art 2 s 53; 1996 c 305 art 2 s 52*

256B.504 [Repealed, 1995 c 248 art 2 s 8]

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 [Repealed, 1996 c 310 s 1]

256B.57 [Repealed, 1996 c 310 s 1]

256B.58 [Repealed, 1996 c 310 s 1]

256B.59 [Repealed, 1996 c 310 s 1]

256B.60 [Repealed, 1996 c 310 s 1]

256B.61 [Repealed, 1996 c 310 s 1]

256B.62 [Repealed, 1996 c 310 s 1]

256B.63 [Repealed, 1996 c 310 s 1]

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. Within 36 hours of the end of the 120–hour transition period, an assessment may be made by the ventilator–dependent recipient, the attending physician, and the hospital staff caring for the recipient. If the persons making the assessment determine that additional communicator or interpreter services are medically necessary, the hospital must contact the commissioner 24 hours prior to the end of the 120–hour transition period and submit the assessment information to the commissioner. The commissioner shall review the request and determine if it is medically necessary to continue the interpreter services or if the hospital staff has had sufficient opportunity to adequately determine the needs of the patient. The commissioner shall determine if continued service is necessary and appropriate and whether or not payments shall continue. The commissioner may not authorize services beyond the limits of the available appropriations for this section. 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; 1991 c 292 art 7 s 20*

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.

(e) This paragraph supersedes paragraph (c) as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, this paragraph expires and the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06. Notwithstanding sections 256B.055, 256B.056, and 256B.06, an individual who becomes ineligible for the program because of failure to submit income reports or recertification forms in a timely manner, shall remain enrolled in the prepaid health plan and shall remain eligible to receive medical assistance coverage through the last day of the month following the month in which the enrollee became ineligible for the medical assistance program.

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. 3a. **County authority.** (a) The commissioner, when implementing the general assistance medical care, or medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance and general assistance medical care funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The commissioner, in conjunction with the county board, shall actively seek to develop a mutually agreeable timetable prior to the development of the request for proposal. At least 90 days before enrollment in the medical assistance and general assistance medical care prepaid programs begins in a county in which the prepaid programs have not been established, the commissioner shall provide a report to the chairs of senate and house committees having jurisdiction over state health care programs which verifies that the commissioner complied with the requirements for county involvement that are specified in this subdivision.

(b) The commissioner shall seek a federal waiver to allow a fee–for–service plan option to MinnesotaCare enrollees. The commissioner shall develop an increase of the premium fees required under section 256.9356 up to 20 percent of the premium fees for the enrollees who elect the fee–for–service option. Prior to implementation, the commissioner shall submit this fee schedule to the chair and ranking minority member of the senate health care committee, the senate health care and family services funding division, the house of representatives health and human services committee, and the house of representatives health and human services finance division.

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; (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: (i) they are 65 years of age or older, or (ii) they reside in Itasca county or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act; (3) recipients who currently have private coverage through a health maintenance organization; (4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense; (5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e); (6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20; and (7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20. Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (6) and (7) may choose to enroll on an elective basis. The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state. Beginning on or after July 1, 1997, the commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under clauses (1) and (3) and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L. Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers. The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical assistance in the individual's county of residence. 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. 4a. [Repealed, 1996 c 451 art 5 s 39]

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

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

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

By January 15, 1996, the commissioner shall report to the legislature on the methodology used to allocate to participating counties available administrative reimbursement for advocacy and enrollment costs. The report shall reflect the commissioner's judgment as to the

adequacy of the funds made available and of the methodology for equitable distribution of the funds. The commissioner must involve participating counties in the development of the report.

Subd. 5a. **Managed care contracts.** Managed care contracts under this section, sections 256.9363, and 256D.03, shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995.

Subd. 5b. **Prospective reimbursement rates.** For prepaid medical assistance and general assistance medical care program contract rates set by the commissioner under subdivision 5 and effective on or after January 1, 1997, through December 31, 1998, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 85 percent of the capitation rates for metropolitan counties, excluding Hennepin county.

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.0911 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. The commissioner shall also develop methods of data collection from county advocacy activities in order to provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance. 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.

Subd. 18. **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. 19. **Limitation on reimbursement to providers not affiliated with a prepaid health plan.** A prepaid health plan may limit any reimbursement it may be required to pay to providers not employed by or under contract with the prepaid health plan to the medical assistance rates for medical assistance enrollees, and the general assistance medical care rates for general assistance medical care enrollees, paid by the commissioner of human services to providers for services to recipients not enrolled in a prepaid health plan.

Subd. 20. **Ombudsperson.** The commissioner shall designate an ombudsperson to advocate for persons required to enroll in prepaid health plans under this section. The ombudsperson 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 ombudsperson 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. 21. **Prepayment coordinator.** The county board shall designate a prepayment coordinator to assist the state agency in implementing this section 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 18.

Subd. 22. **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.

Subd. 23. **Alternative integrated long–term care services; elderly and disabled persons.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long–term care services to elderly and disabled persons that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 17. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the ex-

ceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to elderly persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256.9363, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only.

Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(b) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

Subd. 24. **Social service and public health costs.** The commissioner shall report on recommendations to the legislature by January 15, 1997, identifying county social services and public health administrative costs for each target population that should be excluded from the overall capitation rate.

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; 1991 c 292 art 7 s 25; 1994 c 529 s 11; 1995 c 207 art 6 s 90–102; art 7 s 41; 1995 c 234 art 6 s 40,41; 1996 c 451 art 2 s 33–37; art 5 s 32*

NOTE: The amendment to subdivision 4 by Laws 1996, chapter 451, article 2, section 34, is effective the day following final enactment and upon federal approval. Laws 1996, chapter 451, article 2, section 62, paragraphs (d) and (f).

256B.691 RISK–BASED TRANSPORTATION PAYMENTS.

Any contract with a prepaid health plan under the medical assistance, general assistance medical care, or MinnesotaCare program that requires the health plan to cover transportation services for obtaining medical care for eligible individuals who are ambulatory must provide for payment for those services on a risk basis.

History: *1995 c 207 art 6 s 103*

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. [Repealed, 1991 c 292 art 7 s 26]

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 enroll-

ees 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*

SPECIAL PAYMENTS

256B.74 SPECIAL PAYMENTS.

Subdivision 1. **Hospital reimbursement.** Effective for services rendered on or after July 1, 1991, the commissioner shall reimburse outpatient hospital facility fees at 80 percent of calendar year 1990 submitted charges, not to exceed the Medicare upper payment limit. Services excepted from this payment methodology are emergency room facility fees, clinic facility fees, and those services for which there is a federal maximum allowable payment.

Subd. 2. **Physician reimbursement.** The commissioner shall make payments for physician services rendered on or after July 1, 1992, as follows:

(a) Payments for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient medical services," "pre-

ventive medicine new and established patient," "delivery, antepartum and postpartum care," Caesarean delivery, and pharmacologic management provided to psychiatric patients and HCPCS level three codes for enhanced services for prenatal high risk shall be calculated at the lower of (1) submitted charges, or (2) the median charges in 1989 minus 20 percent. If the median minus 20 percent results in a decrease to rates in effect June 30, 1991, for obstetrical and prenatal services, the rate on those codes in effect on June 30, 1991, shall be increased by an additional five percent.

(b) Payments for level one HCPCS codes titled "critical care" initial or subsequent visits only shall be calculated at the lower of (1) submitted charges, or (2) the median charges in 1989 minus 30 percent.

(c) Payments for all other services shall be calculated at the lower of (1) submitted charges, or (2) the median charges in 1989 minus 40 percent.

(d) In addition to the payment rates in paragraphs (a) to (c), rates for obstetrical services shall be adjusted by the ten percent increase in Laws 1988, chapter 689, article 1, section 2, subdivision 5, and rates for obstetrical and pediatric services shall be adjusted by the 15 percent increase in Laws 1990, chapter 568, article 1, section 2, subdivision 7.

Subd. 3. **Nursing facility reimbursement.** For rate years beginning on or after July 1, 1991, the maximum efficiency incentive per diem payment established annually under section 256B.431, subdivision 2b, paragraph (d), shall be increased to $2.10 effective July 1, 1991, and $2.20 effective July 1, 1992, and shall be indexed for inflation annually beginning July 1, 1993, using Data Resources, Inc., forecast for change in the nursing home market basket.

Subd. 4. **Personal needs allowance.** The commissioner shall provide cost of living increases in the personal needs allowance under section 256B.35, subdivision 1.

Subd. 5. **Dentists.** The commissioner shall increase reimbursement to dentists for services rendered on or after July 1, 1992, by 20 percent for preventative services and five percent for all other services.

Subd. 6. **Health plans.** Effective for services rendered after July 1, 1991, the commissioner shall adjust the monthly medical assistance capitation rate cell established in contract by the amount necessary to accommodate the equivalent value of the reimbursement increase established under subdivisions 1, 2, and 5.

Subd. 7. **Administrative cost.** The commissioner may expend up to $1,700,000 for the administrative costs associated with sections 256.9657 and 256B.74.

Subd. 8. [Repealed, 1992 c 513 art 7 s 135]

Subd. 9. [Repealed, 1992 c 513 art 7 s 135]

Subd. 10. **Implementation; rulemaking.** The commissioner shall implement sections 256.9657 and 256B.74 on July 1, 1991, without complying with the rulemaking requirements of the administrative procedure act. The commissioner may adopt rules to implement Laws 1991, chapter 292, article 4. Rules adopted to implement Laws 1991, chapter 292, article 4, supersede any provisions adopted under the exemption from rulemaking requirements in this section.

History: *1991 c 292 art 4 s 67; 1992 c 464 art 1 s 30; 1992 c 513 art 7 s 123,124; 1996 c 305 art 2 s 53*

NOTE: See also section 256B.75

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements pre-

vail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

History: *1992 c 513 art 7 s 130*

256B.76 PHYSICIAN AND DENTAL REIMBURSEMENT.

(a) The physician reimbursement increase provided in section 256B.74, subdivision 2, shall not be implemented. Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Health Care Finance Administration's common procedural coding system (HCPCS) codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," Caesarean delivery and pharmacologic management provided to psychiatric patients, and HCPCS level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992. If the rate on any procedure code within these categories is different than the rate that would have been paid under the methodology in section 256B.74, subdivision 2, then the larger rate shall be paid;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) The dental reimbursement increase provided in section 256B.74, subdivision 5, shall not be implemented. Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(c) An entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility which was certified prior to January 1, 1993, that is licensed under Minnesota Rules, parts 9570.2000 to 9570.3600, and for whom at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year are medical assistance recipients, shall be reimbursed by the commissioner for rehabilitation services at rates that are 38 percent greater than the maximum reimbursement rate allowed under paragraph (a), clause (2), when those services are (1) provided within the comprehensive outpatient rehabilitation facility and (2) provided to residents of nursing facilities owned by the entity.

History: *1992 c 513 art 7 s 131; 1Sp1993 c 1 art 5 s 123*