

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

dayton, herman & graham

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328

MINNESOTA STATE REGULATIONS

Notice of filing by the Commissioner of Administration

We have received on this date, stamped and filed 2 copies of Rules and Regulations pertaining to

the Public Welfare
(Agency or Board)

Regulation No. DPW Rule 47

Subject: Governing Administration of the Medical Assistance Program.

Department of Administration
Publication, Central Services Division
Documents Section
140 Centennial Office Building
St. Paul, Minnesota 55155
Telephone: (612) 296-2874

FILED
RICHARD L. BRUBACHER
Commissioner of Administration

MAY 28 1976

BY Ed Stenderman
AUTH. SIGNATURE

Stamped and filed with the Secretary of State 5-28-76 1:25PM 1:40PM

Rev. 9-72

April 12, 1976

John M. Broeker
Broeker and Bachman
Attorneys at Law
2850 Metro Drive
Suite 504
Minneapolis, Minnesota 55420

Dear Mr. Broeker:

Enclosed is a copy of the memorandum I sent to Barbara Gill regarding Welfare Rule DPW 49.

Very truly yours,

Michael B. Miller
Special Assistant
Attorney General

MBM/sr

Enclosure

COST OF THIS COPY PAID BY MINNESOTA TAXPAYERS

Attorney General

Thomas L. Fabel
Deputy Attorney General
Department of Welfare

May 21, 1976

Michael B. Miller
Special Assistant
Attorney General

296-4692

DPW Rule 47

Returned herewith is the above-captioned rule. I am returning this rule for deletion of paragraph 1, which has the problem of incorporation by reference of other rules.

MBM/sr

Enclosure

COST OF THIS COPY PAID BY MINNESOTA TAXPAYERS

228

84

Attorney General

Thomas L. Fabel
Deputy Attorney General

June 1, 1976

Michael B. Miller
Special Assistant
Attorney General

296-4692

Public Welfare Rule 47

Returned herewith is your department's copy of Rule 47 as filed.

MBM/mb

Enclosure

COST OF THIS COPY PAID BY MINNESOTA TAXPAYERS

July 7, 1977

John Broeker, Esq.
Broeker, Hedges & Grant
Attorneys at Law
2850 Metro Drive
Suite 504
Bloomington, Minnesota 55420

Dear Mr. Broeker:

Enclosed for your reference is a copy of a memorandum regarding Department of Welfare Rule 49.

Very truly yours,

Michael B. Miller
Special Assistant
Attorney General

MBM:mb

Enclosure

COST OF THIS COPY PAID BY MINNESOTA TAXPAYERS

Attorney General

Thomas L. Fabel
Deputy Attorney General
Department of Welfare

May 21, 1976

Michael B. Miller
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Attorney General

Thomas L. Fabel
Deputy Attorney General

June 1, 1976

296-4692

Michael B. Miller
Special Assistant
Attorney General

Public Welfare Rule 47

Returned herewith is your department's copy of Rule 47 as filed.

MBM/mb

Enclosure

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS

COMMISSIONER OF PUBLIC WELFARE

In The Matter of Proposed Amendments to Rule 47 of the Minnesota Department of Public Welfare Governing Administration of the Medical Assistance Program.

ADOPTED AMENDMENTS

Minnesota Department of Public Welfare Rule 47 is hereby amended as follows:

1. Renumber present section (s) as section (t) and insert a new section (s) to read:

(s) Reimbursement

The state agency shall pay a fee or charge for medical care or services rendered which does not exceed the provider's usual and customary fee or charge to the general public (including advertised prices and discounts limited to special groups) or DPW's maximum allowable charge, whichever is lower.

(a) "Usual and customary" as used herein means that amount the provider charges in the majority of cases for a specified procedure or service.

(b) DPW's "maximum allowable charge" as used herein means a negotiated fee between DPW and provider groups, established in accordance with requirements of applicable federal regulations, but shall not be less than charges actually approved in April, 1976, unless so required by federal regulations.

2. Appendices "A" through "J" of DPW Rule 47 are repealed.

3. The effective date of these amendments is the date of final enactment.

APPROVED AS TO FORM AND LEGALITY
MAY 28 1976 19
WARREN SPANNAUS, ATTORNEY GENERAL
BY /s/ Michael B. Miller
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
MAY 28 1976 1:25 P.M
Joan Anderson Growe
Secretary of State

FILED
RICHARD L. BRUBACHER
Commissioner of Administration
MAY 28 1976
BY Elda Stenderman
AUTH. SIGNATURE 1:40 pm

STATE OF MINNESOTA

COUNTY OF RAMSEY

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#228 Public Welfare
Rule 47

Resubmitted & rec'd. 5/24/76

Due 6/3/76 · (10 days)

ADMIN. 1000

STATE OF MINNESOTA

DEPARTMENT Attorney General

Office Memorandum

TO : Mike Miller

DATE: 5/24/76

FROM : Thomas L. Fabel
Deputy Attorney General

SUBJECT:

Enclosed are five copies of the adopted amendments to Rule 47, as per our discussion on Friday.

Thanks for your assistance in this matter.

TLF/pas
Enc.

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS

COMMISSIONER OF PUBLIC WELFARE

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(a) "Usual and customary" as used herein means that amount the provider charges in the majority of cases for a specified procedure or service.

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2. Appendices "A" through "J" of DPW Rule 47 are repealed.

3. The effective date of these amendments is the date of final enactment.

Minnesota Dental Association

DR. ROGER J. BURKE, PRESIDENT
220 Central Medical Building
St. Paul, Minnesota 55104

May 3, 1976

Mr. Michael B. Miller
Special Assistant to the Attorney General
G19-K State Administration Building
St. Paul, Minnesota 55155

Dear Mr. Miller:

I am writing you as President of the Minnesota Dental Association and in accordance with discussions between our Legislative Committee Chairman and members of the Attorney General's staff concerning the implementation of the reimbursement section of the proposed Rule 47 at the earliest possible date.

We are hopeful that you will be able to put into effect, by whatever procedures are necessary, those parts of the proposed Rule 47 that are necessary for the disbursement procedures and payment of dental services under the new amended rule.

We can appreciate that the new rule involving so may categories of Medical Assistance has presented considerable problems and work for both the Department of Public Welfare and the Attorney General's office. However, on the other hand, we think it is vital that you understand the problems the dental profession has had in the State of Minnesota. We have been operating under the old Rule 47 which originally went into effect in 1967 which authorized payment for dental services under a fixed fee schedule. The fees that were originally authorized have had some minor revisions but are considered extremely low in relation to the current usual and customary fees.

The Minnesota Dental Association has spent countless hours working with the Department of Public Welfare ever since the Centralized Medical Assistance Program was announced in 1974 in order to establish a more realistic fee schedule for dental services; and then, when a complete revision to Rule 47 was proposed, more delay was necessarily caused by (1) the development of the new rule, (2) the lengthy public hearing procedures and (3) the consideration of the testimony provided by various parties regarding the proposed rule. As a result, there has been a great ground swell of impatience among the profession and a request for action which we as officers of the Minnesota Dental Association have been trying to carry out fully realizing the practical problems involved.

However, we feel that the time has come when some specific action must be undertaken and, therefore, unless this question can be resolved as soon as possible, we are concerned about the problems of the patient and the dentist as long as unrealistic fees are being used to try and provide adequate dentistry.

We, therefore, will appreciate your cooperation in assisting to implement the sections of proposed Rule 47 within the next few days that will allow the Department of Public Welfare to reimburse the dental profession for their services at fees that are based upon their usual and customary charges.

We wish to assure you that the Minnesota Dental Association will cooperate with the new rules dealing with the disbursement for dental services; and we will notify our membership of the regulations as promulgated and the methods of complying therewith. We are sure that as the rule is utilized further refinement may suggest itself for further amendment or revision.

Sincerely,

Roger J. Burke

Roger J. Burke, D.D.S.

RJB/abl
Photocc: James J. Hiniker, Deputy Commissioner, Department of Public Welfare

Minnesota Dental Association
DR. ROGER J. BURKE, PRESIDENT
220 Central Medical Building
St. Paul, Minnesota 55104

Mr. Michael B. Miller
Special Assistant to the Attorney General
G19-K State Administration Building
St. Paul, Minnesota 55155

FROM PAUL GETTS

BEFORE THE MINNESOTA DEPARTMENT OF PUBLIC WELFARE

In the matter of the proposed adoption of the Minnesota Department of Public Welfare Rule DPW 47--Medical Assistance

STATEMENT OF POSITION

This Statement is presented on behalf of certain physicians, psychiatric social workers, and psychologists who regularly provide psychotherapy to persons receiving Medical Assistance. (The names and addresses of the persons submitting this Statement are set forth in Appendix A.) As such, these individuals are providers whose interests are directly and substantially affected by proposed Rule DPW 47. More importantly, the professional commitment of these individuals to the quality of psychiatric care compels this protest against the illegal and arbitrary restrictions on psychiatric care contained in the proposed rule.

This Statement is directed only at those portions of proposed Rule DPW 47 which concern the amount, scope, and duration of psychiatric care provided to Medical Assistance recipients. The precise sections attacked are set forth in Appendix B; generally, these provisions include limitations on the number of psychiatric counseling sessions, limitations on the number of days of psychiatric care in private hospitals, and similar restrictions which impede the delivery of adequate psychiatric care to those persons in need. (Unless otherwise noted, any general reference to the proposed rule should be

deemed to be a reference to these provisions only.) The regulations in question are illegal because they violate the express policy of the Medical Assistance program as set forth in federal law and enabling regulations promulgated by the Secretary of Health, Education and Welfare, and because there is no reasonable factual basis for imposing these limitations on psychiatric care alone.

The purpose of proposed Rule DPW 47 is to provide a written State Plan for the administration of a Medical Assistance program which qualifies for federal assistance under Title XIX of the Social Security Act (42 U.S.C. §1396) and the Code of Federal Regulations (45 C.F.R. Part 249). Thus, the proposed rule is subject to and must satisfy requirements of both federal statutes and federal regulations. However, by restricting the availability of psychiatric care, the proposed regulation fails both tests.

Title XIX of the Social Security Act establishes the Medical Assistance program to provide financial assistance to those persons and families "whose income and resources are insufficient to meet the costs of necessary medical services and . . . rehabilitation and other services to help such families and individuals attain or retain capability for independence or self care . . . ." (42 U.S.C. §1396). The goal of the Medical Assistance program is to provide whatever medical care is necessary to restore a person's independence and ability to be self-supportive. Despite the clear requirement of federal law that a state Medical Assistance program

must pay for all necessary medical care for eligible recipients, proposed DPW 47 limits the payment for psychiatric care without regard to professional medical judgment about the necessity for such care. For example, the rule allows a maximum of only ten sessions per year for any individual requiring outpatient psychiatric care. Such a brief program of psychotherapy does little if anything to restore a patient to the "capability for independence or self-help" which is the goal of the federal law. Indeed, in one documented case, it was the opinion of a consulting psychiatrist that such a short term plan would do more harm than good (See discussion below, Page 6). In order to satisfy the federal statute, DPW 47 must permit sufficient payments for individual outpatient psychotherapy to permit the patient and the therapist to establish a viable therapeutic relationship which holds some promise of resolving the patient's psychological problems. There are few circumstances in which a mere ten visits per year satisfy this test.

The statutory shortcomings of DPW 47 are compounded by its violation of the federal regulation prohibiting discrimination against specific medical disciplines, illness or treatments. Specifically, the proposed version of DPW 47 violates 45 C.F.R. §249.10(a)(5)(i), which provides that a state plan must, among other things:

> Specify the amount and/or duration of each item of medical and remedial care and services that will be provided to the categorically needy and to the medically needy if the plan includes the latter group. Such items must be sufficient in amount, duration, and scope to reasonably achieve their purpose. With respect

> to the required services for the categorically needy . . . and the medically needy . . ., the state may not arbitrarily deny or reduce the amount, duration or scope of such services to an otherwise eligible individual solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on services based on such criteria as medical necessity or those contained in utilization or medical review procedures. [Emphasis added.]

This regulation clearly places the psychiatric patient and the psychiatric provider on the same footing as other patients and providers; that is, Medical Assistance benefits must be provided to psychiatric patients and providers in the same manner and in the same amount as such benefits are provided to other Medical Assistance recipients and providers. If psychiatric treatment is deemed medically necessary by a physician, the state Medical Assistance program must provide benefits for such treatment in the same manner as it provides benefits for any other treatment diagnosed as medically necessary.

Proposed DPW 47 manifestly fails this test. The proposed rule limits individual hourly sessions with a licensed psychiatrist to ten per calendar year and requires prior authorization for sessions in excess of that amount and places similar limitations on hospital care for psychiatric problems. No other medical service provided by a licensed physician and diagnosed as medically necessary is subject to any similar restriction. Aside from psychotherapy, prior authorization is required only for "medical, surgical or behavioral modification services aimed specifically at weight reduction," "surgery and other procedures of questionable

medical necessity," and "removal of tattoo."* The equation of such procedures with psychotherapy administered by a competent professional is ludicrous. No person familiar with the principles of psychiatric medicine can argue that such treatments do not assist a person in achieving the "capability for independence or self-help" that is the goal of federal law.

The record in this case provides no justification for subjecting only psychiatric care to prior limitations on the amount, duration or scope of treatment. The Department of Public Welfare presented no evidence differentiating psychiatric services from those of a radiologist, surgeon, internist, or other licensed physician. Federal law contains no such distinction. Nor is the distinction supported by any credible medical theory. (See, e.g., Alexander, Fundamentals of Psychoanalysis, Chapter 1, and Freeman and Small, The Story of Psychoanalysis, Page 16, for a discussion of the role played by psychiatry in modern medicine.) Proper psychiatric treatment can restore a person to independence and self care just as surely as a cast on a broken leg. A similar statement cannot be made for the removal of a tatoo or treatment of questionable medical necessity or weight loss programs.

By limiting the number of psychotherapy sessions and by requiring prior authorization for additional sessions, DPW 47 on its face denies or reduces the amount, duration, and

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*Prior authorization is required for certain treatments provided by non-physician providers such as chiropractors, podiatrists, and optometrists. It is not argued here that these disciplines are--or ought to be--protected by the provisions of 45 C.F.R. §249.10.

scope of psychiatric services "solely because of the diagnosis, type of illness or condition." The imposition of such restrictions solely on psychiatric care violates the Code of Federal Regulations, and the restrictions must be stricken if the State Plan is to satisfy federal law.

Three recent cases demonstrate the potential inimical effect of the proposed regulation on both the patient and society. In one case, a young girl with a history of delinquent behavior, drug abuse, and sexual problems was diagnosed as requiring--and capable of receiving substantial benefit from--long term psychotherapy. Despite this professional judgment, the Department of Public Welfare authorized only twelve sessions. To thus limit treatment would, according to a psychiatrist retained by the state to examine the young woman, have severely worsened her condition and prolonged her incapacity and dependence on public support.

In another case, a young woman had been hospitalized under the care of a psychiatrist in a private hospital and was making satisfactory progress. The Department of Public Welfare insisted upon removing her to a state hospital after the permitted thirty days had expired; that patient has now run away from the state hospital twice, has severely regressed, and must again rely on state support because she cannot function independently.

Finally, in another recent case, a thirty-five year old woman, who had been hospitalized frequently, was receiving outpatient psychotherapy and had stabilized sufficiently to

function without hospitalization for a full year. However, the psychiatric advisory subcommittee of the county welfare board applied the limitations similar to those contained in the proposed regulation and reduced treatment to one session per month. The woman was forced to take an appeal to the state Department of Public Welfare in order to resume her weekly sessions and to continue progress towards independence. Upon finding that one psychotherapy session per month would be insufficient for the patient, the Commissioner concluded:

> We find nothing in Code of Federal Regulations or DPW Rule 47 that limits medical services to eligible recipients. There is provisions [sic] for utilization review. See DPW 47(o). Hennepin County Welfare Department has failed to present convincing evidence or testimony that this request is over-utilization. Also see Minnesota Statutes 256B.04. We must conclude that the petitioner's request is not an unreasonable one.

The policy expressed in the Commissioner's finding echoes that expressed in federal law and regulation: medical care, of whatever type necessary to assist the patient to achieve independence and the capability for self care, shall be paid for by the Medical Assistance program without regard to the type of illness or diagnosis, so long as the recommended treatment is deemed medically necessary by a licensed physician.

It is sadly the case that psychiatric halp is needed most urgently by the very persons whose low incomes make the Medical Assistance program necessary. (See letter from Dr. F.S. Abuzzahab attached as Appendix C.) Low income persons suffer from stress, anxiety, and depression to a greater extent than the general population. Yet the limits proposed by DPW 47 would severely restrict the availability of psychiatric

care for the single population group for whom it may have the greatest benefit. In the three cases cited, the denial of access to adequate psychotherapy condemned the patient to prolonged and unnecessary dependence on public support in state institutions, thus intensifying the problems Medical Assistance is designed to alleviate.

Finally, the explicit limitations on psychotherapy contained in proposed DPW 47 cannot be justified on the ground that these limitations are necessary to prevent fraud or misuse of public funds. Under federal law and the explicit provisions of proposed DPW 47, every medical discipline is subject to the general utilization review procedures of §IV(j) of the proposed rule. Moreover, other provisions of the proposed rule require all providers to keep records and to periodically justify the treatment in question. No physician who treats patients subject to Medical Assistance can legitimately object to these provisions. However, there is no reason whatever for imposing additional restrictions on psychotherapy alone. If the regulation of other medical providers contained in Part IV of the proposed regulation is adequate for surgeons, radiologists, orthopedists, and other medical disciplines, the procedures are adequate for psychiatrists and persons working under their direction.

CONCLUSION

The explicit limitations on psychotherapy contained in proposed DPW 47 violate the general policy of federal law and the specific requirements of federal regulations. There is

no factual or theoretical justification for imposing such limitations on psychotherapy and on no other medical specialty. The provisions of proposed DPW 47 set forth in Appendix B should be stricken.

Respectfully submitted,

Philip W. Getts
Attorney for Persons Listed
in Appendix A

DAYTON, HERMAN & GRAHAM
800 Midland Bank Building
Minneapolis, Minnesota 55401
612/339-7633

APPENDIX A

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Clinical Psychopharmacology Consultants, P.A.
Suite 818, Fairview-St. Mary's Medical Office Building
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Minneapolis, Minnesota 55454

Thomas P. Barton, M.D.
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Minneapolis, Minnesota

B. Robert Berg, A.C.S.W.
1427 Medical Arts Building
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Jean Charnley, A.C.S.W.
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Fred Gross, A.C.S.W.
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APPENDIX B

Attached are several pages from proposed DPW 47 which set forth the proposed restrictions on psychiatric care. Those provisions which are illegal have been lined through and should be omitted for the reasons set forth in the text.

"Intermediate care facility services/chemically dependent" means services provided in an ICF/CD. An "ICF/CD" is a facility licensed by the Minnesota Department of Health, licensed under Minn. Rule DPW 35 and which meets each of the conditions described above.

(C) "Inpatient psychiatric hospital services for individuals under age 21" are those services provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals. Such services include only inpatient services which, in the case of an individual:

(i) Involve active treatment which meets the standards prescribed by the Secretary of Health, Education, and Welfare;

(ii) Are provided by a team (consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and treatment thereof) and determined to be necessary on an inpatient basis and which can reasonably be expected to improve the condition giving rise to the need for such services, to the extent that eventually such services will no longer be necessary; and

(iii) Are provided prior to the date such individual attains age 21, or if the individual was receiving such services during the period immediately preceding his twenty-first birthday, such services may be continued up to the date the individual no longer requires such services or the date the individual attains age 22, whichever date comes first.

(D) Inpatient hospital, SNF and ICF services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.

(i) "Inpatient hospital services in an institution for mental diseases" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a psychiatric hospital which meets the requirements of Title XVIII of the Social Security Act.

(ii) "Inpatient hospital services in an institution for tuberculosis" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a tuberculosis hospital which meets the requirements of Title XVIII of the Social Security Act.

(iii) "Skilled nursing facility services" are those items and services furnished by a skilled nursing facility as defined by applicable federal regulations.

(iv) "Intermediate care facility services" are those items and services furnished by an intermediate care facility, as defined by applicable federal regulations, to residents who have been determined in accordance with such federal regulations to be in need of such care.

(v) An "institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases including medical attention, nursing care and related services.

(vi) An "institution for tuberculosis" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with tuberculosis including medical attention, nursing care and related services.

(E) Long term care facility services. The state agency shall establish written criteria to be used in determining appropriate levels of required nursing care, in accordance with applicable federal regulations.

(F) General limitations.

(i) Payment will be made only to facilities that have in effect an approved utilization review plan and which meet all other requirements of the surveillance and utilization control program prescribed by applicable federal regulations.

(ii) Medical Assistance is not available on behalf of any individual who is an inmate of a public institution (except where a patient in a medical institution [See, Minn. Stat. 256B.02(4)] or a resident of an intermediate care facility) or any individual who has not attained 65 years of age or who is a patient in an institution for tuberculosis or mental diseases. An individual on provisional discharge or convalescent leave from an institution for mental diseases is not considered to be a patient in such institution. An institution for the mentally retarded or an institution for the chemically dependent is not considered an institution for mental diseases.

(iii) Payments to institutions for the mentally retarded or persons with related conditions shall not include reimbursement for vocational and educational activities.

(G) Health care facility report. Every facility required by state law to be licensed by the Minnesota Department of Health shall provide such annual reports to the Commissioner of Public Welfare as may hereafter be required. Each health care facility participating under the MA program shall provide the Commissioner of Public Welfare with a full and complete financial report of the facility's operations, including:

(i) An annual statement of income and expenditures;

(ii) A complete statement of fees and charges;

(iii) The names of all individuals, partnerships and corporations (other than mortgage companies) owning any interest of ten percent (10%) or more of the facility; and

(iv) The names of all owners of interest in the facility as defined in (iii), or the children, parents or spouses of such owners who own an interest in any other health care facility or organization doing business with the MA program or who are otherwise enrolled as providers.

The financial records, reports and supporting data of each participating facility shall be accessible for inspection and audit by the Commissioner of Public Welfare or designees.

(3) Physician services. Physician services are those services provided by or under the personal supervision of a licensed physician or osteopath within the scope of his profession as defined by state law. All physicians currently licensed to practice medicine under Minnesota law are eligible to participate in the MA program. Out-of-state physicians who are licensed in the state of service are also eligible for participation in Minnesota's MA program. The MA program shall pay for all emergency and medically-necessary health care.

(A) The following physician services must receive prior authorization:

(i) All medical, surgical or behavioral modification services aimed specifically at weight reduction.

(ii) Surgery and other procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to interfere with the individual's personal and social adjustment or employability.

(iii) Removal of tattoo.

~~(iv) Payment for physicians' services exceeding thirty (30) days of inpatient psychiatric treatment per calendar year.~~

~~(v) Individual hourly sessions with a licensed psychiatrist in excess of ten (10) per calendar year.~~

(B) The following are limitations to physicians' services:

~~(i) The MA program will pay for up to 10 hourly sessions with a licensed psychiatrist per calendar year for any eligible recipient.~~

~~(ii) The MA program will pay for up to 26 additional hourly sessions with a licensed psychiatrist per calendar year when all of the following conditions exist:~~

~~(aa) Three or more members of one family unit are all seen together at every session; and~~

~~(bb) The 26 hourly sessions extend over a period of time greater than six consecutive months; and~~

~~(cc) At least one of the family members is under age 18.~~

~~(iii) The MA program will pay for ongoing chemotherapy management on a once-a-week average basis, provided that both of the following conditions apply:~~

~~(aa) The medication required is an anti-psychotic or anti-depressant; and~~

~~(bb) No more than 52 sessions take place within a twelve-month period.~~

~~(iv) The MA program will pay for family medical psychotherapy of two family members (conjoint psychotherapy with continuing medical diagnostic evaluation and drug management) as needed for up to two hours per week for a twenty week period. [When more than two family members are involved, *See*, (V)(b)(3)(B)(ii), *supra*.]~~

~~(v) The MA program will pay for multiple family group psychotherapy or group psychotherapy for up to two hours per week for a ten week period.~~

~~(vi) The MA program will pay for medical psychotherapy for up to 100 hourly sessions for eligible recipients under age 18 when:~~

~~(aa) The services are provided by a child psychiatrist or receive prior authorization; and~~

~~(bb) The 100 sessions do not occur during a period of less than twelve consecutive months.~~

(4) Health Maintenance Organizations [HMO]. Health Maintenance Organizations are organizations licensed by the state which provide medical care to a voluntarily enrolled population in a specified geographic area. The MA program shall reimburse participating HMO's through a pre-negotiated and fixed per capita payment determined in accordance with applicable federal regulations made on behalf of enrolled recipients. HMO's shall provide, either directly or through arrangements with other medical providers, for all medical services and supplies covered under the official Medical Assistance State Plan.

(5) Other licensed practitioners. The MA program shall pay for medical and remedial care or services, other than physicians' services, provided by a practitioner currently licensed under Minnesota law and performed within the scope of his practice as defined by state law. Out-of-state practitioners who are licensed in the state of service are also eligible to participate in Minnesota's MA program. This category is limited to services provided by licensed chiropractors, podiatrists, vision care providers, psychologists, midwives and osteopaths not licensed to practice medicine and surgery. Limitations on the number of treatments pertain to each eligible recipient per calendar year.

(A) Chiropractors. Chiropractors must be licensed and conform to the uniform minimum standards promulgated by the Secretary of Health, Education, and Welfare under Title XVIII of the Social Security Act, as amended. The MA program limits payment for services provided by chiropractors as follows:

(i) The request for chiropractic services must originate with the recipient, his family or caseworker and may proceed only with the recipient's full knowledge and consent.

(ii) Payment is limited to manual manipulation of the spine for a diagnosis of subluxation of the spine. No other chiropractic service is covered under the MA program.

(iii) Payment is limited to 3 treatments per month and 12 treatments per calendar year for each eligible recipient. Treatment in excess of these maxima must receive prior authorization.

(B) Podiatrists. The MA program limits payment for podiatry services as follows:

(i) The request for podiatry services must originate with the recipient, his family, his caseworker or, where applicable, the staff of the nursing facility wherein he resides, and may proceed only with the patient's full knowledge and consent.

(ii) A limit of 3 visits per month and 12 visits per year is placed on the following:

(aa) Total office and outpatient visits.
(bb) Total home or nursing home visits.
(cc) Hospital visits

(iii) Treatment in excess of these maxima must receive prior authorization.

(iv) The following podiatry services are not covered under the MA program for nursing home patients:

(aa) Ordinary foot hygiene.
(bb) Use of skin creams to maintain skin tone.
(cc) Normal trimming of nails and other services that can reasonably and safely be performed by LTC facility personnel.

(C) Vision care. "Optometric services" are those services provided by or under the personal supervision of a licensed optometrist within the scope of his profession as defined by state law. "Eyeglasses" are lenses (including frames when necessary) and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select, to aid or improve vision. Eligible providers include optometrists currently licensed by the State Board of Optometry, ophthalmologists currently licensed by the state, opticians who are normally associated with the fabrication and/or dispensing of materials, and out-of-state providers in one of the above classifications licensed by the state of service.

(i) The following vision care services must receive prior authorization:

(aa) Contact lenses:
(1) Supplemental contact lenses.
(2) Contact lens check-up.
(3) Spherical lens fitting (single vision).
(4) Cylindrical, lenticular, aphakic or prism ballast lenses.
(5) Keratoconus lenses.
(6) Cosmetic lenses (disfigurement only).
(7) Fitting previous contact lens wearer.
(8) Soft contact lens fitting.
(9) Fitting monocular patient.

(bb) Custom-fit prosthetic eye.
(cc) Amblyopia therapy.
(1) "Amblyopia" includes all test procedures necessary for classification and determination of expecteds.
(dd) Strasbismus therapy.
(1) "Strabismus" includes all test procedures necessary for classification, degree of squint and determination of expecteds.
(ee) Vision therapy--supplemental evaluation and report.
(ff) More than one (1) pair of eyeglasses in any single 12 month period.
(gg) Photochromatic lenses: Must be accompanied by a statement of medical necessity.
(hh) Sunglasses: Must be accompanied by statement of medical necessity.
(ii) Lens coating-surface or edge.

(ii) The following vision care services are not covered under the MA program:

(aa) Services provided principally for cosmetic reasons, including:

(1) Contact lenses prescribed for reasons other than aphakia, keratoconus, anisocoria or marked acuity improvement over spectacle correction.
(2) Replacement of lenses or frames due to a recipient's personal preference for a change of style or color.

(bb) Technical services related to the provision of non-covered services.

~~(D) Psychologists. Eligible providers are individuals currently licensed by the Minnesota Board of Examiners of Psychologists to practice as licensed consulting psychologists in the fields of psychological counseling and therapy.~~

~~(i) The following psychological services must receive prior authorization:~~

~~(aa) Services in excess of the limitation on the number of visits [See, below].~~

~~(ii) The MA program limits payment for services provided by psychologists as follows:~~

Service	Limitation
(aa) Psychological diagnostic interview examination	One per month, no more than 3 per twelve month period
(bb) Psychological testing batteries	One per month, no more than 3 per twelve month period
(cc) Individual psychotherapy	Ten visits per calendar year
(dd) Family psychotherapy of two family members	Two hours per week, no more than 20 weeks
(ee) Family psychotherapy for three or more members of one family	Twenty-six 30 minute sessions per 6 month period
(ff) Hypnotherapy	Ten 30 minute sessions per twelve month period

(iii) The following psychological services are not covered under the MA program:

(aa) Aversion therapy.
(bb) Medical supplies and equipment.

(6) Outpatient hospital services. "Outpatient hospital services" are preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished by or under the direction of a licensed physician or dentist to an outpatient in an outpatient facility which is licensed as a hospital by the state and which is qualified to participate under Title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation. All outpatient hospitals certified to participate under Medicare (Title XVIII) are eligible to participate in the MA program upon completion of a provider agreement.

(A) The following outpatient hospital services must receive prior authorization:

(i) Kidney dialysis not covered by Medicare.
(ii) Oral surgery (except in emergencies).
(iii) Hemodialysis back-up service.
(iv) Supplemental and tube feedings for patients who have special nutritional needs.
(v) All physician services which must receive prior authorization [*See*, (V)(b)(3)(A), *supra*].

(B) The following are limitations to services provided by outpatient hospitals:

(i) Each hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply will result in denial of payment under the MA program.

(C) The following outpatient hospital services are not covered under the MA program:

(i) Hypoallergenic foods; babyfoods.
(ii) Diapers.
(iii) Charges for services of house staff, interns, residents, administrative or supervisory staff (including physician-owners) who are paid by the hospital or by other sources.

(7) Clinic services. "Clinic services" are preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the direction of a licensed physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients. Mental health centers and family planning agencies or centers are considered "clinics" under this definition.

(A) "Mental health centers" are centers currently receiving grants-in-aid authorized by Minn. Statutes, Chapter 245. Services provided by mental health centers must be provided under the auspices and direction of a licensed psychiatrist or other physician currently enrolled as an eligible provider under the MA program. The MA program will pay for mental health center services provided to residents of nursing homes only if the attending physician helped develop the plan of treatment and periodically reviews that plan.

~~(i) The following are limitations to payment for services~~ provided by mental health centers:

	Service	Limitation
(aa)	Chemotherapy - individual or group	52 transactions per twelve month period
(bb)	Collateral therapy - individual	10 transactions per twelve month period
(cc)	Day treatment	45 transactions per twelve month period
(dd)	Family therapy - group	52 transactions per twelve month period
(ee)	Group psychotherapy	20 transactions per twelve month period
(ff)	Hypnotherapy - individual	10 transactions per twelve month period
(gg)	Individual psychotherapy	52 transactions per twelve month period if under age 21 10 transactions per twelve month period if 21 years of age or older
(hh)	Intake evaluation - individual	1 transaction per twelve month period
(ii)	Mental health information and referral - individual	2 transactions per twelve month period
(jj)	Neurological examinations - individual	1 transaction per twelve month period
(kk)	Non-intake evaluation - individual	1 transaction per twelve month period
(ll)	Psychiatric evaluation - individual	2 transactions per twelve month period
(mm)	Psychodrama - group	20 transactions per twelve month period
(nn)	Psychological evaluation - individual	1 transaction per twelve month period
(oo)	Social evaluation - individual or group	1 transaction per twelve month period
(pp)	Speech therapy - individual	52 transactions per twelve month period
(qq)	Therapy with groups of couples	20 transactions per twelve month period

(ii) The following mental health center services are not covered under the MA program:

(aa) Community planning.
(bb) Community consultation; program consultation.
(cc) Program and service monitoring and evaluation.
(dd) Public information and education.
(ee) Resource development.
(ff) Training and education.

(B) "Family planning agencies" are agencies or clinics which primarily offer family planning related services and have executed either a contract or provider agreement with the state agency. Family planning agencies provide services concerned with the voluntary planning of the conception and bearing of children. Such services include both fertility and infertility programs.

(i) The following are limitations to services provided by family planning agencies:

(aa) The request for such services must originate with the recipient and proceed with his full knowledge and consent.

(bb) The agency or clinic must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment under the MA program.

(8) Home health care services.

(A) "Home health care services" are any of the following items and services when they are prescribed by a licensed physician to a patient in his place of residence, but excluding residence in a hospital, SNF or ICF:

(i) Intermittent or part-time nursing services furnished by a home health agency.

(ii) Intermittent or part-time nursing services of a professional registered nurse or licensed practical nurse under the direction of the patient's physician, when no home health agency services are available.

(iii) Medical supplies, equipment and appliances prescribed by a physician as necessary for the care of the patient and suitable for use in the home.

(iv) Services of a home health aide under the supervision of a professional nurse assigned by a home health agency.

(B) A "home health agency" is a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under Title XVIII of the Social Security Act or is determined by the state agency to currently meet the requirements of applicable federal regulations. The following home health care services are not covered under the MA program:

(i) Homemaker services.

(ii) Social services provided by a home health agency.

(9) Medical supplies. The term "medical supplies" as used herein includes non-durable medical supplies, durable medical equipment, prostheses, orthoses and oxygen.

(A) "Non-durable medical supplies": Those items which have a limited life expectancy (e.g., atomizers, nebulizers, fountain syringes and incontinence pads).

(B) "Durable medical equipment": Equipment which can withstand use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home (e.g., wheel chairs, hospital beds and side rails).

(C) "Prostheses" and "orthoses": Replacement, corrective or supportive devices prescribed for a patient by a physician or other licensed medical practitioner within the scope of his profession as defined by state law, for the purpose of artifically replacing a missing portion of the body or to prevent or correct physical deformity or malfunction or to support a weak or deformed portion of the body.

(D) The MA program pays for oxygen and any equipment necessary for administration of oxygen when prescribed by a licensed physician so long as prior authorization is obtained.

Equipment must meet the definition of durable medical equipment and must be necessary and reasonable for the treatment of an illness or to improve the functioning of a malformed body member. Payment for equipment repair will be allowed only when that equipment is medically necessary. Routine periodic servicing such as testing, cleaning, regulating and checking of a recipient's equipment will not be covered. Extensive, complex maintenance may be covered as a necessary repair. Payment on equipment will not continue after the recipient's need for that equipment ceases to exist. The MA program will only pay for supplies essential to the effective use of medically necessary durable equipment (e.g., distilled water).

Eligible providers include those individuals or agencies who supply and/or service medical supplies. Hearing aid dealers must complete a "Hearing Aid Performance Agreement" to be eligible to participate in the MA program.

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December 1, 1975

APPENDIX C

B. Robert Berg
Gross, Charnley and Berg, Inc.
1426 Medical Arts Building
Minneapolis, MN 55402

Dear Mr. Berg,

I would like to thank you for bringing to my attention through your recent letter the Minnesota Department of Public Welfare hearing on DPW Regulation 47.

It is going to be a sad day for our medical assistance patients if the proposed regulations are carried through to limit the availibility of psychiatric care for the medical assistance patients.

Incidence of functional psychoses such as schizophrenic disorders is 8 - 9 times higher in recipients of medical assistance programs, since these disorders have an early onset in the life of the patient, thus interfering with their education and socialization.

Psychiatric intervention is aimed at restoring patient's function and prevent long term chronicity and disability. Curtailment of such services would not only be self defeating but will discriminate in an inhuman manner towards these patients.

It is my opinion that such a curtailment of psychiatric services will be an anachronistic move, back to the dark ages when patients were shunned because they had psychiatric difficulties.

Please present this letter against the curtailment of any psychiatric services offered to medical assistance recipients.

Cordially yours,

F. S. Abuzzahab Sr., MD, PhD.

FSA:mcs

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CURTIS L. STINE

May 3, 1976

Mr. Michael B. Miller
Special Assistant Attorney General
Department of Administration
State Administration Building
Saint Paul, Minnesota 55155

Dear Mr. Miller:

We are returning to you herewith, your copy of proposed Rule 47. We very much appreciate your cooperation in letting us use your copy in order to obtain a copy for our file. Thank you.

Very truly yours,

BROEKER AND BACHMAN

By John M. Broeker
John M. Broeker

JMB:jp
Encls.

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS

COMMISSIONER OF PUBLIC WELFARE

In the Matter of Proposed Amendments to Rule 47 of the Minnesota Department of Public Welfare Governing Administration of the Medical Assistance Program.

ADOPTED AMENDMENTS

Minnesota Department of Public Welfare Rule 47 is hereby amended as follows:

1. At the end of the opening paragraph of DPW Rule 47 add a sentence to read:

> This rule specifically includes by reference any federal laws or regulations which are mandatory requirements for federal financial participation in the Minnesota Medical Assistance program, and any provision of this rule which is inconsistent with those laws and regulations is superseded thereby.

2. Renumber present section (s) as section (t) and insert a new section (s) to read:

(s) Reimbursement

The state agency shall pay a fee or charge for medical care or services rendered which does not exceed the provider's usual and customary fee or charge to the general public (including advertised prices and discounts limited to special groups) or DPW's maximum allowable charge, whichever is lower.

(a) "Usual and customary" as used herein means that amount the provider charges in the majority of cases for a specified procedure or service.

(b) DPW's "maximum allowable charge" as used herein means a negotiated fee between DPW and provider groups, established in accordance with requirements of applicable federal regulations, but shall not be less than charges actually approved in April, 1976, unless so required by federal regulations.

3. Appendices "A" through "J" of DPW Rule 47 are repealed.

4. The effective date of these amendments is the date of final enactment.

BROEKER AND BACHMAN
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Mr. Michael B. Miller
Special Assistant Attorney General
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dayton, herman & graham attorneys at law (612) 339-7633

Charles K. Dayton/John H. Herman/Kathleen M. Graham/Philip W. Getts 800 Midland Bank Building Minneapolis MN 55401

May 4, 1976

Mr. Michael B. Miller
Special Assistant Attorney General
Room G 19K
State Administration Building
50 Sherburne Avenue
St. Paul, Minnesota 55155

Re: Proposed Regulation DPW 47, Our File 094

Dear Mike:

Thank you for the opportunity to comment on the amendments to DPW 47. As I indicated, the amendments adopted by the Commissioner of Public Welfare violate the express provisions of Federal regulations prohibiting limitations on the amount, duration, and scope of medical reimbursement solely because of diagnosis, type of illness, or condition. The record contains no justification for this discrimination, and there is no possible theory for requiring prior authorization for psychiatric care and for no other recognized medical speciality.

I am enclosing for your information those portions of the Code of Federal Regulations dealing with medical reimbursement under Title XIX of the Social Security Act (42 U.S.C. §1302). I am enclosing all of part 248 and 249 so that you will be able to judge the general scheme required by Federal Regulations. The specific provision prohibiting discrimination against various types of service is found at 45 C.F.R. §249.10(a)(5)(i). You should also note 45 C.F.R. §248.2(a) which expresses the general policy of the Act against arbitrary or inequitable treatment.

The legal arguments on this matter are spelled out in detail in the Statement of Position which I furnished you during our interview. Appended to that Statement is an exhibit which indicates

the specific portions of DPW 47 which, in my opinion, violate Federal law and regulations.

If you have any questions, please call. Thank you again for your cooperation and consideration in this matter.

Sincerely,

Philip W. Getts
PWG/jt

cc: Bob Berg

Enclosure

eligibility. It is a requirement upon the agency, and is fulfilled by providing the following information after a family has been found eligible and been granted assistance: A statement that AFDC has been furnished (date) to relative (name and address) in behalf of children (name and ages) in his home, who appear to have been deserted or abandoned by their parent(s) (name and address, if known). Under this requirement, the appropriate law enforcement officials are those responsible for initiating actions in cases of desertion or abandonment, as those terms are defined under State law.

(b) Criteria will be established for the selection of cases in which notice is given to law enforcement officials that AFDC has been furnished in respect to a dependent child believed to have been deserted or abandoned by a parent. In fulfilling this requirement, the criteria will include instructions for identification of the classes of persons who, under State law, are defined as parents responsible for support of minor children, and against whom legal action may be taken under such laws for desertion or abandonment.

(c) All applicants affected by the reporting requirement will be informed as early as possible during the application process, and each applicant will be afforded the opportunity to withdraw his application, if he wishes, before payment is issued and the required notice sent to the law enforcement officials.

§ 235.110 Fraud.

State plan requirements: A State plan under title I, IV–A, X, XIV, or XVI of the Social Security Act must provide:

(a) That the State agency will establish and maintain:

(1) Methods and criteria for identifying situations in which a question of fraud in the program may exist, and

(2) Procedures developed in cooperation with the State's legal authorities for referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced.

The definition of fraud for purposes of this section will be determined in accordance with State law.

(b) For methods of investigation of situations in which there is a question of fraud, that do not infringe on the legal rights of persons involved and are consistent with the principles recognized as affording due process of law.

(c) For the designation of official position(s) responsible for referral of situations involving suspected fraud to the proper authorities.

PART 237—FISCAL ADMINISTRATION OF FINANCIAL ASSISTANCE PROGRAMS

Sec.

237.50 Recipient count, Federal financial participation.

237.60 Maintenance of State effort; Federal financial participation.

AUTHORITY: The provisions of this Part 237 issued under sec. 1102, 49 Stat. 647; 42 U.S.C. 1302.

§ 237.50 Recipient count, Federal financial participation.

Pursuant to the formulas in sections 3, 403, 1003, 1118, 1121, 1403, and 1603 of the Social Security Act, it is necessary to identify expenditures that may be included in claims for Federal financial participation. The quarterly statement of expenditures and recoveries which is required for OAA, AFDC, AB, APTD, and AABD must include, as a part of the basis for computing the amount of Federal participation in such expenditures, the number of eligible recipients each month. However, where the State is making claims under section 1118 of the Act or under optional provisions for Federal sharing specified in such paragraphs no recipient count is involved. Vendor payments for medical care may not be considered if the State has a plan approved under title XIX of the Act. The procedures for determining recipient count are set forth in paragraphs (a), (b) and (c) of this section.

(a) Adult assistance categories. For each adult assistance category, under title I, X, XIV, or XVI, of the Act, the recipient count for any month may include:

(1) Eligible recipients who receive money payments or in whose behalf protective payments are made for that month:

Provided, that such payments are not excluded from Federal financial participation under the provisions of § 233.145(c) of this chapter; plus

(2) Other eligible recipients in whose behalf payments are made for institutional services in intermediate care facilities for that month, but only in a State which does not have in effect a plan approved under Title XIX of the Act. (See § 233.145(b)(2) of this chapter.)

(b) AFDC category. For the AFDC category under title IV, Part A, of the Act

(1) The recipient count for any month may include:

(i) Eligible recipients in families which receive a money payment, plus

(ii) Eligible children in foster care not otherwise counted in whose behalf a foster care payment is made in such month, plus

(iii) Eligible recipients in families not otherwise counted in whose behalf protective or nonmedical vendor assistance payments are made for such month, not to exceed 10 percent of the total recipients counted under subdivisions (i) and (ii), of this subparagraph. The 10 percent limitation does not apply with respect to individuals for whom protective or nonmedical vendor payments are made pursuant to section 402(a)(19)(F) of the Act because there has been a refusal without good cause to accept employment, work or training:

Provided, That such payments are not excluded from Federal financial participation under the provisions of § 233.145(c) of this chapter.

(2) The recipient count may include all eligible children, plus the eligible relative with whom the children are living (as specified in section 406(a)(1) of the Act).

(3)(i) When at least one of the children in a family is eligible due to the incapacity of his parent in the home, the recipient count may include all eligible children, the parent, and the parent's spouse with whom the children are living, if the needs of such parent and spouse were included in computing the assistance payment.

(ii) As used in subdivision (i) of this subparagraph, the term "parent" means the natural or adoptive parent, or the stepparent who was ceremonially married to the child's natural or adoptive parent and is legally obligated to support the child under State law of general applicability which requires stepparents to support stepchildren to the same extent that natural or adoptive parents are required to support their children; and the term "spouse" means an individual who is the husband or wife of the child's own parent, as defined above, by reason of a ceremonial or other legal marriage.

(4)(i) When at least one of the children in a family is eligible due to the unemployment of his father in the home, the recipient count may include all eligible children, the father, and his wife with whom the children are living, if the needs of such father and wife were included in computing the assistance payment.

(ii) As used in subdivision (i) of this subparagraph, the term "father" means the natural or adoptive father, or the stepfather who was ceremonially married to the child's natural or adoptive mother and is legally obligated to support the child under State law of general applicability which requires stepparents to support stepchildren to the same extent that natural or adoptive parents are required to support their children; and the term "wife" means an individual who is the wife of the child's own father, as defined above, by reason of a ceremonial or other legal marriage.

(5) Where there are two or more dependent children living in a place of residence with two other persons who are not married to each other and each of such other persons is a relative who has responsibility for the care and control of one or more of the dependent children, there may be two separate AFDC families for purposes of aid and recipient count, if neither of such persons is the parent of all the dependent children.

(c) Essential person: An "essential person" or other ineligible person who is living with the eligible person may not be counted as a recipient.

(Sec. 1102, 49 Stat. 647 (42 U.S.C. 1302))

[38 FR 32914, Nov. 29, 1973]

§ 237.60 Maintenance of State effort; Federal financial participation.

For the programs administered under titles I, IV—Part A, X, XIV, XVI, and XIX of the Social Security Act:

(a) For fiscal years ending June 30, 1967, and June 30, 1968, a State may, at its option, apply the "maintenance of State effort" provisions under section 1117 of the Social Security Act on a fiscal year basis rather than on a quarterly basis. If a State exercises this option, it must choose, as the base period against which its effort is to be measured, either the fiscal year ending June 30, 1965, or the fiscal year ending June 30, 1964. Subsections (b) and (c) of section 1117 of the Act (relating to the manner of determining expenditures and reductions) would also be applied on a fiscal year basis if the State exercises this option.

(b) A State may, at its option, apply the "maintenance of State effort" provisions under section 1117 of the Act on the basis of several additional alternatives as to the expenditures (total and Federal share) that will be taken into account in determining whether a reduction is necessary under section 1117 of the Act.

(1) The State may take into account, as previously provided, all expenditures under titles I, IV—Part A, X, XIV, XVI, and XIX (including money payments, vendor medical payments, and costs of administration); or

(2) The State may make the determination

(i) On the basis of these expenditures plus the expenditures under section 523 of the Act (or section 422 of the Social Security Act, as amended by section 240(c) of Public Law 90–248), relating to child welfare services,

(ii) On the basis of money payments alone (under titles I, IV—Part A, X, XIV, and XVI), or

(iii) On the basis of money payments alone plus the expenditures under section 523 or 422 of the Act.

(c) These additional options both as to making the determination on a fiscal year rather than quarterly basis, and as to the expenditures included, may be applied retroactively to July 1, 1966, by any State subject to a reduction under the provisions of section 1117 of the Act as in effect prior to the enactment of section 221 of Public Law 90–248.

(d) The "maintenance of State effort" provisions have been made inapplicable to periods prior to July 1, 1966.

(e) Section 1117 of the Act was repealed, effective July 1, 1968, by section 221(d) of Public Law 90–248.

[34 F.R. 11, Jan. 1, 1969]

PART 246—STATE ORGANIZATION—MEDICAL ASSISTANCE PROGRAMS

§ 246.10 State medical care advisory committees.

(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act must provide that:

(1) There will be an advisory committee to the State agency director on health and medical care services, appointed by the director of the State agency or a higher State authority. Appointments to the committee will provide for rotation and continuity.

(2) The medical care advisory committee will include:

(i) Board certified physicians and other representatives of the health professions who are familiar with the medical needs of low income population groups and with the resources available and required for their care;

(ii) Members of consumers' groups including title XIX recipients, and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; and

(iii) The director of the public welfare department or of the public health department, whichever does not head the single State agency for the title XIX plan.

(3) The medical care advisory committee will have adequate opportunity for meaningful participation in policy development and program administration, including the furtherance of recipient participation in the program of the agency.

(4) The medical care advisory committee will be provided such staff assistance from within the agency and such independent technical assistance as are needed to enable it to make effective recommendations, and will be provided with financial arrangements, where necessary, to make possible the participation of recipients in the work of the committee.

(b) *Federal financial participation.* Federal financial participation of 50 percent is available for the activities of the medical care advisory committee.

(Sec. 1102, 49 Stat. 647; 42 U.S.C. 1302) [36 F.R. 3870, Feb. 27, 1971]

PART 248—COVERAGE AND CONDITIONS OF ELIGIBILITY FOR MEDICAL ASSISTANCE

Sec.

248.1 State plan requirements and options for coverage under the medical assistance program.
248.2 Conditions for State plan approval.
248.3 State plan requirements on financial eligibility for medical assistance programs.
248.4 Federal financial participation.
248.10 Coverage and conditions of eligibility for medical assistance.

248.11 Title XIX; optional inclusion of certain "essential persons" under plan approved under title I, X, XIV, or XVI; Federal financial participation.
248.21 Financial eligibility—medical assistance programs.
248.30 Age.
248.40 Residence.
248.50 Citizenship and alienage.
248.60 Institutional status.
248.70 Blindness.
248.80 Disability.

AUTHORITY: The provisions of this Part 248 issued under sec. 1102, 49 Stat. 647; 42 U.S.C. 1302.

§ 248.1 State plan requirements and options for coverage under the medical assistance program.

The provisions of §§ 248.1 through 248.4 do not apply to Guam, Puerto Rico and the Virgin Islands, with respect to which §§ 248.10, 248.11, and 248.21 apply.

(a) *General provisions governing eligibility for medical assistance.*—(1) *Categorically needy.*—(i) *General.* In order to be considered as categorically needy for purposes of title XIX, an individual must in general be receiving financial assistance or sufficiently in need to be financially eligible for financial assistance under title IV–A or XVI of the Social Security Act, or under a State supplement to title XVI assistance.

(ii) *States limiting coverage by returning to earlier Medicaid standard.* (A) In a State which covers both the categorically needy and medically needy under its title XIX plan, and in addition has exercised its option under section 209(b) of Pub. L. 92–603 to limit Medicaid coverage of aged, blind, and disabled individuals, an individual who meets the more restrictive eligibility criteria through having his title XVI payment (if any) and incurred medical expenses deducted from income is considered as categorically needy if he is eligible for a cash payment under title XVI of the Social Security Act or a State supplementary payment which meets the conditions specified in § 248.2(d).

(B) In a State which covers only the categorically needy under its title XIX plan, and in addition has exercised its option under section 209(b) of Pub. L. 92–603 to limit Medicaid coverage of aged, blind, and disabled individuals, all individuals establishing eligibility for medical assistance by deducting their title XVI payments (if any) and incurred medical expenses from income will be considered categorically needy regardless of whether their income would allow them to qualify for cash assistance.

(2) *Medically needy.* (i) An individual is considered to be medically needy if he has income and resources which exceed the amount of income and resources allowed to the categorically needy but which are insufficient to meet the costs of necessary medical and remedial care and services.

(ii) In determining whether an individual's income is above the medically needy level, medical expenses are not deducted from income. However, in determining eligibility for medical assistance, incurred medical expenses must be deducted from income for a medically needy individual.

(b) *Required coverage of the categorically needy.* A State plan under title XIX of the Social Security Act must specify what groups of individuals are covered as categorically needy for Medicaid. These groups must, as a minimum—(1) In the case of families and children, include: (i) All individuals receiving aid under the State's approved plan under title IV–A;

(ii) All individuals under 21 who are (or would be, except for age or school attendance requirements) dependent children under the State's approved AFDC plan; and

(iii) All families which were receiving assistance under the State's plan under title IV–A in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such assistance because of increased hours of, or increased income from, employment. As long as a member of the family is employed, such families will continue to be eligible for medical assistance, for a period of 4 calendar months beginning with the month in which such family became ineligible for assistance under title IV–A because of increased hours of employment, or increased earnings, to the same extent and under the same conditions as it is furnished to the categorically needy under the title XIX plan in effect during such months.

(2) In the case of the aged, blind and disabled, include one of the groups listed in paragraph (b)(2) (i), (ii) or (iii) of this section, and in addition, those listed

in paragraph (b)(2)(iv), (v) and (vi) of this section:

(i) Individuals receiving a benefit under title XVI (for purposes of the regulations in this part, the phrase "individuals receiving a benefit under title XVI" includes the eligible spouses of such individuals), or

(ii) Individuals receiving a benefit under title XVI or a State supplementary payment which meets the conditions specified in § 248.2(d), or

(iii) Individuals who meet the eligibility criteria used for medical assistance on January 1, 1972 (or any other criteria which are less restrictive than the January 1, 1972 criteria but no less restrictive than the comparable criteria under title XVI or for a State supplementary payment which meets standards described in § 248.2(d)), after the amount of the title XVI payment and State supplementary payment (if any) and incurred medical expenses are deducted from income;

(iv) All individuals who receive a State supplementary payment mandated pursuant to section 212 of Pub. L. 93–66;

(v) All individuals who in December 1973 were eligible as essential spouses under the State title XIX plan which for such month provided for medical assistance to individuals described in section 1905(a)(vi) of the Social Security Act, provided that:

(A) The individual with whom such an essential spouse is living continues to meet the December 1973 criteria for aid or assistance under one of the State plans under titles I, X, XIV or XVI as in effect in such month.

(B) The essential spouse continues to be the spouse of and to live with such individual, and under the State plan approved under title I, X, XIV or XVI as in effect in December 1973, would still be considered to be essential to the well being of such individual, and such spouse's needs would be taken into consideration in determining the amount of aid or assistance furnished to such individual under such State plan.

(vi) All individuals who, for all (or any part of) the month of December 1973:

(A) Were eligible under the State title XIX plan as inpatients or residents in institutions qualified for reimbursement under title XIX of the Act; and

(B)(*1*) Would (except for being an inpatient or resident in such institution) sistance under a State plan approved under title I, X, XIV, or XVI of such Act; or

(*2*) Were, on the basis of need for care in such institution, considered to be eligible for aid or assistance under a State plan under title I, X, XIV or XVI for purposes of determining their eligibility for medical assistance under a State plan approved under title XIX of the Act (whether or not such individuals actually received aid or assistance under a State plan under title I, X, XIV or XVI) provided that:

(*i*) Such individuals continue to be (for all of any month after December 1973) inpatients or residents in such an institution and would (except for being inpatients or residents in such institution) continue to meet the conditions of eligibility to receive aid or assistance under such plan (as such plan was in effect for December 1973), and

(*ii*) Such individuals are determined (under the utilization review and other professional audit procedures applicable to State plans approved under title XIX of the Act) to be in need of care in such an institution.

(3) With respect to both families with children and aged, blind, or disabled individuals include:

(i) Any individual who would be eligible for aid under title IV–A of the Act or benefits or supplementary payments under title XVI (as may be applicable) except for any eligibility condition or other requirement that is specifically prohibited in a program of medical assistance under title XIX.

(ii) for any month prior to July 1, 1975, any individual;

(A) Who, for the month of August 1972, was receiving or eligible for financial assistance under the State's plan approved under title I, IV–A, X, XIV, or XVI of the act and who was also entitled to monthly insurance benefits under title II of the act for the month of August 1972, and

(B) Who, except for the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92–336, would have been eligible for financial assistance for the current month. Under this requirement:

(*1*) An individual qualifies as receiving or eligible for financial assistance for August 1972 if, with respect to such month:

(*i*) He was receiving financial assistance; or

(*ii*) He met all conditions of eligibility for financial assistance under title I, IVA, X, XIV, or XVI as in effect in August 1972 but had not applied, provided the State title XIX plan included such individuals as categorically needy in August 1972; or

(*iii*) He was in a medical facility or interminate care facility, and had he left, would have been eligible for financial assistance, provided the State title XIX plan included such individuals as categorically needy in August 1972.

(*2*) An individual is considered as though he were eligible for financial assistance for the current month (after August 1972 and prior to July 1, 1975) if with respect to such month, except for the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92–336:

(*i*) He would meet all conditions of eligibility for financial assistance (however, he need not file an application). In such case he is eligible under the current title XIX plan to the same extent as individuals who are receiving financial assistance; or

(*ii*) He is in a medical or intermediate care facility and, if he left, would be eligible for financial assistance, provided the State title XIX plan includes such individuals as categorically needy. In such case he is considered as though he were categorically needy and is eligible under the title XIX plan to the same extent as other categorically needy individuals in such a facility. Countable income for categorically needy individuals in such a facility does not include the amount specified as a pass-along in sections 306 of Pub. L. 92–603 and 1007 of Pub. L. 91–172.

(c) *Options for coverage of categorically needy.* A State may at its option also cover additional groups of individuals as categorically needy provided they are so specified in the plan. These groups may include any of the following:

(i) Individuals who meet all the conditions of eligibility, including financial eligibility, for aid under title IV–A, benefits under title XVI or State supplementary payments (provided such supplementary payments meet standards specified in § 248.2(d), and the State plan approved under title XIX specifies that recipients of such payments are treated as categorically needy) but have not applied for such assistance. If such group is included in the plan, it must also include all individuals who meet the financial criteria and who:

(A) Although they were not actually receiving cash assistance, in December 1973 met all the conditions of eligibility, including financial eligibility, for aid under a State plan approved under title X, XIV, or XVI of the Act (by reason of their having been previously determined to meet the criteria for blindness or disability established by such a State plan) and

(B) they were eligible under the State title XIX plan in effect in that month if, for each consecutive month after December 1973 such individuals continue to meet the criteria for blindness or disability, and the financial criteria, established by the State plan, approved under title X, XIV or XVI as it was in effect for December 1973.

(ii) Individuals in a facility eligible for reimbursement for services rendered under title XIX who, if they left such facility would be eligible for aid under title IV–A, benefits under title XVI or State supplementary payments (provided such payments meet standards specified in § 248.2(d), and the State plan approved under title XIX specifies that recipients of such payments are treated as categorically needy). This includes individuals who have enough income to meet their personal needs while in the facility, but not enough to meet their needs outside the facility according to the applicable program.

(iii) Individuals who would be eligible for financial assistance under the State public assistance plan approved under title IV–A except that the State plan imposes eligibility conditions more stringent than, or in addition to, those required under the Social Security Act. For example, individuals who would be eligible for AFDC if the State's program covered families with children deprived of parental support or care to the full extent permitted under title IV–A of the Act, including AFDC for families with unemployed fathers.

(iv) All individuals under 21 who qualify on the basis of financial eligibility, but do not qualify as dependent children under a State's AFDC plan: or groups of such individuals if based on reasonable classifications. Children in foster homes or private institutions, or in subsidized adoptions, for whom public agencies are assuming financial responsibility, in whole or in part, constitute a reasonable classification. The additional

inclusion of children placed in foster homes or private institutions by private, nonprofit agencies would also be considered reasonable. Individuals under age 21 who are in intermediate care facilities or in psychiatric hospitals, also constitute a reasonable classification.

(v) Caretaker relatives enumerated in section 406(a)(1) of the Act who have in their care one or more children under 21 who, except for age or school attendance requirements, would be dependent children under the State's AFDC plan.

(vi) Individuals who would be eligible for financial assistance if their work-related child care costs were paid out of earnings rather than as a service expenditure by the agency, provided the State plan for financial assistance otherwise recognizes child care costs in determining the amount of the payment.

(d) *Coverage of the medically needy.* If the State opts to include medically needy individuals under title XIX, the State plan must specify that it covers all medically needy groups that correspond to the categorically needy groups covered in the plan; except that this requirement will not apply with respect to individuals required to be covered pursuant to paragraph (b)(1)(iii), (2)(iv), (v), and (vi), and (3)(ii) of this section. Included as medically needy are all individuals who are financially eligible under the standard for medical assistance in effect and who, for the month of December 1973, were eligible as medically needy persons by reason of their having been previously determined to meet the criteria for blindness or disability established by a State plan approved under title X, XIV, or XVI of the Act, if, for each consecutive month after December 1973, such individuals continue to meet the criteria for blindness or disability so established by the State plan (as it was in effect for December 1973), and continue to meet the financial criteria established under the title XIX plan as in effect for December 1973.

(e) *Conditions of eligibility.* The State plan must specify all conditions of eligibility that must be met by members of all optional groups included in the plan.

[39 FR 9513, Mar. 11, 1974]

§ 248.2 Conditions for State plan approval.

(a) All groups the State elects to include in the program are based on reasonable classifications that do not result in arbitrary or inequitable treatment of individuals or groups and are not otherwise inconsistent with the broad objectives of title XIX of the Act.

(b) Except for financial eligibility, the conditions of eligibility that are imposed on elective groups

(1) In the case of families and children, are not more stringent or more numerous than those imposed on families and children receiving aid under the approved State title IV–A plan, and

(2) In the case of aged, blind, or disabled individuals, are not more stringent or more numerous than those imposed on such individuals receiving benefits under title XVI (except for individuals receiving a State supplementary payment as provided in paragraph (d) of this section, or individuals who become eligible for medical assistance as provided in § 248.1(b)(2)(iii)).

(c) No age, residence, citizenship, or other requirement is imposed that is prohibited by title XIX of the Act.

(d) If individuals who receive only a State supplementary payment (but no title XVI payment) are covered as categorically needy, the supplementary payment meets the following standards. It is

(1) Regular, in cash and based on need;

(2) Made to some reasonable classification of aged, blind, and disabled individuals who, except for the level of their income, would be eligible for benefits under title XVI; such reasonable classifications are limited to any of the following, or any combination thereof:

(i) The aged, or the blind, or the disabled;

(ii) The aged, or the blind, or the disabled who:

(A) Are in domiciliary facilities or other group-living arrangements as defined in title XVI regulations;

(B) Are receiving a supplemental payment which is administered by the Federal government in accordance with an agreement made pursuant to Section 1616(a) of the Social Security Act, provided, however, that such payment meets conditions specified in paragraph (d)(3) and (4) of this section;

(iii) Other additional classifications as may be specified by the Secretary;

(3) Available to the reasonable classifications of individuals covered on a Statewide basis, and any variations in level of payment by political subdivision are demonstrated to the satisfaction of the Secretary to be based on cost-of-living differentials; and

(4) Equal to the difference between income and the financial standard used to determine eligibility for the supplement. The income allowed under such standard, before application of any disregards applied under title XVI, may not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act, except for those persons required to be covered pursuant to § 248.1(b)(2)(vi) or persons receiving a mandatory supplement under section 212 of P.L. 93–66.

(e) Notwithstanding the provisions specified in paragraph (d) of this section, if a State plan provides that persons who would be eligible except that they are in a medical institution (or intermediate care facility) are covered as categorically needy, the financial standard applied to determine eligibility for such persons who are aged, blind, or disabled may not exceed that standard which will allow income, before application of any disregards applied under title XVI, of up to 300 percent of the SSI benefit rate established by section 1611(b)(1) of the Social Security Act, even though a State supplementary payment might not actually be made. The State plan must specify the financial eligibility standard for such persons.

[39 FR 9515, Mar. 11, 1974]

§ 248.3 State plan requirements on financial eligibility for medical assistance programs.

(a) With respect to the categorically needy, a State plan under title XIX of the Social Security Act must:

(1) Specify the financial eligibility conditions that apply to the covered categorically needy groups.

(i) In the case of families and children, the financial eligibility conditions of the State plan approved under title IV–A shall be applied.

(ii) In the case of aged, blind and disabled individuals, either:

(A) If the State plan provides for categorically needy coverage only for individuals receiving or eligible for a benefit under title XVI, the financial eligibility conditions of title XVI shall be applied;

(B) If the State plan provides for categorically needy coverage for all individuals receiving or eligible for a benefit under title XVI and in addition provides for coverage of defined classifications of persons receiving a State supplementary payment, (*1*) the financial eligibility conditions of title XVI shall be applied for individuals who are receiving or eligible for only a title XVI benefit and are not eligible for a State supplementary payment, and (2) the financial eligibility conditions of the State supplementary payment program shall be applied to individuals receiving such payments, provided that the financial standard for the supplementary payment program does not allow income, before application of any disregards applied under title XVI, which exceeds 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act (except that these conditions will not apply to individuals in institutions required to be covered pursuant to § 248.1(b)(2)(vi) or individuals receiving a mandatory State supplement under sec. 212 of Pub. L. 98–66); or

(C) If the State plan limits coverage by applying any eligibility requirement as restrictive as or less restrictive than those in its January 1, 1972 medical assistance plan but more restrictive than the eligibility criteria for title XVI or supplementary payment recipients, financial eligibility criteria must be specified. These criteria may be: (*1*) As low as those of the January 1, 1972 medical assistance standard, or (2) up to or as high as the standards which would be allowed for title XVI beneficiaries, or for recipients of State supplementary payments as specified in paragraph (a)(1)(ii)(B) of this section.

(2) Provide for the application of income first to maintenance costs, except that this does not preclude imposition of copayments or deductibles pursuant to § 249.40 of this chapter.

(b) With respect to both the categorically needy and, if they are included in the plan, the medically needy, a State plan must:

(1) Provide that only such income and resources as are actually available will be considered and that income and resources will be reasonably evaluated.

(2) Provide that financial responsibility of any individual for any applicant or recipient of medical assistance will be limited to the responsibility of spouse for spouse and of parents for children under age 21, or blind, or disabled.

(3) Specify the extent to which the financial responsibility of any such relatives is taken into account.

(4) Provide that a lower income level for maintenance shall be used for individuals not living in their own homes but receiving care in hospitals, skilled nursing facilities, intermediate care facilities, and institutions for tuberculosis or mental diseases which are covered under title XIX. This lower income level must be reasonable in amount for clothing and personal needs for such individuals, and

(i) For aged, blind, and disabled individuals, such income level must be at a minimum of $25.00 per month;

(ii) For others, States may establish reasonable standards different from that specified in subdivision (i), provided they are based on a reasonable differential in personal needs.

When such an individual's home is maintained for a spouse or other dependents, the appropriate income level for such dependents, plus the individual's income level for maintenance in a long-term care facility, shall be applied. A higher level of maintenance may also be applied for a temporary period, not to exceed six months, to allow an individual to apply his income and resources to maintenance of a home if a physician has certified that such individual is likely to return to the home within such temporary period.

(5) Provide, for individuals in long-term care facilities specified in paragraph (b)(4) of this section, for the application of income first to personal needs, and for the medically needy only, to the title XIX enrollment fee, premium or similar charge imposed under section 1902(a)(14)(B) of the Act, and provide for the application of the remainder to the cost of medical or remedial care.

(6) Provide that, with respect to an aged, blind, or disabled individual receiving a benefit under title XVI or a State supplemental payment, who is not eligible for medical assistance unless he can meet additional eligibility criteria from the January 1972 standard, the amount of such individual's title XVI benefit and State supplemental payment will be disregarded in determining eligibility for medical assistance.

(c) With respect to the medically needy, the State plan must:

(1) Provide levels of income and resources for maintenance, in total dollar amounts, as a basis for establishing financial eligibility for medical assistance. Under this requirement:

(i) Such income levels must be comparable as among individuals and families of varying sizes;

(ii) Except as specified in paragraph (c)(1)(iii) of this section, the income levels for maintenance must be, as a minimum, at the higher of the levels of the payment standards generally used as a measure of financial eligibility in the money payment programs, that is:

(A) In the case of families of three or more, at the level of the payment standard of the State plan approved under title IV–A generally applied;

(B) In the case of individuals, or families (including families with children) of two persons, at the higher of:

(*1*) The payment standard of the State plan approved under title IV–A generally applied, or

(*2*) The highest level of payment which is generally available to individuals in any of the three groups (aged, blind and disabled) who are (or would be, except for income) eligible for benefits under title XIX;

except that this subparagraph (B) shall not be construed to require the provision of medical assistance to any aged, blind or disabled individual who would not be eligible under the medical assistance standard in effect in such State for January 1972.

(iii) The income levels for maintenance may be less than those specified in paragraph (c)(1)(ii) of this section if the level for which Federal financial participation available pursuant to § 248.4 (b)(4) is less, but if so, not lower than the Federal financial participation level.

(iv) Resources which may be held must, as a minimum, be at the higher of the levels allowed under the State plan approved under title IV–A or allowed in the supplemental security income program established under title XVI of the Social Security Act, and the amount of liquid assets which may be held must increase with an increase in the number of individuals in a family (except that a State may allow to aged, blind or disabled individuals only the level of resources allowed in the January 1972 medical assistance standard, if this is not less than the State allows the categorically needy). There must be separate levels established for resources.

(2) Provide that there will be a flexible measurement of available income which will be applied in the following order of priority:

(i) First, for maintenance, so that any income in an amount at or below the established level will be protected for maintenance, except that this does not preclude imposition of the enrollment fee, premium or similar charge, or of copayments or deductibles pursuant to § 249.40 of this chapter;

(ii) Next, income will be applied to costs incurred for medical insurance premiums (including the enrollment fee, premium or similar charge imposed under section 1902(a)(14)(B) of the Act), for any copayments or deductibles imposed under such section, and for necessary medical or remedial care recognized under State law and not encompassed within the State plan for medical assistance. States may set reasonable limits on such medical services for which excess income may be applied. Any medical resource of an individual in the form of insurance or other entitlement will also be applied to such costs. (See also § 250.31 of this chapter regarding third party liability.);

(iii) All of the remaining excess income and medical resources in the form of insurance or other entitlement will be applied to costs of medical assistance included in the State plan. Once such income and resources are exhausted, the full amount, duration and scope of care and services provided by the plan are available.

(3) Provide that all income and resources will be considered in establishing eligibility, and for the flexible application of income to medical costs not in the plan, and for payment toward the medical assistance costs. In considering all income and resources when establishing eligibility, the State plan must provide for:

(i) In the case of families and children, consideration of all disregards applicable to income and resources which are utilized when determining eligibility, or setting aside for future needs under the State's approved title IV–A plan;

(ii) In the case of the aged, blind, or disabled, the highest of:

(A) The disregards applied in title XVI, or

(B) The disregards applied in the State supplementary payment program which are available to all individuals who are or would be (except for their income level) eligible for a title XVI benefit,

except that in a State which has limited coverage of the categorically needy by applying eligibility requirements which are the same as or at a level between those in its January 1, 1972 plan and those under title XVI, disregards which similarly fall within January 1, 1972 and title XVI levels, provided that they are at least the same as those allowed to the aged, blind, and disabled categorically needy.

(4) Provide that only such income and resources will be considered as will be "in hand" within a period, not in excess of six months ahead, including the month in which medical services which are covered under the plan were rendered.

[39 FR 9516, Mar. 11, 1974]

§ 248.4 Federal financial participation.

(a) *Administrative costs.* Federal financial participation is available in the administrative costs of providing medical care and services to all individuals covered under the plan, in the cost of whose medical care and services the Federal government shares.

(b) *Medical assistance.* (1) Except for the exclusion in paragraph (b)(2) of this section, and subject to the provisions of paragraphs (b)(3) and (4) of this section and of Part 250 of this chapter, Federal financial participation is available in payments for medical care and services provided under the State plan to any financially eligible individual who is:

(i) Under the age of 21 (or under age 22 and receiving inpatient psychiatric hospital services pursuant to § 249.10(b)(16) of this chapter); or

(ii) A parent or other caretaker relative specified in section 406(a)(1) of the Act (see § 233.90(c)(1)(v)(*a*) of this chapter) with whom a child under the age of 21 is living, if such relative is eligible or would, except that the child is not regularly attending school or a course of vocational training, and except for need, be eligible to receive payments within the scope of Federal financial participation under title IV–A of the Act. Only one such parent or other caretaker relative, plus the spouse of such parent or caretaker relative who meets the conditions specified in section 406(b)(1) of the Act (see § 237.50(b)(3) and (4) of this chapter), are within the scope of Federal financial participation under title IV–A of the Act; or

(iii) An aged, blind, or disabled individual, as specified in section 1614 of the Social Security Act.

(2) Federal financial participation is not available for care or services provided to any individual who is an inmate

tient in a medical institution or a resident in an intermediate care facility), or who is under age 65 and a patient in an institution for tuberculosis or mental diseases (see exception in paragraph (b)(1)(i) of this section for individuals under age 22). See § 248.60.

(3) Federal financial participation is available in payments made on behalf of individuals specified in the plan as categorically needy, subject to the condition, in respect to aged, blind or disabled individuals receiving State supplementary payments, that the State's eligibility standard for the supplementary payment does not allow income, before application of any disregards applied under title XVI, which exceeds 300 percent of the supplemental security income benefit rate established by section 1611(b)(1) of the Social Security Act, except for those individuals required to be covered pursuant to § 248.1(b)(2)(v) of this chapter or individuals receiving a mandatory supplement under section 212 of Pub. L. 93-66.

(4) Payments in behalf of medically needy individuals are subject to Federal financial participation only to the extent that they are made for a member of a family which has annual income within the following levels:

(i) 133⅓ percent of the amounts specified in paragraph (b)(4)(ii) of this section. Any total yearly income levels established by applying the above percentage which are not multiples of $100 shall be rounded to the next higher multiple of $100. Federal financial participation is available for an individual whose annual income exceeds this level to the extent that medical expenses exceed the income excess (see paragraph (b)(4) subdivision (ii)(C) of this section).

(ii) The amounts to be applied in calculating the income levels referred to in paragraph (b)(4)(i) of this section are the highest money payments which would ordinarily be made to a family of the same size without any income or resources, under the State's approved AFDC plan, subject to the following modifications:

(A) In the case of a single individual the amount of the income level shall be reasonably related to the amounts payable under such plan to families consisting of two or more individuals who are without income or resources.

(B) If the amounts established under such plan are subject to a maximum family limit, the income level for families which exceed such limit will be determined by adding an amount for each member of the family to such limit. The amounts to be added shall be reasonably related to those established under the plan for families which are within the maximum family limit.

(C) In computing a family's or individual's income for purposes of paragraph (b)(4)(i) and (ii) of this section, there shall be excluded any costs (whether in the form of insurance premiums or otherwise) incurred by such family or individual for medical care or for any other type of remedial care recognized under State law, provided that such costs are not subject to reimbursement by a third party.

(5) Federal financial participation is available in medical assistance provided to individuals who were eligible therefor in the month in which the medical care or services were provided, except that this does not apply to costs incurred for medical care by families and individuals in process of establishing eligibility for medical assistance through the incurment of medical expenses which are deducted from income. (See § 206.10(a)(6) of this chapter for retroactive entitlement.)

(6) Federal financial participation is available in medical assistance for individuals, in accordance with the State plan, during a temporary period through the second month following the month in which eligibility ceases, or for the period of time during which financial assistance is received, while the effects of certain eligibility conditions such as blindness, disability, continued absence or incapacity of a parent, or unemployment of a father are being overcome.

(7) Federal financial participation will be available in medical assistance for individuals during a reasonable period of time from the effective date an aged, blind, or disabled individual is no longer eligible for title XVI benefits (in order for the State to determine whether he is still eligible for Medicaid and to allow for notification by the State to such individual of his ineligibility for medical assistance). If the notice is received from the Social Security Administration on or before the 10th of the month, such period may not extend beyond the end of that month, unless the recipient has timely requested a hearing; if the notice is received from the Social Security Administration after the 10th of the month, it may not extend beyond the end of the next month, unless the recipient has timely requested a hearing. The State must take the necessary steps promptly upon receipt of notice from the Social Security Administration.

(8) Notwithstanding any other provision of this section, Federal financial participation is available in medical assistance provided to individuals in groups listed in § 248.1(b)(1)(iii); (2)(iv), (v), and (vi); and (3)(ii); and for persons included within sections 248.1(c)(i) and (d) except for the definition of disability established by title XVI, as specified in those sections.

(c) *Limitation.* If a State furnishes medical assistance on the basis of income levels which are higher than those specified in this section, the State agency must submit to the Department of Health, Education, and Welfare for its approval income levels which are calculated on the basis provided in this section, and must establish procedures to assure that claims for Federal financial participation are limited accordingly.

(d) *Agreement for supplementary payments.* No Federal financial participation is available under title XIX for any given quarter in which the State does not have in effect in such quarter an agreement with the Secretary for State supplementary payments as specified in section 212 of Pub. L. 93-66. This provision does not apply with respect to any State which meets the conditions specified in section 212(f) of Pub. L. 93-66 or to Puerto Rico, Guam, and the Virgin Islands.

[39 FR 9517, Mar. 11, 1974]

§ 248.10 Coverage and conditions of eligibility for medical assistance.

NOTE: Effective January 1, 1974, the provisions of this section are applicable only to Guam, Puerto Rico and the Virgin Islands. See §§ 248.1 through 248.4 for provisions applicable to other jurisdictions participating in the medical assistance program under title XIX of the Social Security Act.

(a) *Definitions.*—When used in this part:

(1) The term "categorically needy" refers to an individual who is receiving financial assistance under the State's approved plan under title I, IV-A, X, XIV, or XVI of the Social Security Act, or is in need under the State's standards for financial eligibility in such plan. (See § 233.20 of this chapter. See also paragraphs (b)(3) and (4) of this section for individuals who are treated as if they were "categorically needy".)

(2) The term "medically needy" refers to an individual whose income and resources equal or exceed the State's standards under the appropriate financial assistance plan but are insufficient to meet his costs for medical insurance premiums and for necessary medical and remedial care and services recognized under State law but not encompassed in the State plan for medical assistance, plus his costs for medical and remedial care and services included in the State plan.

(b) *State plan requirements.*—A State plan under title XIX of the Social Security Act must:

(1) Provide that medical assistance will be available to the following groups of "categorically needy" persons:

(i) All individuals receiving aid or assistance under the State's approved plans under titles I, IV-A, X, XIV, and XVI of the act; this includes all individuals who (*a*) are essential persons under the State plan and (*b*) could be recipients, if the State plan were as broad as permitted for Federal financial participation;

(ii) All individuals under 21 who are, or would be, except for age or school attendance requirements, dependent children under the State's approved AFDC plan;

(iii) All persons who would be eligible for aid or assistance under one of the other approved State plans except for any eligibility condition or other requirement in such plan that is specifically prohibited in a program of medical assistance under title XIX of the act.

(2) Specify any other groups of "categorically needy" individuals (not covered by subparagraph (1) of this paragraph), that will be included in the program. These may include:

(i) Persons who meet all the conditions of eligibility, including financial eligibility, of one of the State's other approved plans, but have not applied for such assistance.

(ii) Persons in a medical or intermediate care facility who, if they left such facility would be eligible for financial assistance under another of the State's approved plans. This includes persons who have enough income to meet their personal needs while in the facility, but not enough to meet their needs outside the facility according to the appropriate State plan. Children may be included in this group if they would meet all condi-

tions of eligibility under the State's AFDC plan if outside the facility.

(iii) Persons who would be eligible for financial assistance under another State public assistance plan, except that the State plan imposes eligibility conditions more stringent than, or in addition to, those required under the Social Security Act. For example, persons who are needy and 18 years of age or older and permanently and totally disabled under the Federal definition of permanent and total disability, but who are excluded from APTD under the State's more restricted definition of disability; or persons who would be eligible for AFDC if the State's program covered families with children deprived of parental support or care to the full extent permitted under title IV–A of the act, including AFDC for families with unemployed fathers.

(iv) All individuals under 21 who qualify on the basis of financial eligibility, but do not qualify as dependent children under a State's AFDC plan; or groups of such individuals if based on reasonable classifications. Children in foster homes or private institutions for whom public agencies are assuming financial responsibility, in whole or in part, constitute a reasonable classification. The additional inclusion of children placed in foster homes or private institutions by private, nonprofit agencies would also be considered reasonable. Effective July 1, 1973, individuals under age 21 who are in intermediate care facilities, including institutions for the mentally retarded, or in psychiatric hospitals, also constitute a reasonable classification.

(v) Caretaker relatives enumerated in section 406(a)(1) of the Act who have in their care one or more children under 21 who, except for age or school attendance requirements, would be dependent children under the State's AFDC plan.

(vi) Individuals who would be eligible for financial assistance if their work-related child care costs were paid out of earnings rather than as a service expenditure by the agency, provided the State plan for financial assistance otherwise recognizes child care costs in determining the amount of the payment.

(3) Provide that medical assistance, to the same extent and under the same conditions as it is furnished to the categorically needy, will also be furnished, for any month after August 1972 and prior to July 1, 1975, to any individual:

(i) Who, for the month of August 1972, was receiving or eligible for financial assistance under the State's plan approved under title I, IV–A, X, XIV, or XVI of the act and who was also entitled to monthly insurance benefits under title II of the act for the month of August 1972, and

(ii) Who, except for the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92–336, would have been eligible for financial assistance for the current month. Under this requirement:

(A) An individual qualifies as receiving or eligible for financial assistance for August 1972 if, with respect to such month:

(*1*) He was receiving financial assistance; or

(2) He met all conditions of eligibility for financial assistance under titles I, IV–A, X, XIV, or XVI as in effect in August 1972 but had not applied, provided the State title XIX plan included such individuals as categorically needy in August 1972; or

(3) He was in a medical facility or intermediate care facility, and, had he left, would have been eligible for financial assistance, provided the State title XIX plan included such individuals as categorically needy in August 1972.

(B) An individual is considered as though he were eligible for financial assistance for the current month (after August 1972 and prior to July 1, 1975) if with respect to such month, except for the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92–336:

(*1*) He would meet all conditions of eligibility for financial assistance (however, he need not file an application). In such case he is eligible under the current title XIX plan to the same extent as individuals who are receiving financial assistance; or

(2) He is in a medical or intermediate care facility and, if he left, would be eligible for financial assistance, provided the State title XIX plan as then in effect includes such individuals as categorically needy. In such case he is considered as though he were categorically needy and is eligible under the title XIX plan to the same extent as other categorically needy individuals in such a facility. Countable income for categorically needy individuals in such a facility does not include the amount specified as a pass-along in

sections 306 of Pub. L. 92–603 and 1007 of Pub. L. 91–172.

(4) Provide, in the case of any family which was receiving assistance under the State's plan under title IV–A in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such assistance because of increased hours of or increased income from employment, that as long as a member of such family is employed, the family will continue to be eligible for medical assistance for a period of 4 calendar months beginning with the month in which the family became ineligible for assistance under title IV–A because of increased hours of employment or increased earnings, to the same extent and under the same conditions as it is furnished to the categorically needy under the title XIX plan in effect during such 4 months.

(5) Specify, if the plan includes the medically needy, that it covers all medically needy groups that correspond to the covered categorically needy groups. Exception: Coverage of "essential" spouses of recipients of OAA, AB, APTD, or AABD does not require coverage of essential spouses of nonmoney payment recipients, either categorically needy or medically needy.

(6) Specify all conditions of eligibility that must be met by members of all optional groups included in the plan.

(7) If the plan includes groups of individuals for whose medical care and services Federal financial participation is not available, specify such groups, and provide that the State agency will establish methods for identifying the expenditures for medical care and services and administration in which Federal financial participation may not be claimed (see para. (d)(1) of this section).

(c) *Conditions for plan approval.* (1) All groups the State elects to include in the program are based on reasonable classifications, that is, they do not result in arbitrary or inequitable treatment of individuals or groups, or result in exclusion of groups or persons on the basis of any classification that is arbitrary or unreasonable, or is otherwise inconsistent with the broad objectives of title XIX of the Act.

(2) There is clarity as to what groups are included, and which are within the scope, and which are outside the scope, of Federal financial participation in the cost of medical assistance provided.

(3) Except for need, the conditions of eligibility that are imposed on elective groups (including any groups for whose medical care and services Federal financial participation is not available) are not more stringent or more numerous than those imposed on individuals receiving aid or assistance under any of the approved State plans.

(4) No age, residence, citizenship, or other requirement is imposed that is prohibited by title XIX of the Act.

(5) No person unrelated to the applicant or recipient is held financially responsible for him; nor is any condition of eligibility imposed that holds a relative responsible who is not the spouse of the individual who needs medical care or services, or the parent of such individual, who is under 21, or is blind, or is permanently and totally disabled.

(d) *Federal financial participation*—(1) *Administrative costs.* Effective October 30, 1972, Federal financial participation in the administrative costs of providing medical care and services is limited to such costs for persons covered under the plan, in the cost of whose medical care and services the Federal Government shares.

(2) *Medical assistance.*—Federal financial participation is available, pursuant to part 250 of this chapter, in payments for medical care and services provided under the State plan to any financially eligible individual who is:

(i) Under the age of 21 (or under age 22 and receiving inpatient psychiatric hospital services pursuant to § 249.10(b)(16) of this chapter); or

(ii) A parent or other caretaker relative specified in section 406(a)(1) of the act (see § 233.90(c)(1)(v)(*a*) of this chapter) with whom a child under the age of 21 is living, if such relative is eligible or would, except that the child is not regularly attending school or a course of vocational training, and except for need, be eligible to receive payments within the scope of Federal financial participation under title IV–A of the act; only one such parent or other caretaker relative, plus the spouse of such parent (who meets the conditions specified in section 406(b)(1) of the act (see § 237.50(b) (3) (4) of this chapter)), are within the scope of Federal financial participation under title IV–A of the act; or

(iii) 65 years of age or older; or
(iv) Blind; or
(v) 18 years of age or older and permanently and totally disabled; or
(vi) The spouse of a recipient of OAA, AB, APTD, or AABD who is considered "an essential person" (see § 248.11);

but excluding any such care or services provided to any individual who is an inmate of a public institution (except as a patient in a medical institution or a resident in an intermediate care facility), or who is under age 65 and a patient in an institution for tuberculosis or mental diseases (see exception in paragraph (d)(2)(i) of this section for individuals under age 22). See § 248.60.

(3) Federal financial participation is available in medical assistance provided to individuals who were eligible therefor in the month in which the medical care or services were provided.

(4) Federal financial participation is available in medical assistance for individuals, in accordance with the State plan, during a temporary period while the effects of certain eligibility conditions such as blindness, disability, continued absence or incapacity of a parent, or unemployment of a father, are being overcome.

[36 FR 3870, Feb. 27, 1971; as amended at 38 FR 33380, Dec. 3, 1973; 39 FR 9518, Mar. 11, 1974; 39 FR 16971, May 10, 1974]

§ 248.11 Title XIX; optional inclusion of certain "essential persons" under plan approved under title I, X, XIV, or XVI; Federal financial participation.

NOTE: Effective January 1, 1974, the provisions of this section are applicable only to Guam, Puerto Rico and the Virgin Islands. See §§ 248.1 through 248.4 for provisions applicable to other jurisdictions participating in the medical assistance program under title XIX of the Social Security Act.

Effective with respect to payments made on or after January 2, 1968, under a State plan approved under title XIX of the Social Security Act, Federal financial participation is available in the costs of medical care and services provided under such a plan to a spouse of a recipient of financial assistance under another plan of the State approved under title I, X, XIV, or XVI of the Act, who is living with and has been determined, in accordance with such other plan, to be essential to the well-being of such recipient, and whose needs are taken into account in determining the amount of financial assistance provided to such recipient.

[34 FR 1320, Jan. 28, 1969; as amended at 39 FR 9518, Mar. 11, 1974]

§ 248.21 Financial eligibility—medical assistance programs.

NOTE: Effective January 1, 1974, the provisions of this section are applicable only to Guam, Puerto Rico and the Virgin Islands. See §§ 248.1 through 248.4 for provisions applicable to other jurisdictions participating in the medical assistance program under title XIX of the Social Security Act.

(a) *State plan requirements.* A State plan under title XIX of the Social Security Act must:

(1) With respect to the categorically needy:

(i) Specify that the financial eligibility conditions of the pertinent financial assistance plan will apply;

(ii) Provide for the application of income first to maintenance costs, except that this does not preclude imposition of copayments or deductibles pursuant to § 249.40 of this chapter;

(2) With respect to both the categorically needy and, if they are included in the plan, the medically needy;

(i) Provide that only such income and resources as are actually available will be considered and that income and resources will be reasonably evaluated:

(ii) Provide that financial responsibility of any individual for any applicant or recipient of medical assistance will be limited to the responsibility of spouse for spouse and of parents for children under age 21, or blind, or permanently and totally disabled;

(iii) Specify the extent to which the financial responsibility of any such relatives is taken into account.

(3) With respect to the medically needy, if they are included in the plan:

(i) Provide levels of income and resources for maintenance, in total dollar amounts, as a basis for establishing financial eligibility for medical assistance. Under this requirement:

(A) Such income levels must be comparable as among individuals and families of varying sizes;

(B) The income levels for maintenance must be, as a minimum, at the levels of the most liberal money payment standard used by the State, at any time on or after January 1, 1966, as a measure of financial eligibility in any categorical money payment program in the State, or at the level for which Federal financial participation is available pursuant to paragraph (c) of this section, whichever is less.

(C) A lower income level for maintenance must be used for individuals not living in their own homes but receiving care in nursing homes, institutions for tuberculosis or mental diseases or other medical or intermediate care facilities providing long-term care. This lower income level must be reasonable in amount for clothing and personal needs for such individuals. When such an individual's home is maintained for a spouse or other dependents, the appropriate income level for such dependents, plus the individual's income level for maintenance in a long-term care facility, is applicable;

(D) Resources which may be held must, as a minimum, be at the most liberal level used in any money payment program in the State on or after January 1, 1966, and the amount of liquid assets which may be held must increase with an increase in the number of individuals in the family. There must be separate levels established for resources.

(ii) Provide that there will be a flexible measurement of available income which will be applied in the following order of priority:

(A) First, for maintenance, so that any income in an amount at or below the established level will be protected for maintenance, except that this does not preclude imposition of the enrollment fee, premium or similar charge, or of copayments or deductibles pursuant to § 249.40 of this chapter;

(B) Next, income will be applied to costs incurred for medical insurance premiums (including the enrollment fee, premium or similar charge imposed under § 249.40 of this chapter), for any co-payments or deductibles imposed under § 249.40 of this chapter, and for necessary medical or remedial care recognized under State law and not encompassed within the State plan for medical assistance. States may set reasonable limits on such medical services for which excess income may be applied. Any medical resource of an individual in the form of insurance or other entitlement will also be applied to such costs. (See also § 250.31 of this chapter regarding third party liability.)

(C) All of the remaining excess income and medical resources in the form of insurance or other entitlement will be applied to costs of medical assistance included in the State plan. Once such income and resources are exhausted, the full amount, duration and scope of care and services provided by the plan are available.

(iii) Provide that all income and resources (after all State policies governing the disregard, or setting aside for future needs, of income and resources in the State's approved plans under titles I, IV-A, X, XIV, and XVI have been applied) will be considered in establishing eligibility, and in the flexible application of income to medical costs not in the State plan, and payment toward the medical assistance costs.

(iv) Provide that only such income and resources will be considered as will be "in hand" within a period, preferably of not more than 3 months, but not in excess of 6 months, ahead, including the month in which medical services were rendered, for which payment would be made under the plan.

(b) *Special situations.* See § 248.10 (b)(3) and (4) of this chapter which provides that certain individuals receiving increased social security benefits pursuant to Public Law 92-336, and certain families with increased earnings, are covered to the same extent and under the same conditions as the categorically needy.

(c) *Federal financial participation.* (1) Federal financial participation is available in payments made in behalf of categorically needy individuals.

(2) Federal financial participation is available in payments made in behalf of the individuals and families described in § 248.10(b)(3) and (4) of this chapter.

(3) Payments in behalf of medically needy individuals are subject to Federal financial participation only to the extent that they are made for a member of a family the annual income of which is within the income levels established in the following:

(i) In the case of any State, the applicable income levels with respect to periods after December 31, 1969, are 133⅓ percent of the amounts specified in paragraph (c)(3)(ii). Any total yearly income levels established by applying the above percentage which are not multiples of $100 shall be rounded to the next higher multiple of $100. Federal financial participation is available for a per-

son whose annual income exceeds this level to the extent that medical expenses exceed the income excess (see paragraph (c)(3)(ii)(C)).

(ii) The amounts to be applied in calculating the income levels referred to in paragraph (c)(3)(i) are the highest amounts which would ordinarily be paid to a family of the same size without any income or resources in the form of money payments, under the approved AFDC plan of the State, subject to the following modifications:

(A) In the case of a single individual the amount of the income level shall be reasonably related to the amounts payable under such plan to families consisting of two or more individuals who are without income or resources.

(B) If the amounts established under such plan are subject to a maximum family limit, the income level for families which exceed such limit will be determined by adding an amount for each member of the family to such limit. The amounts to be added shall be reasonably related to those established under the plan for families which are within the maximum family limit.

(C) In computing a family's or individual's income for purposes of subdivisions (i) and (ii) of this subparagraph, there shall be excluded any costs (whether in the form of insurance premiums or otherwise) incurred by such family or individual for medical care or for any other type of remedial care recognized under State law.

(4) If a State furnishes medical assistance on the basis of income levels which are higher than those specified in this section, the State agency must submit to the Department of Health, Education, and Welfare for its approval income levels which are calculated on the basis provided in this section, and must establish procedures to assure that claims for Federal financial participation are limited accordingly.

[38 FR 33382, Dec. 3, 1973, as amended at 39 FR 5552, Feb. 13, 1974; 39 FR 9518, Mar. 11, 1974]

§ 248.30 Age.

(a) *Conditions for plan approval.* A State plan under title XIX of the Social Security Act may not impose:

(1) Any age requirement of more than 65 years;

(2) Any age requirement which excludes any individual who has not attained 21 years of age (or under 22 years of age and receiving inpatient psychiatric services pursuant to § 249.10(b)(16) of this chapter), or 65 years of age or over. Except in Guam, Puerto Rico and the Virgin Islands, blind and disabled persons are not subject to any Federal age requirement in determining Federal financial participation for medical services (except as the services themselves are limited to persons of a specified age).

(2) Federal determination of whether an individual meets the age requirements of the Social Security Act will be made according to the common-law method (under which a specific age is attained the day before the anniversary of birth), unless the State plan specifies that the popular usage method (under which an age is attained on the anniversary of birth) is used, or that the determination of age by the SSI agency is used.

(3) The State agency may adopt an arbitrary date such as July 1 as the point from which age will be computed in all instances where the month of an individual's birth is not available, but the year can be established.

[39 FR 9518, Mar. 11, 1974]

§ 248.40 Residence.

(a) *State plan requirements.* A State plan under title XIX of the Social Security Act must provide that:

(1) Medical assistance will be furnished to eligible individuals who are residents of the State but are absent therefrom to the same extent that such assistance is furnished under the plan to meet the cost of medical care and services rendered to eligible individuals in such State, at least to the extent that medical care and services are needed in any other State (as defined in section 1101(a)(1)), under any of the following circumstances:

(i) Where an emergency arises from accident or illness;

(ii) Where the health of the individual would be endangered if the care and services are postponed until he returns to the State in which he resides; or

(iii) Where his health would be endangered if he undertook travel to return to such State.

(2) Medical care and services will be provided outside the State to eligible residents of the State, at least in the following situations:

(i) When it is general practice for residents of a particular locality to use medical resources outside the State; or

(ii) When the medical care and services available, or the availability of needed supplementary resources, make it desirable for the individual to use medical facilities outside the State for short or long periods, in accordance with plans developed jointly by the agency and the individual, consistent with medical advice.

(3) The State agency will facilitate the meeting of medical needs within the State for residents from other States.

(b) *Condition for plan approval.* A State plan under title XIX of the Act may not impose any resident requirement which excludes any individual who is a resident of the State. For purposes of this section:

(1) A resident of a State is one who is living in the State voluntarily with the intention of making his home there and not for a temporary purpose. A child is a resident of the State in which he is living other than on a temporary basis. Residence may not depend upon the reason for which the individual entered the State, except insofar as it may bear upon whether he is there voluntarily or for a "temporary purpose."

(2) Residence is retained until abandoned. Temporary absence from the State, with subsequent returns to the State, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of residence.

[Sec. 2, 49 Stat. 620, 74 Stat. 987, sec. 402, 49 Stat. 627, sec. 1002, 49 Stat. 645, sec. 1402, 64 Stat. 555, sec. 1602, 76 Stat. 193, sec. 1902, 70 Stat. 344; 42 U.S.C. 302, 602, 1202, 1352, 1382,

§ 248.50 Citizenship and alienage.

Conditions for plan approval. A State plan under title XIX of the Social Security Act shall include an otherwise eligible individual who is a resident of the United States but only if he is either (a) a citizen or (b) an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 203(a)(7) or section 212(d)(5) of the Immigration and Nationality Act).

[39 FR 9518, Mar. 11, 1974]

§ 248.60 Institutional status.

(a) *Federal financial participation.* (1) Federal financial participation under title XIX of the Social Security Act is not available in medical assistance for any individual who is an inmate of a public institution except as a patient in a medical institution or as a resident of an intermediate care facility.

(2) Federal financial participation under title XIX of the Social Security Act is not available in medical assistance for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases, except for an individual under age 22 who is receiving inpatient psychiatric hospital services pursuant to § 249.10(b)(16) of this chapter.

(3) For purposes of this paragraph:

(i) Federal financial participation is available in the costs of medical assistance for the month in which an individual (if otherwise eligible) became an inmate of a public institution, or a patient in an institution for tuberculosis or mental diseases;

(ii) Whether an institution is one for tuberculosis or mental diseases will be determined by whether its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with tuberculosis or mental diseases (whether or not it is licensed);

(iii) An institution for the mentally retarded is not an institution for mental diseases;

(iv) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in such institution except that such an individual under age

tient psychiatric hospital services pursuant to § 249.10(b)(16) of this chapter may be considered to be a patient in such institution until he is unconditionally released or, if earlier, the date such individual attains age 22.

(b) *Definitions.* For purposes of Federal financial participation under paragraph (a) of this section: (1) "Institution" means an establishment which furnishes (in single or multiple facilities) food and shelter to four or more persons unrelated to the proprietor, and in addition, provides some treatment or services which meet some need beyond the basic provision of food and shelter.

(2) "In an institution" refers to an individual who is admitted to participate in the living arrangements and to receive treatment or services provided there which are appropriate to his requirements.

(3) "Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(4) "Inmate of a public institution" means a person who is living in a public institution. An individual is not considered an inmate when:

(i) He is in a public educational or vocational training institution, for purposes of securing education or vocational training, or

(ii) He is in a public institution for a temporary emergent period pending other arrangements appropriate to his needs.

(5) "Medical institution" means an institution which:

(i) Is organized to provide medical care, including nursing and convalescent care;

(ii) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;

(iii) Is authorized under State law to provide medical care;

(iv) Is staffed by professional personnel who have clear and definite responsibility to the institution in the provision of professional medical and nursing services including adequate and continual medical care and supervision by a physician; sufficient registered nurse or licensed practical nurse supervision and services and nurse aid services to meet nursing care needs; and appropriate guidance by a physician(s) on the professional aspects of operating the facility.

(6) "Institution for tuberculosis" means an institution which is primarily engaged in providing diagnosis, treatment, or care of persons with tuberculosis, including medical attention, nursing care, and related services.

(7) "Institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

(8) "Patient" means an individual who is in need of and receiving professional services directed by a licensed practitioner of the healing arts toward maintenance, improvement or protection of health, or alleviation of illness, disability, or pain.

(9) "Resident" of an intermediate care facility is a patient or other individual who has been admitted to an intermediate care facility (including an institution for the mentally retarded or persons with related conditions or distinct part thereof) prior to the effective date of these regulations, or after that date in accordance with § 250.24 of this chapter and is receiving room and board, and, is under a planned program of care and supervision on a continuous 24-hour-a-day basis, and in the case of institutions for the mentally retarded or persons with related conditions is also receiving active treatment (see § 249.10(d)(1)(v) of this chapter).

(10) "Institution for the mentally retarded or persons with related conditions" means an institution (or distinct part thereof) primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions, which provides in a protected residential setting, individualized ongoing evaluation, planning, 24 hour supervision, coordination and integration of health or rehabilitative services to help each individual reach his maximum of functioning capabilities.

[36 FR 3872, Feb. 27, 1971; as amended at 38 FR 33383, Dec. 3, 1973; 39 FR 2221, Jan. 17, 1974]

§ 248.70 Blindness.

(a) *State plan requirements.* A State plan under title XIX of the Social Security Act must:

(1) Contain a definition of blindness in terms of ophthalmic measurement. This may be the same definition as is used in the Supplemental Security Income program under title XVI of the Act, or a more restrictive definition; however it may not be more restrictive than the definition used by the State in its approved title XIX plan as in effect on January 1, 1972. The definition may be broader than the title XVI definition only for blind individuals who, for the month of December 1973, were eligible for medical assistance by reason of their having been previously determined to meet the criteria for blindness established by a State plan under title X or XVI of the Act, (see § 248.1(b)(2)(vi) and 248.1(d)(2)); and in Guam, Puerto Rico and the Virgin Islands where the definition contained in the State plan approved under titles X or XVI will apply.

(2) Provide that, in any instance in which a determination is to be made whether an individual is blind according to the State's definition, there will be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select. Under this requirement, no examination is necessary when both eyes are missing.

(3) Provide that each eye examination report will be reviewed by a State supervising ophthalmologist who is responsible for making the agency's decision that the applicant or recipient does or does not meet the State's definition of blindness, and for determining if and when reexaminations are necessary.

(b) *Exception.* The requirements of paragraph (a)(2) and (3) of this section are waived for individuals who are determined to be eligible for payments under title XVI on the basis of blindness unless the State's title XIX plan includes a different definition of blindness as described in paragraph (a)(1) of this section.

(c) *Federal financial participation—*

(1) *Assistance payments.* Federal financial participation is available in medical assistance provided to any otherwise eligible person who is blind. Blindness may be considered as continuing until an examination by a qualified examiner establishes the fact that the recipient's vision has improved beyond the State's definintion of blindness.

(2) *Administrative expenses.* Federal financial participation is available in any expenditures incident to the eye examination necessary to determine whether an individual is blind.

[39 FR 9518, Mar. 11, 1974]

§ 248.80 Disability.

(a) *State plan requirements.* A State plan under title XIX of the Social Security Act must:

(1) Contain a definition of disability. This may be the same definition as is used in the Supplemental Security Income program under title XVI of the Act, or a more restrictive definition; however it may not be more restrictive than the definition used by the State in its approved title XIX plan as in effect on January 1, 1972. The definition may be broader than the title XVI definition only for disabled individuals who, for the month of December 1973, were eligible for medical assistance by reason of their having been previously determined to meet the criteria for disability established by a State plan under title XIV or XVI of the Act (see § 248.1(b)(2)(vi) and 248.1(d)(2); and in Guam, Puerto Rico and the Virgin Islands where the definition contained in the State plan approved under titles XIV or XVI will apply.

(2) Provide for the review of each medical report and social history by technically competent persons—not less than a physician and a social worker qualified by professional training and pertinent experience—acting cooperatively, who are responsible for the agency's decision that the applicant does or does not meet the State's definition of disability. Under this requirement:

(i) The medical report must include a substantiated diagnosis, based either on existing medical evidence or upon current medical examination;

(ii) The social history must contain sufficient information to make it possible to relate the medical findings to the activities of the "useful occupation" and to determine whether the individual is totally disabled; and

(iii) The review physician is responsible for setting dates for reexamination; the review team is responsible for reviewing reexamination reports in conjunction with the social data, to determine whether disabled recipients whose health condition may improve continue to meet the State's definition of disability.

(b) *Exception.* The requirements of paragraph (a)(2) of this section are waived for individuals who are determined to be eligible for payments under

title XVI on the basis of disability unless the State's title XIX plan includes a different definition of disability as described in paragraph (a)(1) of this section.

(c) *Federal financial participation*—(1) *Assistance payments.* Federal financial participation is available in medical assistance provided to any otherwise eligible individual who is disabled. Disability may be considered as continuing until the review team establishes the fact that the recipient's disability is no longer within the State's definition of permanent total disability, except that a determination by the Social Security Administration that a title XVI recipient's disability is no longer within the Federal definition of disability may be utilized by the State in lieu of a State review team's determination for individuals who are determined to be eligible for payments under title XVI on the basis of disability unless the State's title XIX plan includes a different definition of disability as described in paragraph (a)(1) of this section.

(2) *Administrative expenses.* Federal financial participation is available in any expenditures incident to the medical examination necessary to determine whether an individual is disabled.

(Sec. 1102, 49 Stat. 647 (42 U.S.C. 1302).) (Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program.)

[39 FR 9518, Mar. 11, 1974, as amended at 39 FR 10253, Apr. 19, 1974]

PART 249—SERVICES AND PAYMENT IN MEDICAL ASSISTANCE PROGRAMS

Sec.
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249.82 Contracts with health insurance organizations, fiscal agents, and private nonmedical institutions.

AUTHORITY: The provisions of this Part 249 issued under sec. 1102, 49 Stat. 647; 42 U.S.C. 1302.

NOTE: For interim policies published under this part, see 34 F.R. 9788, June 24, 1969.

§ 249.10 Amount, duration, and scope of medical assistance.

(a) *State plan requirements.*—A State plan for medical assistance under title XIX of the Social Security Act must:

(1) Specify that at least the first five items of medical and remedial care and services, as set forth in paragraph (b)(1) through (5) of this section, will be provided to the categorically needy.

(2) Specify that, if the plan includes the medically needy, at least the following items of medical and remedial care and services will be provided to the medically needy:

(i) The first five items as set forth in paragraph (b)(1) through (5) of this section; or

(ii) (A) Any seven of the items as set forth in paragraph (b)(1) through (16) of this section; and

(B) If the plan includes inpatient hospital services or skilled nursing facility services, physicians' services to eligible individuals when they are patients in a hospital or skilled nursing facility, even though physicians' services as defined in paragraph (b)(5) of this section are not otherwise included for the medically needy.

(3) In carrying out the requirements in paragraph (a)(1) and (2) of this paragraph with respect to the item of care set forth in paragraph (b)(4)(ii) of this section, provide:

(i) For establishment of administrative mechanisms to identify available screening and diagnostic facilities, to assure that individuals under 21 years of age who are eligible for medical assistance may receive the services of such facilities, and to make available such services as may be included under the State plan;

(ii) For identification of all eligible individuals, including those who are in need of medical or remedial care and services furnished through title V grantees, and for assuring that individuals eligible for title V services are informed of such services and are referred to title V grantees for care and services, as appropriate;

(iii) For agreements to assure maximum utilization of existing screening, diagnostic, and treatment services provided by other public and voluntary agencies such as child health clinics, OEO Neighborhood Health Centers, day care centers, nursery schools, school health programs, family planning clinics, maternity clinics, and similar facilities;

(iv) That early and periodic screening and diagnosis to ascertain physical and mental defects, and treatment of conditions discovered within the limits of the State plan on the amount, duration, and scope of care and services, will be available to all eligible individuals under 21 years of age; and that, in addition, eyeglasses, hearing aids, and other kinds of treatment for visual and hearing defects, and at least such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health, will be available, whether or not otherwise included under the State plan, subject, however, to such utilization controls as may be imposed by the State agency. See § 205.146(c) of this chapter relating to reduction in Federal financial participation under title IV–A of the Act for failure to provide early and periodic screening, diagnosis, and treatment of children.

(4) Effective July 1, 1970, provide for the inclusion of home health services for any eligible individual who, under the plan, is entitled to skilled nursing home services.

(5)(i) Specify the amount and/or duration of each item of medical and remedial care and services that will be provided to the categorically needy and to the medically needy, if the plan includes this latter group. Such items must be sufficient in amount, duration and scope to reasonably achieve their purpose. With respect to the required services for the categorically needy (subparagraph (1) of this paragraph) and the medically needy (subparagraph (2) of this paragraph), the State may not arbitrarily deny or reduce the amount, duration, or scope of, such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition. Appropriate limits may be placed on services based on such criteria as medical necessity or those contained in utilization or medical review procedures.

(ii) Specify that there will be provision for assuring necessary transportation of recipients to and from providers of services and describe the methods that will be used.

(6) Provide that the medical and remedial care and services made available to any categorically needy individual included under the plan will not be less in amount, duration, or scope than those made available to other individuals included under the program, except that:

(i) Skilled nursing facility services may be limited to persons 21 years of age or older;

(ii) Services to persons in institutions for tuberculosis or mental diseases may be limited to persons 65 years of age or over;

(iii) ~~Inpatient psychiatric hospital~~ services as provided in section 1905(a)(16) of the act may be limited to individuals under age 21 (or under age 22 for individuals receiving such services immediately prior to attaining age 21), as specified in section 1905(a)(16) of the act;

(iv) Early and periodic screening and diagnosis for individuals, and treatment of conditions found, as provided in section 1905(a)(4)(B) of the act, may be limited to individuals under 21 years of age;

(v) Benefits under part B of title XVIII of the Social Security Act made available to individuals through a "buy-in" agreement or payment of the premiums, or the payment of part or all of the deductibles, cost sharing or similar charges under part B, may be limited to such individuals for whom, by virtue of such action, these benefits are included as part of the plan;

(vi) Family planning services and supplies may be limited to individuals of child bearing age (including minors who can be considered to be sexually active) who desire such services and supplies; and

(vii) Care and services which are additional to those offered under the State plan and which are made available under a contract between the State (or a politi-

cal subdivision thereof) and an organization providing comprehensive health services may be limited to individuals who reside in the geographic area served by the contracting organization and elect to obtain care and services from it.

(7) Provide that the medical and remedial care and services made available to a group (i.e., either the categorically needy or the medically needy) will be equal in amount, duration, and scope for all individuals within the group, with the permissible exceptions specified in subparagraph (6) of this paragraph.

(8) Include a description of the methods that will be used to assure that the medical and remedial care and services are of high quality, and a description of the standards established by the State to assure high quality care.

(9) With respect to individuals eligible under the plan for family planning services and supplies, provide that there shall be freedom from coercion or pressure of mind and conscience, and freedom of choice of method, so that such individuals can choose in accordance with the dictates of their consciences.

(10) Provide in the case of any State which (i) does not provide for the payment of services provided by an optometrist (other than services covered under § 248.70(a)(2) of this chapter); but (ii) at a prior period did provide for the payment of such services; that where the State plan specifically provides that "physicians' services" includes services which an optometrist is legally authorized to perform, such services shall be included as physicians' services and shall be reimbursed whether furnished by a physician or an optometrist.

(b) *Federal financial participation.* Subject to the limitations in paragraph (c) of this section, Federal financial participation is available in expenditures for medical or remedial care and services under the State plan which meet the following definitions:

(1) *Inpatient hospital services (other than services in an institution for tuberculosis or mental diseases).* "Inpatient hospital services" are those items and services ordinarily furnished by the hospital for the care and treatment of inpatients provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases and which is licensed or formally approved as a hospital by an officially designated State standard-setting authority and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation; and which has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under title XIX of the Act.

(2) *Outpatient hospital services.* "Outpatient hospital services" are those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution which is licensed or formally approved as a hospital by an officially designated State standard-setting authority and is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

(3) *Other laboratory and X-ray services.* The term "other laboratory and X-ray services" means professional and technical laboratory and radiological services ordered by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law, and provided to a patient by, or under the direction, of a physician or licensed practitioner, in an office or similar facility other than a hospital outpatient department or a clinic, and provided to a patient by a laboratory that is qualified to participate under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

(4)(i) *Skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older.* "Skilled nursing facility services" means services ordered by and under the direction of a physician, which as a practical matter can only be provided on an inpatient basis in a skilled nursing facility (which term includes any institution located on an Indian reservation and certified by the Secretary as meeting the requirements of section 1861(j) of the Act), and which are:

(A) Provided by a facility or distinct part of a facility which has not been determined by an officially designated State standard-setting authority not to meet fully all requirements of the State for licensure as a nursing home except as provided in the next sentence. Payments to a nursing home which formerly met fully all such requirements but is currently determined not to meet them, may be recognized for a period specified by the State standard-setting authority, if during such period such home promptly takes all necessary steps to again meet such requirements; and

(B) Provided by a facility or distinct part of a facility which is certified for participation pursuant to § 249.33 as evidenced by an agreement executed in accordance with the provisions of § 249.33, between the single State agency and the facility for the provision of skilled nursing facility services and the making of payments under the plan; except that with respect to skilled nursing facility services furnished by a facility whose provider agreement has expired or has otherwise terminated, the State agency may continue to claim Federal financial participation in payments on behalf of eligible individuals for such services furnished by such institution during a period not to exceed 30 days starting with the date of expiration or other termination of its provider agreement, but only if such individuals were admitted to the facility before the date of expiration or other termination of its provider agreement, and if the State agency makes a showing satisfactory to the Secretary that it has made reasonable efforts to facilitate the orderly transfer of such individuals from such institution to another facility.

(ii) *Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.* Early and periodic screening and diagnosis of individuals under the age of 21 who are eligible under the plan to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Federal financial participation is available for any item of medical or remedial care and services included under this section for individuals under the age of 21. Such care and services may be provided under the plan to individuals under the age of 21, even if such care and services are not provided, or are provided in lesser amount, duration or scope to individuals 21 years of age or older.

(5) *Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere.* "Physicians' services" are those services provided, within the scope of practice of his profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

(6) *Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.* This term means any medical or remedial care or services other than physicians' services, provided within the scope of practice as defined by State law, by an individual licensed as a practitioner under State law.

(7) *Home health care services.*—"Home health care services" in addition to the services of physicians, dentists, physical therapists, and other services and items available to patients in their homes and described elsewhere in these definitions, are any of the following items and services when they are provided on recommendation of a licensed physician to a patient in his place of residence, but not including as a residence a hospital, a skilled nursing facility, or an intermediate care facility:

(i) Intermittent or part-time nursing services furnished by a home health agency;

(ii) Intermittent or part-time nursing services of a professional registered nurse or a licensed practical nurse under the direction of the patient's physician, when no home health agency is available to provide nursing services;

(iii) Medical supplies, equipment, and appliances recommended by the physician as required in the care of the patient and suitable for use in the home;

(iv) Services of a home health aide, who is an individual assigned to give personal care services to a patient in accordance with the plan of treatment outlined for the patient by the attending physician and the home health agency which assigns a professional registered nurse to provide continuing supervision of the aide on her assignment. The term "home health agency" means a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under title XVIII of the Social Security Act, or is determined currently to meet the requirements for such participation.

(8) *Private duty nursing services.* "Private duty nursing services" are nursing services provided by a professional

Check State law re: medicine.

Institutions for medical care only

registered nurse or a licensed practical nurse, under the general direction of the patient's physician, to a patient in his own home or in a hospital, skilled nursing home, or extended care facility when the patient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital, nursing home, or extended care facility.

(9) *Clinic services.* "Clinic services" are preventive diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients.

(10) *Dental services.* "Dental services" are any diagnostic, preventive, or corrective procedures administered by or under the supervision of a dentist in the practice of his profesion. Such services include treatment of the teeth and associated structures of the oral cavity, and of disease, injury, or impairment which may affect the oral or general health of the individual. The term "dentist" means a person licensed to practice dentistry or dental surgery.

(11) *Physical therapy, occupational therapy, treatment of speech, hearing, and language disorders.* The services are defined as follows and include the use of such supplies and equipment as are necessary.

(i) "Physical therapy" means those services prescribed by a physician and provided to a patient by or under the supervision of a qualified physical therapist. A "qualified physical therapist" is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, or its equivalent, and where applicable, is licensed by the State.

(ii) "Occupational therapy" means those services prescribed by a physician and provided to a patient and given by or under the supervision of a qualified occupational therapist. A "qualified occupational therapist" is registered by the American Occupational Therapy Association or is a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and is engaged in the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

(iii) "Services for individuals with speech, hearing, and language disorders" are those diagnostic, screening, preventive or corrective services provided by or under the supervision of a speech pathologist or audiologist in the practice of his profession for which a patient is referred by a physician. A speech pathologist or audiologist is one who has been granted the Certificate of Clinical Competence in the American Speech and Hearing Association, or who has completed the equivalent educational requirements and work experience necessary for such a certificate, or who has completed the academic program and is in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

(12) *Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select.* (i) "Prescribed drugs" are any simple or compounded substance or mixture of substances prescribed as such or in other acceptable dosage forms for the cure, mitigation, or prevention of disease, or for health maintenance, by a physician or other licensed practitioner of the healing arts within the scope of his professional practice as defined and limited by Federal and State law. With respect to "prescribed drugs", Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act. When dispensing, the practitioner must do so on his written prescription and maintain records thereof.

(ii) "Dentures" are artificial structures prescribed by a dentist to replace a full or partial set of teeth and made by, or according to the directions of, a dentist.

(iii) "Prosthetic devices" means replacement, corrective, or supportive devices prescribed for a patient by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law for the purpose of artificially replacing a missing portion of the body, or to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body.

(iv) "Eyeglasses" are lenses, including frames when necessary, and other aids to vision prescribed by a physician skilled in diseases of the eye, or by an optometrist, whichever the patient may select, to aid or improve vision.

(13) *Other diagnostic, screening, preventive, and rehabilitative services.* (i) "Diagnostic services", other than those for which provision is made elsewhere in these definitions, include any medical procedures or supplies recommended for a patient by his physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law, as necessary to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in the patient.

(ii) "Screening services" consist of the use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify suspects for more definitive studies.

(iii) "Preventive services" are those provided by a physician or other licensed practitioner of the healing arts, within the scope of his practice as defined by State law, to prevent illness, disease, disability and other health deviations or their progression, prolong life and promote physical and mental health and efficiency.

(iv) "Rehabilitative services", in addition to those for which provision is made elsewhere in these definitions, include any medical remedial items or services prescribed for a patient by his physician or other licensed practitioner of the healing arts, within the scope of his practice as defined by State law, for the purpose of maximum reduction of physical or mental disability and restoration of the patient to his best possible functional level.

(14) *Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.* For purposes of this subparagraph:

(i) (A) "Inpatient hospital services" in an institution for mental diseases are those items and services which are provided under the direction of a physician for the care and treatment of inpatients in a psychiatric hospital which meets the requirements under title XVIII, section 1861(f) of the Social Security Act.

(B) "Inpatient hospital services" in an institution for tuberculosis are those items and services which are provided under the direction of a physician for the care and treatment of inpatients in a tuberculosis hospital which meets the requirements under title XVIII, section 1861(g) of the Social Security Act.

(ii) "Skilled nursing facility services" are those items and services furnished by a skilled nursing facility as defined in paragraph (b)(4)(i) of this section.

(iii) "Intermediate care facility services" are those items and services furnished by an intermediate care facility as defined in paragraph (b)(15) of this section to residents who have been determined in accordance with § 250.24 of this chapter to be in need of such care.

(iv) An "institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(v) An "institution for tuberculosis" means an institution which is primarily engaged in providing diagnosis, treatment, or care of persons with tuberculosis, including medical attention, nursing care, and related services.

(15) *Intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.* Intermediate care facility services may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions. (See paragraph (d)(1)(vi) of this section.) "Intermediate care facility services" means those items and services furnished by a facility which meets the following conditions:

(i) (A) It meets fully all requirements for licensure under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities. Payments to a facility which formerly met all requirements of the State for licensure, but is currently determined not to meet fully

for a period specified by the State standard-setting authority, if during such period such facility promptly takes all necessary steps to again meet such requirements. Institutions operated by a governmental agency may be considered to be licensed if they meet all requirements which are applied for licensure to the same type of facility in any other ownership category (i.e., nonprofit or proprietary) within the State;

(B) In the case of a public institution for the mentally retarded or persons with related conditions (or distinct part thereof), the primary purpose of such institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;

(C) It meets such standards of safety and sanitation as are applicable to nursing homes under State law;

(D) It meets the standards for an intermediate care facility specified by the Secretary under § 249.12, and in the case of an institution for the mentally retarded or persons with related conditions, also meets the standards specified under § 249.13 no later than three years after the effective date of these regulations; and

(E) Effective no later than 12 months following the effective date of these regulations, it has been determined by the survey agency in accordance with § 249.33 to meet all of the conditions in paragraph (b)(15)(i) of this section as evidenced by an agreement executed between the single State agency and the facility for the provision of intermediate care facility services and the making of payments under the plan; or

(ii) Effective no later than 12 months following the effective date of these regulations:

(A) In the case of a certified participating provider of hospital services or skilled nursing facility services under title XIX or title XVIII of the Social Security Act, it has been determined by the survey agency in accordance with § 249.33 of this part to meet the standards of § 249.12(a)(1)(iii), (3)(i), 4(i)(C), (6)(iv) and (9) and (b)(2), (3), (4), (5) and (6) for the provision of intermediate care facility services and the making of payments under the plan, or

(B) In the case of an institution for the mentally retarded or persons with related conditions (or distinct part thereof) participating as a certified provider of hospital services or skilled nursing facility services under title XIX or title XVIII of the Social Security Act, it has been determined by the survey agency in accordance with § 249.33 to meet the standards of § 249.12(a)(1)(ii)(A)(2), and (iii), (3)(1), (4)(i)(C) and (F), and (9) and (c)(1), (3), (4), (5) and (6), for the provision of intermediate care facility services and the making of payments under the plan.

(iii) Nothing in this section precludes a State from establishing a "distinct part" requirement in an institution providing intermediate care services. *Provided,* Such requirement includes the following provisions:

(A) The distinct part meets all requirements for an intermediate care facility;

(B) The distinct part is an identifiable unit such as an entire ward or contiguous wards, wing, floor or building. It consists of all beds and related facilities in the unit and houses all residents, except as hereafter provided, for whom payment is being made for intermediate care facility services. It is clearly identified and is approved in writing by the survey agency; and

(C) The distinct part may share such central services and facilities as management services, building maintenance and laundry, with other units;

Provided further, That the State may not require transfer of a resident within or between facilities when in the opinion of the attending physician such transfer might be harmful to the physical or mental health of the resident.

(iv) The term "intermediate care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ Scientist, Boston, Mass., but only with respect to institutional services deemed appropriate by the State.

(v) The term "intermediate care facility" also includes any facility located on an Indian reservation, which provides, on a regular basis, health-related care and services and is certified by the Secretary as meeting the provisions of paragraph (b)(15)(i)(C) of this section and the standards of § 249.12 and § 249.13.

With respect to intermediate care facility services furnished by an intermediate care facility whose provider agreement has expired or has otherwise terminated, the State agency may continue to claim Federal financial participation in payments on behalf of eligible individuals for such services furnished by such facility during a period not to exceed 30 days starting with the date of expiration or other termination of its provider agreement, but only if such individuals were admitted to the facility before the date of expiration or other termination of its provider agreement, and if the State agency makes a showing satisfactory to the Secretary that it has made reasonable efforts to facilitate the orderly transfer of such individuals from such facility to another facility.

(16) [Reserved]

(17) *Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.*—This term includes the following items in those States in which they are recognized under State law and under the circumstances, and to the extent to which, they are so recognized:

(i)(A) Transportation, including expenses for transportation and other related travel expenses, necessary to securing medical examinations and/or treatment when determined by the agency to be necessary in the individual case. "Travel expenses" include the cost of transportation for the individual by ambulance, taxicab, common carrier or other appropriate means; the cost of outside meals and lodging en route to medical care, while receiving medical care, and returning from a medical resource; and the cost of an attendant to accompany him, if medically or otherwise necessary. The cost of an attendant may include transportation, meals, lodging, and salary of the attendant, except that no salary may be paid a member of the patient's family.

(B) Transportation as defined in paragraph (b)(17)(i)(A) of this section is recognized as an item of medical assistance only when furnished by a provider to whom a direct vendor payment can appropriately be made by the agency. When other arrangements are made to satisfy the requirement in paragraph (a)(5) of this section, Federal financial participation is available as an administrative cost.

(ii) Services of Christian Science nurses who are listed and certified by the First Church of Christ Scientist, Boston, Mass., when these services have been requested by the patient and are provided (A) by, or under the supervision of, a Christian Science visiting nurse organization listed and certified by the First Church of Christ Scientist, Boston, Mass.; or (B) as private duty services to and individual in his own home or in a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ Scientist, Boston, Mass., when the patient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the sanatorium.

(iii) Care and services provided in Christian Science sanatoria operated by, or listed and certified by, the First Church of Christ Scientist, Boston, Mass.

(iv) Skilled nursing facility services, as defined in paragraph (b)(4)(i) of this section, provided to patients under 21 years of age.

(v) Emergency hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available which is equipped to furnish such services, even though the hospital does not currently meet the conditions for participation under title XVIII of the Social Security Act, or definitions of inpatient or outpatient hospital services set forth in paragraphs (b)(1) and (2) of this section.

(vi) Personal care services in a recipient's home rendered by an individual, not a member of the family, who is qualified to provide such services, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a registered nurse.

(c) *Limitations.* (1) Federal financial participation in expenditures for medical and remedial care and services listed in paragraph (b) of this section is not available with respect to any individual who is an inmate of a public institution (except as a patient in a medical institution or as a resident of an intermediate care facility), or any individual who has not attained 65 years of age who is a patient in an institution for tuberculosis or mental diseases;

(2) Payments to institutions for the mentally retarded or persons with related conditions may not include reimbursement for vocational training and educational activities; and

(3) With respect to expenditures in any calendar quarter prior to January 1, 1975, Federal financial participation for

public institution (or distinct part thereof) for the mentally retarded or persons with related conditions is available only to the extent that:

(i) The cost of such services for individuals in such institution receiving assistance under the State plan in the current calendar quarter, and (ii) the cost of assistance and health, social, or rehabilitative services provided in the current quarter under a plan developed and supervised by a Qualified Mental Retardation Professional (as defined in § 249.12(c)(3)) of such institution for individuals who were released from such institution during the preceding four quarters and would be eligible under the State plan if in such institution exceeds the product of the total number of eligible individuals receiving intermediate care facility services in the institution in the current quarter times the average per capita per quarter non-Federal expenditures in the institution (or distinct part thereof) for the base year. Federal financial participation will be at 100 percent of the cost increase described in the preceding sentence except that such Federal financial participation may not exceed the Federal medical assistance percentage times the cost of intermediate care facility services for eligible individuals in the institution (or distinct part thereof). For purposes of this subparagraph.

(A) The base year shall be the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under title XIX;

(B) The per capita per quarter non-Federal expenditures for the base year and the costs for intermediate care facility services in the institution for each subsequent period in which claims are made are those expenditures for inpatient care and services in such public institution (or distinct part thereof) determined in accordance with Office of Management and Budget circular A-87;

(C) The number of eligible individuals receiving intermediate care facility services in the current quarter means the number of different eligible individuals receiving care for the whole quarter plus the full quarter equivalent number for eligible individuals receiving less than a full quarter's care. In determining the per capita expenditures for the base year, similar methods of computation shall be

(D) Non-Federal expenditures mean the total costs less any Federal funds received directly or indirectly in relation to such costs;

(E) The cost for the current calendar quarter excludes Federal funds received directly or indirectly from any source other than title XIX or section 1115 of the Social Security Act;

(F) The cost of services for individuals released from such institution during the preceding four quarters includes only those State and local expenditures for which Federal financial participation is not received;

(G) As a basis for determining the proper amount of Federal payments, the State or appropriate political subdivision must submit to the single State agency, in such form and at such times as are specified by the single State agency, in accordance with Social and Rehabilitation Service guidelines, estimated and actual cost data and other necessary information for each such institution and for the services provided to individuals released from each such institution during the preceding four quarters; and

(H) The single State agency shall have on file adequate records to substantiate compliance with the requirements of this section and to assure that all necessary adjustments have been made.

(d) *General provisions.* (1) In all the items listed in paragraph (b) of this section, the following definitions apply, except to the extent the context otherwise requires:

(i) "Patient" is an individual who is in need of and receiving professional services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or alleviation of disability or pain.

(ii) "Inpatient" is a patient who has been admitted to a hospital, skilled nursing home, or other medical institution on recommendation of a physician or dentist and is receiving room, board, and professional services in the institution on a continuous 24-hour a day basis.

(iii) "Outpatient" is a patient who is receiving his professional services at an organized medical facility, or distinct part of such facility, which is not providing him with room and board and professional services on a continuous 24-hour-a-day basis.

(iv) "Resident of an intermediate care facility" is a patient or other individual

ate care facility (including an institution for the mentally retarded or persons with related conditions or distinct part thereof) prior to the effective date of these regulations, or after that date in accordance with § 250.24 of this chapter, and is receiving room and board, and, is under a planned program of care and supervision on a continuous 24-hour-a-day basis, and in the case of institutions for the mentally retarded is also receiving active treatment.

(v) For purposes of paragraph (d)(1)(iv) of this section and § 248.60(b) of this chapter, "active treatment" means:

(A) Regular participation, in accordance with an individual plan of care in professionally developed and supervised activities, experiences, or therapies.

(B) An individual "plan of care" which is a written plan setting forth measurable goals or behaviorally stated objectives and prescribing an integrated program of individually designed activities, experiences or therapies necessary to achieve such goals or objectives. The overall objective of the plan is to attain or maintain the optimal physical, intellectual, social, or vocational functioning of which the individual is presently or potentially capable;

(C) An interdisciplinary professional evaluation consisting of complete medical, social and psychological diagnosis and evaluation, and an evaluation of the individual's need for institutional care, prior to but not to exceed 3 months before admission to the institution or, in the case of individuals who make application while in such institution, before requesting payment under the plan;

The evaluation is conducted by a physician, a social worker and other professionals. At least one member of the team meets the requirements of § 249.12(c)(3);

(D) Re-evaluation medically, socially, and psychologically at least annually by the staff involved in carrying out the resident's individual plan of care, including review of the individual's progress toward meeting the plan objectives, the appropriateness of the individual plan of care, assessment of continuing need for institutional care, and consideration of alternate methods of care; and

(E) An individual postinstitutionalization plan (as part of the individual plan of care) developed prior to discharge by a Qualified Mental Retardation Profes-

appropriate professionals, including provision for appropriate services, protective supervision, and other follow-up services in the resident's new environment.

(vi) "Persons with related conditions" are those individuals who have epilepsy, cerebral palsy or other developmental disabilities as defined pursuant to Part C of the Developmental Disabilities Services and Facilities Construction Act Pub. L. 91-517.

(2) Nothing in the Social Security Act or Federal policies thereunder will be construed to require any State to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under its approved State plan if such person objects, or in the case of a child, his parent or guardian objects, to such care on religious grounds. An individual may not be found eligible unless he undergoes such physical examination as is necessary to establish his eligibility, e.g., an examination must be made of an individual applying for medical assistance on the basis of his disability (as disabled under the AFDC, AB, APTD, or AABD program).

[34 F.R. 9784, June 24, 1969, as amended at 35 F.R. 3072, Feb. 17, 1970; 35 F.R. 6792, Apr. 20, 1970; 36 F.R. 21409, Nov. 9, 1971; 36 FR 24004, Dec. 17, 1971; 37 FR 22985, Oct. 27, 1972; 38 FR 12112, May 9, 1973; 39 FR 2221, Jan. 17, 1974; 39 FR 2257, Jan. 17, 1974; 39 FR 8918, Mar. 7, 1974; 39 FR 16971, May 10, 1974; 39 FR 27906, Aug. 2, 1974]

§ 249.12 Standards for intermediate care facilities.

(a) The standards for an intermediate care facility (as defined in § 249.10(b)(15) of this part) which are specified by the Secretary pursuant to section 1905(c) and (d) of the Social Security Act and are applicable to all intermediate care facilities are as follows. The facility:

(1) Maintains methods of administrative management which assure that:

(i) There are on duty during all hours of each day staff sufficient in numbers and qualifications to carry out the policies, responsibilites, and programs of the facility. The numbers and categories of personnel are determined by the number of residents and their particular needs in accordance with guidelines issued by the Social and Rehabilitation Service;

(ii) There are written policies and procedures available to staff, residents and

(A) Govern all areas of service provided by the facility:

(1) Admission, transfer, and discharge of residents policies shall assure that:

(i) Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts;

(ii) As changes occur in their physical or mental condition, necessitating service or care which cannot be adequately provided by the facility, residents are transferred promptly to hospitals, skilled nursing facilities, or other appropriate facilities; and

(iii) Except in the case of an emergency, the resident, his next of kin, attending physician, and the responsible agency, if any, are consulted in advance of the transfer or discharge of any resident, and casework services or other means are utilized to assure that adequate arrangements exist for meeting his needs through other resources; and

(2) In the case of institutions for the mentally retarded or persons with related conditions, policies define the uses of physical restraints, the staff members who must authorize their use, and a mechanism for monitoring and controlling their use;

(B) Set forth the rights of residents and prohibit their mistreatment or abuse;

(C) Provide for the registration and disposition of complaints without threat of discharge or other reprisal against any employee or resident.

(iii) A written account, available to residents and their families, is maintained on a current basis for each resident with written receipts for all personal possessions and funds received by or deposited with the facility and for all disbursements made to or on behalf of the resident;

(iv) The facility has a written and regularly rehearsed plan for staff and residents to be followed in case of fire, explosion or other emergency;

(v) There are written procedures for personnel to follow in an emergency, including care of the resident, notification of the attending physician and other persons responsible for the resident, arrangements for transportation, for hospitalization, or other appropriate services;

(vi) There is an orientation program for all new employees that includes review of all facility policies. An inservice education program is planned and conducted for the development and improvement of skills of all the facility's personnel. Records are maintained which indicate the content of, and participation in, all such orientation and staff development programs;

(vii) The facility is in conformity with Federal, State, and local laws, codes, and regulations pertaining to health and safety, including procurement, dispensing, administration, safeguarding and disposal of medications and controlled substances; building, construction, maintenance and equipment standards; sanitation; communicabl. and reportable diseases; and post-mortem procedures.

(2) Has in effect a transfer agreement with one or more hospitals sufficiently close to the facility to make feasible the transfer between them of residents and their records, which provide the basis for effective working arrangements under which inpatient hospital care or other hospital services are available promptly to the facility's residents when needed. Any facility which does not have such an agreement in effect but which is found by the survey agency to have attempted in good faith to enter into such an agreement with a hospital shall be considered to have such an agreement in effect if and for so long as the survey agency finds that to do so is in the public interest and essential to assuring intermediate care facility services for eligible persons in the community.

(3) Maintains effective arrangements

(i) For required institutional services through a written agreement with an outside resource in those instances where the facility does not employ a qualified professional person to render a required service. The responsibilities, functions, and objectives and the terms of agreement with each such resource are delineated in writing and signed by the administrator or authorized representative and the resource;

(ii) Through which medical and remedial services required by the resident but not regularly provided within the facility can be obtained promptly when needed.

(4) Maintains an organized resident record system which assures that:

(i) There is available to professional and other staff directly involved with the resident and to appropriate representatives of the State agency a record for each resident which includes as a minimum:

(A) Identification information and admission data including past resident medical and social history;

(B) Copies of initial and periodic examinations, evaluations, and progress notes including all plans of care and any modifications thereto, and discharge summaries;

(C) An overall plan of care setting forth goals to be accomplished, prescribing an integrated program of individually designed activities, therapies, and treatments necessary to achieve such goals, and indicating which professional service or individual is responsible for each element of care or service prescribed in the plan;

(D) Entries describing treatments and services rendered and medications administered;

(E) All symptoms and other indications of illness or injury including the date, time, and action taken regarding each; and

(F) In the case of institutions for the mentally retarded or persons with related conditions, the resident's legal status, developmental history, a copy of the post-institutionalization plan of care and a signed order for any physical restraints including justification and duration of application;

(ii) Records are adequately safeguarded against destruction, loss, or unauthorized use; and

(iii) Records are retained for a minimum of 3 years following a resident's discharge.

(5) Meets such provisions of the Life Safety Code of the National Fire Protection Association (21st Edition, 1967) as are applicable to institutional occupancies; except that:

(i) For facilities of 15 beds or less, the State survey agency may apply the Lodging or Rooming Houses section of the residential occupancy requirements of the Code for institutions for the mentally retarded or persons with related conditions and intermediate care facilities primarily engaged in the treatment of alcoholism and drug abuse, all of whose residents are currently certified by a physician or in the case of an institution for the mentally retarded or persons with related conditions by a physician or psychologist as defined in paragraph (c)(3)(i) of this section, as:

(A) Ambulatory;

(B) Engaged in active programs for rehabilitation which are designed to and can reasonably be expected to lead to independent living, or in the case of an institution for the mentally retarded or persons with related conditions, receiving active treatment; and

(C) Capable of following directions and taking appropriate action for self-preservation under emergency conditions;

(ii) In accordance with criteria issued by the Secretary, the State survey agency may waive the application to any such facility of specific provisions of such Code, for such periods as it deems appropriate, which provisions if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver will not adversely affect the health and safety of the residents; and

(iii) The Life Safety Code shall not apply in any State if the Secretary makes a finding that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents in intermediate care facilities.

Where waivers permit the participation of an existing facility of two or more stories which is not of at least 2-hour fire resistive construction, blind, nonambulatory or physically handicapped residents are not housed above the street level floor unless the facility is of 1-hour protected non-combustible construction (as defined in National Fire Protection Association Standard #220), fully sprinklered 1-hour protected ordinary construction or fully sprinklered 1-hour protected wood frame construction.

(6) Maintains conditions relating to environment and sanitation as set forth below:

(i) Resident living areas are designed and equipped for the comfort and privacy of the resident. Each room is equipped with or conveniently located near adequate toilet and bathing facilities appropriate in number, size, and design to meet the needs of residents. Each room is at or above grade level and each resident room contains a suitable bed, closet space which provides security and privacy for clothing and personal belongings, and other appropriate furniture;

(A) Resident bedrooms have no more than 4 beds. Single resident rooms measure at least 100 square feet, and multiresident rooms provide a minimum of 80 square feet per bed. The survey agency may waive in existing buildings, for such

sions which, if rigidly enforced, would result in unreasonable hardship upon the facility but only if such waiver is in accordance with the particular needs of the residents and will not adversely affect their health and safety. Each room is equipped with a resident call system; or

(B) In the case of institutions for the mentally retarded or persons with related conditions, the number of residents in multi-resident bedrooms does not exceed 12 persons. Single resident rooms measure 100 square feet, and multi-resident rooms provide a minimum of 80 square feet per bed. The survey agency may waive in existing buildings, for such periods as deemed appropriate, provisions which, if rigidly enforced, would result in unreasonable hardship upon the institution but only if such waiver is in accordance with the particular needs of the residents and will not adversely affect their health and safety; and

(ii) The facility has available at all times a quantity of linen essential for proper care and comfort of residents. Each bed is equipped with clean linen;

(iii) An adequate supply of hot water for resident use is available at all times. Temperature of hot water at plumbing fixtures used by residents is automatically regulated by control valves;

(iv) Except in the case of an institution for the mentally retarded or persons with related conditions, corridors used by residents are equipped with firmly secured handrails;

(v) Provision is made for isolating residents with infectious diseases;

(vi) Areas utilized to provide therapy services are of sufficient size and appropriate design to accommodate necessary equipment, conduct examinations, and provide treatment;

(vii) The facility provides one or more areas for resident dining, diversional, and social activities; and areas used for corridor traffic shall not be considered as areas for dining, diversional or social activities;

(viii) If a multipurpose room is used for dining and diversional and social activities, there is sufficient space to accommodate all activities and prevent their interference with each other;

(ix) The facility is accessible to and functional for residents, personnel, and the public. All necessary accommodations are made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, disabilities of coordination, as well as other disabilities in accordance with the American National Standards Institute (ANSI) Standard No. A117.1 (1961) American Standard Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped. The survey agency may waive in existing buildings, for such periods as deemed appropriate, specific provisions of ANSI Standard No. A117.1 (1961) which, if rigidly enforced, would result in unreasonable hardship upon the facility, but only if such waiver will not adversely affect the health and safety of residents. For purposes of ANSI Standard No. A117.1 (1961), "existing buildings" are defined as those facilities or parts thereof whose construction plans are approved and stamped by the appropriate State agency responsible therefor before the date these regulations become effective.

(7) Provides or arranges menus and meal service so that:

(i) At least three meals or their equivalent are served daily, at regular times with not more than 14 hours between a substantial evening meal and breakfast;

(ii) A designated staff member suited by training or experience in food management or nutrition is responsible for planning and supervision of menus and meal service;

(iii) If the facility accepts or retains individuals in need of medically prescribed special diets, the menus for such diets are planned by a professionally qualified dietitian, or are reviewed and approved by the attending physician, and the facility provides supervision of the preparation and serving of the meals and their acceptance by the resident;

(iv) Menus are planned and followed to meet nutritional needs of residents, in accordance with physicians' orders and to the extent medically possible, in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;

(v) Records of menus as actually served are retained for 30 days;

(vi) All food is procured, stored, prepared, distributed, and served under sanitary conditions; and

(vii) Individuals needing special equipment, implements, or utensils to assist them when eating have such items provided.

(8) Implements methods and procedures relating to drugs and biologicals

(i) If the facility does not employ a licensed pharmacist, it has formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and recordkeeping of drugs and biologicals;

(ii) Medications administered to a resident are ordered either in writing or orally by the resident's attending or staff physician. Physician's oral orders for prescription drugs are given only to a licensed nurse, pharmacist, or physician. All oral orders for medication are immediately recorded and signed by the person receiving them and are countersigned by the attending physician in a manner consistent with good medical practice;

(iii) Medications not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies and the attending physician is notified;

(iv) Self-administration of medication is allowed only with permission of the resident's attending physician;

(v) A registered nurse reviews monthly each resident's medications and notifies the physician when changes are appropriate. Medications are reviewed quarterly by the attending or staff physician; and

(vi) All personnel administering medications must have completed a State-approved training program in medication administration.

(9) Provides health services which assure that each resident receives treatments, medications, diet, and other health services as prescribed and planned, all hours of each day, in accordance with the following:

(i) Immediate supervision of the facility's health services on all days of each week is by a registered nurse or licensed practical (or vocational) nurse employed full-time on the day shift in the intermediate care facility and who is currently licensed to practice in the State: *Provided,* That:

(A) In the case of facilities where a licensed practical (or vocational) nurse serves as the supervisor of health services, consultation is provided by a registered nurse, through formal contract, at regular intervals, but not less than 4 hours weekly;

(B) By January 1975, licensed practical (or vocational) nurses serving as

ing that includes either graduation from a State approved school of practical nursing or education and other training that is considered by the State authority responsible for licensing of practical nurses to provide a background that is equivalent to graduation from a State approved school of practical nursing, or have successfully completed the Public Health Service examination for waivered licensed practical (vocational) nurses; and

(C) Other categories of licensed personnel with special training in the care of residents may serve as charge nurse: *Provided,* That such person is licensed by the State in such category following completion of a course of training which includes at least the number of classroom and practice hours in all of the nursing subjects included in the program of a State approved school of practical (or vocational) nursing as evidenced by a report to the single State agency by the agency or agencies of the State responsible for the licensure of such personnel comparing the courses in the respective curricula; and

(ii) Responsible staff members are on duty and awake at all times to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies;

(iii) In the case of an institution for the mentally retarded or persons with related conditions, with 15 beds or fewer which has only residents certified by a physician as not in need of professional nursing services, paragraph (a)(9)(i) and (ii) of this section may be met if the institution arranges through formal contract for the services of a registered nurse or public health nurse to visit as required for the care of minor illnesses, injuries, or emergencies, and consultation on the health aspects of the individual plan of care; and if a responsible staff member is on duty at all times who is immediately accessible, to whom residents can report injuries, symptoms of illness, and emergencies;

(iv) A written health care plan is developed and implemented by appropriate staff for each resident in accordance with instructions of the attending or staff physician. The plan is reviewed and revised as needed, but not less often than quarterly;

(v) Nursing services are provided in accordance with the needs of the residents and, in the case of a facility other

tions, restorative nursing care is provided to each resident to achieve and maintain the highest possible degree of function, self-care and independence.

(b) In addition, for intermediate care facilities other than institutions for the mentally retarded or persons with related conditions, the following standards specified pursuant to section 1905(c) of the Social Security Act shall apply.

(1) The facility is administered by a person licensed in the State as a nursing home administrator or, in the case of a hospital qualifying as an intermediate care facility, by the hospital administrator, with the necessary authority and responsibility for management of the facility and implementation of administrative policies.

(2) The administrator or an individual on the professional staff of the facility is designated as resident services director and is assigned responsibility for the coordination and monitoring of the residents' overall plans of care.

(3) The facility provides, according to the needs of each resident, specialized and supportive rehabilitative services either directly or through arrangements with qualified outside resources, which are designed to preserve and improve abilities for independent function, prevent insofar as possible progressive disabilities, and restore maximum function, and which are:

(i) Provided under a written plan of care, developed in consultation with the attending physician and if necessary, an appropriate therapist. The plan is based on the attending physician's orders and an assessment of the resident's needs. The resident's progress is reviewed regularly, and the plan is altered or revised as necessary;

(ii) Provided in accordance with accepted professional practices by qualified therapists or by qualified assistants as defined in 20 CFR 405.1101(m), (n), (q), (r), and (t) or other supportive personnel under appropriate supervision.

(4) The facility provides or arranges for social services as needed by the resident, designed to promote preservation of the resident's physical and mental health.

(i) A designated staff member suited by training or experience is responsible for arranging for social services and for the integration of social services with other elements of the plan of care.

(ii) A plan for such care is recorded in the resident's record and is periodically evaluated in conjunction with the resident's total plan of care.

(5) The facility provides an activities program designed to encourage restoration to self-care and maintenance of normal activity which assures that:

(i) A staff member qualified by experience or training in directing group activity is responsible for the direction and supervision of the activities program;

(ii) A plan for independent and group activities is developed for each resident in accordance with his needs and interests;

(iii) The plan is incorporated in his overall plan of care and is reviewed with the resident's participation at least quarterly and altered as needed;

(iv) Adequate recreation areas are provided with sufficient equipment and materials available to support independent and group activities; and

(6) The facility maintains policies and procedures to assure that each resident's health care is under the continuing supervision of a physician who sees the resident as needed and in no case less often than every 60 days, unless justified otherwise and documented by the attending physician.

(c) In addition, for institutions for the mentally retarded or persons with related conditions the following standards specified pursuant to section 1905(d) of the Social Security Act shall apply.

(1) Residents are admitted when it has been determined in accordance with § 249.10(d)(1)(v)(c) that the resident is in need of the care and services provided by the institution.

(2) The institution is administered by a person licensed in the State as a nursing home administrator or by a Qualified Mental Retardation Professional who meets the requirements set forth in subparagraph (3) of this paragraph however, in the case of an institution licensed as a nursing home, by a person licensed in the State as a nursing home administrator, or, in the case of a hospital qualifying as an institution for the mentally retarded or persons with related conditions, by the hospital administrator. The administrator has the necessary authority and responsibility for management of the institution and implementation of administrative policies.

(3) The institution provides for a Qualified Mental Retardation Professional who is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the institution's program, recording each resident's progress and initiating periodic review of each individual plan of care for necessary modifications or adjustments. The term "Qualified Mental Retardation Professional" means:

(i) A psychologist with at least a master's degree from an accredited program and with specialized training or 1 year of experience in treating the mentally retarded;

(ii) A physician licensed under State law to practice medicine or osteopathy and with specialized training or 1 year of experience in treating the mentally retarded;

(iii) An educator with a degree in education from an accredited program and with specialized training or 1 year of experience in working with the mentally retarded;

(iv) A social worker with a bachelor's degree in social work from an accredited program, or a bachelor's degree in a field other than social work and at least three years social work experience under the supervision of a qualified social worker, and with specialized training or 1 year of experience in working with the mentally retarded;

(v) A physical or occupational therapist as defined in 20 CFR 405.1101(m) or (q) and who has specialized training or 1 year of experience in treating the mentally retarded;

(vi) A speech pathologist or audiologist as defined in 20 CFR 405.1101(t) and who has specialized training or 1 year of experience in treating the mentally retarded;

(vii) A registered nurse who has specialized training or 1 year of experience in treating the mentally retarded;

(viii) A therapeutic recreation specialist who is a graduate of an accredited program and where applicable, is licensed or registered in the State, and who has specialized training or 1 year of experience in working with the mentally retarded.

(4) The institution provides all necessary resident living services, training, and guidance in the activities of daily living, and development of self-help skills for maximum independence, and, as needed by the individual resident, provides directly or through arrangements the following:

(i) Dental services to provide evaluation, diagnosis, treatment and annual review, including care for dental emergencies, administered by or under the supervision of a dentist licensed in the State to practice dentistry or dental surgery;

(ii) Physical and occupational therapy services for purposes of initiating, monitoring and followup of individualized treatment programs rendered by or under the supervision of a physician with special training or experience in the specialty or a physical therapist or an occupational therapist as defined in 20 CFR 405.1101(m) or (q);

(iii) Psychological services including participation in the evaluation and periodic reviews, individual treatment, and consultation and training services to program staff, rendered by a psychologist with a master's degree from an accredited program;

(iv) Social services available to all residents as appropriate, including evaluation and counseling, with referral to, and use of, other community resources as appropriate, participation in periodic reviews and planning for community placement, discharge and followup services;

(v) Speech pathology and audiology services to maximize the communication skills of residents for purposes of initiation, monitoring and followup of individualized treatment programs under the direction of a physician with special training or experience in the specialty or a therapist as defined in 20 CFR 405.1101(t);

(vi) Organized recreational activities for residents consistent with their needs and capabilities, including provision of adequate recreation areas, equipment and materials to support independent and organized activities; and

(vii) Physician services including a complete physicial examination at least annually and formal arrangements to provide for medical emergencies on a 24-hour, 7-days-a-week-basis.

(5) The institution has a direct care staff which conducts a resident living program designed to provide training in activities of daily living and development of self-help and social skills, and to carry out the recommendations and plans for treatment of each resident under the supervision of a person (or persons) whose training and experience is appropriate for the program and who is qualified to supervise and direct activities of daily living and

(6) No later than three years after the effective date of these regulations the institution meets the standards specified

in § 249.13. For institutions determined to meet the standards specified in § 249.13, the following sections of paragraphs (a) and (c) of this section do not apply: (a)(1)(i), (ii), (iv), (v) and (vi); (a)(4); (a)(6)(i)(B), (iii), (v), (vi), (vii), and (viii); (a)(7); (a)(8); (c)(4); and (c)(5).

[39 FR 2223, Jan. 17, 1974; 39 FR 8918, Mar. 7, 1974]

§ 249.13 Standards for intermediate care facility services in institutions for the mentally retarded or persons with related conditions.

Effective not later than 3 years after the effective date of these regulations the standards for intermediate care facility services (as defined in § 249.10(b)(15)) in an institution for the mentally retarded or persons with related conditions which are specified by the Secretary pursuant to section 1905(c) and (d) of the Social Security Act and referred to in § 249.12(c)(6), are specified in this section. At such time as an institution is deemed to meet the standards contained in this section, such institution will no longer be required to meet the following provisions of § 249.12: (a)(1)(i), (ii), (iv), (v) and (vi); (a)(4); (a)(6)(i)(B), (iii), (v), (vi), (vii) and (viii); (a)(7); (a)(8); (c)(4); and (c)(5).

(a) *Administrative policies and practices*—(1) *General policies and practices.* (i) The facility shall have a written outline of the philosophy, objectives, and goals it is striving to achieve, that is available for distribution to staff, consumer representatives, and the interested public, and that shall include but need not be limited to:

(A) Its role in the State comprehensive program for the mentally retarded;

(B) Its goals for its residents; and

(C) Its concept of its relationship to the parents of its residents, or to their surrogates.

(ii) The facility shall have a written statement of policies and procedures concerning the rights of residents that assure the civil rights of all residents.

(iii) The facility shall have a written statement of policies and procedures that protect the financial interests of residents and when large sums accrue to the resident, provide for counseling of the resident concerning their use, and for appropriate protection of such funds. These policies shall permit normalized and normalizing possession and use of money by residents for work payment and property administration as, for example, in performing cash and check transactions and in buying clothes and other items.

(iv) Policies and procedures in the major operating units of the facility shall be described in manuals that are current, relevant, available, and followed.

(v) The facility shall have a plan for a continuing management audit to insure compliance with State laws and regulations and the effective implementation of its stated policies and procedures.

(vi) A governing body of the facility shall exercise general direction and shall establish policies concerning the operation of the facility and the welfare of the individuals served.

(vii) The governing body shall establish appropriate qualifications of education, experience, personal factors, and skills for the chief executive officer.

(viii) The chief executive officer shall make arrangements so that some one individual is responsible for the administrative direction of the facility at all times.

(ix) A table of organization shall provide for and show the major operating programs of the facility, with staff divisions, the administrative personnel in charge of the programs and divisions, and their lines of authority, responsibility, and communication.

(x) The administration of the facility shall provide for effective staff and resident participation and communication.

(A) Standing committees appropriate to the facility, such as human rights, research review, and infection shall be constituted and shall meet regularly. Committees shall include the participation of direct-care staff, whenever appropriate.

(B) Minutes and reports of staff meetings, and of standing and ad hoc committee meetings shall include records of recommendations and their implementation, and shall be kept and filed.

(xi) There shall be an active program of ready, open, and honest communication with the residents and families.

(A) The facility shall maintain active means of keeping residents' families or surrogates informed of activities related to the residents that may be of interest to them or of significant changes in the resident's condition.

(B) Communications to the facility from residents' relatives shall be promptly and appropriately handled and answered.

(C) Close relatives and parent surrogates shall be permitted to visit at any reasonable hour, and without prior notice unless contra-indicated by the residents' needs. Steps shall be taken, however, so that the privacy and rights of the other residents are not infringed by this practice.

(D) Parents shall be permitted to visit all parts of the facility that provide services to residents.

(E) Frequent and informal visits home shall be encouraged, and the regulations of the facility shall facilitate rather than inhibit such visitations.

(2) *Admission and release.* (i) No individual whose needs cannot be met by the facility shall be admitted to it. The number admitted as residents to the facility shall not exceed:

(A) its rated capacity; and

(B) its provisions for adequate programming.

(ii) The laws, regulations, and procedures concerning admission, readmission, and release shall be summarized and available for distribution.

(iii) The residential facility shall admit only residents who have had a comprehensive evaluation, covering physical, emotional, social, and cognitive factors, conducted by an appropriately constituted interdisciplinary team.

(iv) Initially, service need shall be defined without regard to the actual availability of the desirable options. All available and applicable programs of care, treatment, and training shall be investigated and weighed, and the deliberations and findings recorded. Admissions to the residential facility shall occur only when it is determined to be the optimal available plan. Where admission is not the optimal measure, but must nevertheless be recommended or implemented, its inappropriateness shall be clearly acknowledged and plans shall be initiated for the continued and active exploration of alternatives.

(v) Within the period of one month after admission there shall be:

(A) A review and updating of the preadmission evaluation;

(B) A prognosis that can be used for programming and placement;

(C) Direct-care personnel participation in the aforementioned activities;

(D) Recorded in the resident's unit record the results of the evaluations; and

(E) A written interpretation of the evaluation, in action terms, which is made to:

(*1*) The direct-care personnel responsible for carrying out the resident's program;

(*2*) The special services staff responsible for carrying out the resident's program; and

(*3*) The resident's parents or his surrogates.

(vi) There shall be a regular, at least annual, joint review of the status of each resident by all relevant personnel, including personnel in the living unit, with program recommendations for implementation. This review shall include:

(A) Consideration of the advisability of continued residence and alternative programs;

(B) At the time of the resident's attaining majority, or if he becomes emancipated prior thereto:

(*1*) The need for guardianship of the resident; and

(*2*) The exercise of the resident's civil and legal rights.

(vii) The results of these reviews shall be:

(A) Recorded in the resident's unit record;

(B) Made available to relevant personnel;

(C) Interpreted to the resident's parents or surrogates who shall be involved in planning and decision making; and

(D) Interpreted to the resident, when appropriate.

(viii) At the time of permanent release or transfer, there shall be recorded a summary of findings, progress and plans.

(ix) Planning for release shall include provision for appropriate services, including protective supervision and other follow-up services, in the resident's new environment. Procedures shall be established so that parents or guardians who request the release of a resident are counseled concerning the advantages and disadvantages of such release.

(x) When a resident is transferred to another facility, there shall be:

(A) Written evidence of the reason for the transfer; and

(B) Except in an emergency, prior knowledge, and ordinarily the written consent, of the resident and his guardian.

(xi) In the event of any unusual occurrence, including serious illness or accident, impending death, or death, the resident's next of kin, or the person who functions in that capacity (a guardian or citizen advocate) shall be notified promptly.

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Mr. Michael Miller
Office of Attorney General
Room G19-K
State of Minnesota Administration Bldg.
Saint Paul, Minnesota 55155

ADMIN. 1000

STATE OF MINNESOTA

DEPARTMENT Attorney General

Office Memorandum

TO : Mike Miller

DATE: 4/29/76

FROM : Tom Fabel

SUBJECT:

Enclosed is DPW Rule 47. I will call you tomorrow to arrange a meeting to discuss it.

TLF/pas

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155

OFFICE OF THE
COMMISSIONER
612/296-2701

GENERAL
INFORMATION
612/296-6117

April 14, 1976

The Honorable Warren Spannaus
Attorney General
State Capitol - Room #102
St. Paul, Minnesota 55155

Dear Mr. Spannaus:

Enclosed herewith you will find copies of the recently amended version of Minn. Rule DPW 47, along with the necessary documents pertaining to the promulgation and adoption of that rule as required by Minn. Rules Atty. Gen. 301-305.

Please approve the form and legality of Minn. Rule DPW 47 so that it may be properly filed with the Secretary of State pursuant to applicable provisions of the state's Administrative Procedures Act.

Thank you for your consideration and assistance in this matter.

Sincerely,

Vera J. Likins
Commissioner

VJL:rek
enclosure

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OF COUNSEL
CURTIS L. STINE

May 12, 1976

Mr. Michael Miller
Office of Attorney General
Room G19-K
State of Minnesota Administration Bldg.
Saint Paul, Minnesota 55155

Re: Adopted Amendments Department of Public Welfare Rule 47.

Dear Mr. Miller:

On behalf of our client, the Minnesota Association of Health Care Facilities, we do not at the present time intend to challenge the above referenced amendments submitted to your office on Friday, April 30, 1976, as to "form and legality". We appreciate having been notified of the submission of the "Adopted Amendments" to your office. We also appreciate your cooperation in making such amendments available to us for our perusal.

Very truly yours,

BROEKER AND BACHMAN

By John M. Broeker
John M. Broeker

JMB:jp
cc: Ms. Vera Likins
Mr. James Hiniker
Mr. Thomas Fabel

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS

COMMISSIONER OF PUBLIC WELFARE

In the Matter of Proposed Amendments
to Rule 47 of the Minnesota
Department of Public Welfare
Governing Administration of
the Medical Assistance Program

ORDER FOR HEARING

To effectively implement Minnesota Statutes 1974, Chapter 256B, as amended, the Commissioner of the Minnesota Department of Public Welfare deems it necessary to consider amendment of the rule first captioned-above, pursuant to the authority vested in me by Minnesota Statutes 256B.04, subd. 2 (1974).

NOW, THEREFORE, IT IS ORDERED this 26th day of August, 1975, that a public hearing on proposed amendments to Minn. Rule DPW 47 be held in the Minnesota Veterans' Home Auditorium, East 51st Street and Minnehaha Avenue, Minneapolis, Minnesota, on Wednesday, November 19, 1975, commencing at 8:30 A.M., and continuing until all representatives of associations and other interested groups or persons have had an opportunity to be heard.

IT IS FURTHER ORDERED, that notice of said hearing be given pursuant to the provisions of Minnesota Statutes 15.0412, subd. 4 (1974), as amended by Minnesota Laws 1975, Chapter 380; and to all representatives of associations or other interested groups or persons who have registered their names with the Secretary of State for that purpose and all persons who are presently members of the Minnesota Legislature.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Vera J. Likins
Commissioner

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS

COMMISSIONER OF PUBLIC WELFARE

In the Matter of Proposed Amendments
to Rule 47 of the Minnesota
Department of Public Welfare
Governing Administration of
the Medical Assistance Program

NOTICE OF HEARING

Notice is hereby given that a public hearing will be held pursuant to Minnesota Statutes 15.0412, subd. 4 (1974), as amended by Minnesota Laws 1975, Chapter 413, regarding the above-entitled matter, in the Minnesota Veteran's Home Auditorium, East 51st Street and Minnehaha Avenue, Minneapolis, Minnesota, on Wednesday, November 19, 1975, commencing at 8:30 A.M., and continuing until all representatives or other interested groups or persons have had an opportunity to be heard concerning adoption of the proposed amendments to Minn. Rule DPW 47, by submitting either oral or written data, statements or arguments. Statements or briefs may be submitted without appearing at the hearing.

Under Minnesota Statutes 10A.01, subd. 11 (1974), any individual representing persons or associations attempting to influence administrative action, such as promulgation of amendments to this rule, must register with the State Ethics Commission as a lobbyist within five (5) days of the commencement of such activity by the individual. (The State Ethics Commission is located at Room 410, State Office Building, St. Paul, Minnesota 55155.)

The proposed amendments to Minn. Rule DPW 47 relate to:

(1) The application process under the Minnesota Medical Assistance program.
(2) Eligibility factors and criteria under the Minnesota Medical Assistance program.
(3) General administration of the Minnesota Medical Assistance program.
(4) The types of medical services covered and not covered under the Minnesota Medical Assistance program.
(5) Reimbursement procedures under the Minnesota Medical Assistance program.

Testimony or other evidence to be submitted for consideration should be pertinent to the matter at hand and may be presented either orally or in writing at the public hearing or by mailing a statement to Commissioner Vera J. Likins, Minnesota Department of Public Welfare, Fourth Floor, Centennial Office Building, St. Paul, Minnesota 55155, within 20 days following conclusion of the hearing. If the person submitting a written document cannot be present to read his statement at the hearing, the document will be entered into the record. For those persons wishing to submit written statements or exhibits, it is requested that at least three (3) copies of each statement, exhibit or summary be furnished at the hearing. It is suggested that to save time and avoid duplication, those organizations or associations sharing common viewpoints or interests in these proceedings join together where possible and present a single statement on behalf of such interests.

Copies of the proposed amendments to Minn. Rule DPW 47 are now available and may be obtained by writing: Irene Goldman, MA Policy Specialist, 690 North Robert Street, St. Paul, Minnesota 55117. Additional copies will be available at the door on the date of the hearing.

DATED: October 15, 1975.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Vera J. Likins

VERA J. LIKINS
Commissioner

Building #15:
Chapel, Auditorium and

STATE OF MINNESOTA

COUNTY OF RAMSEY

In the Matter of Proposed Amendments
to Rule 47 of the Minnesota
Department of Public Welfare
Governing Administration of
the Medical Assistance Program

AFFIDAVIT

IRENE R. GOLDMAN, being duly sworn on oath deposes and says:

1) That she is an employee of the Department of Public Welfare of the State of Minnesota.

2) That on the 26th day of August, 1975, she went to the Secretary of State's office for the State of Minnesota and requested a current list of all representatives of associations and other interested groups or persons who had registered their names with the Secretary of State for the purpose of obtaining notices of public hearings relating to the promulgation of regulations pursuant to Minnesota Statutes 15.0412.

3) That on the 26th day of August, 1975, at 8:45 A.M., in response to the above request, the Secretary of State provided her with such a list, a copy of which is attached hereto and incorporated by reference.

Further affiant sayeth not.

Irene R. Goldman
IRENE R. GOLDMAN

Subscribed to and sworn to before
me this 17th day of October, 1975

Lorraine C. Pfeffer

LORRAINE C. PFEFFER
Notary Public, Dakota Co. Minn.
My Commission Expires Sept. 29, 1979

PUBLIC WELFARE

Allin, Kent, Welfare Advocacy Unit, 370 Selby Ave., St. Paul 55102

Blade, Joe -Mpls Star, 425 Portland Ave.,Mpls.

Community Mental Health Board of the Northern Pines Mental Health Center, 103-105 1st St. S.E., Little Falls 56345

Curtis, Dr. E.Louis, Prof.Education, U of M., Morris 56267

Deephaven Montessori School, Inc. 188 So. Circle A Drive, Wayzata 55391

Goldberg, Paula, 5315 James Ave. S., Mpls. 55419

Kurtz, Mrs. Kirsten, Mn. Nurses' Assn., 1821 Univ. Ave.,St. Paul 55104

Legal Aid Society, 501 Park Ave., Mpls. 55415

Local #34, AFSC & ME, Box 2016, Commerce Sta., Mpls.55415

Lutheran Soc.Service,Attn.H.L.Paulsen, 2414 Park Ave S.,Mpls. 55404

Minneapolis & Hennepin County Mental Health Clinic,619 S. 5th St.,MPls., 55415

Minnesota Ass'n Ed. of Young Children,373 So.Griggs-Midway1821 Univ.St.Paul. 55104

Minnesota Legislative Comm. of Blind, 1605 Eustis, St. Paul 55108

Minn. State Pharmaceutical Ass'n., 2388 Univ. Ave. St.Paul 55104

Moratzka, Timothy, 1304 Vermillion St., Hastings 55033

Neff, Dr. Walter S., Virginia 55792

Northland Mental Health Center, 415 S. Pokegema, Grand Rapids 55744

Public Relief, BD. of Public Welfare, Attn.Dir.Jensen, 250 S. 4th St.,Mpls.5541

Sister Letitia M. Close, B.V.M., 415 Summit Ave., St.Paul 55102

Southwestern Mental Health Center, 306 N. McKenzie St., Luverne 56156

Upper Mississippi Mental Health Center, Attn: Dr. Howard C.Reid,510Beltrami Av Bemidji

Veterans' Affairs, Veterans Service Bldg., St. Paul 55155

Welfare Rights Organization,% Stephen Parsons, 1118 Newton Av.No.Mpls.55411

West Central Mental Health Center, 323 W. 6th St., Willmar 56201

ANTHONY DICK WDSM RADIO
230 E SUPR ST
DULUTH MN
55802

ARNOLD ROBERT MESPA
41 SHERBURNE
ST PAUL MN
55103

ASMUSSEN,DENNIS,MPLS
3036 UNIV AVE SE
MPLS MN
55414

ASSOCIATED GEN CONTROF MN
48 E 6TH STREET
ST PAUL MN
55101

ASSN RESIDENCES FOR RETARDED
459 RICE SUITE 301
ST PAUL MN
55103

AUTOMOBILE MFRS ASSN INC
55 SHERBURNE AVE
ST PAUL MN
55103

BADALICH JOHN P
2025 THOMPSON AVE
SO ST PAUL MN
55075

BARRETT FRED
ST LOUIS CO COURT HOUSE
DULUTH MN

BECKLIN ROBERT C
447 N W 4TH
CAMBRIDGE MN
55008

BEECHER EVERETT
10 10 1ST ST SO
HOPKINS MN

BERGERUD ALF
300 ROANOKE BLDG
MPLS MN
55402

BERGSETH THOMAS
1011 NICOLLET MALL
MPLS MN
55403

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NORTH BRANCH MN
55056

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55431

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RR4
RED WING MN
55066

BROEKER JOHN
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55420

BRUBACHER RICHARD COMM ADM
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MPLS. MN
55455

BUR.ENGR.INC.DIV. MR.KIBIGER
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MPLS. MN

BUR NATL AFFAIRS INC
1231 25TH ST NW
WASHINGTON DC
20037

CAIN RUTH
730 E 38TH ST
MPLS MN
55407

CAIRNS JOHN A
47TH FLR IDS CENTER
MPLS MN
55402

CARRISON DALE K
MANKATO STATE COLLEGE
MANKATO MN
56001

CENTRAL BUSINESS DATA
BENSON RADIO ARCADE BLD
BENSON MN
56215

ALLENDORF MARSHALL
220 GRAIN EX 400 S 4TH
MPLS MN
55415

ALTMAN MILTON H
707 DEGREE OF HONOR BLD
ST PAUL MN
55101

ANCHOR BLOCK COMPANY
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ST PAUL MN
55165

ANDERSON GRAHAM
951 E HENN
MPLS MN
55414

ANDERSON JAMES
7703 NORMANDALE RD
MPLS MN
55435

ANDERSON STANFORD P
14600 MINNETONKA BLVD
MINNETONKA MN
55343

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366 JACKSON ST
ST PAUL MN
55101

AM CAMPING ASSN MRS LEACOCK
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55112

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VIRGINIA MN
55792

ANDERSON HAROLD
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MANKATO MN
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55435

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ST PAUL MN
55101

WHITING RALPH
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ST PAUL MN
55102

WHITLOCK A G
ECON LAB OSBORN BLDG
ST PAUL MN
55102

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OSSEO MN
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WILSON R GARY PPG INDUSTR
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PITTSBURGH PA
15222

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WYANT CLINTON W ATTY

ATKIN MN
56431

WELK G V NORTHERN STATES
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MPLS MN
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WESTIN CHAS W
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NATIONAL BLDG
MPLS MN
55402

ASSN OF MINN COUNTIES
55 SHERBURNE AVE #203
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BABCOCK LOCHER NELSON ET
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ANOKA MN
55303

BARKER KENT
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55420

BARTHOLOW HAROLD E FIRE C
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COON RAPIDS MN
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BEST FLANAGAN ET AL
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MPLS MN
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BROOKS WILLIAM F JR
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55401

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IND DIST #561
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BUCHHOLTZ CHARLES
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BURGER ALBERT
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ST PAUL MN
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GOLDEN VALLEY MN
55422

HOUSE APPROPRIATIONS COMM
RM 109 STATE CAPITOL
ST PAUL MN
55101

HOUSE ED STANDING SUB COMM
RM 109 STATE CAPITOL
ST PAUL MN
55101

HUMAN RIGHTS
200 CAPITOL SQ BLDG
ST PAUL MN
55101

HUNT JAMES P JR
11470 GALTIER DR
BURNSVILLE MN
55378

INGEBRIGTSEN DR K H
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MPLS MN
55414

INTERSTATE POWER RM STEELE
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DUBUQUE IA
52001

IUOE LOC 49 CHAS SWENSON
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ST PAUL MN
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55406

JENSEN CARL A
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SLEEPY EYE MN
56085

JOHNSON & SANDERSON
ST MARYS HOSPITAL
ROCHESTER MN
55901

JOHNSON M.D. FRUNDT & FRUNDT
BLUE EARTH MN
56013

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265 S LAFAYETTE RD
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55107

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55102

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ST CLOUD MN
56301

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55102

HEAD & TRUHN
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55402

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MPLS MN
55415

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DOWNTOWN AIRPORT
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56201

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C/O BARBAROSSA R3
OSSEO MN
55369

HUTCHISON R.M. ANOKA CO.COMP
COURT HOUSE
ANOKA MN
55303

HYLAND DEAN
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MPLS MN
55419

INGVALSON VERN MN.FARM BUR.
3110 WOODDALE DR PO 337
OST PAUL MN
55165

INS FED OF MINN
902 SOO LINE BLDG
MPLS MN
55402

IVERSON DR JOS DEPT ED
ST OLAF COLLEGE
NORTHFIELD MN
55057

IZAAK WALTON LEAGUE MN DI
106 TIMES BLDG 57 S 4TH
MPLS MN
55401

JAIN NIRMAL ENIV PROCESS
1220 GLENWOOD AVE
MPLS MN
55405

JENOS INC
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DULUTH MN
55801

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MPLS MN
55406

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55433

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BETHEL MN
55006

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KIMBALL ROBERT
647 CAPITOL SQ BLDG
ST PAUL MN
55101

KING,TIMOTHY
5335 OAKLAND AVE S
MPLS MN
55407

KNUTSON DR KEITH,BIOLOGY DPT
ST CLOUD STATE
ST CLOUD MN
56301

KOPP MRS VERNON
2050 65TH ST E
INVER GR HGHT MN
55075

LAKE SUPERIOR INDUSTRIAL BUR
626 FIRST AM. BK. BLDG.
DULUTH MN
55802

LAPP LAZAR LAURIE ET AL
1200 BUILDERS EXCHANGE
MINNEAPOLIS MN
55402

LEAGUE WOMEN VOTERS OF MINN
555 WABASHA
ST PAUL MN
55102

LOCS CALVIN J
6809 LYNDALE AVE SO
MPLS MN
55423

MCDONALD PHILIP M
2077 SELBY AVE
ST PAUL MN
55104

KLOSTER MARION PEAVEY CO
730 2ND AVE S
MPLS MN
55402

KNUTSON R N GRANNIS ETAL
F J SCHULT BLDG
ST ST PAUL MN
55075

KRAMER ERNEST R
717 DELAWARE ST SE
MPLS MN
55440

LANAHAN E F - SIBLEY CO
184 E 6TH ST
ST PAUL MN
55101

LARSON C L
3800 MINNEHAHA AVE SO
MPLS MN
55406

LIBBEY LEONARD
BOX 17011 NOKOMIS STA
MPLS MN
55417

LOKE DOUG
2701 N LEXINGTON AVE
ROSEVILLE MN
55113

MCFADDEN G H DISPATCH-PRESS
55 E 4TH ST
ST PAUL MN
55101

MALONE E I COMM LABOR & INDU
444 LAFAYETTE RD 5TH FL
ST PAUL MN
55101

MANTHEY T J PICKANDS MATHER
1100 SUPERIOR AVE
CLEVELAND OH
44114

MASTOR & MATTSON LTD
315 PEAVEY BLDG
MPLS MN
55402

MECCA
867 GRAND AVE
ST PAUL MN
55105

MEIEROTTO, JOAN
1794 SO LEXINGTON
ST PAUL MN
55118

METROPOLITAN COUNCIL LIBRARY
300 METRO SQUARE
ST PAUL MN
55155

MIDLAND GLASS- HD SPURLING
PO BOX 69
SHAKOPEE MN
55379

KLUZ STEVEN J
1910 1ST NATL BK BLDG
MPLS MN
55402

KNOPP TIMOTHY
COLLEGE FORESTRY U OF M
ST PAUL MN
55108

KNUDSON ROBT
4375 BROWNDALE AVE
MPLS MN
55424

KOLLER MR & MRS ERWIN A
1568 DULUTH ST
ST PAUL MN
55108

KRONLOKKEN J E
10048 NORD RD
BLOOMINGTON MN
55437

LANGVIN DAVID
7500 80TH ST S
COTTAGE GROVE MN
55016

LANSING & OAKES
400 SIBLEY ST
ST PAUL MN
55101

LARSON HANS P DIV HOSP SERV
717 DELAWARE ST SE
MPLS MN
55440

LEAGUE MN MUNIC
300 HANOVER 480 CEDAR
ST PAUL MN
55101

LINDALL & JONATHAN DEVELOP.
VILLAGE ONE CENTER
CHASKA MN
55318

LOCKNER GARY
R R 1 BOX 23
BAUDETTE MN
56623

LYNCH DONALD SIBLEY CO
184 E 6TH ST
ST PAUL MN
55102

MCKIBBON MRS SHIRLEY
11 EVERGREEN LN
BABBITT MN
55706

MCLELLAN LARKIN
215 ADM BLDG ST CAPITOL
ST PAUL MN
55101

MANKATO STAT STUDENT SENATE
CENTENNIAL STUDENT UN
MANKATO MN
56001

MANKATO STATE STUDENT AS
BOX 58 MANKATO COLLEGE
MANKATO MN
56001

MAUL WARREN E
320 S 4TH ST
MPLS MN
55415

MAYO FOUNDATION G ORWOLL
200 FIRST AVE NW
ROCHESTER MN
55901

MERRITT GRANT POLLUTION CONT
1935 W CO RD 32
ROSEVILLE MN
55113

MET TFR MEN ASSN A ROSENT
1821 UNIV AVE
ST PAUL MN
55104

MILLER RICHARD A
1020 PLYMOUTH BLDG
MPLS MN
55402

MILLER TOM
2311 PILLSBURY AVE S
MPLS MN
55404

MPLS CHAMBER COMM TRANSP DPT
15 S 5TH ST
MPLS MN
55402

MIDLAND GLASS-HD SPURLING
PO BOX 69
SHAKOPEE MN
55379

MINN AFL-CIO, L U LA SHOMB
414 AUDITORIUM ST
ST PAUL MN
55102

MINN. ASSN. PET RETAILERS
1115 2ND AVE. SO.
MINNEAPOLIS MN
55403

MINN COMMUNITY DEVELOP SERV
512 ROSSMOR BLDG
ST PAUL MN
55101

MINN ELECTRICAL ASSN INC
525 SO 7TH
MPLS MN
55415

MINN HEREFORD-LJ SCHAFER

BUFFALO LAKE MN
55314

MINN LAND USE COMMITTEE
4344 IDS CENTER
MPLS MN
55402

MINN PETROLEUM COUNCIL
1020 NORTHERN FED BLDG
ST PAUL MN
55102

MINN RETAIL FEDERATION
7600 PARKLAWN STE 457
MPLS MN
55435

MINN SOC CERTIFIED PUB ACCTS
1102 WESLEY TEMPLE BLDG
MPLS MN
55403

MINN STATE MED ASSN
375 JACKSON ST
ST PAUL MN
55101

MPLS CITY ATTORNEY
325M CITY HALL
MPLS MN
55415

MILLER PAUL J PHARMACY SERV
ST MARYS HOSP
ROCHESTER MN
55901

MINN ASPHALT PAVEMENT ASSN
555 WABASHA RM 209
ST PAUL MN
55102

MINN ASSN WATERSHED DIST'S

ADA MN
56510

MINN COUNCIL STATE EMP NO 6
475 RICE ST
ST PAUL MN
55103

MINN ENV LAW INST INC
PO BOX 15076 COMM STA
MPLS MN
55415

MINN. HOTEL & MTR. ASSN
2001 UNIVERSITY AVE
ST PAUL MN

MINN LP GAS ASSN
7515 WAYZATA BLVD 106
MPLS MN
55426

MINN POULTRY & HATCHERY ASSN
BOX 158
MADELIA MN
56062

MINN RETAIL HARDWARE ASSN
3033 EXCELSIOR BLVD 313
MPLS MN
55416

MINN STATE BAR ASSN
100 MINN FED BLDG
MPLS MN
55402

MINN STATE RETIREMENT SYSTEM
529 JACKSON ST
ST PAUL MN
55101

MPLS STAR PRESS ROOM
STATE CAPITOL
ST PAUL MN
55101

MPLS TRIBUNE CITY DESK
425 PORTLAND AVE
MPLS MN
55415

MINN APT ASSN
GRIGGS-MIDWAY BLDG
ST PAUL MN
55104

MN. ASN.C&IND H.O.PETERSO
480 CEDAR ST.
ST.PAUL MN
55101

MINN ASSN COOPERATIVES
55 SHERBURNE AVE
ST PAUL MN
55103

MINN ASSN ELEC COOPERATIV
4901 W 77TH ST
MPLS MN
55435

MINN AUTOMOBILE DEALERS ASSN
GRIGGS MIDWAY BLDG
ST PAUL MN
55104

MINN COMM FOR HANDICAPPED
METRO SQ 492 7TH & ROBT
ST PAUL MN
55101

MINN DEPT HEALTH J C MCKASY
717 DELAWARE S E
MPLS MN
55440

MINN DENTAL HYGIENISTS
5041 YVONNE TERRACE
MPLS MN
55436

MINN FARMERS UNION PRES OFF
1275 UNIV AVE
ST PAUL MN
55104

MINN FOOD RETAILERS ASSN
555 WABASHA
ST PAUL MN
55101

MINN HOUSING INST N T CARTER
7801 METRO PKWY
MPLS MN
55420

MINN HWYS MANAGEMENT SERV
407 HWY BLDG
ST PAUL MN
55101

MINNE MINE CREDIT UNION
3000 HUDSON PK S 100
ST PAUL MN
55119

MINN.MTR.TRANSP. .J.N.D
1821 UNIV.
ST.PAUL MN
55104

MN REP STATE CENTRAL COMM
555 WABASHA AVE
ST PAUL MN
55102

MINN RESTAURANT ASSN
2001 UNIVERSITY AVE.
ST PAUL MN 55
104

MINN SCH BUS OPERATORS ASSN

FARIBAULT MN
55021

MINN SOCIETY ARCHITECTS A
NW NATL BK BLDG
ST PAUL MN
55101

MINN STATE BD PHARMACY
717 DELAWARE ST SE #351
MPLS MN
55414

MINN STATE CAPITOL EMP UN
PO BOX 3215
ST PAUL MN
55165

MINN TEAMSTERS CREDIT UNION
2021 HENN AVE E
MPLS MN
55413

MINN TBR PRODUCERS ASSN
200 CHRISTIE BLDG
DULUTH MN
55802

MINN.TURKEY GROWERS ASSN
2363 UNIV AVE
ST PAUL MN
55114

MINN VETERANS FED ASSN
2175 W HWY 36
ROSEVILLE MN
55113

MN PUB INT RESEARCH GROUP
3036 UNIV AVE SE
MPLS MN
55414

MOFFITT R.C. DIR.ENV.CONTROL
MPLS.CITY HALL RM 301M
MPLS MN
55415

MORTON BUILDINGS INC
R #1
FOLEY MN
56329

MPIRG
BOX 45 ST MARYS COLLEGE
WINONA MN
55987

NASS GLD V HENN CO GEN HOSP
5TH AND PORTLAND AVE
MPLS MN
55415

NATL CAR RENTAL ATT D MITZEL
5501 GREEN VALLEY DR
MPLS MN
55437

NAT'L SOLID WASTES-R. GRASSO
1730 RHODE ISLAND AV.NW
WASHINGTON DC
20036

NCEC INC C/O DR DAHLBERG
CONCORDIA COLLEGE
MOORHEAD MN
56560

NESBITT JOHN
7851 METRO PKWY S 118
MPLS MN
55420

NELMAN RALPH W
RT 2 BOX 125
EMBARRASS MN
55732

NORTH CENTRAL ELEC ASSN
PO BOX 202
BATTLE LAKE MN
56515

NW COUNTRY ELEVATOR ASSN
802 GRAIN EXCH BLDG
MPLS MN
55415

NW BELL TEL CO LEGAL DEPT
224 S 5TH ST RM 2000
MPLS MN
55402

NYQUIST DEAN A
3707 53RD PL N
BROOKLYN CTR MN
55429

OFFICE OF THE GOVERNOR
130 STATE CAPITOL
ST PAUL MN
55101

OLD COLONY GAS & OIL COMPANY
17TH AVE N AT 2ND ST
MPLS MN
55411

OTTER TAIL POWER CO.
215 S. CASCADE ST.
FERGUS FALLS MN
56537

PAYNE WM B
2400 FIRST NATL BK BLDG
MPLS MN
55402

PETERSON JOHN W
510 NW BK BLDG
ST PAUL MN
55101

PHAR MFGRS ASSN WM D PATTON
1155 15TH ST NW
WASHINGTON DC DC
20005

PHILLIPS LEGISLATIVE SERVICE
459 RICE ST
ST PAUL MN
55103

MINN WATER RESOURCES BD
RM 206 555 WABASHA ST
ST PAUL MN
55102

MINN-WISC BOUNDARY AREA C
600 2ND ST
HUDSON WI
54016

MCOD R BLOOMINGTON HLTH DEPT
10200 PENN SQ
BLOOMINGTON MN
55431

MOONEY, MICHAEL A.
BOX 903, ST.JOHN'S UNIV
COLLEGEVILLE MN
56321

MUELLER SHIRLEY A
787 W COTTAGE AVE
ST PAUL MN
55117

NATL COUNCIL JEWISH WOMEN
4330 CEDAR LK RD
MPLS MN
55416

NATL FAMILY INS CO
2147 UNIV AVE
ST PAUL MN
55114

NELSON DONALD E NSP CO
414 NICOLLET AVE
MPLS MN
55401

NEDELL HAROLD - MEINEKE
6300 W LOOP S SUITE 200
BELLAIRE TX
77401

NIELSEN STOCK & BLACKBURN
415 730 BLDG
MPLS MN

NO SUB MONTESSORI-S SADDL
2487 HELEN COURT
NO ST PAUL MN
55109

NURSING HOME ADMRS BD EXAMRS
RM 340 717 DELAWARE SE
MPLS MN
55414

NUTTER JULIA
743 W MONTANA
ST PAUL MN
55117

O'BRIEN J.DENNIS
1100 1ST NATL.BANK BLDG
MINNEAPOLIS MN
55402

OCONNOR GREEN THOMAS ET A
845 NW BANK BLDG
MPLS MN
55402

OLOFSON ARTHUR MBD & MAINC
927 SOO LINE BLDG
MPLS MN
55402

OSTRUM DONALD E
PO BOX 33163
COON RAPIDS MN
55433

PATTISON ORVIS
BOX 645
WILLMAR MN
56201

PAYNE COL ALVIN

DEGRAFF MN
56233

PETERSON GARY
854 MIDLAND BK BLDG
MPLS MN
55401

PFEIFER AND SHULTZ, INC
1433 UTICA AVE S
MPLS MN
55416

PINNETTI NICK M HALEY & ASS.
40 CENTRAL PARK S
NEW YORK NY
10019

POPOVICH PETER S
314 MINN BLDG
ST PAUL MN
55101

PORTER LYLE O
TRACY MN
56175

PORT AUTH CITY OF ST PAUL
330 MINNESOTA BLDG
ST PAUL MN
55101

PRAUSE JOS.C.
2220 105TH AVE.N.W.
COON RAPIDS MN
55433

PROCTOR&GAMBLE L THECHARCUS
IVORYDALE TECH CENTER
CINCINNATI OH
45217

QUIRIN E W
408 HWY BLDG
ST PAUL MN
55155

RAUENHORST CORP-C ANDERSON
7900 XERXES S. S-2200
MPLS MN
55431

RED OWL STORES INC
215 E EXCELSIOR AVE
HOPKINS MN
55343

RAMSEY CO MEDICAL SOCIETY
1500 LOWRY MEDICAL BLDG
ST PAUL MN
55102

RICHARDSON THOS
7851 METRO PKWY S 103
MPLS MN
55420

ROBBIE JOSEPH
904 CARGILL BLDG NO CTR
MPLS MN
55402

ROBERTS DAVID E
1200 NW NATL BK BLDG
ST PAUL MN
55101

SAN SIMEON DEVELOP CORP
OLD 1ST STATE BK BLDG
PAYNESVILLE MN

SAX DOVE & STENSON
310 ENDICOTT BLDG
ST PAUL MN
55101

ST PAUL ASSN PLBG HTG MECH
614 AM NATL BK
ST PAUL MN
55101

SCARBOROUGH WILLIAM
DIV.ED. U.M.
MORRIS MN
56267

SCHLICHT REV ROBT
611 W MAIN ST
BELLE PLAINE MN
56011

SCHMIDT LARRY WCCO-TV NEWS
50 S 9TH ST
MPLS MN
55402

SCHNEIDER MAHLON
GREEN GIANT
LESUEUR MN
56058

SCHWERMAN EARL JR
1535 6TH AVE SE
ROCHESTER MN
55901

SCHWINN ROBT.P.
1400 SCO LINE BLDG.
MPLS. MN
55402

SENATE COUN OFF ROOM 24
STATE CAPITOL
ST PAUL MN
55101

SENATE FINANCE COMMITTEE
113 STATE CAPITOL
ST PAUL MN
55101

POSS DONALD G
6301 SHINGLE CREEK PKWY
BROOKLYN CTR MN
55430

POYZER ROBT
BOX 675
FERGUS FALLS MN
56357

PULSCHER RBT SPRINGSTED INC
813 OSBORN BLDG
ST PAUL MN
55102

RADMAN RICHARD-LABOR TEMPLE
418 AUDITORIUM
ST PAUL MN
55102

RANALLO CLARENCE
800 CENTRAL AVE N E
MPLS MN
55413

REID DAVID H
5633 WASHBURN AVE S
MPLS MN
55410

RENNER R.H. ST PAUL AREA
300 OSBORN BLDG.
ST PAUL MN
55102

RICHARDS MONTGOMERY ET AL
1430 RAND TOWER
MPLS MN
55402

ROE DAVID
175 AURORA
ST PAUL MN
55103

ROSS ALFRED
6356 WARE RD
LINO LAKES MN
55014

RUDY FLOYD
118 AVE C
CLOQUET MN
55720

SANFORD S M
7000 PORTLAND AVE
RICHFIELD MN
55423

SATHRE, HARVEY
375 MARION STREET
ST PAUL MN
55103

ST PAUL BUR HLTH DR P COX
555 CEDAR ST
ST PAUL MN
55101

ST PAUL FOOD RETAILERS AS
1220 ARCADE
ST PAUL MN
55106

SCHMIDT D R MN ASSN REALTORS
6101 WAYZATA BLVD
MPLS MN
55416

SCHMIDT H W TCHRS RETIREM
302 CAPITOL SQ BLDG
ST PAUL MN
55101

SCHUTZ LINDA
RM 328 CAPITOL BLDG
ST PAUL MN
55155

SCHWARTAU NEAL METH HOSP
201 W CENTER ST
ROCHESTER MN
55901

SCHNEIDER & NEESER
706 1ST ST SO PO BX 876
WILLMAR MN
56201

SCHROEDER ALFRED H
2172 CARROLL AVE
ST PAUL MN
55104

SENATE GOV OP COMM
RM 303 STATE CAPITOL
ST PAUL MN
55155

SHABATURA EUGENE H
2833 LAKE AVE SO
DULUTH MN
55811

SHARP BOB
4129 HIGHWOOD RD
ST LOUIS PK MN
55416

SHAW ROBERT M
616 MOBIL OIL BLDG
MPLS MN
55402

SKELLY OIL CO R R WELLINGTON
PO BOX 436
KANSAS CITY MO

SLOCUM CHARLES A
1203 IDS TOWER
MPLS MN
55402

SNELL LYN
BOX 314
EDEN VALLEY MN
55329

SNYDER ROBERT W
248 CO B U OF M
ST PAUL MN
55101

STANSFIELD ARLENE LAND OLKS
PO BOX 116
MPLS MN
55440

STATE BD.BARBER EXAMINERS
555 WABASHA
ST PAUL MN
55102

STEELWORKERS CREDIT UNION
BOX 250
BABBITT MN
55706

STENSLAND M.E. PRES. MVPA
203 NW 22ND ST.
AUSTIN MN
55912

SULLIVAN J KIRK
PO BOX 200
BOISE ID
83701

SUMMIT NATL BANK D L MORRILL
205 AURORA AVE
ST PAUL MN
55103

SWANSON DALE
P O BOX 339
FOREST LAKE MN
55025

SWANSON GERALD H
212 CITY HALL
ROCHESTER MN
55901

TATE VERN 3M CO
3M CENTER 220/6W
ST PAUL MN
55101

THOMPSON CONRAD
1107 23RD ST NW
ROCHESTER MN
55901

TOUCHE ROSS & CO K H STOCKE
780 NORTHSTAR CNTR
MPLS MN
55402

TWIN CITY RETAIL DRUGGIST AS
2388 UNIV AVE
ST PAUL MN
55104

VAN CLEVE JOHN H
2101 HENN AVE
MPLS MN
55405

VERRILL JOHN E
DEPT SECONDARY ED UOF M
DULUTH MN
55812

VILLAGE OF WOODBURY-F.STRONG
561 TOWER DRIVE
NEWPORT MN
55055

VOS LEROY
2137 BURNS AVE
ST PAUL MN
55119

SHELL OIL CO. A.A. ROQUET
ONE SHELL PLAZA BX 2463
HOUSTON TX
77001

SMERIKA WM.
BOISE CASCADE PAPERS
INTL FALLS MN
56649

SODERBERG HAROLD J
1500 MIDWEST PLAZA BLDG
MPLS MN
55402

STATE BD VETERINARY EXAMINER
C/O DR A C SPANNAUS DVM
WACONIA MN

STOLPESTAD BROWN & SMITH
1550 NW BK BLDG
ST PAUL MN
55101

SUSSEL CO.ATTN:TED SCHWENKER
1850 COMO AVE.
ST PAUL MN
55108

SWEITZER R L HONEYWELL INC
2701 4TH AVE S
MPLS MN
55408

THOMPSON HESSIAN ET AL
1500 MIDWEST PLAZA BLDG
MPLS MN
55402

VAN DRAKE STEPHEN R
BOX 353
PELICAN RAPID MN
56572

VOLDNESS PERRY
IDS 8TH & MARQUETTE
MPLS MN
55402

WALD JEAN
5746 SANDER DR
MPLS MN
55417

SITE ENGINEERS INC
900 REDWELL LANE
APPLE VALLEY MN
55124

SMITH MICHAEL
1423 NEWTON AVE N
MPLS MN
55411

SODERMAN ANTHONY
152 S PLAZA BLDG
MPLS MN
55416

STD AM LIFE & ANNUITY CO
3801 W 50TH ST
MPLS MN
55410

STUPKA & MOREM
MIDTOWN BLDG
AUSTIN MN
55912

SWANSON BURT E
W-2162 1ST NATL BK BLDG
ST PAUL MN
55101

TIMESAVERS INC ATT K S VO
5270 HANSON COURT
MPLS MN
55422

UNION STOCK YARDS
ATTN PRES
SO ST PAUL MN
55075

VAN EVERA MUNDT ET AL
700 TORREY BLDG
DULUTH MN
55802

VOSS REV GORDON O
11120 NE 7TH ST
BLAINE MN
55434

WALIGORA ROBERT
3228 SO 17TH AVE
MPLS MN
55407

	ADDRESS	CITY	STATE	ZIP CODE
MOFFLIT, R.C.	RM 130 M.M. MPLS. CITY HALL	MPLS	MN	55415
RENQUIST, ARTHUR, NSA, CO	4454 NICOLLET MALL	MPLS	MN	55409
BECK, PAT	9553 HYACINTH AVE	ST. PAUL	MN	55106
BROWN, H.D.	4961 RIDGEBERRY LANE	MINNETONKA	MN	55343
NEREN, MADONNA	3216 NEAL AVE S	HOPKINS	MN	55305
REAGAN, MICHAEL, C/O ADMIN.	C/O MINN. LEARNING CTR.	BRAINERD	MN	56401
HOUSE, RESORGAN	550 CEDAR ST. CAPITOL	St. PAUL	MN	55155

STATE OF MINNESOTA

COUNTY OF RAMSEY

In the Matter of Proposed Amendments
to Rule 47 of the Minnesota
Department of Public Welfare
Governing Administration of
the Medical Assistance Program

AFFIDAVIT OF MAILING

IRENE R. GOLDMAN, being first duly sworn, deposes and says:

That on the 17th day of October, 1975, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Hearing by depositing in the United States mail at said City of St. Paul, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the attached Certificate of the Secretary of State as well as to all members currently serving in the Minnesota Legislature, and other interested individuals.

Irene R Goldman
IRENE R. GOLDMAN

Subscribed to and sworn to before
me this 17th day of October, 1975

Lorraine C. Pfeiffer

LORRAINE C. PFEIFFER
Notary Public, Dakota Co. Minn.
My Commission Expires Sept. 29, 1979

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS

COMMISSIONER OF PUBLIC WELFARE

In the Matter of Proposed Amendments
to Rule 47 of the Minnesota Department
of Public Welfare Governing Administration
of the Medical Assistance Program

STATEMENT OF NEED

The above-captioned rule is an amendment to an existing administrative rule of the Minnesota Department of Public Welfare. The last time Minn. Rule DPW 47 was amended was November 26, 1974.

The need to amend Minn. Rule DPW 47 arises because of recent changes in and clarification of Minnesota's Medical Assistance [MA] program policies and procedures.

The section entitled "Application for Medical Assistance" [II] is added to this proposed rule in order to explain the MA application process. The section entitled "Eligibility Factors Under the Medical Assistance Program" [III] is added to this proposed rule in order to clarify the eligibility criteria of age, residence, citizenship, income and resources, relative responsibility, remarriage of parent and institutional status, as well as to spell out the individual's right to a fair hearing upon notice of termination or denial of Medical Assistance.

Amendment to the sub-section entitled "Free Choice of Provider" [IV(a)] is necessary in order to delineate the extent of such free choice. Amendment to the sub-section entitled "County Medical Assistance Plan" [IV(b)] is necessary in order to comply with the requirements of a statewide centralized disbursement system. The sub-section entitled "Records" [IV(d)] is amended in order to define the record-keeping responsibilities of the state and local welfare agencies as well as individual medical providers. Amendment to the sub-section entitled "Third-Party Liability" [IV(e)] is necessary in order to react to and comply with recently-enacted legislation. The sub-section entitled "Identification Card" [IV(f)] is amended in order to clarify procedures governing issuance and use of MA cards.

Amendment to the sub-section entitled "Agreements with Providers" [IV(g)] is proposed in order to specify Medical Assistance program requirements regarding such contracts. The sub-section entitled "Qualification of Eligible Providers" [IV(h)] is amended in order to explain the determination of provider qualifications under the Medical Assistance program. The sub-section entitled "Prior Authorization" [IV(i)] is added to the proposed rule in order to outline the criteria used when prior authorization of certain services is required. Amendment to the sub-section entitled "Utilization Control" [IV(j)] is proposed in order to comply with the requirements of applicable federal regulations.

An amendment to Minn. Rule DPW 47 is necessary in order to delineate specific services which are not covered under the Medical Assistance program, limitations to the services which are covered under the program, services for which prior authorization must be obtained, and to define those individuals, groups, associations and facilities which are eligible to provide services under the program.

Amendment to the subdivision entitled "Inpatient Hospital Services" [V(b)(1)] is necessary in order to delete material concerning utilization review of such services. This material has been updated and incorporated into a separate section of the rule which is entitled "Utilization Control" [IV(j)]. The subdivision entitled "Long Term Care Facility Services" [V(b)(2)] is added in order to define and explain services provided by skilled nursing facilities, intermediate care facilities and tuberculosis and mental hospitals.

Amendment to the subdivision entitled "Physician Services" [V(b)(3)] is proposed in order to distinguish these services from those provided by licensed dentists. Services provided by dentists are incorporated into the subdivision entitled "Dental Services"[V(b)(12)].

An amendment to Minn. Rule DPW 47 is necessary in order to include Health Maintenance Organizations as providers eligible to participate in the Medical Assistance program [subdivision V(b)(4)]. The subdivision entitled "Other Licensed Practitioners" [V(b)(5)] is amended in order to bring it up to date with current MA program policies and procedures. Amendment to the subdivision entitled "Clinic Services" [V(b)(7)] is proposed in order to include the definition and extent of services provided by mental health centers and family planning agencies. Similarly, the subdivision entitled "Home Health Care Services" [V(b)(8)] is amended in order to provide for such services when furnished by registered nurses, licensed practical nurses and home health aides.

Amendment to the subdivision entitled "Medical Supplies" [V(b)(9)] is proposed in order to clarify the nature and extent of these medical supplies which are reimbursable under the MA program. The subdivision entitled "Private Duty Nursing Services" [V(b)(10)] is amended in order to conform to current MA program requirements. An amendment to Minn. Rule DPW 47 is needed so that the subdivision entitled "Rehabilitative and Therapeutic Services" [V(b)(11)] may be revised in order to distinguish between such services when provided in long term care facilities, by independent practitioners and by rehabilitation agencies.

An amendment to the subdivision entitled "Pharmacy Services" [V(b)(14)] is proposed so that these services may be delineated in greater detail. The subdivision entitled "Other Diagnosis, Screening, Preventive and Rehabilitative Services" [V(b)(15)] is amended to include definitions of these services. The subdivision entitled "Early Periodic Screening, Diagnosis and Treatment" [V(b)(16)] is added to the proposed rule in order to comply with the requirements of applicable federal regulations. Amendment to the subdivision entitled "Health Care Insurance Premiums" [V(b)(17)] is proposed in order to permit the state agency to base payment for such coverage on the cost-effectiveness of particular health care insurance policies. Amendment to the subdivision entitled "Other Medical Care" [V(b)(18)] is proposed in order to provide definitions and descriptions of such care and to comply with the express terms of applicable federal regulations.

In order to explain Medical Assistance program reimbursement policies and procedures, it is proposed that a separate section entitled "Reimbursement" [VI] be added to Minn. Rule DPW 47. "Maximum allowable charges" are defined and explained in this section and payment policies are spelled out[VI(a) and (b)]. The sub-section entitled "Billing Procedures" [VI(c)] is amended to include time restrictions, reporting and coding requirements, contractual arrangements and to provide for assignment on Medicare billings. Fraud is separated into two separate sections entitled "Provider Fraud" [VI(d)] and "Recipient Fraud" [VI(e)] wherein "fraud" is defined and the consequences

of fraudulent actions are outlined. In order to provide for a means of recovery of Medical Assistance payments erroneously made or fraudulently obtained, the section entitled "Authority to Recover from Medical Providers" [VI(f)] is added to the proposed rule.

Finally, it is proposed that the fee schedules contained under Appendices "A" through "J" accompanying existing Minn. Rule DPW 47 be repealed since they are out of date and, therefore, no longer pertinent.

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

Dated: November 7, 1975

Vera J. Likins
Commissioner

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS

COMMISSIONER OF PUBLIC WELFARE

In the Matter of Proposed Amendments to Rule 47 of the Minnesota Department of Public Welfare Governing Administration of the Medical Assistance Program.

FINDINGS OF FACT

The above-captioned matter came on for hearing before a hearing officer duly appointed by the Minnesota Commissioner of Public Welfare on the 19th day of November, 1975, at 8:30 A.M. in the Minnesota Veterans' Home Auditorium, East 51st and Minnehaha Ave., Minneapolis, Minnesota, after proper notice required by Minn. Stat. § 15.0412 (1974) as amended, was served upon all persons, associations and other interested groups registered with the Minnesota Secretary of State for that purpose.

After affording interested persons an opportunity to present written and oral data, statements, and arguments, having considered all of the testimony and evidence adduced, and upon the records, files and proceedings herein, the Commissioner of Public Welfare makes and enters the following findings of fact:

1. Minn. Stat. §§ 256B.04 subd. 4., 256B.065, 256B.18,

and 256B.22 require the Minnesota Department of Public Welfare to cooperate with the United States Department of Health, Education and Welfare in administration of the Minnesota Medical Assistance program, and to implement provisions complying with Title XIX of the Federal Social Security Act and its implementing regulations. It is therefore necessary to add a specific provision to the opening paragraph of DPW Rule 47 including in the rule by reference any federal law, federal regulation, or state law pertaining to the Minnesota Medical Assistance program and stating that any provision of DPW Rule 47 which is inconsistent with those laws and regulations is thereby superseded.

2. 45 C.F.R. § 250.30 lists the requirements for provider reimbursement under state Medical Assistance plans. Appendices "A" through "J" of DPW Rule 47 are Minnesota's plan for reimbursement, but evidence presented by the Department at the hearing (testimony of David Van Wyk, Supervisor of the Medical Assistance Unit, Minnesota Department of Public Welfare, page 3 of the transcript) establishes that these appendices, which were last revised in February, 1970, are out-of-date and should be revised or repealed.

4. In lieu of Appendices "A" through "J", the Department proposed to reimburse providers through negotiated rates with each provider group, but subject to the limitations of 45 C.F.R.

§ 250.30. The provisions of the reimbursement procedure are found in part (s) of the adopted amendments (subpart (1) of part (VI) of the proposed amendments).

5. Part (s) limits provider reimbursement to the "usual and customary charge" or DPW's "maximum allowable charge", whichever is lower. This limit is required by parts (a)(3) and (b) of 45 C.F.R. § 250.30.

6. The definition of "usual and customary" charge as the amount the provider charges in the majority of cases for a specified procedure or service fulfills the uses of that term in 45 C.F.R. § 230.30(b).

7. The definition of DPW's "maximum allowable charge" as a negotiated fee which for each provider group is no lower than the one approved in April, 1976, unless so required by federal regulations, meets with federal standards found for reasonable charges in 45 C.F.R. § 250.30(a).

NOW, THEREFORE, based upon the foregoing findings of fact, it is hereby concluded that the amendments to Minn. Rule DPW 47 as ultimately adopted are reasonable and necessary administrative amendments with a basis in law and fact.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Vera J. Likins

VERA J. LIKINS
Commissioner

P R O P O S E D

Minn. Rule DPW 47 -- Medical Assistance

(I) Introduction

(a) This rule governs administration of the Medical Assistance [MA] program in Minnesota. The provisions of this rule are to be read in conjunction with Title XIX of the federal Social Security Act, Title 45 of the Code of Federal Regulations, Minnesota Statutes, Chapter 256B, and other rules of the Minnesota Department of Public Welfare [hereinafter, DPW or the state agency] which is responsible for the administration of the Title XIX program in Minnesota.

(b) The Commissioner of Public Welfare may issue policy bulletins and manual material to the local welfare agencies and vendors of medical care and services to clarify the provisions of this rule and may prescribe forms to be used in administration of the MA program. Where a policy bulletin amends any provision of this rule, the change shall be implemented according to the Commissioner's instructions, but the Commissioner shall issue an Order for Hearing on the amendment within 90 days of its effective date.

(c) The MA program shall be administered to provide eligible needy persons whose financial resources are not adequate to meet the cost of medical care and services with such care and services, according to the provisions of this rule.

(d) The MA program shall not be administered to deny applicants and recipients their individual and civil rights, nor to disclose information regarding them except as provided under applicable state law and/or official departmental rules and regulations.

(e) This rule is binding on all county welfare boards [hereinafter referred to as local welfare agencies] in the State of Minnesota administering the MA program [Title XIX], on all providers of service participating in the MA program and on all applicants/recipients under the MA program, and on the state agency.

(f) The official State Plan is the submitted and approved federal pre-print which indicates those options covered by Minnesota Statutes.

(II) Application for Medical Assistance

(a) Definitions

(1) "Applicant": A person who has directly, or through his authorized representative (or where incompetent or incapacitated, through someone acting responsibly for him), made application for Medical Assistance with his local welfare agency.

(2) "Application": The action by which an individual indicates in writing to the agency administering public assistance his desire to receive Medical Assistance. An application is distinguished from an "inquiry", which is simply a request for information about eligibility requirements for Medical Assistance.

(b) Any person may apply for Medical Assistance to the local welfare agency in the county in which he resides and has established an abode. In such cases, the local agency shall promptly advise the applicant of the MA program's eligibility requirements.

(c) Each application form shall be signed by the applicant or the applicant's responsible relative, legal guardian or authorized representative.

(d) As soon as possible, but no later than 45 days from the date of application for Medical Assistance in the case of families, the aged and the blind, or no later than 60 days in the case of the disabled, the local welfare agency shall conduct a personal interview with the applicant and determine his eligiblity for Medical Assistance. All eligibility conditions shall be met within these time limits.

(e) Each applicant shall be notified in writing that his application has been approved or denied, unless the applicant dies or cannot be located. If the application is denied, the individual shall be notified in writing of the reasons for denial and of his right to appeal.

(f) Any person has the right to re-apply for Medical Assistance. New applications must be taken whenever a previous application has been denied or withdrawn, or when the county of financial responsibility has been changed.

(g) Medical Assistance eligibility shall be redetermined in accordance with the provisions of applicable federal regulations. In those cases where the local welfare agency receives information about a change in case facts, eligibility shall be reviewed within 30 days of receipt of that information.

(h) The local welfare agency shall verify information cited in this section and contained in the application received from the applicant or other persons or agencies only with the applicant's written permission. If the applicant refuses to cooperate with the local welfare agency in verifying the needed information, his application shall be automatically denied. The following information shall be verified:

(1) Social Security numbers (as provided under (i) below) of all individuals applying for or receiving Medical Assistance and the parents of dependent children.

(2) The applicant's income and property holdings.

(3) Any other information affecting eligibility as deemed necessary under the circumstances of each particular case.

(i) For assistance under Title XIX of the Social Security Act, the local welfare agency shall request each applicant to supply the Social Security number [SSN] for each individual (including children) for whom assistance is requested. Furnishing or applying for a SSN is not an eligibility factor for Medical Assistance and benefits cannot be denied because an individual will not furnish or apply for a SSN or consent to use of a SSN.

(1) The local, state and federal agencies are prohibited from using an individual's SSN without the written consent of the individual, unless required by law to use that number.

(2) The local welfare agency shall request in writing the authority to use the individual's SSN to validate information contained in the application.

(j) Local welfare agencies shall give a copy of the state agency's informational pamphlet on Medical Assistance to every person who inquires about, indicates a need for, and/or applies for any of the categorical aid programs.

(k) Individuals found eligible for Aid to Families with Dependent Children [AFDC] shall be eligible for Medical Assistance without a separate application. Aged, blind or disabled individuals found eligible for Minnesota Supplemental Aid [MSA] shall be eligible for Medical Assistance without a separate application. Aged, blind or disabled Supplemental Security Income [SSI] recipients are required to file a separate application for Medical Assistance. All other individuals not specified herein shall file a separate Medical Assistance application.

(l) Medical Assistance eligibility for a recipient of categorical assistance ends when there is no longer eligibility for that assistance. At that point, the individual shall file a separate Medical Assistance application and the MA program eligibility criteria must be applied.

(m) Any individual has the right to apply for Medical Assistance regardless of whether or not it appears he will be found eligible for participation in the MA program.

(III) Eligibility Factors Under the Medical Assistance Program

(a) Age

(1) Individuals eligible for Medical Assistance by reason of receiving a categorical form of public assistance, or who would be eligible under a category except for residence or amounts of income or resources, must meet the specific age requirements of the appropriate category.

(2) Medical Assistance is available on behalf of otherwise eligible individuals who were, for any portion of the month in which they received medical care or services, under 21 years of age (or under 22 years of age and receiving in-patient psychiatric hospital services), or 65 years of age or older.

(3) Unborn children are eligible for Medical Assistance during the last three months of the mother's pregnancy (as medically certified), so long as the mother is eligible under the AFDC program.

(b) Residence

(1) "Residence" or "abode": Where a person lives and intends to remain indefinitely.

(2) Minnesota residence is an eligibility requirement for Medical Assistance but no specific length of residence is required. A person loses Minnesota residence when he leaves the state with the intent to establish a home elsewhere. Evidence of intent under this rule is not simply the person's stated intentions but includes consideration of objective criteria associated with the move (e.g., movement of possessions, rent payments, changes in voter or driver's license registrations).

(3) A "resident" of Minnesota is a person who is living in the state voluntarily with the intention of making Minnesota his permanent home. A child is a resident of Minnesota if he is living in the state on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether he is there voluntarily or for a temporary purpose.

(4) Under the following circumstances, Medical Assistance will be furnished to eligible individuals who are residents of Minnesota but who are absent from the state, to the same extent that such assistance is furnished under the MA program to meet the cost of medical care and services rendered to eligible individuals within the state:

(A) Where an emergency arises from accident or illness;

(B) Where the health of the individual would be endangered if the care and services are postponed until he returns to Minnesota;

(C) Where his health would be endangered if he attempted to return to Minnesota in order to receive medical care.

(5) Medical care and services will be provided outside Minnesota to eligible residents of this state in the following situations:

(A) When it is general practice for residents of Minnesota to use medical resources beyond the borders of this state; or

(B) When the availability of necessary medical care, services or supplementary resources make it desirable for the individual to use medical facilities outside the state, for short or long periods of time and in accordance with plans developed jointly by the local welfare agency and the individual, based upon sound medical advice.

(6) The state agency shall meet the medical needs of eligible residents of other states residing in Minnesota.

(7) Residence is deemed retained until abandoned. Temporary absence from Minnesota, with subsequent return to the state or intent to return when the purpose of the absence has been accomplished, does not interrupt continuity of residence.

(c) Citizenship and Alienage

(1) Medical Assistance payments may be made on behalf of any otherwise eligible individual who is a resident of the United States, but only if he is either:

(A) A citizen of the United States; or

(B) An alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(d) Income and Resources

(1) Income

(A) Medical Assistance may be paid for any person who anticipates receiving annual net income up to the amounts specified under state law. Individuals or families with income in excess of these maxima and who in the month of application or during the three preceding months incur expenses for medical care that total more than one-half the annual excess income, may also be eligible for participation in the MA program.

(B) In the determination of eligibility for MA-only (over 65 years of age), and MA-categorically related, "income" is the total net income the applicant and spouse expect to receive from all sources during the year.

(C) In determining eligibility for Medical Assistance for children under 18 years of age, the local welfare agency must consider all income of parents and children under 18 years of age who are in the home.

(D) Definitions

(i) "Income": Any benefit received by or available to a Medical Assistance recipient as earnings or otherwise. Income may be earned or unearned. In family groups living together, the income of a spouse is considered available to his/her spouse and the income of a parent is considered available to his/her children under 18 years of age. All income, except non-cash items provided free of cost, is considered a resource to be evaluated in determining the need of each Medical Assistance applicant/recipient.

(ii) "Net income": The amount left after deducting allowable expenses and income disregards.

(iii) "Earned income": Income received in the form of wages, salary, commissions or profits from activities in which the applicant/recipient is engaged as an employee or as a self-employed person.

(iv) "Unearned income": Income which is not the direct result of labor or services performed by the individual as an employee or as a self-employed person.

(E) The following employment expenses are to be deducted in determining net earned income:

(i) Mandatory retirement fund deductions.

(ii) Transportation costs to and from work based on the actual cost of public transportation or car-pool payments, or 15¢ per mile for the actual number of miles driven, not to exceed 100 miles per day of employment (unless the recipient can establish actual higher transportation costs).

(iii) Cost of work uniforms.

(iv) FICA and SMI payments.

(v) Federal and state income taxes withheld.

(vi) Union dues.

(vii) Professional association dues required for employment.

(viii) Health insurance premiums.

(ix) Cost of tools and equipment used on the job.

(x) One dollar per day for the cost of meals eaten during employment hours (unless the recipient can establish actual higher work-related meal expenses).

(xi) Public liability insurance required by the employer when an automobile is used in employment and the cost is not compensated by the employer.

(F) Rental income is considered unearned income.

(G) Lump sum payments and windfalls (e.g., Social Security retroactive benefits, inheritances, income tax refunds, gifts) are considered a resource which will necessitate a redetermination of Medical Assistance eligibility.

(H) Income of a Medical Assistance recipient, as in any other public assistance program, shall first be applied to the maintenance needs of the recipient or his legal dependents up to the statutory standards.

(I) Income that is within the legal maxima of the MA program is to be disregarded (and used for maintenance needs) in determining the amount of payments made for medical services, except in nursing home, convalescent care unit, state veterans' facility and state hospital cases. In such cases, if the applicant/recipient has legal dependents (spouse and/or minor dependent children), the family's total net income, within the Medical Assistance legal maxima, is to be applied to the maintenance needs of the patient and those legal dependents. In such a situation the only income to be considered allocable to the maintenance needs of the long term care facility patient is the allowance for personal needs and clothing. The remainder of the income within the legal maxima for the family is to be attributed to the maintenance needs of the legal dependents with any income over the Medical Assistance maxima to be applied to the institutional charges. If the patient has no legal dependents, any income in excess of the allowance for his personal needs and clothing is to be applied to the costs of long term care facility services.

(J) Income from an SSI grant is to be disregarded in determining the Medical Assistance eligibility of an SSI recipient. However, to be eligible under the MA program, other sources of income must comply with MA program standards.

(K) Persons receiving a maintenance grant under the AFDC or MSA programs shall be automatically eligible for Medical Assistance.

(L) Persons who have income in excess of the Medical Assistance income maxima and who do not qualify for categorical assistance because their income is in excess of the limits of those programs, may qualify for Medical Assistance through the spend-down provision of the MA program:

(i) "Spend-down" means to reduce available or anticipated income which exceeds the amount protected by state law for maintenance needs. Such reduction must be for current medical obligations.

(aa) "Current" means medical obligations during the period of time the applicant is requesting assistance and which are allowable under state and federal law, or federal regulations.

(bb) "Medical obligations" are amounts owed any eligible provider for medical care, services or supplies which are covered under the MA program.

(ii) Spend-down applies only to income.

(iii) Spend-down is computed by the local welfare agency and is a condition of eligibility.

(aa) Spend-down is computed by first determining the current and anticipated annual income of the applicant and his responsible relatives under state law.

(bb) The amount protected under state law is subtracted to determine the amount of anticipated annual income to be used to meet medical obligations.

(cc) This amount is reduced by one-half to indicate the anticipated income available during the next six (6) months.

(iv) The spend-down requirement cannot be assumed by any third-party; such third-party resource shall be applied against medical obligations prior to determining the applicant/recipient's unmet medical obligation.

(aa) For the purpose of spend-down only, "third-party" means anyone other than the applicant/recipient or his responsible relatives.

(v) The amount of anticipated income shall be paid or incurred prior to establishing eligibility for Medical Assistance, except in those instances where a continuing spend-down exists.

(aa) "Continuing spend-down" means the spend-down requirement is met on a monthly basis rather than on a six-month basis.

(1) Continuing spend-down is limited to institutionalized individuals and those special situations individually approved by the state agency.

(vi) When Medical Assistance eligibility is established through the spend-down provision, eligibility shall be limited to a period of six months beginning with the first of the month in which medical obligations are first incurred. This six month period may include retroactive coverage of up to three months prior to the first of the month in which the application was made.

(2) Resources

(A) Real property. Medical Assistance may be available to any individual who, either alone or together with his/her spouse, does not have equity in real property exceeding that permitted under state law.

(i) In situations where the appropriate local welfare board determines that an applicant/recipient's excess equity in real estate cannot be converted into cash to meet his current maintenance needs, or that liquidation of the property would result in an undue hardship, the board may waive the equity limitation.

(aa) It is not intended that this waiver provision be applied universally to achieve Medical Assistance eligibility for applicants or recipients. Instead, the following considerations shall act to restrict waiver of the real property equity limitation:

(1) No maximum limit on the value of equity in real property to be waived shall be adopted by a local welfare board or local welfare agency as a matter of practice or general policy.

(2) The circumstances and conditions under which the excess equity in real property was waived shall be examined periodically for changes in current market value, opportunity for sale or mortgage, or other pertinent factors.

(B) Personal property. Medical Assistance may be available to any individual whose cash or liquid assets do not exceed the limits established by state law.

(i) Under the MA program, the following items are exempted in determining the value of personal property owned by the applicant/recipient:

(aa) Household goods and furniture presently used in the applicant's/recipient's residence.

(bb) Wearing apparel.

(cc) Life insurance policies with combined cash surrender values not exceeding $1,000 per insured person (individual applicant and each legal dependent or legally responsible member of his family).

(dd) Burial plots.

(ee) Prepaid burial contracts not exceeding $750 for the applicant/recipient and each legally dependent member of his family, plus $200 in accrued interest under each such contract. In order to be covered by this exemption, either the funeral director must be the "trustee" and the applicant/recipient (or a member of his family for whom he is legally responsible) the "beneficiary" under the terms of such burial contract, or a trust account must be created restricting use of its funds to payment of funeral and burial costs.

(ii) Equity in personal property exceeding the applicable program maxima may be waived when the appropriate local welfare board determines that liquidation of the property would result in undue hardship.

(iii) If personal property increases in value beyond the limits allowed under applicable state law, it will not defeat Medical Assistance eligibility if the applicant/recipient, within 15 calendar days from the date he received notice from the local welfare agency, either:

(aa) Transfers the excess to an excluded type of property; or

(bb) Uses the excess to repay the local welfare agency and/or state agency for Medical Assistance already received.

(iv) A trust fund is subject to the personal property limitations mandated under applicable state law unless it can be affirmatively demonstrated that such fund cannot be made available to meet the individual's medical needs.

(C) At the time of filing application for Medical Assistance, each applicant shall submit a complete and accurate list and description of all real and non-exempt personal property in which he has an equitable interest. Such list of property shall include not only the property currently owned, but all property in which he had an equitable interest during the three years prior to applying for Medical Assistance.

(D) Transfers of property. The establishment of initial or continuing eligibility for Medical Assistance by disposing of resources which otherwise would be available for the applicant/recipient's support is contrary to public policy. In some instances, such dispositions may constitute a criminal offense on the part of the donor and/or donee of the property.

(i) The following provisions shall govern property transfers as they affect potential eligibility under the MA program:

(aa) Each applicant for and recipient of Medical Assistance shall be required to reveal whether he has transferred within the preceding three years real or personal property with a total fair market value in excess of $750 without receiving adequate consideration for such property. Any property so transferred shall be viewed as an available resource for the medical needs of the applicant/recipient.

(bb) The applicant or recipient who has transferred property as described in this section shall be required to provide to the local welfare agency a description, including value, of the property transferred; the name or names of all persons who received such property; and the specific circumstances under which the property was transferred.

(cc) The applicant or recipient who has transferred property as described herein shall be required to make a reasonable effort in cooperation with the local welfare agency to reacquire the property transferred.

(dd) The information required by (bb) and the efforts made to reacquire the property mandated by (cc), shall be entered in the applicant/recipient's case record with the appropriate eligibility determination.

(ee) If return of the property or adequate consideration for the property cannot be arranged by the local welfare agency, the matter of the property transfer shall be reported with full documentation to the county attorney for possible criminal prosecution or civil action.

(ff) Transfer of property in violation of this rule shall not, in itself, constitute automatic ineligibility for Medical Assistance since such property may be deemed, in fact, to be unavailable to meet the applicant/recipient's medical needs.

(E) Types of property ownership. For purposes of eligibility under the MA program, joint tenants shall be deemed to own equal shares and rights in the property, whereas the equity held by tenants-in-common shall be prorated according to the share of ownership held by each tenant.

(e) Relative Responsibility. Within the limitations provided by state law and this rule, the spouse of an applicant or the parent of an applicant under 18 years of age shall be charged with the cost of medical services before Medical Assistance shall be available. The local welfare agency shall not withhold, delay or deny Medical Assistance because a responsible relative deemed able to contribute fails or refuses to accept financial responsibility. When the local welfare agency determines that a responsible relative is able to contribute without undue hardship to himself or his immediate family but refuses to contribute, the local welfare agency shall exhaust

all available administrative procedures to obtain that relative's contribution. When such procedures fail, the local welfare agency shall consult its county attorney regarding possible legal action.

(1) The local welfare agency shall assess the income and resources of an applicant, together with that of his/her spouse, in determining eligibility for Medical Assistance, subject to the following limitations:

(A) If spouses are living separately, the local welfare agency may determine that the marital relationship has experienced a breakdown likely to make spousal support impractical.

(i) Where there is joint ownership of either real or personal property in excess of statutory allowances, the local welfare agency cannot conclude that a total breakdown of the marital relationship has taken place.

(B) If the responsible relative fails to contribute support, after the local welfare agency notifies him of his obligation to do so, the local welfare agency shall notify the county attorney in an effort to commence legal action against that relative.

(C) The amount of support recoverable from a responsible relative (other than an absent parent) shall not exceed the amount of assistance paid on behalf of the recipient.

(f) Remarriage of Parent. In the event that a parent with dependent children under 18 years of age remarries and applies for Medical Assistance on behalf of those dependent minor children residing with him or her, the following provisions shall apply in determining available income with relation to eligibility for Medical Assistance:

(1) All income and resources of natural or adoptive parents who reside in the home are to be considered available to meet the medical needs of the children.

(2) All income and resources of the children themselves must be considered available to meet the medical needs of the children so long as such income and resources are under the control of the parents.

(3) All other income and resources available to the Medical Assistance family unit received in the form of gifts, income-in-kind, support payments, whether from responsible relatives or other family members, must be considered as a resource available to the children in determining their eligibility for Medical Assistance.

(4) All income-in-kind received by the natural or adoptive parent must also be considered as an income or resource in determining Medical Assistance eligibility for the children.

(5) Proof of actual contribution by relatives or other persons may be obtained by reference to previous income tax returns on which these children may have been declared as dependent by the parent or adult family member. Such proof of support or contribution may also be obtained by direct inquiry of the adult family members residing in the home.

(g) Institutional Status. An individual who is an inmate of a public institution, except as a patient in a medical institution or as a resident of an intermediate care facility, is not eligible for Medical Assistance. Individuals over age 65 and under age 21 who are patients in institutions for mental diseases or tuberculosis are eligible for Medical Assistance if all conditions of eligibility are satisfied.

(1) Definitions

(A) "Inmate": A person who is being retained and who is living in the institution.

(B) "Public institution": A facility that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(C) "Patient": An individual who is in need of and receiving professional services directed by a licensed practitioner of the healing arts towards the maintenance, improvement or protection of health, or the alleviation of illness, disability or pain.

(D) "Resident": An individual receiving room, board and a planned program of care and supervision on a continuous 24-hour-a-day basis as determined necessary by a licensed physician or, if appropriate, a mental retardation team.

(E) "Institution": An establishment which furnishes (in single or multiple facilities) food and shelter to four or more individuals unrelated to the proprietor and, in addition, provides treatment services which meet some needs of the individuals beyond the basic provision of food and shelter.

(h) Termination and/or Reduction of Medical Assistance

(1) Medical Assistance applicants and recipients have the right to a fair hearing in accordance with established procedures and consistent with applicable state law and federal regulations when aggrieved by action or inaction of the local and/or state welfare agencies. Termination of Medical Assistance may be effected only at the end of the month, except in the case of the death of the recipient.

(A) An applicant/recipient for Medical Assistance is entitled to a hearing when the local welfare agency fails to act on his application within the time limits imposed by applicable federal regulations, or when his Medical Assistance coverage is to be denied or terminated [*See*, (II)(d), *supra*].

(B) The local welfare agency board shall give the applicant/recipient timely advance notice of its intention to deny or terminate Medical Assistance. This notice shall be in writing and mailed to the applicant/recipient at least 10 calendar days prior to the effective date of such proposed action and shall clearly state what action the local welfare agency intends to take, the reasons for such proposed action and the right to appeal such proposed action.

(C) If the applicant/recipient appeals the proposed action before it is effected, the action shall not be taken until the appeal is heard and decided in accordance with applicable state law and federal regulations.

(IV) General Administration

(a) Free Choice of Provider. Subject to the following limitations, the MA program shall provide eligible recipients with free choice of participating local medical providers. The term "local" as used herein means that geographic area surrounding the recipient's residence which is viewed by the local welfare agency as reasonable for obtaining any given medical service.

(1) Free choice is limited by the choice available to the local population.

(2) Eligible recipients may exercise free choice by enrolling in participating Health Maintenance Organizations [HMO]. While enrolled in an HMO, the recipient is limited to free choice within that HMO.

(3) Free choice of patients in long term care facilities may be limited as follows:

(A) Provision of medications may be limited to a particular pharmacy, subject to the written approval of the patient, and/or his responsible relative or guardian, pursuant to a service agreement existing between the facility and the pharmacy.

(b) County Medical Assistance Plan. Counties shall administer the MA program according to the rules, procedural regulations and policies of the state agency, Minnesota Department of Public Welfare [DPW]. Each local welfare agency shall develop methods and procedures for keeping adequate records to:

(1) Verify current individual eligibility for the MA program.

(2) Justify that payment for long term care facility services was correctly made.

(3) Record individual eligibility for levels of care or other federal regulatory requirements as prescribed by the state agency.

(c) The county of service (physical residence of eligible recipient) is responsible for submitting necessary information to DPW to insure compilation of an accurate recipient eligibility file. The county of service is solely and fully responsible for any payments made on behalf of ineligible recipients as a result of:

(1) Late or inaccurate redeterminations of eligibility.

(2) Non-compliance with utilization review and control requirements [*See*, (IV)(j), *infra*].

(3) Inaccurate or incomplete record-keeping or failure to satisfy other written requirements [*See*, (IV)(d)(2), *infra*].

(4) Failure to submit accurate information on recipient eligibility to DPW.

(d) Records. The state and local welfare agencies and all medical providers shall maintain separate medical and/or fiscal records.

(1) The state agency shall:

(A) Keep records necessary for a centralized disbursement system which maximizes federal financial participation [FFP];

(B) Maintain a recipient eligibility file based on information supplied by the county of service;

(C) Maintain records on all eligible providers; and

(D) Maintain an information retrieval system for necessary statistical reports and/or audits of payment.

(2) Local welfare agencies shall:

(A) Maintain eligibility records prescribed by DPW as necessary or advisable for administration of the MA program; and

(B) Maintain necessary records relevant to a utilization review and control system which has received written approval by DPW.

(3) Medical providers participating in the MA program shall:

(A) Maintain for at least five (5) years, in the manner prescribed by DPW in accordance with applicable federal regulations, medical and financial records fully disclosing the extent of service provided, the medical necessity for such service and payment claimed under the MA program;

(B) On request, make their records available to DPW, the state legislative audit commission and the Department of Health, Education, and Welfare (or representatives of those agencies) in order to justify all payments made and the propriety of all services rendered under the MA program;

(C) Not be held responsible for breach of confidentiality or violation of the physician-patient privilege for information submitted to the state agency which is required in administration of the MA program.

(e) Third-Party Liability. The term "third-party" as used herein includes, but is not limited to, insurance companies, (including HMO's); other governmental programs such as Medicare; Workmen's Compensation; and potential defendants in legal actions arising out of any type of accident or intentional tort. Insurance companies are liable for full payment of policy benefits on behalf of beneficiaries. Any recovery through court action shall be considered as a resource to the recipient in determining eligibility for Medical Assistance. A trust fund is a resource of first recourse.

(1) Each applicant or recipient shall as a condition of eligibility:

(A) Notify his county of service of any health care coverage available to him or his dependents and agree to apply all proceeds received or potentially receivable by him or his spouse from private health care coverage to the costs of medical care for himself, his spouse and children; and

(B) Assign any rights accruing under private health care coverage to the state agency, to be applied against the cost of medical care paid for by the MA program.

(2) The local welfare agency shall:

(A) Determine and identify any third-party which has a potential legal liability to pay for medical care provided eligible Medical Assistance recipients prior to establishing or continuing recipient eligibility; and

(B) As provided under state law, file its verified lien statements within 180 days from the date the last item of medical care was furnished.

(3) The state agency shall:

(A) Seek recovery of all third-party liability benefits;

(B) Distinguish between third-party liability which is a current resource and one which is not current, based on the following considerations:

(i) Current liability consists of but is not limited to, known amounts of participation or coverage payable by liable third parties; the amount of actual claims, payments or settlements received.

(ii) Liability which is not current includes potential resources such as legal actions or disputable claims whose results are speculative and uncertain. In such cases, the state agency shall either perfect a lien or refer the matter to the county attorney in the county of financial responsibility for the purpose of perfecting a lien.

(C) File its verified lien statement within 180 days from the date the last item of medical care was furnished; and

(D) Refrain from withholding payment on behalf of an otherwise eligible recipient when third party liability cannot be readily determined or collected.

(f) Identification Card. The state agency or the local welfare agency as directed by the state agency shall periodically issue Medical Assistance identification [ID] cards to eligible recipients, or if the recipient is legally incompetent to his guardian. Recipients shall show each provider a valid ID card establishing identity and current eligibility before obtaining medical care. The provider may deny service or contact the local welfare agency if the recipient fails to present a currently valid ID card. The state agency may restrict the use of ID cards to particular providers of specified services when necessary to prevent duplication or documented abuse of services,to prevent violation of prior-authorization requirements, or to assure continuity of care. The state agency will periodically issue ID cards until instructed by the county of service that Medical Assistance eligibility no longer exists. The state agency shall automatically cease to issue cards when a spend-down period ends, when eligibility redeterminations are more than two months overdue, or when the special four month AFDC extended medical periods terminate in accordance with applicable federal regulations. The state agency shall be fully responsible for payments made on behalf of ineligible individuals due to state processing error.

(g) Agreements with Providers. An eligible provider is a vendor of medical care, services or supplies which meets federal and state standards for participation in the MA program, complies with all requirements of this rule, and executes a provider agreement. Providers shall complete and sign an appropriate provider agreement in the form stipulated by DPW. Failure by the provider to comply with federal and state statutes, rules, regulations and policies shall result in termination of the provider agreement, ineligibility to receive MA program reimbursement and, where appropriate, action to recover Medical Assistance funds. In order to be eligible for reimbursement under the Minnesota MA program, out-of-state providers must complete and sign an appropriate provider agreement and comply with all licensing and certification requirements of the state or Canadian province in which they are located.

(h) Qualification of Eligible Providers. The state agency shall determine the qualification and eligibility of each provider of medical care, services and supplies, Any medical provider who refuses to allow a proper survey and/or reimbursement agency access to its records shall become an ineligible provider upon written notification from DPW.

(i) Prior Authorization. The state agency shall establish and implement methods and practices for prior authorization of those items of care and services covered under the MA program which it deems necessary to ensure closer professional scrutiny, or which experience has indicated are associated with high costs or frequent furnishing

of excess services, or where the item or service is to be furnished by providers whose prior pattern of service has been questionable. [*See, generally, (V), infra, for services which must receive prior authorization.*] Items of care and services requiring prior authorization shall be evaluated against written criteria selected and developed by the state agency. Such methods and procedures shall:

(1) Safeguard against the unnecessary or inappropriate utilization of care and services;

(2) Safeguard against excess payments;

(3) Assess the quality and timeliness of such services;

(4) Determine if less expensive alternative medical care, services or supplies are usable;

(5) Promote the most effective and appropriate use of available services and facilities; and

(6) Attempt to rectify misutilization practices of providers, recipients and institutions.

The state agency may delegate the responsibility for prior authorization of specific items and services to the local welfare agency which shall be responsible for implementing the methods and procedures prescribed. Copies of such methods and procedures shall be on file with the state agency.

(j) Utilization Control.

(1) Providers shall comply with all requirements promulgated to support the statewide surveillance and utilization control program as specified by federal regulations. Such program shall include:

(A) An ongoing evaluation of the necessity for and the quality and timeliness of the services provided to eligible individuals under the MA program in order to promote the most effective and appropriate use of available services and facilities.

(B) A post-payment review process which allows for the development and review of recipient utilization profiles, provider service profiles, exception criteria, and one which identifies exceptions in order to rectify misutilization practices of recipients, providers and institutions.

(2) Under this surveillance and utilization control program, all inpatient facilities shall:

(A) Have in effect a written utilization review plan which meets the requirements of applicable state law and federal regulations;

(B) Provide that the committee performing the utilization review activities will review each eligible individual's discharge plan to be developed in accordance with applicable state law and federal regulations;

(C) Obtain physician certification prior to or at the time of admission that such inpatient services are medically necessary or, in the case of an individual who applies for Medical Assistance while in an institution, obtain physician certification prior to authorization of payment;

(D) Obtain physician recertification at least every 60 days thereafter that such services continue to be medically necessary;

(E) Develop written plans of care in accordance with applicable state law and rederal regulations; and

(F) Cooperate in a quality assurance and review program established by the Minnesota Department of Health in cooperation with DPW and in accordance with the provisions of applicable state law and federal regulations.

(3) In accordance with the surveillance and utilization control program, all long term care facilities (i.e., skilled nursing facilities, intermediate care facilities, mental hospitals) shall provide for:

(A) A periodic review and evaluation of the necessity for admission and continued stay of each eligible individual receiving inpatient long-term care facility services. Such review and evaluation shall be performed by medical and other appropriate professional staff who are not themselves directly responsible for the care of eligible individuals, nor financially interested in any such institution nor (except in the case of mental hospitals) employed by such institution. Such reviews and evaluations shall be carried out in accordance with the requirements specified in applicable federal regulations.

(B) Review by the state agency (or its designee) of the recommendations for admission, in accordance with applicable federal regulations.

(4) Under the surveillance and utilization control program, the state agency shall:

(A) Establish and implement a program of medical review (including medical evaluation and on-site inspection) of the care provided patients in mental hospitals and skilled nursing facilities, and a program of independent professional review (including medical evaluation and on-site inspection) of the care provided residents in intermediate care facilities both of which shall satisfy the requirements of applicable federal regulations.

(B) Conduct a statewide utilization control program and take all necessary corrective action to ensure the effectiveness of such program and establish the necessary methods and procedures to implement this responsibility. Copies of such methods and procedures shall be on file with the state agency.

(C) Establish written criteria to be used in implementing the utilization control program in order to evaluate the appropriateness and quality of care and services provided under the MA program (except in the case of hospitals, mental hospitals and skilled nursing facilities which are otherwise required to meet the provisions of applicable federal regulations).

(V) Services Under the Medical Assistance Program

(a) The following services are not covered under the MA program:

(1) Medical services or supplies paid for directly by the recipient.
(2) Medications dispensed by a physician that could reasonably be obtained from a licensed pharmacy.
(3) Medical services or supplies where the requisite prior authorization was not received or was denied.
(4) Autopsies.
(5) Missed appointments.
(6) Telephone calls or other non face-to-face communication between the provider and the recipient.
(7) Routine reports (e.g., Social Security, insurance).
(8) Investigational surgery or procedures (e.g., research efforts not clearly essential to the patient's health).
(9) Illegal operations and other procedures prohibited by law.
(10) Artificial insemination.
(11) Transsexual surgery.
(12) Aversion therapy (including cash payments from recipients).
(13) Cosmetic surgery aimed at beautification only.
(14) Weight reduction programs unless:
(aa) The program treats a medical condition causing obesity; or
(bb) Obesity interferes with the health, well-being or employability of the recipient.
(15) Billing charges.
(16) Mileage charged by eligible providers.
(17) Reversal of voluntary sterilization procedures.
(18) Medical care or services for an individual who is an inmate of a public institution, except as a patient in a medical institution or as a resident of an intermediate care facility (i.e., an individual who is under the care or control of a correctional authority).

(b) The following services are covered under the MA program:

(1) Inpatient hospital services. "Inpatient hospital services" are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients; and which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental diseases; and which is licensed or formally approved as a hospital by the Minnesota Department of Health; and which is qualified to participate under Title XVIII of the Social Security Act or is determined currently to meet the requirements for such participation; and which has in effect a utilization review plan applicable to all patients who receive Medical Assistance under Title XIX of the Social Security Act which meets applicable federal requirements, unless a waiver has been granted by the Secretary of the Department of Health, Education, and Welfare. All inpatient hospitals certified for participation under Medicare (Title XVIII) are eligible to participate in the MA program upon completion of a provider agreement.

(A) The following inpatient hospitalization services must receive prior authorization:
(i) Surgery or other procedures of marginal medical necessity
(B) The following limitations apply to inpatient hospital services:
(i) Private room - must be certified by a licensed physician as medically necessary.
(ii) The hospital must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment by DPW.

(C) The following inpatient hospital services are not covered under the MA program:

(i) Leave days, leaves-of-absence and reserved beds as defined under federal regulations.

(2) Long term care facility services. "Long term care facility services" are those services provided in facilities (or distinct parts thereof) licensed by the Minnesota Department of Health and certified as an eligible provider of skilled nursing facility services, intermediate care facility services, tuberculosis or mental hospital services, or those facilities similarly licensed in another state or a Canadian province. The term "long term care facilities" [LTC] as used herein includes skilled nursing facilities [SNF], intermediate care facilities [ICF], and tuberculosis or mental hospitals.

(A) "Skilled nursing facility services" (other than services in an institution for tuberculosis or mental disease) are those services provided in a SNF. A SNF is a facility:

(i) Certified as meeting the requirements of Title XVIII of the Social Security Act, except that the exclusion contained therein with respect to institutions which are primarily for the care of tuberculosis or mental disease shall not apply and

(ii) Which meets the requirements of applicable federal regulations.

(B) "Intermediate care facility services" (other than services in an institution for tuberculosis or mental disease) are those services provided for individuals who are determined, in accordance with Title XIX of the Social Security Act, to be in need of the care provided in an ICF. An ICF is an institution which:

(i) Is licensed under state law to provide on a regular basis health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities;

(ii) Satisfies the standards prescribed by the Secretary of Health, Education, and Welfare as necessary for the proper provision of such care as enumerated in applicable federal regulations; and

(iii) Meets such standards of safety and sanitation as mandated by federal regulations and as established as applicable to nursing homes under state law.

The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements described above. With respect to services furnished to individuals under age 65, the term intermediate care facility does not include any public institution for mental diseases or mental defects except it may include services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

"Intermediate care facility services I" means services provided in an ICF-1. An "ICF-I" is an institution licensed as a nursing home and which meet each of the conditions described above. "Intermediate care facility services II" means services provided in an ICF-II. An "ICF-II" is an institution licensed at least as a boarding-care home and which meets each of the conditions described above.

"Intermediate care facility services/mentally retarded" means services provided in an ICF/MR. An "ICF/MR" is an institution licensed by the Minnesota Department of Health, licensed in accordance with Minn. Rule DPW 34 and which meets each of the conditions described above.

"Intermediate care facility services/chemically dependent" means services provided in an ICF/CD. An "ICF/CD" is a facility licensed by the Minnesota Department of Health, licensed under Minn. Rule DPW 35 and which meets each of the conditions described above.

(C) "Inpatient psychiatric hospital services for individuals under age 21" are those services provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals. Such services include only inpatient services which, in the case of an individual:

(i) Involve active treatment which meets the standards prescribed by the Secretary of Health, Education, and Welfare;

(ii) Are provided by a team (consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and treatment thereof) and determined to be necessary on an inpatient basis and which can reasonably be expected to improve the condition giving rise to the need for such services, to the extent that eventually such services will no longer be necessary; and

(iii) Are provided prior to the date such individual attains age 21, or if the individual was receiving such services during the period immediately preceding his twenty-first birthday, such services may be continued up to the date the individual no longer requires such services or the date the individual attains age 22, whichever date comes first.

(D) Inpatient hospital, SNF and ICF services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases.

(i) "Inpatient hospital services in an institution for mental diseases" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a psychiatric hospital which meets the requirements of Title XVIII of the Social Security Act.

(ii) "Inpatient hospital services in an institution for tuberculosis" are those items and services which are provided under the direction of a licensed physician for the care and treatment of inpatients in a tuberculosis hospital which meets the requirements of Title XVIII of the Social Security Act.

(iii) "Skilled nursing facility services" are those items and services furnished by a skilled nursing facility as defined by applicable federal regulations.

(iv) "Intermediate care facility services" are those items and services furnished by an intermediate care facility, as defined by applicable federal regulations, to residents who have been determined in accordance with such federal regulations to be in need of such care.

(v) An "institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases including medical attention, nursing care and related services.

(vi) An "institution for tuberculosis" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with tuberculosis including medical attention, nursing care and related services.

(E) Long term care facility services. The state agency shall establish written criteria to be used in determining appropriate levels of required nursing care, in accordance with applicable federal regulations.

(F) General limitations.

(i) Payment will be made only to facilities that have in effect an approved utilization review plan and which meet all other requirements of the surveillance and utilization control program prescribed by applicable federal regulations.

(ii) Medical Assistance is not available on behalf of any individual who is an inmate of a public institution (except where a patient in a medical institution [See, Minn. Stat. 256B.02(4)] or a resident of an intermediate care facility) or any individual who has not attained 65 years of age or who is a patient in an institution for tuberculosis or mental diseases. An individual on provisional discharge or convalescent leave from an institution for mental diseases is not considered to be a patient in such institution. An institution for the mentally retarded or an institution for the chemically dependent is not considered an institution for mental diseases.

(iii) Payments to institutions for the mentally retarded or persons with related conditions shall not include reimbursement for vocational and educational activities.

(G) Health care facility report. Every facility required by state law to be licensed by the Minnesota Department of Health shall provide such annual reports to the Commissioner of Public Welfare as may hereafter be required. Each health care facility participating under the MA program shall provide the Commissioner of Public Welfare with a full and complete financial report of the facility's operations, including:

(i) An annual statement of income and expenditures;

(ii) A complete statement of fees and charges;

(iii) The names of all individuals, partnerships and corporations (other than mortgage companies) owning any interest of ten percent (10%) or more of the facility; and

(iv) The names of all owners of interest in the facility as defined in (iii), or the children, parents or spouses of such owners who own an interest in any other health care facility or organization doing business with the MA program or who are otherwise enrolled as providers.

The financial records, reports and supporting data of each participating facility shall be accessible for inspection and audit by the Commissioner of Public Welfare or designees.

(3) Physician services. Physician services are those services provided by or under the personal supervision of a licensed physician or osteopath within the scope of his profession as defined by state law. All physicians currently licensed to practice medicine under Minnesota law are eligible to participate in the MA program. Out-of-state physicians who are licensed in the state of service are also eligible for participation in Minnesota's MA program. The MA program shall pay for all emergency and medically-necessary health care.

(A) The following physician services must receive prior authorization:

(i) All medical, surgical or behavioral modification services aimed specifically at weight reduction.

(ii) Surgery and other procedures of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to interfere with the individual's personal and social adjustment or employability.

(iii) Removal of tattoo.

(iv) Payment for physicians' services exceeding thirty (30) days of inpatient psychiatric treatment per calendar year.

(v) Individual hourly sessions with a licensed psychiatrist in excess of ten (10) per calendar year.

(B) The following are limitations to physicians' services:

(i) The MA program will pay for up to 10 hourly sessions with a licensed psychiatrist per calendar year for any eligible recipient.

(ii) The MA program will pay for up to 26 additional hourly sessions with a licensed psychiatrist per calendar year when all of the following conditions exist:

(aa) Three or more members of one family unit are all seen together at every session; and

(bb) The 26 hourly sessions extend over a period of time greater than six consecutive months; and

(cc) At least one of the family members is under age 18.

(iii) The MA program will pay for ongoing chemotherapy management on a once-a-week average basis, provided that both of the following conditions apply:

(aa) The medication required is an anti-psychotic or anti-depressant; and

(bb) No more than 52 sessions take place within a twelve month period.

(iv) The MA program will pay for family medical psychotherapy of two family members (conjoint psychotherapy with continuing medical diagnostic evaluation and drug management) as needed for up to two hours per week for a twenty week period. [When more than two family members are involved, *See*, (V)(b)(3)(B)(ii), *supra*.]

(v) The MA program will pay for multiple family group-psychotherapy or group-psychotherapy for up to two hours per week for a ten week period.

(vi) The MA program will pay for medical psychotherapy for up to 100 hourly sessions for eligible recipients under age 18 when:

(aa) The services are provided by a child psychiatrist or receive prior authorization; and

(bb) The 100 sessions do not occur during a period of less than twelve consecutive months.

(4) Health Maintenance Organizations [HMO]. Health Maintenance Organizations are organizations licensed by the state which provide medical care to a voluntarily enrolled population in a specified geographic area. The MA program shall reimburse participating HMO's through a pre-negotiated and fixed per capita payment determined in accordance with applicable federal regulations made on behalf of enrolled recipients. HMO's shall provide, either directly or through arrangements with other medical providers, for all medical services and supplies covered under the official Medical Assistance State Plan.

(5) Other licensed practitioners. The MA program shall pay for medical and remedial care or services, other than physicians' services, provided by a practitioner currently licensed under Minnesota law and performed within the scope of his practice as defined by state law. Out-of-state practitioners who are licensed in the state of service are also eligible to participate in Minnesota's MA program. This category is limited to services provided by licensed chiropractors, podiatrists, vision care providers, psychologists, midwives and osteopaths not licensed to practice medicine and surgery. Limitations on the number of treatments pertain to each eligible recipient per calendar year.

(A) Chiropractors. Chiropractors must be licensed and conform to the uniform minimum standards promulgated by the Secretary of Health, Education, and Welfare under Title XVIII of the Social Security Act, as amended. The MA program limits payment for services provided by chiropractors as follows:

(i) The request for chiropractic services must originate with the recipient, his family or caseworker and may proceed only with the recipient's full knowledge and consent.

(ii) Payment is limited to manual manipulation of the spine for a diagnosis of subluxation of the spine. No other chiropractic service is covered under the MA program.

(iii) Payment is limited to 3 treatments per month and 12 treatments per calendar year for each eligible recipient. Treatment in excess of these maxima must receive prior authorization.

(B) Podiatrists. The MA program limits payment for podiatry services as follows:

(i) The request for podiatry services must originate with the recipient, his family, his caseworker or, where applicable, the staff of the nursing facility wherein he resides, and may proceed only with the patient's full knowledge and consent.

(ii) A limit of 3 visits per month and 12 visits per year is placed on the following:

(aa) Total office and outpatient visits.
(bb) Total home or nursing home visits.
(cc) Hospital visits

(iii) Treatment in excess of these maxima must receive prior authorization.

(iv) The following podiatry services are not covered under the MA program for nursing home patients:

(aa) Ordinary foot hygiene.
(bb) Use of skin creams to maintain skin tone.
(cc) Normal trimming of nails and other services that can reasonably and safely be performed by LTC facility personnel.

(C) Vision care. "Optometric services" are those services provided by or under the personal supervision of a licensed optometrist within the scope of his profession as defined by state law. "Eyeglasses" are lenses (including frames when necessary) and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select, to aid or improve vision. Eligible providers include optometrists currently licensed by the State Board of Optometry, ophthalmologists currently licensed by the state, opticians who are normally associated with the fabrication and/or dispensing of materials, and out-of-state providers in one of the above classifications licensed by the state of service.

(i) The following vision care services must receive prior authorization:

(aa) Contact lenses:
(1) Supplemental contact lenses.
(2) Contact lens check-up.
(3) Spherical lens fitting (single vision).
(4) Cylindrical, lenticular, aphakic or prism ballast lenses.
(5) Keratoconus lenses.
(6) Cosmetic lenses (disfigurement only).
(7) Fitting previous contact lens wearer.
(8) Soft contact lens fitting.
(9) Fitting monocular patient.

(bb) Custom-fit prosthetic eye.
(cc) Amblyopia therapy.
(1) "Amblyopia" includes all test procedures necessary for classification and determination of expecteds.
(dd) Strasbismus therapy.
(1) "Strabismus" includes all test procedures necessary for classification, degree of squint and determination of expecteds.
(ee) Vision therapy--supplemental evaluation and report.
(ff) More than one (1) pair of eyeglasses in any single 12 month period.
(gg) Photochromatic lenses: Must be accompanied by a statement of medical necessity.
(hh) Sunglasses: Must be accompanied by statement of medical necessity.
(ii) Lens coating-surface or edge.

(ii) The following vision care services are not covered under the MA program:

(aa) Services provided principally for cosmetic reasons, including:

(1) Contact lenses prescribed for reasons other than aphakia, keratoconus, anisocoria or marked acuity improvement over spectacle correction.
(2) Replacement of lenses or frames due to a recipient's personal preference for a change of style or color.

(bb) Technical services related to the provision of non-covered services.

(D) Psychologists. Eligible providers are individuals currently licensed by the Minnesota Board of Examiners of Psychologists to practice as licensed consulting psychologists in the fields of psychological counseling and therapy.

(i) The following psychological services must receive prior authorization:

(aa) Services in excess of the limitation on the number of visits [See, below].

(ii) The MA program limits payment for services provided by psychologists as follows:

Service	Limitation
(aa) Psychological diagnostic interview examination	One per month, no more than 3 per twelve month period
(bb) Psychological testing batteries	One per month, no more than 3 per twelve month period
(cc) Individual psychotherapy	Ten visits per calendar year
(dd) Family psychotherapy of two family members	Two hours per week, no more than 20 weeks
(ee) Family psychotherapy for three or more members of one family	Twenty-six 30 minute sessions per 6 month period
(ff) Hypnotherapy	Ten 30 minute sessions per twelve month period

(iii) The following psychological services are not covered under the MA program:

(aa) Aversion therapy.
(bb) Medical supplies and equipment.

(6) Outpatient hospital services. "Outpatient hospital services" are preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished by or under the direction of a licensed physician or dentist to an outpatient in an outpatient facility which is licensed as a hospital by the state and which is qualified to participate under Title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation. All outpatient hospitals certified to participate under Medicare (Title XVIII) are eligible to participate in the MA program upon completion of a provider agreement.

(A) The following outpatient hospital services must receive prior authorization:

(i) Kidney dialysis not covered by Medicare.
(ii) Oral surgery (except in emergencies).
(iii) Hemodialysis back-up service.
(iv) Supplemental and tube feedings for patients who have special nutritional needs.
(v) All physician services which must receive prior authorization [*See*, (V)(b)(3)(A), *supra*].

(B) The following are limitations to services provided by outpatient hospitals:

(i) Each hospital shall comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply will result in denial of payment under the MA program.

(C) The following outpatient hospital services are not covered under the MA program:

(i) Hypoallergenic foods; babyfoods.
(ii) Diapers.
(iii) Charges for services of house staff, interns, residents, administrative or supervisory staff (including physician-owners) who are paid by the hospital or by other sources.

(7) Clinic services. "Clinic services" are preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished to an outpatient by or under the direction of a licensed physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to outpatients. Mental health centers and family planning agencies or centers are considered "clinics" under this definition.

(A) "Mental health centers" are centers currently receiving grants-in-aid authorized by Minn. Statutes, Chapter 245. Services provided by mental health centers must be provided under the auspices and direction of a licensed psychiatrist or other physician currently enrolled as an eligible provider under the MA program. The MA program will pay for mental health center services provided to residents of nursing homes only if the attending physician helped develop the plan of treatment and periodically reviews that plan.

(i) The following are limitations to payment for services provided by mental health centers:

	Service	Limitation
(aa)	Chemotherapy - individual or group	52 transactions per twelve month period
(bb)	Collateral therapy - individual	10 transactions per twelve month period
(cc)	Day treatment	45 transactions per twelve month period
(dd)	Family therapy - group	52 transactions per twelve month period
(ee)	Group psychotherapy	20 transactions per twelve month period
(ff)	Hypnotherapy - individual	10 transactions per twelve month period
(gg)	Individual psychotherapy	52 transactions per twelve month period if under age 21 10 transactions per twelve month period if 21 years of age or older
(hh)	Intake evaluation - individual	1 transaction per twelve month period
(ii)	Mental health information and referral - individual	2 transactions per twelve month period
(jj)	Neurological examinations - individual	1 transaction per twelve month period
(kk)	Non-intake evaluation - individual	1 transaction per twelve month period
(ll)	Psychiatric evaluation - individual	2 transactions per twelve month period
(mm)	Psychodrama - group	20 transactions per twelve month period
(nn)	Psychological evaluation - individual	1 transaction per twelve month period
(oo)	Social evaluation - individual or group	1 transaction per twelve month period
(pp)	Speech therapy - individual	52 transactions per twelve month period
(qq)	Therapy with groups of couples	20 transactions per twelve month period

(ii) The following mental health center services are not covered under the MA program:

(aa) Community planning.
(bb) Community consultation; program consultation.
(cc) Program and service monitoring and evaluation.
(dd) Public information and education.
(ee) Resource development.
(ff) Training and education.

(B) "Family planning agencies" are agencies or clinics which primarily offer family planning related services and have executed either a contract or provider agreement with the state agency. Family planning agencies provide services concerned with the voluntary planning of the conception and bearing of children. Such services include both fertility and infertility programs.

(i) The following are limitations to services provided by family planning agencies:

(aa) The request for such services must originate with the recipient and proceed with his full knowledge and consent.

(bb) The agency or clinic must comply with all federal and state regulations concerning informed consent for voluntary sterilization procedures. Failure to comply with these requirements will result in denial of payment under the MA program.

(8) Home health care services.

(A) "Home health care services" are any of the following items and services when they are prescribed by a licensed physician to a patient in his place of residence, but excluding residence in a hospital, SNF or ICF:

(i) Intermittent or part-time nursing services furnished by a home health agency.

(ii) Intermittent or part-time nursing services of a professional registered nurse or licensed practical nurse under the direction of the patient's physician, when no home health agency services are available.

(iii) Medical supplies, equipment and appliances prescribed by a physician as necessary for the care of the patient and suitable for use in the home.

(iv) Services of a home health aide under the supervision of a professional nurse assigned by a home health agency.

(B) A "home health agency" is a public or private agency or organization, or a subdivision of such an agency or organization, which is qualified to participate as a home health agency under Title XVIII of the Social Security Act or is determined by the state agency to currently meet the requirements of applicable federal regulations. The following home health care services are not covered under the MA program:

(i) Homemaker services.

(ii) Social services provided by a home health agency.

(9) Medical supplies. The term "medical supplies" as used herein includes non-durable medical supplies, durable medical equipment, prostheses, orthoses and oxygen.

(A) "Non-durable medical supplies": Those items which have a limited life expectancy (e.g., atomizers, nebulizers, fountain syringes and incontinence pads).

(B) "Durable medical equipment": Equipment which can withstand use, is primarily used for medical purposes, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home (e.g., wheel chairs, hospital beds and side rails).

(C) "Prostheses" and "orthoses": Replacement, corrective or supportive devices prescribed for a patient by a physician or other licensed medical practitioner within the scope of his profession as defined by state law, for the purpose of artifically replacing a missing portion of the body or to prevent or correct physical deformity or malfunction or to support a weak or deformed portion of the body.

(D) The MA program pays for oxygen and any equipment necessary for administration of oxygen when prescribed by a licensed physician so long as prior authorization is obtained.

Equipment must meet the definition of durable medical equipment and must be necessary and reasonable for the treatment of an illness or to improve the functioning of a malformed body member. Payment for equipment repair will be allowed only when that equipment is medically necessary. Routine periodic servicing such as testing, cleaning, regulating and checking of a recipient's equipment will not be covered. Extensive, complex maintenance may be covered as a necessary repair. Payment on equipment will not continue after the recipient's need for that equipment ceases to exist. The MA program will only pay for supplies essential to the effective use of medically necessary durable equipment (e.g., distilled water).

Eligible providers include those individuals or agencies who supply and/or service medical supplies. Hearing aid dealers must complete a "Hearing Aid Performance Agreement" to be eligible to participate in the MA program.

(E) The following medical supplies must receive prior authorization:

(i) Non-durable medical supplies, when:

(aa) The cost is $15 or more; or

(bb) It is not included in the Minnesota Medical Assistance Supplies, Equipment, Prostheses and Orthoses Formulary (hereinafter, the "formulary").

(ii) Durable medical equipment, when:

(aa) The purchase, projected cumulative rental, repair or maintenance is $30 or more; or

(bb) The item or service is not listed in the formulary.

(iii) Prostheses and orthoses, when:

(aa) The purchase, projected cumulative rental, or repair is $50 or more;

(bb) The order is for an indwelling catheter (which requires a diagnosis of permanent urinary incontinence); or

(cc) The order is for a hearing aid, repairs to hearing aids when the costs of parts and labor exceeds $50, repairs under $50 if performed by a hearing aid dealer more than once a year, or visits by a hearing aid dealer/servicer to the recipient's home in excess of one visit per year.

(iv) Oxygen and any equipment necessary for the administration of oxygen.

(F) The following items are not covered under the MA program:

(i) Equipment primarily and customarily used for non-medical purposes, i.e.:

(aa) Air conditioners.
(bb) Food blenders.
(cc) Exercycles.
(dd) Orthopedic mattresses.
(ee) Stock orthopedic shoes.
(ff) Dehumidifiers.
(gg) Humidifiers.
(hh) Air filters.
(ii) Auto modifications.
(jj) Books.
(kk) TV sets.
(ll) Bicycles.
(mm) Household items.
(nn) Safety bars.
(oo) Training equipment.

(ii) Comfort or convenience items (i.e., electric beds, elevators, waterbeds, cushion lift chairs).

(iii) Stock orthopedic shoes and other supportive devices for the feet, unless attached to a leg brace.

(iv) Durable medical equipment and supplies for recipients who are residents of long term care facilities.

(v) The three follow-up visits per year at the hearing aid dealer's office or service center specified in the Hearing Aid Performance Agreement.

(vi) Reimbursement to long term care facilities for any medical supplies other than allowed under Minn. Rules DPW 49 and 52.

(10) Private duty nursing services. "Private duty nursing services" are nursing services provided by a professional registered nurse or a licensed practical nurse under the general direction of the patient's physician to the patient in his own home or in a hospital or SNF, when the patient requires individual and continual care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the hospital or SNF. Eligible providers include registered nurses and licensed practical nurses in independent practice who provide services separate and apart from any employment or contract with any agency, organization or facility.

(A) The MA program pays for private duty nursing services only:

(i) When ordered in writing by the patient's primary physician or consulting physician;

(ii) In hospitals having no intensive care unit capable of meeting the patient's needs;

(iii) In the family residence when there is no available home health care agency to provide the required level of nursing care which meets the requirements for participation under Title XVIII of the Social Security Act.

(iv) If the private duty nurse is not a member of the patient's family.

(11) Rehabilitative and therapeutic services. "Rehabilitative and therapeutic services" are provided for the purpose of increasing or maintaining the maximum level of functional independence of patients. These services are defined as follows and include the use of such supplies and equipment as necessary, when pursuant to physician orders and when purchased by a facility, agency or independent practitioner.

(A) Rehabilitative and therapeutic services in long term care facilities.

(i) "Physical therapy": Those services prescribed by a physician and provided to a patient by a qualified physical therapist. A "qualified physical therapist" is a graduate of a school of physical therapy approved by the State Board of Medical Examiners for training physical therapists and who has a valid Minnesota certificate of registration.

(ii) "Occupational therapy": Those services prescribed by a physician and provided to a patient by a qualified occupational therapist. A "qualified occupational therapist" is a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and/or who is registered by the American Occupational Therapy Association.

(iii) "Services for individuals with speech, hearing and language disorders": Those diagnostic, screening, preventive or corrective services prescribed by a physician and provided by a qualified speech pathologist or a qualified audiologist in the practice of his profession. A "qualified speech pathologist" or "qualified audiologist" shall have a Certificate of Clinical Competence from the American Speech and Hearing Association, or shall have completed the equivalent educational requirements and work experience necessary for obtaining such a certificate, or shall have completed the academic program and be in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

(iv) Long term care facility agreements with qualified rehabilitative personnel. If the facility does not employ qualified rehabilitative personnel to render services to be provided by the facility, it shall make arrangements to have services provided by an outside resource -- i.e., a person or agency certified by the Minnesota Department of Health who will provide direct service to patients or act as a consultant to the facility. The responsibilities, functions, objectives and terms of such agreements, including financial arrangements and charges of each outside resource, shall be in writing and signed by an authorized representative of the facility and the person or certified agency representative providing the service.

The facility shall assume professional and administrative responsibility, including billing, for the services provided and such terms shall be expressly stated in all agreements. The necessity for such an agreement applies equally to a combination hospital-LTC facility housed in the same building complex.

(aa) A consultant to a facility shall be a qualified physical therapist, occupational therapist, or speech pathologist or audiologist (as these terms are herein defined), depending on the particular service(s) offered.

(bb) Each consultant shall advise the administrator of the contracting facility of all recommendations and plans for implementing particular services, and shall continually assess ongoing programs being administered at such facility by submitting periodic written reports to be kept by the administrator for the purpose of follow-up action and evaluation of performance.

(cc) Costs incurred by the facility for services rendered by qualified rehabilitative consultants are reimbursed through the health facility cost report and shall not be billed separately under the MA program.

(v) Specialized rehabilitative service requirements -- inpatient and outpatient.

(aa) Restorative therapy. There must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonably and generally predictable period of time. This expectation shall be based on an assessment made by the attending physician of the patient's restorative potential after consultation with qualified rehabilitative personnel.

(bb) Specialized maintenance therapy. Physician orders must relate the necessity for specialized maintenance therapy to the patient's particular disabilities. Such therapy must be necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's condition. Specialized maintenance therapy shall be provided only by qualified rehabilitative personnel and only to those patients who cannot be adequately and appropriately treated solely within the facility's nursing program.

(vi) Billing and reimbursement.

(aa) The long term care facility in which the recipient resides shall bill on behalf of the rehabilitative personnel, agency or hospital for services provided. In cases where a patient residing in a facility is provided specialized rehabilitative services in a setting other than his residential facility, the residential facility shall bill for services provided pursuant to agreement with the agency, hospital or other institution where the service is provided. Reimbursement will be for the amount billed unless that exceeds the procedure maximum or the maximum rate per patient per day. Costs related to billing, space, equipment, and utilities are included in the facility's per diem rate.

(bb) Reimbursement to qualified rehabilitative personnel under contract with a facility: Each facility shall bill the MA program on behalf of qualified rehabilitative personnel providing services under contract to it. The amount paid rehabilitative personnel for services provided must be the same amount paid under the MA program. Facilities are prohibited from charging the MA program more than the amount actually paid to rehabilitative personnel providing services.

(cc) Reimbursement to qualified rehabilitative personnel salaried by the facility: Each facility shall bill on behalf of salaried, qualified rehabilitative personnel for the services provided. At the end of each fiscal year, the facility shall:

(1) Determine the total number of treatment sessions provided by each salaried, qualified rehabilitative employee during the fiscal year. A "treatment session" is defined as one or more treatment procedures provided to one patient during one session.

(2) Determine, for each qualified rehabilitative employee, the total number of treatment sessions (as defined herein) provided to eligible recipients and indicate this number as a percentage of the total number of treatment sessions provided by that employee.

(3) Multiply the resulting percentage by the salary of the employee. If Medical Assistance reimbursement exceeds the percentage of salary related to treatment sessions provided to Medical Assistance recipients, the excess amount shall be applied to and, therefore, reduce the "General and Administration" expenses on the health facility cost report submitted by the respective facility.

(vii) The following rehabilitative and therapeutic services are not reimbursable as a separate charge under the MA program when furnished in a long term care facility:

(aa) Services authorized by a physician but not documented in the patient's medical record.

(bb) Services provided by assistants, aides and/or other supportive personnel. Salaries and costs related to these personnel are to be included as part of the facility's rate determination in accordance with the health facility cost report.

(cc) Rehabilitative services provided by nursing personnel.

(dd) Services for personal comfort.

(ee) Services of qualified rehabilitative personnel related to training or consultation of facility staff.

(ff) Activities programs.

(gg) Services of a rehabilitative nature provided by living unit personnel, qualified mental retardation professionals, direct care staff, and training or habilitational personnel.

(hh) Screening procedures not ordered by a physician.

(ii) Services not reasonable and necessary to the treatment of the patient's condition.

(jj) Services provided without written orders of the patient's attending physician.

(kk) Services not related to a written treatment plan designed by the attending physician after any needed consultation with appropriate rehabilitative personnel.

(ll) Services provided without physician review of the patient's progress and plan of care at least once every 30 days, with written certification and re-certification by the physician.

(mm) Services of a preventive or maintenance nature when physician orders do not relate such services to the patient's disabilities.

(nn) Physical therapy services not authorized after the initial 90-day service period by an independent medical consultant, the facility's utilization review committee, or through the local welfare agency's approved review plan.

(oo) Outpatient services provided by a facility not certified as an outpatient provider.

(pp) Outpatient services provided off the facility's premises.

(qq) Outpatient services when the patient is not seen by his physician at least once every 30 days and/or when there is no certification and recertification by the physician.

(rr) Outpatient services provided by intermediate care facilities and intermediate care facilities for the mentally retarded.

(ss) Services provided by an outside resource without a current written agreement between the facility and such resource.

(tt) Services provided by an outside resource not certified by the Minnesota Department of Health, when such certification is required.

(uu) Services billed for by any source other than the

skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

(B) Speech pathology, audiology and physical therapy provided by independent practitioners. Such services are of a diagnostic, screening, preventive or corrective nature and provided to individuals with speech, hearing and language disorders or physical impairments.

(i) "Speech pathology": Those services prescribed by a licensed physician and provided to a patient by a qualified speech pathologist in independent practice. A "qualified speech pathologist in independent practice" shall have received a Certificate of Clinical Competence from the American Speech and Hearing Association [ASHA] or shall have submitted to the MA program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

(ii) "Audiology": Those services prescribed by a licensed physician and provided to a patient by a qualified audiologist in independent practice. A "qualified audiologist in independent practice" shall have received the Certificate of Clinical Competence from ASHA or shall have submitted to the MA program an equivalency statement from ASHA indicating that ASHA certification standards have been met.

(iii) "Physical therapy": Those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist in independent practice. A "qualified physical therapist in independent practice" is a graduate of a school of physical therapy approved by the State Board of Medical Examiners for training physical therapists and an individual who has a valid Minnesota Certificate of Registration and who has been surveyed by the Minnesota Department of Health and received federal certification.

(iv) The following services are not covered as independent practitioner services under the MA program:

(aa) Services provided in settings other than the independent practitioner speech pathologist's, audiologist's or physical therapist's own office or the recipient's place of residence. "Place of residence" excludes skilled nursing facilities, intermediate care facilities, hospitals, rehabilitation agencies, home health agencies, public health agencies, clinics and day activity centers.

(bb) Services provided by an independent practitioner speech pathologist, audiologist or physical therapist not maintaining at his own expense an office or office space and the necessary equipment to provide an adequate treatment program.

(cc) Services which are not physician prescribed.

(dd) Any service authorized by a physician but not documented in the clinical record of the patient.

(ee) Training or consultation provided by a speech pathologist, audiologist or physical therapist to an agency, facility or other institution.

(ff) Services of a speech pathologist, audiologist or physical therapist in independent practice provided in any setting other than the independent practitioner's office or the patient's home.

(gg) Screening procedures not physician authorized.

(hh) Services of a speech pathologist, audiologist or physical therapist employed and salaried by physicians.

(ii) Services provided under a written treatment plan which is not reviewed at least once every 30 days with certification and recertification by the ordering physician.

(C) Rehabilitation agencies. Eligible providers include all rehabilitation agencies participating in the Medicare program (Title XVIII) who have signed and returned to the state agency a provider agreement within sixty (60) days after receipt thereof. "Rehabilitation agency services" are those services provided by certified rehabilitation agencies and defined as follows:

(i) "Medical services": Those services provided to a patient within the scope and practice of medicine as defined by Minnesota law and performed by a currently licensed physician.

(ii) "Psychological services": Those services provided to a patient by a psychologist licensed to practice within the field of psychological counseling and therapy.

(iii) "Psychosocial services": Those services provided to a patient by a social worker for whom a licensed physician assumes total professional and administrative responsibility as if the services were provided by the physician himself. To receive reimbursement under the MA program all psychosocial services shall be ordered by a licensed physician.

(iv) "Physical therapy": Those services prescribed by a licensed physician and provided to a patient by a qualified physical therapist. Other personnel may assist physical therapists in performing physical therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified physical therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified physical therapist.

(v) "Occupational therapy": Those services prescribed by a licensed physician and provided to a patient by a qualified occupational therapist. Other personnel may assist occupational therapists in performing occupational therapy services and in the performance of duties that do not require professional therapy knowledge and skill. The full responsibility for patient instruction or treatment remains with the qualified occupational therapist in consultation with the attending physician. When services of support personnel are utilized, there must be direct on-site observation and supervision by the qualified occupational therapist.

(vi) "Speech pathology or audiology services for individuals with speech, hearing and language disorders": Those diagnostic, screening, preventive or corrective services provided by a qualified speech pathologist or audiologist in the practice of his profession for which a patient is referred by a licensed physician.

(vii) "Special services": Physician-ordered and monitored evaluations, classes, clinics or programs provided to patients generally by a rehabilitation team.

(viii) The MA program will reimburse for services provided only by the following qualified personnel:

(aa) Physicians. A qualified physician who is currently licensed in the State of Minnesota to practice medicine or, if an out-of-state physician, who is licensed in the state of service.

(bb) Psychologists. A qualified psychologist who is currently licensed by the Minnesota State Board of Examiners of Psychologists as a licensed consulting psychologist or a licensed psychologist.

(cc) Social workers. A qualified social worker is an individual with a master's degree from a school of social work accredited by the Council on Social Work Education.

(dd) Physical therapists. A qualified physical therapist is a graduate of a school of physical therapy approved by the Minnesota State Board of Medical Examiners for training physical therapists and who has a valid Minnesota Certificate of Registration.

(ee) Occupational therapists. A qualified occupational therapist is a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and/or who is registered by the American Occupational Therapy Association.

(ff) Speech pathologists and audiologists. A qualified speech pathologist or audiologist is an individual with a Certificate of Clinical Competence from the American Speech and Hearing Association or an individual who has completed the equivalent educational requirements and work experience necessary for obtaining such a certificate, or who has completed the academic program and is in the process of accumulating the necessary supervised work experience required to qualify for such a certificate.

(ix) Agreements with qualified rehabilitative personnel. If the rehabilitation agency does not employ qualified rehabilitative personnel to render services to be provided by the agency, it shall make arrangements to have services provided by an outside resource -- i.e., a person or agency certified by the Minnesota Department of Health who will provide direct service to patients. Such services shall be furnished in accordance with the terms of a written contract which shall provide for retention by the rehabilitation agency of responsibility, control and supervision of such services. Such contracts shall include the following terms:

(aa) Services shall be furnished in accordance with the plan of care established by the licensed physician responsible for the patient's care.

(bb) The areas and settings in which rehabilitative services are to be furnished.

(cc) Personnel and services contracted for shall meet the same requirements as those which would be applicable if the personnel and services were furnished directly by the rehabilitation agency.

(dd) Personnel contracted with shall participate in conferences required to coordinate the care and treatment of individual patients.

(ee) Provide for the preparation of treatment records, including progress notes and observations, and for the prompt incorporation of such information into the clinical records of the rehabilitation agency.

(ff) The financial arrangements of such contracts. The rehabilitation agency shall bill the MA program on behalf of personnel contracted with for services provided.

(gg) The period of time the contract is to be in effect and the manner of termination and renewal.

(x) Rehabilitation agencies -- non-covered services include:

(aa) Services provided to a patient not seen by a licensed physician at least at 30-day intervals.

(bb) Services provided without physician orders (excluding psychological services).

(cc) Services provided without physician review of the plan of care and certification and recertification at least at 30-day intervals.

(dd) Psychosocial services provided by a social worker when a licensed physician does not assume professional and administrative responsibility for such services.

(ee) Services authorized by a physician but not documented in the patient's clinical record.

(ff) Services provided in day activity centers which are subsidiaries of rehabilitation agencies.

(12) Dental services. "Dental services" are diagnostic, preventive or corrective procedures administered by or under the supervision of a licensed dentist. The MA program pays for all emergency care and basic oral health needs. "Dentures" are artificial structures prescribed by a dentist to replace a full or partial set of teeth and made by or according to the directions of a licensed dentist. Eligible providers are dentists licensed to practice dentistry in Minnesota, another state or a Canadian province.

(A) The following dental services and procedures must receive prior authorization:

(i) Pedodontics (when the secondary tooth has completed two-thirds of its development).
(ii) Hospitalization for dental treatment.
(iii) Periodontics.
(iv) Root canal therapy (molars only).
(v) Gold restorations and/or inlays.
(vi) Fixed prosthodontics.
(vii) Removable prosthodontics.
(viii) Orthodontics.
(ix) Surgical services except emergencies.
(x) Removal of impacted teeth.

(B) The following are limitations on the MA dental program:

(i) Oral hygiene instruction - 1 time only.
(ii) Dentures (any type) - 1 per 5 year period, except under special circumstances and only then if prior authorization is received.
(iii) Relines or rebase - 1 every 3 years, except under special circumstances and only then if prior authorization is received.
(iv) Patients in hospitals or long term care facilities -- 3 visits per diagnosis. (As used herein, "diagnosis" means evaluation, determination of medical condition and plan of treatment. This limitation applies to inpatient hospital facilities only if the recipient has been hospitalized in order to treat a dental condition.)

(C) The following services are not covered under the MA dental program:

(i) Additional clasps for partial dentures.
(ii) Bases.
(iii) Sealants.
(iv) Local anesthetics.
(v) Toothbrushes and/or other hygiene aids.

(13) Other laboratory and x-ray services. "Other laboratory and x-ray services" include professional and technical laboratory and radiological services ordered by a licensed physician, dentist or other licensed practitioner within the scope of his practice as defined by state law and who is not employed by that laboratory. The MA program shall pay for such services only when provided by or under the direction of a physician or licensed practitioner in an office or similar facility other than a hospital outpatient department or clinic. Such laboratory must be qualified to participate under Title XVIII of the Social Security Act, or be currently determined to meet the requirements for such participation. Eligible providers are facilities that render professional and technical laboratory services as described herein.

(14) Pharmacy services. A "pharmacy" is a facility licensed by the State Board of Pharmacy in which prescriptions, drugs, medicines, chemicals and poisons are compounded, dispensed, vended or sold on a retail basis. "Prescribed drugs" are any simple or compounded substance or mixture of substances prescribed for the care, mitigation or prevention of disease or for health maintenance, by a physician, dentist or other licensed medical practitioner within the scope of his professional practice as defined by state law. The MA program covers prescribed drugs obtained from a licensed pharmacy or from a hospital in which drug dispensing is under the supervision of a licensed pharmacist. All licensed pharmacies are eligible to participate in the MA program when the pharmacist in charge has enrolled as a provider in accordance with state agency requirements. The MA program shall pay for pharmaceuticals prescribed and dispensed by a physician or dentist in his office when there is no licensed pharmacy within the recipient's local trade area, as defined in (IV)(a), *supra*. The state agency may limit payment to legend and non-legend drugs included in a formulary approved by the state agency, if such action is deemed necessary for proper administration of the program.

(A) The following are service limitations of the MA pharmacy program:

(i) Pharmaceuticals must be prescribed by a licensed physician, dentist or other authorized licensed practitioner of the healing arts. The drug dispenser must keep the signed prescription on file for 5 years, subject to audit at any reasonable time [*See*, (IV)(d)(3), *supra*].

(ii) Telephone orders, where legal, must be reduced to writing with the name of the prescribing physician shown and must be signed by the pharmacist.

(iii) Prescription refills:

(aa) The prescriber must indicate, either verbally or by specification on the original prescription, approval for refilling the prescription.

(bb) As many as five (5) refills may be authorized by the prescriber, but in such cases the total amount authorized must be dispensed within six (6) months of the original prescription date.

(cc) In the absence of specific refill instructions, the prescription will be interpreted to be not refillable. Refills are covered only when refilled by the pharmacy where the original prescription was filled.

(iv) The quantity supplied will depend on the usual and customary prescribing practice of the physician provided that the quantity does not exceed 30 days for acute illness and 100 days for maintenance therapy.

(B) The following services must receive prior authorization:

(i) Supplemental and tube feedings for patients who have special nutritional needs. The patient's dietary requirements must be identified on a physician's prescription and the product(s) must be available from an eligible supplier.

(ii) Hypoallergenic foods for children under 24 months of age.

(C) The following items are not covered under the MA pharmacy program:

(i) Non-legend drugs, stocked by a long term care facility and administered to a patient in such facility for short term (up to 36 hours) therapy.

(ii) Cosmetic products (including hypoallergenic cosmetics).

(iii) Toiletries (non-medicated soaps, body lotions, powders) used for personal cleaning and grooming.

(iv) Oral antiseptics.

(v) Dentifrices and other dental hygiene equipment and supplies.

(vi) Throat lozenges.

(vii) Contact lens wetting solutions and cleaners.

(viii) Investigational drugs.

(ix) Biologicals provided directly to a recipient (i.e., vaccines, sera, toxoids).

(x) Amphetamines, amphetamine derivates and any other Drug Enforcement Agency Schedule II anorexient agents for weight control purposes.

(xi) Nutritional services:

(aa) Modified diets consisting of conventional foods.

(bb) Salt and sugar substitutes; salt or sugar-free specialty food and beverage products.

(cc) Baby foods.

(dd) Hypoallergenic foods [*See*, (V)(b)(14)(B), *supra*].

(ee) Alcholic beverages.

(xii) Any medication not prescribed by a licensed physician, dentist or other licensed practitioner authorized by the state to prescribe drugs within the scope of his practice.

(15) Other diagnostic, screening, preventive and rehabilitative services. The MA program provides for these services as described herein.

(A) "Diagnostic services", other than those for which provision is made elsewhere in this rule, include any medical procedure or supplies recommended for a patient by his physician or other licensed medical practitioner within the scope of his practice as defined by state law, as necessary to enable him to identify the existence, nature or extent of illness, injury or other health deviation of the patient.

(B) "Screening services" consist of the use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations, or to identify suspects for more definitive studies.

(C) "Preventive services" are those services provided by a licensed physician or other licensed medical practitioner within the scope of his practice as defined by state law, to prevent illness, disease, disability and other health deviations or their progression, and to prolong life and promote physical and mental health efficiency.

(D) "Rehabilitative services" include any medical remedial items or services, except those expressly excluded under this rule, which are prescribed by a licensed physician or other licensed medical practitioner within the scope of his practice as defined by state law, for the purpose of reducing physical or mental disability and restoring the patient to his best possible functional level. Prior authorization must be obtained on any services for which payment is claimed under this section.

(16) Early periodic screening, diagnosis and treatment [EPSDT]. The MA program provides for early and periodic screening and diagnosis of individuals under the age of 21 to ascertain physical or mental defects and for health care, treatment and other measures to correct or ameliorate defects and any chronic conditions discovered thereby. Services rendered by providers other than licensed physicians are reimbursable only if the Minnesota Department of Health has previously approved the screening activities.

(A) In order to comply with federal and state EPSDT requirements, local welfare agencies shall:

(i) Notify in writing on an annual basis all recipients eligible for EPSDT services about the existence of such services;

(ii) Provide or arrange for provision of screening services when they are requested;
(iii) Arrange for needed corrective treatment; and
(iv) Maintain adequate EPSDT records and report activities as required by federal and state agencies.

(17) Health care insurance premiums. The MA program shall pay health insurance premiums determined by the state agency to be cost-effective, for:

(A) Eligible recipients not covered under Title XVIII of the Social Security Act, when coverage under the insurance policy justifies the premium charged and the policy provides coverage only for health care.
(B) Supplemental medical insurance [SMI] on a buy-in basis for eligible recipients covered under Title XVIII of the Social Security Act.
(C) Such other insurance programs as the state agency may approve for eligible recipients.

(18) Other medical care. The MA program shall pay for other necessary medical and/or remedial care as follows:

(A) Transportation only when furnished by an enrolled medical provider licensed by the Minnesota Department of Health [*See*, (IV)(g), *supra*].
(i) The following services rendered by medical transportation providers are not covered under the MA program:
(aa) Any routine service determined by the local welfare agency not to be medically necessary.
(bb) Ambulance service in cases where another means of transportation would have sufficed.
(B) Emergency hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital equipped to furnish such services even though the hospital does not currently meet the conditions for participation under Title XVIII of the Social Security Act or the definitions of inpatient or outpatient services.
(C) Personal care services in a recipient's home rendered by an individual, other than a member of the patient's family, who is qualified to provide such services, when the services are prescribed by a physician and supervised by a registered nurse in accordance with a plan of treatment.
(D) Whole blood, including items and services required in the collection, storage and administration thereof, when it has been ordered by a licensed physician and is not available to the patient from other sources.
(E) Crippled children services program [CCS]. Pursuant to a cooperative agreement between the Minnesota Department of Public Welfare and the Minnesota Department of Health, DPW will reimburse the state's CCS program (Title V) for diagnostic, evaluation and ongoing medical follow-up services in CCS field clinics for Medical Assistance eligible children up to 21 years of age. DPW will also reimburse CCS for evaluation, diagnosis and/or consultation provided Medical Assistance eligible children who are residents of the Minnesota School for the Deaf, the Minnesota School for the Blind and Visually Handicapped and certain other state institutions.

(VI) Reimbursement

(a) Maximum Allowable Charges. The state agency shall pay a fee or charge for medical care or services rendered which does not exceed the provider's usual and customary fee or charge to the general public (including advertised prices and discounts limited to special groups) or DPW's maximum allowable charge, whichever is lower.

(1) "Usual and customary" as used herein means that amount the provider charges in the majority of cases for a specified procedure or service.

(2) DPW's "maximum allowable charge" as used herein means the charge established in accordance with requirements of applicable federal regulations.

(b) Payments to Eligible Providers. Participation in the MA program is limited to those providers of medical care, service and supplies who accept as payment in full amounts paid in accordance with DPW's maximum allowable charges. Providers are prohibited from requesting or receiving additional payment from the recipient, his relatives or guardian, except to meet the spend-down provision of state law. Providers will be directly paid for providing medical care and services rendered within the scope of practice recognized under federal and state law and regulations. The state agency or, where appropriate, the local welfare agency, may pay the employer of an approved provider only if required under a written contract between the provider and the employer. The state agency shall have access to all such contracts at its request. Payment will not exceed the provider's usual and customary fee to the public (including advertised prices and discounts limited to special groups) or the state maximum allowable charge, whichever is lower. In no instance shall payment exceed the allowable charge under Title XVIII.

(c) Billing Procedures. Providers of medical care and services shall bill the state agency up to their usual and customary fee and only after the medical care or services have been provided. Medical bills should be presented for payment at the conclusion of each month's service. Providers shall bill within twelve (12) months of the date of service or, in unusual circumstances, in accordance with applicable federally-imposed time restrictions. The state agency shall deny payment until the following criteria have been met:

(1) Providers submit all necessary forms and reports to the appropriate state or local welfare agency.

(2) All prior authorization requirements are fulfilled.

(3) Providers bill for care or services rendered on prescribed forms according to state agency instructions.

(A) The state agency shall require providers to submit diagnosis and procedure codes on all billings when deemed necessary for proper administration of the MA program, to comply with applicable federal regulations and to maximize federal financial participation.

(4) Providers shall bill the state agency directly, except as follows:

(A) Where a written contract or other formal arrangement exists between the provider of the service and any agency, institution or group, in which case such agency, institution or group shall bill the state agency.

(B) If Medicare coverage exists, the provider shall accept assignment on a Medicare billing.

(d) Provider Fraud. Medical Assistance payments made on behalf of eligible recipients may be made only to eligible medical providers who certify that the payments billed for and received were correctly due and collectable for medical care or services supplied, and further acknowledge that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable federal or state law. Fee-splitting, kickbacks or any division of payment received under the MA program is expressly prohibited and such actions shall constitute fraud on the part of the provider. Any provider determined by the state agency to have submitted false claims shall be ineligible to participate in the MA program. Such provider's eligibility may be reinstated at the discretion of the state agency.

(e) Recipient Fraud. The following actions shall constitute fraud on the part of an applicant/recipient of Medical Assistance:

(1) Obtaining or attempting to obtain, or aiding any person to obtain by means of a willfully false statement or representation, or by impersonation or other fraudulent device, assistance to which he is not entitled, or assistance greater than to which he is entitled.

(2) Knowingly aiding in buying or in any way disposing of the property of a recipient of assistance without consent of the local welfare agency with intent to defeat the purposes of Minn. Statutes, Chapter 256B.

Any applicant/recipient determined by the state agency to have committed fraudulent actions shall be ineligible to receive Medical Assistance and shall be prosecuted in accordance with Minn. Statutes 609.52.

(f) Authority to Recover from Medical Providers. The state agency is authorized to recover any Medical Assistance funds paid to providers when it determines that such payment was obtained fraudulently or erroneously. Such recovery may be accomplished through withholding current obligations due the provider or by demanding that the provider refund amounts so received. Recovery under the MA program is permitted for intentional as well as unintentional error on the part of the provider or state or local welfare agency; for failure to comply fully with all utilization control requirements; prior authorization procedures or billing procedures; for failure to properly report third-party payments' and for fraudulent actions on the part of the provider.

(VII) Miscellaneous

(a) Former Minn. Rule DPW 47, including Appendices "A" through "J", is hereby repealed.

(b) The effective date of this rule is _____.

The Commissioner proposes that the following changes be made to proposed Minn. Rule DPW 47.

PAGE	CITATION	PROPOSED CHANGE
1	(I)(f)	Strike "pre-print", put in "document"
2	(II)(b)	Change first sentence to read: Any person has the right to apply for Medical Assistance to the local welfare agency in the county in which he resides and has established an abode, regardless of whether or not it appears he will be found eligible for participation in the MA program.
2	(II)(f)	add: An approved application shall be appended by an addendum thereto for the purpose of adding additional eligible persons or when the payee has changed his/her name.
3	(II)(i)(2)	substitute: The local welfare agency shall request in writing and obtain written consent to use the individual's SSN to validate information contained in the application.
3	(II)(k)	Insert before last sentence: Cases converted from state administered payments under OAA, AB and AD programs which are terminated by SSI require a separate application and determination of eligibility.
3	(II)(m)	Change to read: The county in which the applicant resides at the time of application for Medical Assistance is the county of financial responsibility.
4	(III)(a)(3)	Change to read: The unborn are eligible for Medical Assistance during the last three months of the mother's pregnancy (as medically certified), so long as other factors of AFDC eligibility exist.
4	(III)(b)(3)	Add: An agricultural migrant who meets all other eligibility requirements and who has an abode in another state shall be eligible for Medical Assistance.
4	(III)(b)(1)	Strike "indefinitely"
5	(III)(b)(6)	Change to read: The state agency shall assist in meeting the medical needs of residents of other states who are eligible for Medical Assistance in that state while they are within Minnesota.
5	(III)(b)(7)	Delete and add entire section to (III)(b)(3).
5	(III)(d)(1)(C)	Add: Eligibility of individuals between 18 and 21 years of age shall be determined either separately or as part of a family unit.
5	(III)(d)(1)(D)(i)	Last sentence: All income, except non-cash items provided free of cost, is considered a resource to be evaluated in determining the need of Medical Assistance applicants/recipients.

PAGE	CITATION	PROPOSED CHANGE
6	(III)(d)(1)(E)(ii)	Change 15¢ to 13¢ per mile.
6	(III)(d)(1)(E)(x)	Add: that are necessary and reasonable).
6	(III)(d)(1)(I)	Change first sentence to read: Income that is within the legal maxima of the MA program is not to be considered in determining.... Add after third sentence: Retarded or handicapped persons living in skilled nursing facilities, intermediate care facilities, or intermediate care facilities/mentally retarded who are employed under a plan of rehabilitation are eligible for a special personal allowance from earned income as specified in state statutes.
7	(III)(d)(1)(L)(iii)(bb)	Strike "to be used", put in "available".
7	(III)(d)(1)(L)(v)	Strike "anticipated income", put in "spend-down".
8	(III)(d)(2)(A)(i)(aa)(2)	Insert after "periodically", (at least annually).
9	(III)(d)(2)(E)	Substitute: The owner of property in joint tenancy shall be considered as owning one-half of the value of such property, but the county or the joint tenant may establish ownership of a greater or lesser amount. An owner of property as a tenant-in-common owns his pro-rata share of the property's value. All other types of ownership shall be evaluated according to the law.
10	(III)(f)	Change title to read: Marriage or remarriage of parent. In first sentence, insert after "age", marries or
10	(III)(f)(3)	Strike "family" before unit.
11	(III)(g)(1)(A)	Insert "involuntarily" before "retained".
12	(IV)(a)(3)(A)	Change to read: Provision of medications may be limited to a particular pharmacy, pursuant to a service agreement existing between the facility and the pharmacy. Such limitation is subject to the written approval of the patient and/or his responsible relative or guardian and in accordance with the facility's admission policies.
13	(IV)(d)(2)(B)	Change to read: Maintain necessary records relevant to DPW's utilization review and control system.
13	(IV)(e)	Add to second sentence: up to the liability of the MA program.
13	(IV)(e)(1)(A) and (B)	Delete, put in as new subsection (III)(d)(2)(F).
13	(IV)(e)(2)(B)	Change "180 days" to "one year".
14	(IV)(e)(2)(C)	Change "180 days" to "one year".

PAGE	CITATION	PROPOSED CHANGE
14	(IV)(f)	Insert before last sentence: Local welfare agencies shall notify the recipient during the first five days of the last month of eligibility prior to the automatic discontinuance to issue ID cards.
14	(IV)(h)	Strike "qualification and"
17	(V)(a)(3)	Strike "received", put in "submitted".
17	(V)(a)(7)	Add: unless requested by the state agency.
17	(V)(a)(12)	Add: unless prior authorization is received in accordance with Minn. Rule DPW 39.
17	(V)(a)(19)	Add: Duplication of services by more than one provider without appropriate medical referrals.
17	(V)(b)(1)(A)(i)	Change to read: Medical care of marginal medical necessity.
17	(V)(b)(1)(B)(i)	Add: unless the private room rate does not exceed the semi-private room rate in that hospital.
18	(V)(b)(2)(b)(iii)	End with "regulations".
18	(V)(b)(2)(b)(iii)	Change third paragraph as follows: Intermediate care facility services I to intermediate care facility services/nursing home. "ICF I" to "ICF-NH". "Intermediate care facility services II" to "Intermediate care facility services/boarding care home". "ICF II" to "ICF-BCH". "Intermediate care facility services/BCH means services provided in an ICF-BCH or which could be provided in an ICF-BCH".
19	(V)(b)(2)(E)	Change to read: Levels of care.
21	(V)(b)(3)(B)(vi)(aa)	Insert before "child": board certified or board eligible
21	(V)(b)(4)	Change in first sentence: "medical care" to "comprehensive health care"
21	(V)(b)(4)	Add: HMO services shall be provided in accordance with the HMO contract and shall not be subject to service limitations, prior authorization requirements and billing and recovery procedures as are all other providers under this rule.
22	(V)(b)(5)(B)(i)	Change "nursing home" to "long term care facility".
	(ii)	Change "nursing home" to "long term care facility".
	(iv)	Change "nursing home" to "long term care facility".

PAGE	CITATION	PROPOSED CHANGE
24	(V)(b)(5)(D)(iii)(aa)	Strike
24	(V)(b)(7)	Delete "Mental health centers and". Sentence to read: Family planning .....
24	(V)(b)(7)(A)	Change to: (V)(b)(19). Change to read: "Mental health centers" are centers currently receiving grants-in-aid who are operating in accordance with Minn. Rule DPW 28. Services provided by mental health centers must be provided under the auspices and direction of a licensed psychiatrist or licensed consulting psychologist currently enrolled as an eligible provider under the MA program. The MA program will pay for mental health center services provided to residents of long term care facilities only if the attending physician helped develop the plan of treatment and periodically reviews that plan.
25	(V)(b)(7)(A)(i)	Change to: (V)(b)(19)(A) Mental health centers are subject to the same service limitations and prior authorization requirements as is the practitioner under whose auspices or direction the services are rendered.
27	(V)(b)(9)(F)(i)(ee)	Delete
28	(V)(b)(11)(A)	Add: Such services must be provided in accordance with applicable federal regulations, state law and DPW rules.
28	(V)(b)(11)(A)(i)	Change to: A "qualified physical therapist" is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, and, has a valid Minnesota Certificate of Registration.
28	(V)(b)(11)(A)(iv)	Strike
29	(V)(b)(11)(A)(vi)(aa)	Strike from "Reimbursement" through "per diem rate".
29	(V)(b)(11)(A)(vi)(bb)	First sentence: Insert after "personnel": (including rehabilitation assistants and aides) Insert after "for" in second sentence: direct Insert after "personnel" in last sentence: directly
29	(V)(b)(11)(A)(vi)(cc)	Add after "personnel" in first sentence: (including rehabilitative assistants and aides)

PAGE	CITATION	PROPOSED CHANGE
30	(V)(b)(11)(A)(vi)(cc)(3)	Insert after first sentence: "Salary" means all direct costs related to employment.
30	(V)(b)(11)(A)(vii)(kk)	Strike
	(V)(b)(11)(A)(vii)(qq) thru (tt)	Strike
31	(V)(b)(11)(B)	Add: Such services must be provided in accordance with applicable federal regulations, state law and DPW rules.
31	(V)(b)(11)(B)(iii)	Change second sentence to: A "qualified physical therapist in independent practice" is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, has a valid Minnesota Certificate of Registration, and has been certified as an independent practitioner by the Minnesota Department of Health.
32	(V)(b)(11)(C)	Insert in the last sentence after "agencies": in accordance with applicable federal regulations, state law and DPW rules
32	(V)(b)(11)(C)(viii)(dd)	Change to: A qualified physical therapist is a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association, and, has a valid Minnesota Certificate of Registration.
33	(V)(b)(11)(C)(ix)	Strike
	(V)(b)(11)(C)(x)(aa) and (cc)	Strike
34	(V)(b)(12)(C)(iv)	Add: when billed as a separate procedure.
38	(VI)(c)	Insert after first sentence: Providers proven to consistently bill in excess of their usual and customary fee shall be referred to the SURS program for investigation and, if appropriate, shall be determined ineligible to participate in the MA program.
39	(VI)(e)(2)	Last sentence: change "prosecuted" to "subject to prosecution".

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS

COMMISSIONER OF PUBLIC WELFARE

In the Matter of Proposed Amendments
to Rule 47 of the Minnesota
Department of Public Welfare
Governing Administration of the
Medical Assistance Program

ORDER ADOPTING RULES

The above-entitled matter came on for hearing before a duly appointed hearing officer of the Commissioner of Public Welfare of the State of Minnesota on the 19th day of November, 1975, at 8:30 a.m. in the Minnesota Veterans' Home Auditorium, East 51st Street and Minnehaha Avenue, Minneapolis, Minnesota, after proper notice required by Minnesota Statutes 15.0412, subd. 4 (1974), as amended, was served upon all persons, associations and other interested groups registered with the Secretary of State for that purpose.

After affording interested persons an opportunity to present written and oral data, statements and arguments, having heard all of the testimony, having considered all of the evidence adduced and upon the records, files and proceedings herein, and applicable statutory standards or criteria, and having confirmed the need for the above-captioned rule;

NOW, THEREFORE, IT IS ORDERED that this rule identified as Minn. Rule DPW 47 is adopted this 14th day of April, 1976, pursuant to the authority vested in me by Minn. Stat. Sec. 256B.04, Subd. 2 (1974).

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Vera J. Likins

VERA J. LIKINS
Commissioner