CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

256B.02 DEFINITIONS.

[For text of subd 1, see M.S.1982]

Subd. 2. "Excluded time" means any period of time an applicant spends in a hospital, sanatorium, nursing home, boarding home, shelter, halfway house, foster home, semi-independent living domicile, residential facility offering care, board and lodging facility offering 24-hour care or supervision of mentally ill, mentally retarded, or physically disabled persons, or other institution for the hospitalization or care of human beings, as defined in sections 144.50, 144A.01, or 245.782, subdivision 6.

Subd. 3. "County of financial responsibility" means:

(a) for an applicant who resides in the state and is not in a facility described in subdivision 2, the county in which he or she resides at the time of application;

(b) for an applicant who resides in a facility described in subdivision 2, the county in which he or she resided immediately before entering the facility; and

(c) for an applicant who has not resided in this state for any time other than the excluded time, the county in which the applicant resides at the time of making application.

Notwithstanding clauses (a) to (c), the county of financial responsibility for medical assistance recipients is the same county as that from which a recipient is receiving a maintenance grant or money payment under the program of aid to families with dependent children. There can be a redetermination of the county of financial responsibility for former recipients of the medical assistance program who have been ineligible for at least one month, so long as that redetermination is in accord with the provisions of this subdivision.

[For text of subds 4 to 7, see M.S.1982]

Subd. 8. **Medical assistance; medical care.** "Medical assistance" or "medical care" means payment of part or all of the cost of the following care and services for eligible individuals whose income and resources are insufficient to meet all of this cost:

(1) Inpatient hospital services. A second medical opinion is required prior to reimbursement for elective surgeries. The commissioner shall publish in the State

Register a proposed list of elective surgeries that require a second medical opinion prior to reimbursement. The list is not subject to the requirements of sections 14.01 to 14.70. The commissioner's decision whether a second medical opinion is required, made in accordance with rules governing that decision, is not subject to administrative appeal;

(2) Skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 256B.50, subdivision 1, for mentally retarded individuals residing in intermediate care facilities for the mentally retarded;

(3) Physicians' services;

(4) Outpatient hospital or nonprofit community health clinic services or physician-directed clinic services. The physician-directed clinic staff shall include at least two physicians, one of whom is on the premises whenever the clinic is open, and all services shall be provided under the direct supervision of the physician who is on the premises. Hospital outpatient departments are subject to the same limitations and reimbursements as other enrolled vendors for all services, except initial triage, emergency services, and services not provided or immediately available in clinics, physicians' offices, or by other enrolled providers. "Emergency services" means those medical services required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death or are necessary to alleviate severe pain. Neither the hospital, its employees, nor any physician or dentist, shall be liable in any action arising out of a determination not to render emergency services or care if reasonable care is exercised in determining the condition of the person, or in determining the appropriateness of the facilities, or the qualifications and availability of personnel to render these services consistent with this section;

(5) Community mental health center services, as defined in rules adopted by the commissioner pursuant to section 256B.04, subdivision 2, and provided by a community mental health center as defined in section 245.62, subdivision 2;

(6) Home health care services;

(7) Private duty nursing services;

(8) Physical therapy and related services;

(9) Dental services, excluding cast metal restorations;

(10) Laboratory and xray services;

(11) The following if prescribed by a licensed practitioner: drugs, eyeglasses, dentures, and prosthetic devices. The commissioner shall designate a formulary committee which shall advise the commissioner on the names of drugs for which payment shall be made, recommend a system for reimbursing providers on a set fee or charge basis rather than the present system, and develop methods encouraging use of generic drugs when they are less expensive and equally effective as trademark drugs. The commissioner shall appoint the formulary committee members no later than 30 days following July 1, 1981. The formulary committee shall consist of nine members, four of whom shall be physicians who are not employed by the department of public welfare, 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 public welfare, and a majority of whose practice is for persons paying privately or through health insurance, a consumer representative, and a nursing home representative. Committee members shall serve two year terms and shall serve without compensation. The commissioner may establish a drug formulary. Its establishment and publica-

tion shall not be subject to the requirements of the Administrative Procedure Act, but the formulary committee shall review and comment on the formulary contents. Prior authorization may be required by the commissioner, with the consent of the drug formulary committee, before certain formulary drugs are eligible for payment. The formulary shall not include: drugs or products for which there is no federal funding; over the counter drugs, except for antacids, acetaminophen, family planning products, aspirin, insulin, prenatal vitamins, and vitamins for children under the age of seven; or any other over the counter drug identified by the commissioner, in consultation with the appropriate professional consultants under contract with or employed by the state agency, as necessary, appropriate and cost effective for the treatment of certain specified chronic diseases, conditions or disorders, and this determination shall not be subject to the requirements of chapter 14, the Administrative Procedure Act; nutritional products, except for those products needed for treatment of phenylketonuria, hyperlysinemia, maple syrup urine disease, a combined allergy to human milk, cow milk, and soy formula, or any other childhood or adult diseases, conditions, or disorders identified by the commissioner as requiring a similarly necessary nutritional product; anorectics; and drugs for which medical value has not been established. Separate payment shall not be made for nutritional products for residents of long-term care facilities; payment for dietary requirements is a component of the per diem rate paid to these facilities. Payment to drug vendors shall not be modified before the formulary is established except that the commissioner shall not permit payment for any drugs which may not by law be included in the formulary, and his determination shall not be subject to chapter 14, the Administrative Procedure Act. The commissioner shall publish conditions for prohibiting payment for specific drugs after considering the formulary committee's recommendations.

The basis for determining the amount of payment shall be the actual acquisition costs of the drugs plus a fixed dispensing fee established by the commissioner. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Establishment of this fee shall not be subject to the requirements of the Administrative Procedure Act. Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, unless the prescriber specifically indicates "dispense as written" on the prescription as required by section 151.21, subdivision 2.

Notwithstanding the above provisions, implementation of any change in the fixed dispensing fee which has not been subject to the Administrative Procedure Act shall be limited to not more than 180 days, unless, during that time, the commissioner shall have initiated rulemaking through the Administrative Procedure Act;

(12) Diagnostic, screening, and preventive services;

(13) Health care pre-payment plan premiums and insurance premiums if paid directly to a vendor and supplementary medical insurance benefits under Title XVIII of the Social Security Act;

(14) Abortion services, but only if one of the following conditions is met:

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

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

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

(15) Transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by nonambulatory persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, common carrier, or other recognized providers of transportation services. For the purpose of this clause, a person who is incapable of transport by taxicab or bus shall be considered to be nonambulatory;

(16) To the extent authorized by rule of the state agency, costs of bus or taxicab transportation incurred by any ambulatory eligible person for obtaining nonemergency medical care;

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

(18) Any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law.

[For text of subds 9 and 10, see M.S.1982]

History: *1981 c 360 art 2 s 54; 1Sp1981 c 4 art 4 s 22; 1983 c 151 s 1,2; 1983 c 312 art 1 s 27; 1983 c 312 art 5 s 10; 1983 c 312 art 9 s 4*

256B.03 PAYMENTS TO VENDORS.

[For text of subd 1, see M.S.1982]

Subd. 2. **Limit on annual increase to long-term care providers.** Notwithstanding the provisions of sections 256B.42 to 256B.48, Laws 1981, chapter 360, article II, section 2, or any other provision of chapter 360, and rules promulgated under those sections, rates paid to a skilled nursing facility or an intermediate care facility, including boarding care facilities and supervised living facilities, except state owned and operated facilities, for rate years beginning during the biennium ending June 30, 1983, shall not exceed by more than ten percent the final rate allowed to the facility for the preceding rate year. For purposes of this section, "final rate" means the rate established after any adjustment by the commissioner, including but not limited to adjustments resulting from cost report reviews, field audits, and computations of unimplemented cost changes. Regardless of any rate appeal, the rate established shall be the rate paid and shall remain in effect until final resolution of the appeal, subsequent desk or field audit adjustment, notwithstanding any provision of law or rule to the contrary.

Notwithstanding provisions of section 256B.45, subdivision 1, the commissioner shall not increase the percentage for investment allowances.

History: *1981 c 360 art 2 s 54; 1Sp1981 c 4 art 4 s 22; 3SP1982 c 1 art 2 s 4; 1983 c 312 art 1 s 27*

256B.04 DUTIES OF STATE AGENCY.

[For text of subds 1 to 13, see M.S.1982]

Subd. 14. **Competitive bidding.** The commissioner shall utilize volume purchase through competitive bidding under the provisions of chapter 16, to provide the following items:

(1) Eyeglasses;

(2) Oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) Hearing aids and supplies; and

(4) Durable medical equipment, including but not limited to:

(a) hospital beds;

(b) commodes;

(c) glide-about chairs;

(d) patient lift apparatus;

(e) wheelchairs and accessories;

(f) oxygen administration equipment;

(g) respiratory therapy equipment; and

(h) electronic diagnostic, therapeutic and life support systems.

Subd. 15. **Utilization review.** Establish on a statewide basis a new program to safeguard against unnecessary or inappropriate use of medical assistance services, against excess payments, against unnecessary or inappropriate hospital admissions or lengths of stay, and against underutilization of services in pre-paid 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 pre-payment and post-payment review systems to determine if utilization is reasonable and necessary. The determination of whether services are reasonable and necessary shall be made by the commissioner in consultation with a professional services advisory group appointed by the commissioner. An aggrieved party may appeal the commissioner's determination pursuant to the contested case procedures of chapter 14.

History: *1983 c 312 art 5 s 11,12*

256B.041 CENTRALIZED DISBURSEMENT OF MEDICAL ASSISTANCE PAYMENTS.

[For text of subd 1, see M.S.1982]

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.

[For text of subds 3 and 4, see M.S.1982]

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

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

[For text of subds 6 and 7, see M.S.1982]

History: *1983 c 312 art 5 s 13,14*

NOTE: Subdivision 2, as amended by Laws 1983, chapter 312, article 5, section 13, is effective July 1, 1984. See Laws 1983, chapter 312, article 5, section 41.

NOTE: Subdivision 5, as amended by Laws 1983, chapter 312, article 5, section 14, is effective July 1, 1984. See Laws 1983, chapter 312, article 5, section 41.

256B.06 ELIGIBILITY REQUIREMENTS.

Subdivision 1. Medical assistance may be paid for any person:

(1) Who is a child eligible for or receiving adoption assistance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676; or

(2) Who is a child eligible for or receiving foster care maintenance payments under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676; or

(3) Who is eligible for or receiving public assistance, or a woman who is pregnant, as medically verified, and who would be eligible for assistance under the aid to families with dependent children program if the child had been born and living with the woman; or

(4) Who meets the categorical eligibility requirements of the supplemental security income program and the other eligibility requirements of this section; or

(5) Who except for the amount of income or resources would qualify for supplemental security income for the aged, blind and disabled, or aid to families with dependent children and is in need of medical assistance; or

(6) Who is under 21 years of age and in need of medical care that neither he nor his relatives responsible under sections 256B.01 to 256B.26 are financially able to provide; or

(7) Who is residing in a hospital for treatment of mental disease or tuberculosis and is 65 years of age or older and without means sufficient to pay the per capita hospital charge; and

(8) Who resides in Minnesota, or, if absent from the state, is deemed to be a resident of Minnesota in accordance with the regulations of the state agency; and

(9) Who alone, or together with his spouse, does not own real property other than the homestead. For the purposes of this section, "homestead" means the

house owned and occupied by the applicant as his dwelling place, together with the land upon which it is situated and an area no greater than two contiguous lots in a platted or laid out city or town or 80 contiguous acres in unplatted land. Occupancy or exemption shall be determined as provided in chapter 510 and applicable law, including continuing exemption by filing notice under section 510.07. Real estate not used as a home may not be retained unless it produces net income applicable to the family's needs or the family is making a continuing effort to sell it at a fair and reasonable price or unless sale of the real estate would net an insignificant amount of income applicable to the family's needs, or unless the commissioner determines that sale of the real estate would cause undue hardship; and

(10) Who individually does not own more than $3,000 in cash or liquid assets, or if a member of a household with two family members (husband and wife, or parent and child), does not own more than $6,000 in cash or liquid assets, plus $200 for each additional legal dependent. Cash and liquid assets may include a prepaid funeral contract and insurance policies with cash surrender value. The value of the following shall not be included:

(a) the homestead, and (b) one motor vehicle licensed pursuant to chapter 168 and defined as: (1) passenger automobile, (2) station wagon, (3) motorcycle, (4) motorized bicycle or (5) truck of the weight found in categories A to E, of section 168.013, subdivision 1e; and

(11) Who has or anticipates receiving an annual income not in excess of $2,600 for a single person, or $3,250 for two family members (husband and wife, parent and child, or two siblings), plus $625 for each additional legal dependent, or who has income in excess of these maxima and in the month of application, or during the three months prior to the month of application, incurs expenses for medical care that total more than one-half of the annual excess income in accordance with the regulations of the state agency. In computing income to determine eligibility of persons who are not residents of long term care facilities, the commissioner shall disregard increases in income due solely to increases in federal retiree, survivor's, and disability insurance benefits, veterans administration benefits, and railroad retirement benefits in the percentage amount established in the biennial appropriations law unless prohibited by federal law or regulation. If prohibited, the commissioner shall first seek a waiver. In excess income cases, eligibility shall be limited to a period of six months beginning with the first of the month in which these medical obligations are first incurred; and

(12) Who has continuing monthly expenses for medical care that are more than the amount of his excess income, computed on a monthly basis, in which case eligibility may be established before the total income obligation referred to in the preceding paragraph is incurred, and medical assistance payments may be made to cover the monthly unmet medical need. In licensed nursing home and state hospital cases, income over and above that required for justified needs, determined pursuant to a schedule of contributions established by the commissioner of public welfare, is to be applied to the cost of institutional care. The commissioner of public welfare may establish a schedule of contributions to be made by the spouse of a nursing home resident to the cost of care and shall seek a waiver from federal regulations which establish the amount required to be contributed by either spouse when one spouse is a nursing home resident; and

(13) Who has applied or agrees to apply all proceeds received or receivable by him or his spouse from automobile accident coverage and private health care coverage to the costs of medical care for himself, his spouse, and children. The state agency may require from any applicant or recipient of medical assistance the

assignment of any rights accruing under private health care coverage. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment shall not be effective as to benefits paid or provided under automobile accident coverage and private health care coverage prior to receipt of the assignment by the person or organization providing the benefits.

[For text of subd 3, see M.S.1982]

History: *1983 c 312 art 5 s 15*

256B.061 ELIGIBILITY.

If any individual has been determined to be eligible for medical assistance, it will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he 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 his application for or receipt of medical assistance benefits.

History: *1983 c 312 art 5 s 16*

256B.064 INELIGIBLE PROVIDER.

[For text of subd 1, see M.S.1982]

Subd. 1a. **Grounds for monetary recovery and sanctions against vendors.** The commissioner may seek monetary recovery and impose sanctions against vendors of medical care for any of the following: fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; a pattern of presentment of false or duplicate claims or claims for services not medically necessary; a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; suspension or termination as a Medicare vendor; and refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients. No sanction may be imposed or monetary recovery obtained against any vendor of nursing home or convalescent care for providing services not medically necessary when the services provided were ordered by a licensed health professional not an employee of the vendor. The determination of services not medically necessary shall be made by the commissioner in consultation with a provider advisory committee appointed by the commissioner on the recommendation of appropriate professional organizations.

[For text of subds 1b to 2, see M.S.1982]

History: *1983 c 312 art 5 s 17*

256B.07 EXCEPTIONS IN DETERMINING RESOURCES.

A local agency may, within the scope of regulations set by the commissioner of public welfare, waive the requirement of liquidation of excess assets when the liquidation would cause undue hardship. Household goods and furniture in use in the home, wearing apparel, and personal property used as a regular abode by the

applicant or recipient and a lot in a burial plot shall not be considered as resources available to meet medical needs.

History: *1983 c 312 art 5 s 18*

256B.091 NURSING HOME PRE-ADMISSION SCREENING PROGRAM.

Subdivision 1. **Purpose.** It is the purpose of this section to prevent inappropriate nursing home or boarding care home placement by establishing a program of preadmission screening teams for all medical assistance recipients and any individual who would become eligible for medical assistance within 180 days of admission to a licensed nursing home or boarding care home participating in the program. Further, it is the purpose of this section and the program to gain further information about how to contain costs associated with inappropriate nursing home or boarding care home admissions. The commissioners of public welfare and health shall seek to maximize use of available federal and state funds and establish the broadest program possible within the appropriation available.

Subd. 2. **Screening teams; establishment.** Each county agency designated by the commissioner of public welfare to participate in the program shall contract with the local board of health organized under section 145.911 to 145.922 or other public or nonprofit agency to establish a screening team to assess, prior to admission to a nursing home or a boarding care home licensed under section 144A.02 or sections 144.50 to 144.56, that is certified for medical assistance as a skilled nursing facility, intermediate care facility level I, or intermediate care facility level II, the health and social needs of medical assistance recipients and individuals who would become eligible for medical assistance within 180 days of nursing home or boarding care home admission. Each local screening team shall be composed of a public health nurse from the local public health nursing service and a social worker from the local community welfare agency. Each screening team shall have a physician available for consultation and shall utilize individuals' attending physicians' physical assessment forms, if any, in assessing needs. The individual's physician shall be included on the screening team if the physician chooses to participate. If the individual is being discharged from an acute care facility, a discharge planner from that facility may be present, at the facility's request, during the screening team's assessment of the individual and may participate in discussions but not in making the screening team's recommendations under subdivision 3, clause (e). If the assessment procedure or screening team recommendation results in a delay of the individual's discharge from the acute care facility, the facility shall not be denied medical assistance reimbursement or incur any other financial or regulatory penalty of the medical assistance program that would otherwise be caused by the individual's extended length of stay; 50 percent of the cost of this reimbursement or financial or regulatory penalty shall be paid by the state and 50 percent shall be paid by the county. Other personnel as deemed appropriate by the county agency may be included on the team. The county agency may contract with an acute care facility to have the facility's discharge planners perform the functions of a screening team with regard to individuals discharged from the facility and in those cases the discharge planners may participate in making recommendations under subdivision 3, clause (e). No member of a screening team shall have a direct or indirect financial or self-serving interest in a nursing home or noninstitutional referral such that it would not be possible for the member to consider each case objectively.

[For text of subd 3, see M.S.1982]

Subd. 4. **Screening of persons.** Prior to nursing home or boarding care home admission, screening teams shall assess the needs of all persons receiving medical assistance and of all persons who would be eligible for medical assistance within 180 days of admission to a nursing home or boarding care home, except patients transferred from other nursing homes or patients who, having entered acute care facilities from nursing homes, are returning to nursing home care. Any other interested person may be assessed by a screening team upon payment of a fee based upon a sliding fee scale.

[For text of subds 5 to 7, see M.S.1982]

Subd. 8. **Alternative care grants.** The commissioner shall provide grants to counties participating in the program to pay costs of providing alternative care to individuals screened under subdivision 4. Payment is available under this subdivision only for individuals (1) for whom the screening team would recommend nursing home admission if alternative care were not available; (2) who are receiving medical assistance or who would be eligible for medical assistance within 180 days of admission to a nursing home; and (3) who need services that are not available at that time in the county through other public assistance.

Grants may be used for payment of costs of providing services such as, but not limited to, foster care for elderly persons, day care whether or not offered through a nursing home, nutritional counseling, or medical social services, which services are provided by a licensed health care provider, a home health service eligible for reimbursement under Titles XVIII and XIX of the federal Social Security Act, or by persons employed by or contracted with by the county board or the local welfare agency. The county agency shall ensure that a plan of care is established for each individual in accordance with subdivision 3, clause (e)(2). The plan shall include any services prescribed by the individual's attending physician as necessary and follow up services as necessary. The county agency shall provide documentation to the commissioner verifying that the individual's alternative care is not available at that time through any other public assistance or service program and shall provide documentation in each individual's plan of care that the most cost effective alternatives available have been offered to the individual. Grants to counties under this subdivision are subject to audit by the commissioner for fiscal and utilization control.

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

The commissioner shall apply for a waiver for federal financial participation to expand the availability of services under this subdivision. The commissioner shall provide grants to counties from the nonfederal share, unless the commissioner obtains a federal waiver for medical assistance payments, of medical assistance appropriations. A county agency may use grant money to supplement but not supplant services available through other public assistance or service programs and shall not use grant money to establish new programs for which public money is available through sources other than grants provided under this subdivision. A county agency shall not use grant money to provide care under this subdivision to an individual if the anticipated cost of providing this care would exceed the average payment, as determined by the commissioner, for the level of nursing

home care that the recipient would receive if placed in a nursing home. The nonfederal share may be used to pay up to 90 percent of the start-up and service delivery costs of providing care under this subdivision. Each county agency that receives a grant shall pay ten percent of the costs.

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

[For text of subd 9, see M.S.1982]

History: *1983 c 199 s 6-9*

256B.092 CASE MANAGEMENT OF MENTALLY RETARDED PERSONS.

Subdivision 1. **County of financial responsibility; duties.** Before any services shall be rendered to mentally retarded persons in need of social service and medical assistance, the county of financial responsibility shall conduct a diagnostic evaluation in order to determine whether the person is or may be mentally retarded. If a client is diagnosed mentally retarded, that county must conduct a needs assessment, develop an individual service plan, and authorize placement for services. If the county of financial responsibility places a client in another county for services, the placement shall be made in cooperation with the host county of service, and arrangements shall be made between the two counties for ongoing social service, including annual reviews of the client's individual service plan. The host county may not make changes in the service plan without approval by the county of financial responsibility.

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

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

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

Subd. 5. **Federal waivers.** The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 to 1396p, as amended through December 31, 1982, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a state hospital or a community intermediate care facility for mentally retarded persons. The commissioner may seek amendments to the waivers or apply for additional

waivers under United States Code, title 42, sections 1396 to 1396p, as amended through December 31, 1982, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services that would have been provided without the waivered services.

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

Subd. 7. **Screening teams established.** Each county agency shall establish a screening team which, under the direction of the county case manager, shall make an evaluation of need for home and community-based services of persons who are entitled to the level of care provided by an intermediate care facility for mentally retarded persons or for whom there is a reasonable indication that they might need the services in the near future. The screening team shall make an evaluation of need within 15 working days of the request for service and within five working days of an emergency admission of an individual to an intermediate care facility for mentally retarded persons. The screening team shall consist of the case manager, the client, a parent or guardian, a qualified mental retardation professional, as defined in the Code of Federal Regulations, title 42, section 442.401, as amended through December 31, 1982, assigned by the commissioner. The case manager shall consult with the client's physician or other persons as necessary to make this evaluation. Other persons may be invited to attend meetings of the screening team. No member of the screening team shall have any direct or indirect service provider interest in the case.

Subd. 8. **Screening team duties.** The screening team shall:

(a) review diagnostic data;

(b) review health, social, and developmental assessment data using a uniform screening tool specified by the commissioner;

(c) identify the level of services needed to maintain the person in the most normal and least restrictive setting that is consistent with treatment needs;

(d) identify other noninstitutional public assistance or social service that may prevent or delay long-term residential placement;

(e) determine whether a client is in serious need of long-term residential care;

(f) make recommendations to the county agency regarding placement and payment for: (1) social service or public assistance support to maintain a client in the client's own home or other place of residence; (2) training and habilitation service, vocational rehabilitation, and employment training activities; (3) community residential placement; (4) state hospital placement; or (5) a home and community-based alternative to community residential placement or state hospital placement;

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

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

Subd. 9. **Reimbursement.** Payment shall not be provided to a service provider for any recipient placed in an intermediate care facility for the mentally retarded prior to the recipient being screened by the screening team. The commissioner shall not deny reimbursement for: (a) an individual admitted to an intermediate care facility for mentally retarded who is assessed to need long-term supportive services, if long-term supportive services other than intermediate care are not available in that community; (b) any individual admitted to an intermedi-

ate care facility for the mentally retarded under emergency circumstances; (c) any eligible individual placed in the intermediate care facility for the mentally retarded 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 mentally retarded, the individual or the individual's legal representative insists on intermediate care placement. The screening team shall provide documentation that the most cost effective alternatives available were offered to this individual or the individual's legal representative.

History: *1983 c 312 art 9 s 5*

NOTE: This section is repealed effective June 30, 1984, if a home and community-based waiver under United States Code, title 42, section 1396n(c), as amended through December 31, 1982, is not approved by June 30, 1984. See Laws 1983, chapter 312, article 9, section 11.

256B.14 RELATIVE'S RESPONSIBILITY.

[For text of subd 1, see M.S.1982]

Subd. 2. **Actions to obtain payment.** The state agency shall promulgate rules to determine the ability of responsible relatives to contribute partial or complete repayment of medical assistance furnished to recipients for whom they are responsible. In determining the resource contribution of a spouse at the time of the first medical assistance application, all medical assistance exclusions shall be allowed, and a resource limit of $10,000 for nonexcluded resources shall be implemented. Above these limits, a contribution of one-third of the excess resources shall be required. These rules shall not require repayment when payment would cause undue hardship to the responsible relative or his or her immediate family. The county agency shall give the responsible relative notice of the amount of the repayment. If the state agency or county agency finds that notice of the payment obligation was given to the responsible relative, but that the relative failed or refused to pay, a cause of action exists against the responsible relative for that portion of medical assistance granted after notice was given to the responsible relative, which the relative was determined to be able to pay.

The action may be brought by the state agency or the county agency in the county where assistance was granted, for the assistance, together with the costs of disbursements incurred due to the action.

In addition to granting the county or state agency a money judgment, the court may, upon a motion or order to show cause, order continuing contributions by a responsible relative found able to repay the county or state agency. The order shall be effective only for the period of time during which the recipient receives medical assistance from the county or state agency.

History: *1983 c 312 art 5 s 19*

256B.17 TRANSFERS OF PROPERTY.

[For text of subds 1 to 3, see M.S.1982]

Subd. 4. **Period of ineligibility.** For any uncompensated transfer, the period of ineligibility shall be calculated by dividing the transferred amount by the statewide average monthly skilled nursing facility per diem for the previous calendar year to determine the number of months of ineligibility. The individual shall remain ineligible until this fixed ineligibility period has expired, subject to the exclusions contained in section 256B.06, subdivision 1.

Subd. 5. **Exclusions for homestead transfers.** Notwithstanding subdivision 4, an individual shall not be ineligible if the transferred property is a homestead as defined by section 256B.06, subdivision 1, and one of the following conditions applies:

(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 home 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 home at fair market value or for other valuable consideration; or

(4) the local agency determines that denial of eligibility would cause undue hardship for the individual, based on imminent threat to the individual's health and well-being.

Subd. 6. **Exception for asset transfers.** Notwithstanding the provisions of subdivisions 1 to 5, an institutionalized spouse who applies for medical assistance on or after July 1, 1983, may transfer liquid assets to his or her noninstitutionalized spouse without loss of eligibility if all of the following conditions apply:

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

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

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

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

Subd. 7. **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.

Subd. 8. **Effective date.** Subdivisions 5, 6, and 7, and the changes in subdivision 4 made by Laws 1983, chapter 312, article 5, section 20 apply to transfers made on or after June 10, 1983, regardless of the individual's status in relation to eligibility for medical assistance.

History: *1983 c 312 art 5 s 20-24*

256B.19 DIVISION OF COST.

[For text of subds 1 and 2, see M.S.1982]

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

History: *1983 c 312 art 9 s 6*

256B.27 MEDICAL ASSISTANCE; COST REPORTS.

[For text of subds 1 to 2a, see M.S.1982]

Subd. 3. The commissioner of public welfare, with the written consent of the recipient, on file wih the local welfare agency, shall be allowed access to all personal medical records of medical assistance recipients solely for the purposes of investigating whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which the vendor knows to be false in whole or in part; or (b) the medical care was medically necessary. The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records. The determination of provision of services not medically necessary shall be made by the commissioner in consultation with an advisory committee of vendors as appointed by the commissioner on the recommendation of appropriate professional organizations. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of public welfare 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 public welfare in writing to examine all personal medical records developed while receiving medical assistance for the purpose of investigating whether or not a vendor has submitted a claim for reimbursement, a cost report or a rate application which the vendor knows to be false in whole or in part, or in order to determine whether or not the medical care provided was medically necessary.

[For text of subd 5, see M.S.1982]

History: *1983 c 312 art 5 s 25,26*

256B.41 INTENT.

Subdivision 1. **Authority.** The commissioner shall establish, by rule, procedures for determining rates for care of residents of nursing homes which qualify as vendors of medical assistance, and for implementing the provisions of sections 256B.41, 256B.421, 256B.431, 256B.47, 256B.48, 256B.50, and 256B.502. The procedures shall be based on methods and standards that the commissioner finds are adequate to provide for the costs that must be incurred for the care of residents in efficiently and economically operated nursing homes and shall specify the costs that are allowable for establishing payment rates through medical assistance.

Subd. 2. **Federal requirements.** If any provision of sections 256B.41, 256B.421, 256B.431, 256B.47, 256B.48, 256B.50, and 256B.502, is determined by the United States government to be in conflict with existing or future requirements of the United States government with respect to federal participation in medical assistance, the federal requirements shall prevail.

History: *1983 c 199 s 10*

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

256B.421 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 256B.41, 256B.421, 256B.431, 256B.47, 256B.48, 256B.50, and 256B.502, the following terms and phrases shall have the meaning given to them.

Subd. 2. **Actual allowable historical operating cost per diem.** "Actual allowable historical operating cost per diem" means the per diem payment for actual

costs, including operating costs, allowed by the commissioner for the most recent reporting year.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of public welfare.

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, medical directors, accounting personnel, data processing personnel, and all clerical personnel; board of directors fees; business office functions and supplies; travel; telephone and telegraph; advertising; licenses and permits; 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. These costs shall be included in general and administrative costs in total, without direct or indirect allocation to other cost categories.

In a nursing home of 60 or fewer beds, part of an administrator's salary may be allocated to other cost categories to the extent justified in records kept by the nursing home. Central or home office costs representing services of required consultants in areas including, but not limited to, dietary, pharmacy, social services, or activities may be allocated to the appropriate department, but only if those costs are directly identified by the nursing home.

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

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

Subd. 8. **Operating costs.** "Operating costs" means the day-to-day costs of operating the facility in compliance with licensure and certification standards. Operating cost categories are: nursing, including nurses and nursing assistants training; dietary; laundry and linen; housekeeping; plant operation and maintenance; other care-related services; general and administration; payroll taxes; real estate taxes and actual special assessments paid; and fringe benefits, including clerical training.

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

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

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

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

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

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

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

History: *1983 c 199 s 11*

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

256B.431 RATE DETERMINATION.

Subdivision 1. **In general.** The commissioner shall determine prospective payment rates for resident care costs. In determining the rates, the commissioner shall group nursing homes according to different levels of care and geographic location until July 1, 1985, and after that date, mix of resident needs, and geographic location, as defined by the commissioner. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. Until groups are established according to mix of resident needs, the commissioner shall group all convalescent and nursing care units attached to hospitals into one group for purposes of determining reimbursement for operating costs. On or before June 15, 1983, the commissioner shall mail notices to each nursing home of the rates to be effective from July 1 of that year to June 30 of the following year. In subsequent years, the commissioner shall provide notice to each nursing home on or before May 1 of the rates effective for the following rate year. If a statute enacted after May 1 affects the rates, the commissioner shall provide a revised notice to each nursing home as soon as possible.

The commissioner shall establish, by rule, limitations on compensation recognized in the historical base for top management personnel. 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.

Subd. 2. **Operating costs.** (a) 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

10 percent for nursing homes with more than 100 certified beds in total,

12 percent for nursing homes with fewer than 101 but more than 40 certified beds in total,

14 percent for nursing homes with 40 or fewer certified beds in total, and

15 percent for convalescent and nursing care units attached to hospitals for the rate year beginning July 1, 1983,

of the expenditures in all operating cost categories except fringe benefits, payroll taxes, and general and administration.

(b) For the rate year beginning July 1, 1983, and ending June 30, 1984, the prospective operating cost payment rate for each nursing home shall be deter-

mined 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 paragraph (a). The commissioner shall calculate the 60th percentile of actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1.

(1) Within each group, each nursing home whose actual allowable historical operating cost per diem as determined under this paragraph (b) 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.

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

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

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

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

(c) For subsequent years, the commissioner shall:

(1) 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;

(2) Establish the 60th percentile of actual allowable historical operating cost per diems for each group of nursing homes established under subdivision 1 based on cost reports of allowable operating costs in the previous reporting year. The commissioner shall analyze and evaluate each nursing home's report of allowable operating costs incurred by the nursing home during the reporting year immediately preceding the rate year for which the payment rate becomes effective. The allowable historical operating costs, after the commissioner's analysis and evaluation, shall be added together and divided by the actual number of resident days in order to compute the actual allowable historical operating cost per diem;

(3) Establish a composite index for each group by determining the weighted average of all economic change indicators applied to the operating cost categories in that group;

(4) Within each group, each nursing home shall receive the 60th percentile increased by the composite index calculated in paragraph (c)(3). The historical base for determining the prospective payment rate shall not exceed the operating cost payment rates during that reporting year.

The commissioner shall include the reported actual real estate tax liability of each proprietary nursing home as an operating cost of that nursing home. The commissioner shall include a reported actual special assessment for each nursing home as an operating cost of that nursing home. Total real estate tax liability and actual special assessments paid for each nursing home (i) shall be divided by actual resident days in order to compute the operating cost payment rate for this operating cost category, but (ii) shall not be used to compute the 60th percentile.

(d) The commissioner shall allow the nursing home to keep, as an efficiency incentive, the difference between the nursing home's operating cost payment rate established for that rate year and the actual historical operating costs incurred for that rate year, if the latter amount is smaller. If a nursing home's actual historic operating costs are greater than the prospective payment rate for that rate year, there shall be no retroactive cost settle-up. If an annual cost report or field audit indicates that the expenditures for direct resident care have been reduced in amounts large enough to indicate a possible detrimental effect on the quality of care, the commissioner shall notify the commissioner of health and the interagency board for quality assurance. If a field audit reveals that unallowable expenditures have been included in the nursing home's historical operating costs, the commissioner shall disallow the expenditures and recover the entire overpayment. The commissioner shall establish, by rule, procedures for assessing an interest charge at the rate determined for unpaid taxes or penalties under section 270.75 on any outstanding balance resulting from an overpayment or underpayment.

(e) The commissioner may negotiate, with a nursing home that is eligible to receive medical assistance payments, a payment rate of up to 125 percent of the allowed payment rate to be paid for a period of up to three months for individuals who have been hospitalized for more than 100 days, who have extensive care needs based on nursing hours actually provided or mental or physical disability, or need for respite care for a specified and limited time period, and based on an assessment of the nursing home's resident mix as determined by the commissioner of health. The payment rate negotiated and paid pursuant to this paragraph is specifically exempt from the definition of "rule" and the rule-making procedures required by chapter 14 and section 256B.502.

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

Subd. 3. **Property-related costs.** For rate years beginning July 1, 1983 and July 1, 1984, property-related costs shall be reimbursed to each nursing home at the level recognized in the most recent cost report received by December 31, 1982 and audited by March 1, 1983, and may be subsequently adjusted to reflect the

costs recognized in the final rate for that cost report, adjusted for rate limitations in effect before the effective date of this section. Property-related costs include: depreciation, interest, earnings or investment allowance, lease, or rental payments. No adjustments shall be made as a result of sales or reorganizations of provider entities.

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

(i) The cost incurred is reasonable, necessary, and ordinary;

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

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

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

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

For rate years beginning on or after July 1, 1985, the commissioner, by permanent rule, shall reimburse nursing home providers that are vendors in the medical assistance program for the rental use of their property. The "rent" is the amount of periodic payment which a renter might expect to pay for the right to the agreed use of the real estate and the depreciable equipment as it exists. "Real estate" means land improvements, buildings, and attached fixtures used directly for resident care. "Depreciable equipment" means the standard moveable resident care equipment and support service equipment generally used in long-term care facilities.

In developing the method for determining payment rates for the rental use of nursing homes, the commissioner shall consider factors designed to:

(i) simplify the administrative procedures for determining payment rates for property-related costs;

(ii) minimize discretionary or appealable decisions;

(iii) eliminate any incentives to sell nursing homes;

(iv) recognize legitimate costs of preserving and replacing property;

(v) recognize the existing costs of outstanding indebtedness allowable under the statutes and rules in effect on May 1, 1983;

(vi) address the current value of, if used directly for patient care, land improvements, buildings, attached fixtures, and equipment;

(vii) establish an investment per bed limitation;

(viii) reward efficient management of capital assets;

(ix) provide equitable treatment of facilities;

(x) consider a variable rate; and

(xi) phase in implementation of the rental reimbursement method.

No later than January 1, 1984, the commissioner shall report to the legislature on any further action necessary or desirable in order to implement the purposes and provisions of this subdivision.

Subd. 4. **Special rates.** A newly constructed nursing home or one with a capacity increase of 50 percent or more may, upon written application to the commissioner, receive an interim payment rate for reimbursement for property-related costs calculated pursuant to the statutes and rules in effect on May 1, 1983 and for operating costs negotiated by the commissioner based upon the 60th percentile established for the appropriate group under subdivision 2, paragraph (b) to be effective from the first day a medical assistance recipient resides in the home or for the added beds. For newly constructed nursing homes which are not included in the calculation of the 60th percentile for any group, subdivision 2(f), 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 temporary 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. The commissioner shall establish by rule procedures for determining payment rates for nursing homes which provide care under a lesser care level than the level for which the nursing home is certified.

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

History: *1983 c 199 s 12*

256B.433 ANCILLARY SERVICES.

The commissioner shall promulgate rules pursuant to the Administrative Procedure Act to set the amount and method of payment for ancillary materials and services provided to recipients residing in long-term care facilities. Payment for materials and services may be made to either the nursing home in the operating cost per diem, to the vendor of ancillary services pursuant to 12 MCAR 2.047 or to a nursing home pursuant to 12 MCAR 2.047. Payment for the same or similar service to a recipient shall not be made to both the nursing home and the vendor. The commissioner shall ensure that charges for ancillary materials and services are as would be incurred by a prudent buyer.

History: *1983 c 199 s 18*

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.

Subdivision 1. **Nonallowable costs.** The following costs shall not be recognized as allowable: (1) political contributions; (2) salaries or expenses of a

lobbyist, as defined in section 10A.01, subdivision 11, for lobbying activities; (3) advertising designed to encourage potential residents to select a particular nursing home; (4) assessments levied by the commissioner of health for uncorrected violations; (5) legal and related expenses for unsuccessful challenges to decisions by governmental agencies; (6) memberships in sports, health or similar social clubs or organizations; and (7) costs incurred for activities directly related to influencing employees with respect to unionization. The commissioner shall by rule exclude the costs of any other items not directly related to the provision of resident care.

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

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

History: *1983 c 199 s 13*

256B.48 CONDITIONS FOR PARTICIPATION.

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

(a) Charging private paying residents rates for similar services which exceed those which are approved by the state agency for medical assistance recipients as determined by the prospective desk audit rate, except under the following circumstances: the nursing home may (1) charge private paying residents a higher rate for a private room, and (2) charge for special services which are not included in the daily rate if medical assistance residents are charged separately at the same rate for the same services in addition to the daily rate paid by the commissioner. A nursing home that charges a private paying resident a rate in violation of this clause is subject to an action by the state of Minnesota or any of its subdivisions or agencies for civil damages. A private paying resident or the resident's legal representative has a cause of action for civil damages against a nursing home that charges the resident rates in violation of this clause. The damages awarded shall include three times the payments that result from the violation, together with costs and disbursements, including reasonable attorneys' fees or their equivalent. A private paying resident or the resident's legal representative, the state, subdivision or agency, or a nursing home may request a hearing to determine the allowed rate or rates at issue in the cause of action. Within 15 calendar days after receiving a request for such a hearing, the commissioner shall request assignment of a hearing examiner under sections 14.48 to 14.56 to conduct the hearing as soon as possible or according to agreement by the parties. The hearing examiner shall issue a report within 15 calendar days following the close of the hearing. The prohibition set forth in this clause shall not apply to facilities licensed as boarding care facilities which are not certified as skilled or intermediate care facilities level I or II for reimbursement through medical assistance;

(b) Requiring an applicant for admission to the home, or the guardian or conservator of the applicant, as a condition of admission, to pay any fee or deposit in excess of $100, loan any money to the nursing home, or promise to leave all or part of the applicant's estate to the home;

(c) Requiring any resident of the nursing home to utilize a vendor of health care services who is a licensed physician or pharmacist chosen by the nursing home;

(d) Requiring any applicant to the nursing home, or the applicant's guardian or conservator, as a condition of admission, to assure that the applicant is neither eligible for nor will seek public assistance for payment of nursing home care costs;

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

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

The prohibitions set forth in clause (b) shall not apply to a retirement home with more than 325 beds including at least 150 licensed nursing home beds and which:

(1) is owned and operated by an organization tax-exempt under section 290.05, subdivision 1, clause (i); and

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

(3) agrees in writing at the time of admission to the home to permit the applicant, or his 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 his individual account upon request; and

(4) agrees in writing at the time of admission to the home to permit the applicant to withdraw from the home at any time and to receive, upon withdrawal, the balance of his individual account.

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

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

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

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

(d) Upon request, provide the state agency with separate, audited financial statements as specified in clause (a) for every organization with which the facility

conducts business and which is owned in whole or in part by an individual or entity which has an ownership interest in the facility;

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

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

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

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

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

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

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

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

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

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

(d) use any combination of the foregoing actions.

History: *1983 c 199 s 14*

256B.50 APPEALS.

A nursing home may appeal a decision arising from the application of standards or methods pursuant to sections 256B.41 and 256B.47 if the appeal, if successful, would result in a change to the nursing home's payment rate. To appeal, the nursing home shall notify the commissioner of its intent to appeal within 30 days and submit a written appeal request within 60 days of receiving notice of the payment rate determination or decision. The appeal request shall specify each disputed item, the reason for the dispute, an estimate of the dollar amount involved for each disputed item, the computation that the nursing home believes is correct, the authority in statute or rule upon which the nursing home relies for each disputed item, the name and address of the person or firm with whom contacts may be made regarding the appeal, and other information required by the commissioner. The appeal shall be heard by a hearing examiner according to sections 14.48 to 14.56, or upon agreement by both parties according to a

modified appeals procedure established by the commissioner and the hearing examiner. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner's determination is incorrect. Regardless of any rate appeal, the rate established shall be the rate paid and shall remain in effect until final resolution of the appeal or subsequent desk or field audit adjustment, notwithstanding any provision of law or rule to the contrary. To challenge the validity of rules established by the commissioner pursuant to sections 256B.41, 256B.421, 256B.431, 256B.47, 256B.48, 256B.50, and 256B.502, a nursing home shall comply with section 14.44.

History: *1983 c 199 s 15*

256B.501 RATES FOR COMMUNITY-BASED SERVICES FOR THE MENTALLY RETARDED.

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

(a) "Commissioner" means the commissioner of public welfare.

(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 the mentally retarded.

(c) "Waivered service" means home or community-based service authorized under United States Code, title 42, section 1396n(c), as amended through December 31, 1982, and defined in the Minnesota state plan for the provision of medical assistance services. Waivered services include, at a minimum, case management, family training and support, developmental training homes, supervised living arrangements, semi-independent living services, respite care, and training and habilitation services.

(d) "Training and habilitation services" are those health and social services needed to ensure optimal functioning of persons who are mentally retarded or have related conditions. Training and habilitation services shall be provided to a client away from the residence unless medically contraindicated by an organization which does not have a direct or indirect financial interest in the organization which provides the person's residential services. This requirement shall not apply to any developmental achievement center which has applied for licensure prior to April 15, 1983.

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

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

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

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

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

(d) incentives to reward accumulation of equity.

In establishing rules and procedures for setting rates for care of residents in intermediate care facilities for mentally retarded persons, the commissioner shall consider the recommendations contained in the February 11, 1983, Report of the Legislative Auditor on Community Residential Programs for the Mentally Retarded and the recommendations contained in the 1982 Report of the Department of Public Welfare Rule 52 Task Force. Rates paid to supervised living facilities for rate years beginning during the fiscal biennium ending June 30, 1985, shall not exceed the final rate allowed the facility for the previous rate year by more than five percent.

Subd. 4. **Waivered services.** In establishing rates for waivered services the commissioner shall consider the need for flexibility in the provision of those services to meet individual needs identified by the screening team.

Subd. 5. **Training and habilitation services.** (a) Except as provided in subdivision 6, rates for reimbursement under medical assistance for training and habilitation services provided by a developmental achievement center either as a waivered service or to residents of an intermediate care facility for mentally retarded persons shall be established and paid in acccordance with this subdivision effective January 1, 1984.

(b) Prior to August 1, 1983, the county board shall submit to the commissioner its contractual per diem rate and its maximum per client annual payment limitations, if any, for each developmental achievement center it administers pursuant to section 252.24, subdivision 1, for the period from July 1, 1983, through December 31, 1983, which shall be the medical assistance reimbursement rate established for that developmental achievement center for 1983. If the county rate is based on average daily attendance which is less than 93 percent of the developmental achievement center's average enrollment for the period from July 1, 1983, to December 31, 1983, the commissioner shall adjust that rate based on 93 percent average daily attendance.

(c) The base per diem reimbursement rate established for 1983 may be increased by the commissioner in 1984 in an amount up to the projected percentage change in the average value of the consumer price index (all urban) for 1984 over 1983. In subsequent years, the increase in the per diem rate shall not exceed the projected percentage change in the average annual value of the consumer price index (all urban) for the same time period.

(d) The county board in which an intermediate care facility for mentally retarded persons is located shall contract annually with that facility and with the appropriate developmental achievement center or training and habilitation service provider for provision of training and habilitation services for each resident of the facility for whom the services are required by the resident's individual service plan. This contract shall specify the county payment rate or the medical assistance reimbursement rate, as appropriate; the training and habilitation services to be provided; and the performance standards for program provision and evaluation. A similar contract shall be entered into between the county and the developmental

achievement center for persons receiving training and habilitation services from that center as a waivered service.

(e) The commissioner shall reimburse under medical assistance up to 210 days of training and habilitation services at developmental achievement centers for those centers which provided less than or equal to 210 days of training and habilitation services in calendar year 1982. For developmental achievement centers providing more than 210 days of services in 1982, the commissioner shall not reimburse under medical assistance in excess of the number of days provided by those programs in 1982.

(f) Medical assistance payments for training and habilitation services shall be made directly to the training and habilitation provider after submission of invoices to the medical assistance program following procedures established by the medical assistance program.

(g) Nothing in this subdivision shall prohibit county boards from contracting for rates for services not reimbursed under medical assistance.

Subd. 6. **New developmental achievement programs; rates.** The commissioner, upon the recommendation of the local county board, shall determine the medical assistance reimbursement rate for new developmental achievement programs. The payment rate shall not exceed 125 percent of the average payment rate in the region.

Subd. 7. **Alternative rates for training and habilitation services.** Alternative methods may be proposed by the counties or the commissioner for provision of training and habilitation services during daytime hours apart from a residential facility to persons for whom needs identified in their individual service plan are not met by the training and habilitation services provided at a developmental achievement center. The commissioner shall establish procedures for approval of the proposals and for medical assistance payment of rates which shall not exceed the average rate allowed in that county for training and habilitation services pursuant to subdivision 5. Nothing in this subdivision prohibits a county from contracting with a developmental achievement center for those purposes.

Subd. 8. **Payment for persons with special needs.** The commissioner shall establish by December 31, 1983, procedures to be followed by the counties to seek authorization from the commissioner for medical assistance reimbursement for waivered services or training and habilitation services for very dependent persons with special needs in an amount in excess of the rates allowed pursuant to subdivisions 2, 4, 5, and 6, and procedures to be followed for rate limitation exemptions for intermediate care facilities for mentally retarded persons. No excess payment or limitation exemption shall be authorized unless the need for the service is documented in the individual service plan of the person or persons to be served, the type and duration of the services needed are stated, and there is a basis for estimated cost of the services.

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

Subd. 9. **Reporting requirements.** The developmental achievement center shall submit to the county and the commissioner no later than March 1 of each year an annual report which includes the actual program revenues and expenditures, client information, and program information. The information shall be submitted on forms prescribed by the commissioner.

Subd. 10. **Rules.** To implement this section, the commissioner shall promulgate temporary and permanent rules in accordance with chapter 14. To implement subdivision 3, the commissioner shall promulgate temporary rules by Octo-

ber 1, 1983, and permanent rules in accordance with sections 14.01 to 14.38. Notwithstanding the provisions of section 14.35, the temporary rule promulgated to implement subdivision 3 shall be effective for up to 720 days.

History: *1983 c 312 art 9 s 7*

NOTE: Subdivisions 1, 4, and 10 are repealed effective June 30, 1984, if a home and community-based waiver under United States Code, title 42, section 1396n(c), as amended through December 31, 1982, is not approved by June 30, 1984. See Laws 1983, chapter 312, article 9, section 11.

256B.502 TEMPORARY AND PERMANENT RULES; REPORT.

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

History: *1983 c 199 s 16*

256B.503 RULES.

To implement Laws 1983, chapter 312, article 9, sections 1 to 7, the commissioner shall promulgate temporary and permanent rules in accordance with sections 14.01 to 14.38.

History: *1983 c 312 art 9 s 8*

256B.58 ADMINISTRATION.

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

History: *1983 c 260 s 57*

256B.69 PREPAYMENT DEMONSTRATION PROJECT.

Subdivision 1. **Purpose.** The commissioner of public welfare 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 public welfare. For the remainder of this section, the commissioner's responsibilities for methods and policies for implementing the project will be proposed by the project advisory committees and approved by the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *1983 c 312 art 5 s 27*

NOTE: *This section, as added by Laws 1983, chapter 312, article 5, section 27, is repealed effective July 1, 1985, if the project implementation phase has not begun by that date.* See Laws 1983, chapter 312, article 5, section 40.

256B.70 DEMONSTRATION PROJECT WAIVER.

Each hospital that participates as a provider in a demonstration project, established by the commissioner of public welfare to deliver medical assistance

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*

NOTE: This section, as added by Laws 1983, chapter 312, article 5, section 28, is repealed effective July 1, 1985, if the project implementation phase has not begun by that date. See Laws 1983, chapter 312, article 5, section 40.

256B.71 SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION.

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

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

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

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

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

History: *1983 c 295 s 1*