CHAPTER 9510
DEPARTMENT OF HUMAN SERVICES
RATES FOR HEALTH CARE FACILITIES

9510.0010 [Repealed, 23 SR 1597]

9510.0020 [Repealed, 23 SR 1597]

9510.0030 [Repealed, 23 SR 1597]

9510.0040 [Repealed, 23 SR 1597]

9510.0050 [Repealed, 23 SR 1597]

9510.0060 [Repealed, 23 SR 1597]

9510.0070 [Repealed, 23 SR 1597]

9510.0080 [Repealed, 23 SR 1597]

9510.0090 [Repealed, 23 SR 1597]

9510.0100 [Repealed, 23 SR 1597]

9510.0110 [Repealed, 23 SR 1597]

9510.0120 [Repealed, 23 SR 1597]

9510.0130 [Repealed, 23 SR 1597]

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9510.0170 [Repealed, 23 SR 1597]

9510.0180 [Repealed, 23 SR 1597]

9510.0190 [Repealed, 23 SR 1597]

9510.0200 [Repealed, 23 SR 1597]

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9510.0240 [Repealed, 23 SR 1597]

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9510.0270 [Repealed, 23 SR 1597]

9510.0280 [Repealed, 23 SR 1597]

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9510.0890 [Repealed, 23 SR 1597]

9510.1000 [Repealed, 23 SR 1597]

9510.1010 [Repealed, 23 SR 1597]

SPECIAL NEEDS RATE EXCEPTION FOR VERY DEPENDENT PERSONS WITH SPECIAL NEEDS

9510.1020 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9510.1020 to 9510.1140 have the meanings given them in this part.

Subp. 2. **Case manager.** "Case manager" has the meaning given it in part 9525.0004, subpart 4.

Subp. 3. **Client.** "Client" means a person who is receiving training and habilitation services or intermediate care facility for the mentally retarded services funded under the medical assistance program.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or a designated representative.

Subp. 5. **County.** "County" means the county board of commissioners for the county which provides case management services to the client or the county board of commissioners' designated representative.

Subp. 6. **Degenerative disease.** "Degenerative disease" means a category of neurological impairment such as Hurler's syndrome, tuberous sclerosis, Alzheimer's disease, or Huntington's chorea with a disorganization of motor function or chronic brain syndrome.

Subp. 7. **Employee benefits.** "Employee benefits" means compensation actually paid to or for the benefit of the employees other than salary. Employee benefits include group health or dental insurance, group life insurance, pensions or profit sharing plans, governmentally required retirement plans, sick leave, vacations, and in kind benefits. Employee benefits do not include payroll-related costs.

Subp. 8. **Equipment.** "Equipment" means aids designed to increase a client's ability to live and function independently which are purchased for the client, remain the property of the client and can be moved with the client upon discharge.

Subp. 9. **Intermediate care facility for the mentally retarded or ICF/MR.** "Intermediate care facility for the mentally retarded" or "ICF/MR" means a program licensed to serve residents having mental retardation or related conditions under Minnesota Statutes, section 252.28, and a physical plant licensed as a supervised living facility under Minnesota Statutes, chapter 144, which together are certified by the Minnesota Department of Health as an intermediate care facility for the mentally retarded.

Subp. 10. **Medical review team.** "Medical review team" means a group of physicians and social workers who are under contract with the Department of Human Services to review a medical and social history for the purpose of determining a person's disability within the scope of the regulations of the Social Security Administration.

Subp. 11. **Provider.** "Provider" means the person or entity operating a licensed training and habilitation service or an ICF/MR.

Subp. 12. **Payroll-related costs.** "Payroll-related costs" means the employer's share of social security withholding taxes, workers' compensation insurance or actual cost if self insured, and state and federal unemployment compensation taxes or costs.

Subp. 13. **Special needs rate exception payment.** "Special needs rate exception payment" means a payment established under parts 9510.1020 to 9510.1140.

Subp. 14. **Staff intervention.** "Staff intervention" means the direct client care provided by program personnel or outside program consultants, or the training of direct care program personnel by outside program consultants for the purpose of addressing the client's needs as identified in the special needs rate exception application.

Subp. 15. **Regional treatment center.** "Regional treatment center" means an ICF/MR or nursing home owned and operated by the state of Minnesota.

Subp. 16. **Training and habilitation services.** "Training and habilitation services" means health and social services provided under Minnesota Statutes, sections 252.40 to 252.47. For purposes of parts 9510.1020 to 9510.1140, training and habilitation services do not include training and habilitation services provided as a waivered service as defined in Minnesota Statutes, section 256B.501, subdivision 1, and parts 9525.1800 to 9525.1930.

Statutory Authority: *MS s 252.46; 256B.092; 256B.501*

History: *10 SR 922; 12 SR 1148; 14 SR 2354; 18 SR 2244*

9510.1030 APPLICABILITY AND PURPOSE.

Subpart 1. **Applicability.** Parts 9510.1020 to 9510.1140 establish procedures for counties and providers to follow to seek authorization for a special needs rate exception for very dependent persons with special needs and establish procedures for determining the special needs rate exception payments for training and habilitation services and for intermediate care facilities for the mentally retarded. Parts 9510.1020 to 9510.1140 do not apply to persons with mental retardation or related conditions who reside in a regional treatment center.

Subp. 2. **Purpose.** The purpose of the special needs rate exception is to provide to a specific client those staff interventions or equipment whose costs are not included in the per diem rate of the intermediate care facility for the mentally retarded or the per diem rate of the training and habilitation service. The special needs rate exception payment is intended to fund short-term special needs for a specific client in order to prevent the placement or retention of the client in a regional treatment center. The special needs rate exception is only to be allowed after all other funding sources or alternatives have been exhausted.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 12 SR 1148; 14 SR 2354*

9510.1040 APPLICATION TO BE COMPLETED BY PROVIDER.

Subpart 1. **Application.** The provider shall apply to the county for a special needs rate exception to cover the cost of a staff intervention or piece of equipment necessary to serve clients eligible under part 9510.1050, subpart 2. A separate application must be completed for each client unless the staff intervention or equipment is shared by the clients identified. If more than one client is included in the application, client information must be submitted for each client. The application must include the information in subparts 2 to 4.

Subp. 2. **Information about client's needs and methods used to address needs.** The provider shall:

A. identify the client including:

(1) name;

(2) name and address of the client's legal representative;

(3) medical assistance identification number;

(4) date of admission or anticipated admission to the provider's program;

(5) diagnosis;

(6) age;

(7) current residence; and

(8) current day program;

B. describe the client's special need or needs which put the client at risk of regional treatment center placement or continued regional treatment center placement;

C. describe the proposed staff intervention including:

(1) the amount of staff or consultant time required;

(2) qualifications of the program staff or outside consultants providing the intervention;

(3) type of intervention;

(4) frequency of intervention;

(5) intensity of intervention; and

(6) duration of intervention;

D. describe the equipment needed and the plan for use of the equipment by the client;

E. identify the total cost and the unit cost of the equipment or the staff intervention;

F. describe the modifications needed to integrate the equipment and staff intervention into the client's individual program plan;

G. describe the projected behavioral outcomes of the staff intervention or the use of the equipment and when the outcomes will be achieved;

H. describe how the client's progress toward the behavioral outcomes in item G will be measured and monitored by the provider; and

I. describe the degree of family involvement with the client.

Subp. 3. **Information about provider.** The provider shall submit:

A. information identifying the provider including:

(1) name and address of the provider;

(2) name and address of the place where the staff intervention and equipment will be delivered, if different from subitem (1);

(3) name and telephone number of the person authorized to answer questions about the application; and

(4) medical assistance provider number; and

B. and explanation of the efforts used to meet the client's needs within the provider's current per diem rate, including:

(1) modifications made to the individual program plan;

(2) reallocation of current program personnel;

(3) training and in-service provided to program personnel for the year immediately preceding the date of the provider's application to the county; and

(4) other available resources used.

Subp. 4. **Supporting documentation.** The provider shall submit with the application the following:

A. A copy of the individual program plan including the measurable behavioral outcomes which are anticipated to be achieved by the client as a result of the proposed staff intervention or the equipment.

B. Documentation of the provider's historical costs on which the current per diem rate is based. An ICF/MR provider shall submit a copy of the most recent rate determination letter. A training and habilitation service program shall submit a copy of its current budget, year-to-date expenses, and current assets.

C. Work papers showing the method used to determine the cost of the staff intervention and equipment identified in subpart 2, item E, including the hourly wage of staff who will implement the intervention, the unit cost of consultation or training services, and the unit cost of equipment requested.

D. Documentation that any equipment requested in the application is not available from the Department of Vocational Rehabilitation or covered under parts 9505.0170 to 9505.0475.

E. Documentation that any consultant services requested in the application are not services covered under parts 9505.0170 to 9505.0475.

F. The name and address of any vendor or contractor to be reimbursed by the special needs rate exception and the name of the person or persons who will actually provide the equipment or services if known.

G. A plan to decrease the client's reliance on the proposed staff intervention.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 14 SR 2354*

9510.1050 COUNTY REVIEW OF PROVIDER'S APPLICATION.

Subpart 1. **Criteria.** The county shall determine if the provider submitting the application and the client or clients identified in the application meet the criteria in subparts 2 to 5. The county shall submit to the commissioner the applications which meet the criteria in subparts 2 to 5.

Subp. 2. **Client eligibility.** A client shall be eligible for a special needs rate exception if the client meets the criteria in items A to D:

A. the client is eligible for medical assistance under Minnesota Statutes, chapter 256B;

B. the client is a resident of an ICF/MR;

C. the client is a person as defined in part 9525.0004, subpart 19, and has at least one of the following characteristics:

(1) severe maladaptive behavior as listed in unit (a), (b), or (c);

(a) self-injurious behavior which is a clear danger to the client such as ingesting inedibles; removing major items of clothing; striking, biting, or scratching self; moving into dangerous situations which clearly threaten or endanger the client's life, sensory abilities, limb mobility, brain functioning, physical appearance, or other major physical functions; or

(b) aggressive behaviors which are a clear danger to others such as striking, scratching, or biting others; throwing heavy objects at others; attempting inappropriate sexual activity with others; or pushing or placing others into dangerous situations which clearly threaten or endanger their life, sensory abilities, limb mobility, brain functioning, sexual integrity, physical appearance, or other major physical functions; or

(c) destructive behaviors which result in extensive property damage;

(2) severe physical disabilities such as deafness, blindness, or motor problems which require short-term environmental orientation training;

(3) medical conditions as listed in unit (a) or (b);

(a) degenerative diseases diagnosed by a physician as terminal; or

(b) short-term medical disabilities that can be treated within the level of care the Minnesota Department of Health certifies the ICF/MR to provide, such as temporary immobility, intermittent catheterization, or postoperative recuperation;

D. the client is at risk of placement in a regional treatment center within 60 days or of remaining in a regional treatment center, unless additional resources are provided through parts 9510.1020 to 9510.1140 due to:

(1) conditions and characteristics described in item C; and

(2) the unavailability of other resources as determined under subpart 4.

Subp. 3. **General provider eligibility.** A provider shall be eligible for a special needs rate exception if the provider meets the following criteria:

A. The existing program or services offered by the provider cannot be modified to meet the client's needs within the provider's approved per diem rates.

B. The provider's historical cost per diem does not include the historical cost of providing the same or similar clients with the same or similar staff interventions.

C. The provider is willing to serve or continue to serve a client who is eligible for a special needs rate under subpart 2 if the special needs rate exception is approved.

Subp. 4. **Availability of other resources.** The provider shall be eligible for a special needs rate exception only if the county determines that:

A. There are no other existing resources or services covered under parts 9505.0170 to 9505.0475 available to meet the client's needs.

B. There are no other appropriate ICFs/MR, training and habilitation services, or other services located within a reasonable distance available to meet the person's needs within their current rates. To determine if another ICF/MR, training and habilitation service, or other service is appropriate for the client, the case manager shall:

(1) Consider the placement preferences of the client and family of the client. If the client cannot communicate a preference, the client's legal representative must be consulted.

(2) Consider whether the location of the alternative ICF/MR training and habilitation service or other service will impair the current level of family involvement.

(3) Consider the length of time that the client will need the additional services.

Subp. 5. **Evaluation of staff intervention and equipment purchases.** The county shall review the information submitted in accordance with part 9510.1040 to determine if:

A. the proposed staff intervention and equipment are allowable for purposes of reimbursement under parts 9510.1020 to 9510.1140;

B. all proposed services and service providers comply with applicable professional and program licensure standards;

C. the proposed staff intervention and equipment purchases meet the identified client needs; and

D. the provider has included a plan to decrease the client's reliance on the proposed staff intervention which shall ensure integration of the client into the existing program when the special needs rate exception terminates.

Statutory Authority: *MS s 252.46; 256B.092; 256B.501*

History: *10 SR 922; 12 SR 1148; 14 SR 2354; 18 SR 2244*

9510.1060 COUNTY APPROVAL PROCESS.

Subpart 1. **Time period.** The county shall approve or deny applications within ten working days of the date the complete application was received from the provider. Approval or denial shall be made in accordance with subparts 2 to 4.

Subp. 2. **Consultation with county of financial responsibility.** If the county which receives the provider's application is not the county of financial responsibility, the county which receives the provider's application shall consult with the county of financial responsibility before approving the provider's application. The county of financial responsibility's statement of approval or objections must be forwarded to the commissioner with the provider's approved application or notice of denial. If the county of financial responsibility's statement of approval or objections are not forwarded to the commissioner, the county's application shall not be considered complete.

Subp. 3. **County approval or denial.** The county shall review the provider's application to determine if the application is complete and meets the criteria in 9510.1020 to 9510.1140. The county shall approve the provider's application if the application is complete and meets the criteria. The county shall deny the provider's application if the application is incomplete or does not meet the criteria unless the provider's application can be adjusted to meet the criteria or the county submits a written request for a variance under part 9510.1100.

Subp. 4. **Notification.** The county shall send the provider and the client written notice of the county's decision on the provider's application as soon as a decision is made or within ten working days after receipt of the application, whichever occurs first. If the county denies the provider's application, the county shall notify the commission-

er, provider, client, and the client's legal representative of the reasons for the denial in writing. The notice of the denial must state the specific provisions of the provider's application on which the county based the denial.

Statutory Authority: *MS s 256B.501*

History: *10 SR 922*

9510.1070 COUNTY'S APPLICATION TO COMMISSIONER.

If the county approves the provider's application, the county shall apply to the commissioner for a special needs rate exception within ten working days of the date of receipt by the county from the provider of a complete application and supporting documentation. To apply for a special needs rate exception, the county shall submit to the commissioner a copy of the provider's approved application and supporting documentation and the following documents:

A. documentation of the steps taken by the county to determine client and provider eligibility in accordance with parts 9510.1020 to 9510.1140, including documentation of the conditions which put the client at risk of regional treatment center placement or continued regional treatment center placement;

B. a copy of the client's current individual service plan which explains the need to place or retain the eligible client in a regional treatment center if the requested services cannot be provided and the sections of the individual program plans which include the methodology and measurable outcomes of the proposed intervention;

C. a copy of the client's most recent medical evaluation signed by a physician;

D. a copy of the client's regional treatment center discharge plan, if the special needs rate exception is requested to facilitate the client's discharge from a regional treatment center;

E. a copy of the county's plan to coordinate and monitor the implementation of the proposed staff intervention described in the application submitted according to part 9510.1040;

F. a letter from the county of financial responsibility stating approval of the changes in the individual service plan if the county submitting the application is not the county of financial responsibility; or if the county of financial responsibility does not approve the changes, a letter stating the reasons the county of financial responsibility does not approve the changes and describing the actions, if any, to be taken by the county of financial responsibility; and

G. if the special needs rate exception is not requested for both the day training and habilitation service and the ICF/MR, a written explanation must be provided by the county.

Statutory Authority: *MS s 252.46; 256B.092; 256B.501*

History: *10 SR 922; 14 SR 2354; 18 SR 2244*

9510.1080 COMMISSIONER'S DETERMINATION.

The commissioner shall review the county application to determine if the requirements in parts 9510.1020 to 9510.1140 are satisfied in determining whether to approve or deny an application for a special needs rate exception. The commissioner shall notify the county, provider, the client, and the client's legal representative of the decision within ten working days of the date the commissioner receives a completed application from the county. The special needs rate exception, if approved by the commissioner, must be effective as of the date the county submits a completed application to the commissioner. If the commissioner denies the application, the commissioner shall notify the county, provider, and client or client's representative in writing of the reasons for the denial.

Statutory Authority: *MS s 256B.501*

History: *10 SR 922*

9510.1090 ESTABLISHING SPECIAL NEEDS RATE EXCEPTION PAYMENT.

Subpart 1. **Established by commissioner.** The commissioner shall establish the special needs rate exception payment according to subparts 2 to 5.

Subp. 2. **Allowable costs.** Unless otherwise reimbursable by the Department of Vocational Rehabilitation or by direct payments under parts 9505.0170 to 9505.0475, the following costs, if approved by the commissioner in accordance with parts 9510.1020 to 9510.1140 and 9553.0010 to 9553.0080, are allowable for purposes of establishing the special needs rate exception payment:

A. additional salary, employee benefits, and payroll-related costs for direct care staff required to meet the client's needs as identified in the provider's application;

B. additional costs of services provided by a licensed medical, therapeutic, or rehabilitation practitioner; a mental health practitioner supervised by a board-certified psychiatrist; or a licensed psychologist or licensed consulting psychologist;

C. the costs of equipment required to meet the client's needs as identified in the provider's application.

Subp. 3. **Nonallowable costs.** Only costs listed in subpart 2 are allowable for purposes of establishing the special needs rate exception. All other costs shall be disallowed.

Subp. 4. **Limitation.** The combined per diem costs of training and habilitation services, ICF/MR services, and the special needs rate exception payment and any other special needs rate exception payments in effect for the same client, shall not exceed the medical assistance per diem cost of providing services to persons with mental retardation or related conditions in regional treatment centers. For the purpose of determining this limitation, items A to F apply.

A. The training and habilitation services per diem in effect on the date the provider's completed application is submitted to the county must be multiplied by the number of days the services are provided annually.

B. The ICF/MR's temporary or final payment rate in effect on the date the provider's completed application is submitted to the county must be multiplied by 365.

C. The special needs rate exception amount must not exceed the total of the costs allowable under subpart 2. If a special needs rate exception is necessary for a client in both the ICF/MR and the training and habilitation service program, the amounts of both special needs rate exceptions must be combined. If the client is currently receiving a special needs rate exception, that amount must also be included.

D. The amounts determined in items A to C must be combined and divided by 365 to determine the combined per diem cost.

E. The regional treatment center medical assistance per diem rate must be the rate in effect on the date the provider's completed application is submitted to the county.

F. If the per diem cost in item D exceeds the per diem cost in item E, the commissioner shall deny the special needs rate exception application unless the per diem cost can be adjusted to meet the client's needs within the per diem cost in item E or the commissioner grants a variance under part 9510.1100.

Subp. 5. **Computation of special needs rate exception payment.** The special needs rate exception payment must be calculated as follows:

A. The cost of additional equipment allowed in accordance with subpart 2, item C shall be paid as a lump sum payment during the first billing period following approval of the special needs rate exception.

B. Except as provided in item C, in order to compute the special needs rate exception payment for personnel costs, the costs of additional personnel allowable according to subpart 2, items A and B, must be divided by the estimated number of days the staff intervention will be needed.

C. In order to compute the special needs rate exception payment for personnel costs which vary during the estimated staff intervention period, the costs

must be assigned on a monthly basis proportionate to the actual personnel costs incurred and then divided by the number of client days in the month.

D. Costs computed under items B and C shall be reimbursed as incurred and billed.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 12 SR 1148; 14 SR 2354*

9510.1100 VARIANCE REQUEST.

Subpart 1. **Variance request.** The county may request a variance from the commissioner to approve a provider application which exceeds the limit in part 9510.1090, subpart 4 by up to 15 percent, if the provider meets the criteria in subpart 2.

Subp. 2. **Eligible provider.** A licensed provider of training and habilitation services may apply for a variance if the provider is not an ICF/MR and provides or plans to provide training and habilitation services to a client who resides in an ICF/MR which has a per diem rate equal to or greater than 85 percent of the medical assistance per diem cost of providing services to persons with mental retardation or related conditions in the regional treatment centers.

Subp. 3. **Submittal of request.** The county shall submit the written variance request, including documentation showing that the provider meets the criteria for a variance, with the county's application for the special needs rate exception payment.

Subp. 4. **Review of variance request; notification.** The commissioner shall review the variance request with the county's application for the special needs rate exception payment. If the county's application meets all of the requirements in parts 9510.1020 to 9510.1140 except the limitation in part 9510.1090 subpart 4 and the provider is eligible to apply for a variance under subpart 2, the commissioner shall approve the request. If the commissioner denies the variance request, the commissioner shall notify the county, provider, client, and the client's legal representative within ten days of receipt of the variance request of the reasons for the denial.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 12 SR 1148; 14 SR 2354*

9510.1110 EMERGENCY PROCEDURE.

Subpart 1. **Definition.** For the purposes of this part, an emergency is either:

A. a postoperative condition resulting from unplanned surgery or unanticipated complications resulting from planned surgery which would result in continued placement in a hospital or skilled nursing facility, loss of placement in a community ICF/MR, and admission to a regional treatment center within 60 days; or

B. the sudden onset of self-injurious or aggressive client behavior which results in an immediate danger to self or others; which would result in immediate admission to the regional treatment center in the absence of intervention.

Subp. 2. **Emergency approval.** In an emergency, the county may approve the addition of staff, consultation, or staff training necessary to intervene in the emergency without obtaining prior approval of a special needs rate exception from the commissioner if the county determines that all other client and provider eligibility is met. Only costs meeting the definitions under part 9510.1090, subpart 2, items A and B, shall be allowed under this part. No funds spent will be reimbursed, even in an emergency, without the county's approval. In an emergency, the county shall:

A. notify the commissioner by telephone no later than the next working day and in writing within three working days of the client's situation, and state in the notice a description of the behaviors or medical condition requiring emergency intervention and the actions taken by the provider to control the behaviors, and expenditures authorized by the case manager; and

B. complete and submit, according to parts 9510.1020 to 9510.1140, an application for a special needs rate exception for the emergency period and for any

additional period, within 30 days of the date the county notified the commissioner of the emergency.

Subp. 3. **Reimbursement for emergency services.** A special needs rate exception for the costs identified in part 9510.1090, subpart 2, item A or B, approved in accordance with subpart 2 shall be reimbursable for a period not to exceed 30 days from the date the county notifies the commissioner of the emergency. No payment shall be authorized by the commissioner for services provided during an emergency until an application is submitted to the commissioner by the county delineating actual costs of the intervention. The total amount authorized for payment by the commissioner is subject to the per diem limitations under part 9510.1090, subpart 4.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 14 SR 2354*

9510.1120 DURATION OF SPECIAL NEEDS RATE EXCEPTION.

Subpart 1. **Maximum length of time for a special needs rate exception.** A special needs rate exception for a staff intervention must be limited to one approval per eligible client for a period of time not to exceed one year from the date of receipt of the county application by the commissioner except as provided in subpart 2.

Subp. 2. **Renewals.** If the county determines that a special needs rate exception should be continued after the period initially approved, the county shall submit a new application in accordance with parts 9510.1020 to 9510.1140 at least 30 days prior to the date the special needs rate exception is scheduled to terminate. The county application for a renewal must contain a program and fiscal evaluation demonstrating the effectiveness of the initial special needs rate exception. A special needs rate exception for a staff intervention must be limited to two renewals, each of one year or less, per identified special need.

Subp. 3. **Terminations.** The commissioner may terminate the special needs rate exception prior to the date stated in the application upon recommendation by the county. The county may recommend termination if:

A. the rate is no longer necessary because other funds are available;

B. the rate is no longer necessary because a more appropriate residential or day training and habilitation placement is available;

C. there is evidence that the funds have not been used for the purposes stated in the application;

D. the client's needs have changed and can be met without the special needs rate exception; or

E. no progress has been made in rectifying the identified problem area. This item shall not apply to services provided to clients with degenerative diseases if the criteria in subitems (1) to (4) are met:

(1) the service is required due to the degenerative disease;

(2) the client's physician has determined that no progress in the identified problem area can be expected;

(3) the county submitted the determination by the client's physician to the commissioner with the first quarterly program and fiscal review under part 9510.1130, subpart 2 and requested an exception to this item; and

(4) the county's request for an exception to this item has been reviewed by the state medical review team of the Department of Human Services and the state medical review team has verified that no progress in the identified problem area can be expected.

The commissioner shall notify the county and the provider 15 days before discontinuing payments due to termination.

Statutory Authority: *MS s 256B.501*

History: *10 SR 922*

9510.1130 RECORDS, REPORTS, AUDITS, AND REPAYMENT.

Subpart 1. **Records.** The provider shall maintain complete program and fiscal records and supporting documentation identifying the services and costs provided under the special needs rate exception. The costs must be maintained in well-organized files and identified in accounts separate from other facility or program costs. Costs authorized and approved under these parts do not become part of a provider's historic cost base for the purpose of setting rates under parts 9553.0010 to 9553.0080 or Minnesota Statutes, section 252.46. The provider's records shall be kept for five years and be subject to the maintenance schedule, audit availability requirements, and other provisions of parts 9505.2160 to 9505.2245.

Subp. 2. **Reports.** The county shall submit items A and B to the commissioner.

A. A quarterly program and fiscal review of the overall effectiveness of the services to be provided under the special needs allowance unless the commissioner determines that a different schedule of reviews is needed to evaluate the success of the program or redetermine the special needs rate exception payment. The review must be submitted no more than 30 days after the end of each quarter in which a special needs rate exception is in place and must include:

(1) the provider's compliance with the application;

(2) the client's progress in attaining the measurable behavioral outcomes in the individual program plan for which the special needs rate exception was requested;

(3) the county and provider's plans to reduce reliance on the special needs rate exception; and

(4) changes implemented in the type, frequency, or intensity of the staff intervention approved under parts 9510.1080 and 9510.1090.

B. A final report submitted within 90 days of termination of a special needs rate exception which documents the following:

(1) the extent to which the program goals identified in the special needs rate exception application were accomplished;

(2) the total amount of money paid to the provider through the special needs rate exception payment for equipment and actual costs and types of equipment purchased;

(3) the amount of expenditures incurred by the provider for costs allowable under part 9510.1090, subpart 2; and

(4) the total amount of unexpended funds determined by subtracting subitem (3) from subitem (2).

Subp. 3. **Audits.** The commissioner may conduct program and fiscal audits of any provider receiving a special needs rate exception to identify any overpayments made to the provider and ensure compliance with parts 9510.1020 to 9510.1140.

Subp. 4. **Repayment.** Any overpayments to the provider included in the special needs rate exception payment must be paid back to the medical assistance program within 60 days of the date the provider receives the notice of overpayment from the county or the commissioner. No retroactive payment must be made if the provider's costs exceed the special needs rate exception payment.

Statutory Authority: *MS s 252.46; 256B.501*

History: *10 SR 922; 14 SR 2354*

9510.1140 APPEALS.

Subpart 1. **By provider.** A provider whose application for a special needs rate exception is denied or not acted on within the deadlines in part 9510.1060, subpart 1, or whose special needs rate exception is suspended, reduced, or terminated by the county may appeal the action or decision to the commissioner. The appeal must be submitted to the commissioner in writing within 30 days of the date the provider

received notification or should have received notification of the action or decision. The appeal must state the reasons the provider is appealing the county's action or decision including the bases for the county's action or decision which are disputed, the specific sections of the provider's application which the provider is relying on for the appeal, and an explanation of why the provider disagrees with the county's action or decision.

The commissioner shall review the application and supporting documentation submitted to the county and any additional documents submitted with the appeal to determine if the provider can prove by a preponderance of evidence that it is eligible for a special needs rate exception and in compliance with parts 9510.1020 to 9510.1140. Within 30 days of receipt of the provider's appeal, the commissioner shall notify the provider of the commissioner's decision. No special needs rate exception payment will be made pending the outcome of the appeal.

Subp. 2. **By county.** If the county disagrees with the commissioner's decision on the county application, the county may appeal the decision to the commissioner and request reconsideration. To be reconsidered, the appeal must be filed in writing, with the commissioner, within ten days of the date the commissioner gave notice to the county of the decision on the county application. The appeal must state the reasons why the county is appealing the commissioner's decision and present evidence explaining why the county disagrees with the commissioner's decision. Within 30 days of receipt of the county's appeal, the commissioner shall review the evidence presented in the county's appeal and send written notification to the county of the commissioner's decision on the appeal. No special needs rate exception payment shall be made pending the outcome of the appeal. The commissioner's decision on the appeal shall be final.

Statutory Authority: *MS s 256B.501*

History: *10 SR 922*

MEDICAL CARE SURCHARGE

9510.2000 PURPOSE AND SCOPE.

Subpart 1. **Purpose.** The purpose of parts 9510.2000 to 9510.2050 is to govern the administration of the medical care surcharge under Minnesota Statutes, section 256.9657.

Subp. 2. **Scope.** Parts 9510.2000 to 9510.2050 apply to nursing homes, Minnesota hospitals, and HMOs operating on or after October 1, 1992.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860*

9510.2010 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9510.2000 to 9510.2050, the following terms have the meanings given them in this part.

Subp. 2. **Appeal.** "Appeal" means a written request made to the commissioner by a nursing home, Minnesota hospital, or HMO for a contested case hearing under Minnesota Statutes, chapter 14, regarding the amount of the medical care surcharge.

Subp. 3. **Closed or closing.** "Closed" or "closing" means the facility has suspended the practice of providing inpatient hospital services, has suspended the practice of providing outpatient services, has suspended operation as a nursing home, or is in the process of suspending services under a plan of closure approved by the department.

Subp. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subp. 5. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 6. **Federal Indian Health Service facility.** "Federal Indian Health Service facility" means a facility of the Indian Health Service, including a hospital, nursing facility, or other type of facility that provides services or a type of service otherwise

covered under the state's medical assistance program, whether operated by the federal Indian Health Service or by an Indian tribe or tribal organization.

Subp. 7. **Health maintenance organization or HMO.** "Health maintenance organization" or "HMO" means a health maintenance organization licensed and operating under Minnesota Statutes, chapter 62D.

Subp. 8. **Hospital.** "Hospital" has the meaning given in part 9505.0175, subpart 16, but does not include federal Indian Health Service facilities and regional treatment centers.

Subp. 9. **Medical care surcharge.** "Medical care surcharge" means the amount of tax to be paid by a nursing home, Minnesota hospital, or HMO under Minnesota Statutes, section 256.9657.

Subp. 10. **Minnesota hospital.** "Minnesota hospital" means a hospital located in Minnesota.

Subp. 11. **Nursing home.** "Nursing home" means a facility as defined in Minnesota Statutes, section 144A.01, subdivision 5, and licensed under Minnesota Statutes, chapter 144A.

Subp. 12. **Regional treatment center.** "Regional treatment center" means a "state facility" as defined in Minnesota Statutes, section 246.50, subdivision 3.

Subp. 13. **Settle-up.** "Settle-up" means to reduce an amount subsequently owed or to make a payment after resolution of an appeal under part 9510.2040 between a nursing home, Minnesota hospital, or HMO and the department in order to settle the difference between the medical care surcharge paid and the medical care surcharge owed.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860*

9510.2020 MEDICAL CARE SURCHARGE.

Subpart 1. **Nursing homes.** Effective October 1, 1992, and each July 1 after, an annual medical care surcharge of $535 is levied upon each nursing home bed licensed by the Minnesota Department of Health in nonstate operated nursing homes. Each nonstate operated nursing home must pay the surcharge for those beds licensed in its nursing home as of July 1 of each year, except that if the number of licensed beds is reduced after July 1, but prior to August 1, the surcharge shall be based on the number of remaining licensed beds. A nursing home entitled to a reduction in the number of beds subject to the surcharge under this provision must demonstrate to the satisfaction of the commissioner by August 5 that the number of beds has been reduced. Payments are due in equal monthly installments on the 15th day of each month beginning November 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12. The November 15, 1992, payment shall be based on the number of licensed nursing home beds in the nursing home on July 1, 1992. Beginning July 1, 1993, the surcharge will be based on the number of licensed beds in the nursing home on July 1, 1993, and will change yearly on July 1 based on the then existing number of licensed nursing home beds in that nursing home.

Subp. 2. **Minnesota hospitals.** Effective October 1, 1992, each Minnesota hospital must pay an annual medical care surcharge equal to 1.4 percent of that hospital's net patient revenue, excluding that hospital's net Medicare revenues, as reported to the health care cost information system for the fiscal year two years before the fiscal year ending June 30. This surcharge shall be paid in monthly installments due the 15th of the month, beginning October 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12.

For the purpose of this subpart, the definitions in items A to D apply.

A. "Fiscal year" has the meaning given in part 4650.0102, subpart 19.

B. "Health care cost information system" means the reporting system as defined by parts 4650.0102 to 4650.0174.

C. "Net Medicare revenue" means any patient revenue attributable to the Social Security Act, title XVIII.

D. "Net patient revenue" has the meaning given "revenue" in part 4650.0102, subpart 36.

Subp. 3. **Health maintenance organizations.** Health maintenance organizations must pay an annual medical care surcharge equal to six-tenths of one percent of the total premium revenues of that health maintenance organization as reported to the commissioner of the Department of Health for the fiscal year two years before the fiscal year ending June 30. This surcharge shall be paid in monthly installments due the 15th day of the month, beginning October 15, 1992. The monthly payment must be equal to the annual surcharge divided by 12.

For the purposes of this subpart, "total premium revenues" mean:

A. premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time, normally one month; and

B. premiums from Medicare wrap-around subscribers for health benefits which supplement Medicare coverage.

If advance payments are made under item A or B to the HMO for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

Subp. 4. **Installment due date, acceptable postmark.** An installment payment postmarked on or before the 12th of a month satisfies the due date requirement for the 15th day of the month.

Subp. 5. **Closed or closing nursing homes and hospitals.** The medical care surcharge as amended in 1992 does not apply to Minnesota hospitals or nursing homes closed before October 1, 1992.

Nursing homes that close or are in the process of closing after October 1, 1992, are subject to the medical care surcharge for each month after October 1, 1992, in which the home operates and maintains licensed beds.

Minnesota hospitals that close or are in the process of closing after October 1, 1992, are subject to the medical care surcharge until the first month after the hospital is completely closed.

Subp. 6. **Nursing homes and hospitals that change ownership or enter into receivership.** The medical care surcharge continues for nursing homes and Minnesota hospitals that change ownership or enter into receivership.

Subp. 7. **HMOs that cease operation.** HMOs that cease operation after October 1, 1992, are subject to the medical care surcharge until the first month after the HMO completely ceases operation. The medical care surcharge continues for HMOs that merge as long as any of the certificates of authority of the merging HMOs remain in force. If the certificate of authority for a merging HMO no longer remains in force, the medical care surcharge for that HMO will be discontinued.

Subp. 8. **Nursing homes, Minnesota hospitals, and HMOs that begin operations after October 1, 1992.** Nursing homes, Minnesota hospitals, and HMOs that begin operations after October 1, 1992, are subject to the medical care surcharge under item A, B, or C.

A. The medical care surcharge will apply to a nursing home that begins operation after October 1, 1992, effective on July 1 immediately after the home becomes licensed. The nursing home shall be billed beginning on August 15 for the period of July 1 through July 31.

B. The surcharge for Minnesota hospitals begins the month immediately after the date when data has been reported to the health care cost information system for the fiscal year two years before the year of surcharge.

C. The surcharge for health maintenance organizations begins the month immediately after the date when data have been reported to the commissioner of health for the fiscal year two years before the year of surcharge.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860; 19 SR 1419*

9510.2030 NOTIFICATION OF SURCHARGE AMOUNT.

The commissioner must give written notice to a nursing home, Minnesota hospital, or HMO of the medical care surcharge amount owed at least 30 days before the date each payment is due. Notwithstanding the requirement that the monthly installments under part 9510.2020, subparts 1, 2, and 3, are due on the 15th day of the month, if written notice from the commissioner under this part is not received at least 30 days prior to the 15th, the due date of the monthly installment will be extended to 30 days from the day the notice is actually received by the nursing home, hospital, or HMO.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860*

9510.2040 SURCHARGE APPEALS.

Subpart 1. **When allowed.** A nursing home, Minnesota hospital, or HMO may appeal the amount of each medical care surcharge payment assessed under Minnesota Statutes, section 256.9657.

Subp. 2. **Criteria.** To be effective, an appeal must meet the criteria in items A and B.

A. The nursing home, Minnesota hospital, or HMO must appeal to the commissioner in writing. The appeal must be received by the commissioner no later than 30 days after the nursing home, Minnesota hospital, or HMO receives notice of the medical care surcharge amount. Unless the nursing home, Minnesota hospital, or HMO can establish a different date of receipt, the commissioner shall determine the date of receipt of the notice of the medical care surcharge amount to be three days after the notice was mailed by the commissioner, excluding Sundays and holidays.

B. The appeal must specify:

(1) the basis for the dispute;

(2) the computation and the amount the appealing party believes to be correct;

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

(4) a statement under oath indicating the date on which the payment notice was received by the appealing party.

Subp. 3. **Resolution.** The commissioner and the appealing party may attempt to resolve the appeal informally. If the dispute is not resolved informally between the commissioner and the party filing the appeal under subpart 2, item A, the appeal will be heard according to the contested case provisions in Minnesota Statutes, chapter 14, and the rules of the Office of Administrative Hearings. Upon agreement of both parties, the dispute may be resolved informally through any modified appeal procedures established by agreement between the commissioner and the chief administrative law judge.

Subp. 4. **Surcharge payment during appeal.** The monthly medical care surcharge amounts established by the commissioner before an appeal must be paid by the dates due while an appeal is pending.

Subp. 5. **Resolution of appeal.** If an appeal results in a determination that payment is due the appealing party, the commissioner shall settle-up with the appellant after the exhaustion of the appeal process. For purposes of this subpart, "exhaustion of the appeal process" means within 45 days of the date of the final decision of the court of appeals or the Minnesota Supreme Court if such a judicial review is sought. If no

judicial review is sought, "exhaustion of the appeal process" means within 45 days of the date of the final decision of the commissioner.

Subp. 6. **Monthly appeals.** An appeal must be filed for each month's disputed medical care surcharge amount due. The appeals may be consolidated in a contested case hearing under Minnesota Statutes, chapter 14. The medical care surcharge amount shall not be adjusted for any month for which an appeal was not filed.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860*

9510.2050 ENFORCEMENT.

According to Minnesota Statutes, section 256.9657, subdivision 7, the commissioner shall impose civil penalties and interest on medical care surcharge payments that are more than 30 days overdue.

A three percent penalty is assessed the first day past due, and each 30 days after that, up to 24 percent in the aggregate. Interest will be calculated based on the following formula: tax balance multiplied by interest rate multiplied by length of time. The rate of interest is determined according to Minnesota Statutes, section 270.75.

The medical care surcharge notice shall include the tax amount and due date, plus any penalty and interest if not paid by the due date.

Statutory Authority: *MS s 256.9657; 256B.74*

History: *17 SR 2860*