

Minnesota Attorney General: Administrative Rules Proceedings

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STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT 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.

REPORT OF HEARING EXAMINER

The above-entitled matter came on for hearing on June 1, 1976 at the State Office Building, St. Paul, before Steve M. Mihalchick, Hearing Examiner appointed by the Chief Hearing Examiner. The hearing continued on June 2nd and June 25th, 1976 until all interested persons had an opportunity to be heard concerning the adoption of the proposed rules.

The Department panel included: James Hiniker, Deputy Commissioner; Robert Baird, Assistant Commissioner; Roger Johnson, M.D.; Russell Roberts, D.D.D.; John Bush, R.Ph.; Wyllis Akre, O.D.; Bradley Stoneking; Tom Gaylord; Charlene Seavey; Jean Morley; Warren Nyhus; Irving Bernstein, M.D.; Thomas L. Fabel, Deputy Attorney General; Thomas H. Jenson, Special Assistant Attorney General.

Public speakers at the hearing were: John Broeker and Kathrun E. Baerwald, attorneys representing the Minnesota Association of Health Care Facilities (MAHCF); Dr. Richard Anonsen, President, Minnesota State Medical Association; Dr. Frederick Walter, President, Minnesota Academy of Family Physicians; Carl Gustafson, Administrative Director of the Foundation for Health Care Evaluation; Howard Kelly, Hennepin County Welfare Department; Pamela Parker, Executive Director, Nursing Home Residents Advisory Council; Fred Sattler, representing the Minnesota Hospital Association; Harry LeMieux, President, Minnesota Association of Health Care Facilities; Kay Roberts, physical therapist; Philip Getts, attorney, representing certain psychiatrists; Ben Kubes, physical therapist.

Included in the record are some 120 Department exhibits and 80 public exhibits and comments. References in this report to exhibits will be by exhibit number and page, if appropriate, e.g.: Ex. bf. at 13.

Pursuant to Minn. Stat. § 15.0412, subd. 4 (Supp. 1975), this report shall be available to all affected individuals upon request for at least ten days before the Department takes any final action on the proposed amendments.

The Department shall, if it proposes to adopt the rules as originally proposed or amended, submit the complete hearing record to the Chief Hearing Examiner no sooner than ten days following receipt of this Report. It shall include the rules as originally proposed and the rules as proposed for adoption in final form. The Chief Hearing Examiner shall complete his review and submit his report to the Department on the issues of substantial changes in the rules and compliance with Minn. Stat. § 15.0412 within ten calendar days. Thereafter, the Department will be responsible for filing the rules with the Attorney General.

Based upon the records and proceedings herein, the Examiner makes the following:

FINDINGS AND CONCLUSIONS

PROCEDURAL REQUIREMENTS

1. On April 30, 1976, the Department (DPW) mailed a Notice of Hearing to all persons and associations who had registered their names with the Secretary of State for the purpose of receiving such notice as well as to all current members of the Legislature and other interested individuals.

2. On May 6, 1976, the Department filed the following documents with the Office of Hearing Examiners:

(a) The Order for Hearing;
(b) The Notice of Hearing as mailed;
(c) The Affidavit of Receipt of the Secretary of State's list;
(d) The Affidavit of Mailing;
(e) A Statement of Need;
(f) The names of Agency Personnel who will represent the agency; and
(g) A list of documentary evidence to be presented at the hearing.

3. Supplemental lists of evidence were filed on May 24, 1976 and May 28, 1976.

4. The Department completed its presentation on June 2, 1976. The Examiner recessed the hearing until June 25, 1976 to allow interested persons to examine the numerous exhibits that had been submitted to that point and encouraged all persons to

submit additional comments prior to June 25th.

5. The record was closed on July 15, 1976, after allowing 20 days for the submission of written comments.

6. The Notice of Hearing (Ex. E) did not contain a citation to the Department's statutory authority to adopt the proposed rule, as required by Minn. Rule HE 102(c)(4). Such a citation was made in the Order for Hearing (Ex. D).

7. The Examiner concludes that all relevant, substantive and procedural requirements of law and rule have been substantially fulfilled. The defect in the Notice is inconsequential. Objection to the adequacy of the Statement of Need (Ex. H) was raised (Ex. be, ¶ 10). The purpose of the Statement of Need, and the Summary of Evidence, is to allow persons who may wish to contest proposed rules the opportunity to prepare a rebuttal. Whatever defect there may have been was cured by the 23-day recess in the hearings. Interested persons had not merely a chance to see and prepare for a proposed presentation, they had before them the Department's entire "case-in-chief."

STATUTORY AUTHORITY

8. Minn. Rule DPW 47 is intended to implement Minn. Stat. Ch. 256B, Medical Assistance for Needy Persons. The program is administered by county agencies under the supervision of the "State Agency", (the Commissioner of Public Welfare). Minn. Stat. § 256B.04, subd. 2, provides that the State Agency shall:

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

9. The Examiner concludes that DPW has documented its statutory authority to adopt the proposed rule. Given the general authority, any provision of the rule which is necessary and reasonable for carrying out the purposes of Chapter 256B is authorized.

MINN. RULE DPW 47(I) - INTRODUCTION

10. DPW 47(I), with the exception noted in ¶12, is necessary and reasonable to provide a general introduction to the rule by describing the scope and purpose of the rule.

11. As originally proposed, DPW 47(I)(b) allowed the Commissioner to issue policy bulletins and manuals. Several objections were raised to the use of the word "policy," because "policy" can only be adopted under rule-making procedures. In response to those comments, the Department has suggested that the word "policy" be changed to "instructional" to make it clear that the Department does not intend to circumvent rule-making requirements. As Department personnel testified (T. 18), in a program as massive as Medical Assistance, it is necessary to clarify and modify details of administration without affecting any general policies.

12. DPW 47(I)(c) is a general statement of the purpose of the Medical Assistance Program (MA program). The policy expressed in Minn. Stat. § 256B.01 is to provide medical assistance for needy persons whose resources are not adequate to meet the cost of such care. This section adds the qualification that such persons must "have demonstrated the need for such services." That qualification attracted some attention (Exs. be at 12, cy and cz). One problem is that the rule does not say how the need is demonstrated. Further, from the general comments of Department personnel, it appears that this section does not actually reflect their intention. What they meant was that the program will provide necessary medical care to eligible recipients. The rule as written appears to make demonstration of need for a particular service a requirement for eligibility. That would be contrary to 45 C.F.R. 248.1, et seq.. It confuses recipient eligibility with medical service eligibility, and should be modified by striking the quoted phrase. Unless modified, the section is unreasonable. See ¶ 16.

13. DPW 47(I)(d), raises the issue of confidentiality. The subject also occurs in sections (II)(j), (III)(e), (IV)(a)(3)(B), and (IV)(h). It will be discussed in more detail below. Here, it is a reasonable introductory statement.

14. The Department has demonstrated the need for and reasonableness of DPW 47(I) except for the qualification noted in ¶12.

DWP 47(II) APPLICATION FOR MEDICAL ASSISTANCE.

15. The Department testified that many of the provisions in this section are mandated by federal regulations. In a heavily federally financed program such as this, it is axiomatic that state officials are bound by valid Federal statutes and regulations in administering the program. Steere v. State, ____Minn. _____, 243 N.W. 2d 112 (1976). Any provision that is required by law or regulation is thereby necessary and reasonable. Subsections (a), (c), (d), (e), (g) and (i) are specifically required by Federal regulations.

16. DPW 47(II)(b) contains a provision similar to that of DPW 47(I)(e); namely, "One condition of eligibility is a demonstrated need for medical care and service." The comments of ¶12 apply here. As stated in Ex. be at 13:

> ". . . this section of Proposed Rule 47 is clearly in conflict with federal regulations. If an individual is among the group of persons who is categorically needy, he or she is automatically eligible for Medical Assistance. While the individual may have to obtain prior authorization as provided in Rule 47 for medical care and services, he or she is nevertheless eligible to become a participant in the Medical Assistance program whether or not he or she has a current need for medical care or services. Federal regulations as well as state statutes clearly state that all persons who are categorically needy are eligible for Medical Assistance."

The subsection, as written, creates some confusion between the eligibility of the recipient and the eligibility of the medical service to be provided. It is unreasonable as written; the sentence should be deleted.

17. DPW 47(II)(h) requires the county agencies to verify certain information in an application and makes refusal to cooperate by the applicants cause for automatic denial. Although some of the citations to Federal regulations by the Department were in error (See Ex. be at 14), Minn. Stat. § 256B.09 clearly requires investigations. Often investigation will be possible only if the applicant provides the information and source of verification. One comment (Ex. cn) thought the term "refuse to cooperate" was too vague and could be applied where persons are

unable to cooperate because of some disability. The Examiner disagrees; "refuse" connotes a knowing and deliberate choice not to cooperate.

18. DPW 47(II)(j) contains a provision that all applicants shall be informed that their medical records may be released to various state and Federal agencies, and that they must sign a written consent to such release. Based upon testimony by a representative of the Minnesota State Medical Association (T.39), the Department has suggested that the provison be enlarged by adding "and other appropriate agencies" to the list of those to whom the records could be released and by a phrase making the consent a condition of eligibility for Medical Assistance. Again, this raises the matter of confidentiality and generated several comments (Exs. aa, aq, be at 15, bf, bj and cn; T. 39 and 45). Minn. Laws 1976, Ch. 188, § 3, requires applicants, as a condition of eligibility for Medical Assistance, to authorize, in writing, the Commissioner to examine personal medical records developed while receiving medical assistance for the sole purpose of investigating whether or not a vendor has submitted a fraudulent claim, report or rate application. The consent required by the proposed rule is obviously broader than that required by the statute. Unless Federal law or regulation requires the broader consent, the rule as written is unreasonable. The Department cited 45 C.F.R. 250.21 for support. That section requires that providers must agree to furnish the Department such information regarding any payments claimed as the Department may request. Such information apparently includes medical records, but Federal regulations include further restrictions on release of medical records. 45 C.F.R. 205.50 requires that, pursuant to a state statute, the use or disclosure of information concerning applicants or recipients will be limited to purposes directly connected with administration of the MA program. That section also requires the Department to clearly define what types of information must be safeguarded and the conditions under which it may be used or disclosed. Minnesota has a statute imposing criminal and civil sanctions for improper use or disclosure of private or confidential

information. Minn. Stat. § 15.162, et seq. Therefore, the release of information, including medical records, to appropriate agencies is authorized and requiring written consent is reasonable. However, the rule falls short of clearly defining the conditions for use or release of information as required by 45 C.F.R. 205.50(a)(2), and Minn. Stat. § 15.165(a). The rule must be modified to state such definitions and to provide that the applicant be notified of the conditions. Likewise, the suggested addition that records may be released "to other appropriate agencies" creates further ambiguities and is unreasonable unless the criteria for determining an "appropppriate" agency is clearly defined.

to be rewritten

19. DPW 47(II)(f), (k), (l) and (m) are needed to clarify the mechanics of the application procedures and do so in a reasonable manner.

20. The Examiner concludes that the Department has demonstrated the need for and reasonableness of all provisions of DPW 47(II), except the last sentence of DPW 47(II)(b) and DPW 47(II)(j). The latter section is necessary, but should be modified to clearly define the conditions for release and use of safeguarded information in accordance with 45 C.F.R. 205.50(a)(2) and Minn. Stat. § 15.162 et seq.

DPW 47(III) ELIGIBILITY FACTORS UNDER THE MEDICAL ASSISTANCE PROGRAM.

21. DPW 47(III)(a) is necessary to specify the age requirements for eligiblity, and is reasonable in that it restates the requirements as found in Minn. Stat. § 256B.06 and 45 C.F.R. § 248.60(a)(2).

22. DPW 47(III)(b), defining residence, is based upon Federal regulations, Chapter 256B, and court decisions, and is necessary and reasonable. A question was raised in post-hearing comments (Ex. be at 16) as to whether paragraphs (4) and (5), regarding payment for services rendered outside the State, applied cnly to existing recipients or also to people who meet the eligibility requirements but who have not yet applied for assistance. The Department should examine those subsections to determine whether they accurately reflect their intention.

23. DPW 47(III)(c), Citizenship and Alienage, is necessary and is reasonable because it is a direct quote from 45 C.F.R. § 248.50.

24. DPW 47(III)(d), Income and Resources. Subsection (1) of this section discusses income and begins by referencing the statutes in which the income maxima are set, namely Minn. Stat. §§ 256B.06 and 256B.14. Two comments (Ex. cy and cz), objected to subparagraph (III)(d)(1)(C) and suggested that income from part-time employment by minors in the home should not be included in family income. Department personnel testified that inclusion of all family income was required by Minn. Stat. § 256B.14. That section states:

W.N. will modify

> "The financial responsibility of a relative for an applicant or recipient of medical assistance shall not extend beyond the relationship of a spouse, or a parent of an applicant who is under 18 years of age."

The language of the statute is clear; the income of a sibling cannot be included in determining gross income of an applicant. The only time the income of the child should be considered is when he is, himself, the applicant. Section (III)(d)(1)(D)(i) seems to make that distinction clear in its definition of income, but (III)(d)(1)(C) must be modified to comport with the statute. Some question as to the inclusion of non-cash income in the definition was raised in Ex. bj because of the difficulty of enforcing such provisions. However, a person is eligible only if he has certain amounts of income and resources, and if he has non-cash income that can be converted into cash, that must be done before eligibility exists. Difficulty of enforcement should not over-ride the basic concept.

25. Department personnel presented testimony on each of the remaining sections of subsection (1), income, and showed that each was a reasonable application of the basic requirement that only income that is available to the applicant be considered. In some cases, specific inclusions or exclusions are mandated by Federal regulations. Comments were directed at § (III)(d)(1)(E) (Exs. cy and cz) stating that the transportation costs of 13 cents per mile and the cost of meals allowance of $1.00 per day should be raised.

The Department presented no specific testimony on the 13 cents figure but stated that the $1.00 meal cost allowance was based upon experience and efficiency of administration. The provision does contain exceptions to allow the recipient to establish higher meal and mileage costs, and it is reasonable.

Comments in Ex. bj were directed at the harshness of the application of § (III)(d)(1)(I), which requires any income over the maxima to be applied to the recipient's medical costs. The section is specifically required by 45 C.F.R. 248.3(c)(2) and Minn. Stat. § 256B.36.

26. Section (III)(d)(2)(A), dealing with real property, restates the definition of equity given in Minn. Stat. § 256B.06, subd. 1(7), and the method for waiver of the equity limitation provided in Minn. Stat. § 256B.07. There was no opposition expressed to the proposed rule and it was supported by one comment (Ex. bf). One suggestion was made (Ex. be at 17) that a person requiring immediate medical care be permitted to get medical assistance immediately on the condition that the property which is not exempt be put for sale and the proceeds from the sale be used to reimburse the responsible county for medical assistance benefits paid to medical providers. The Examiner makes no recommendation on the suggestion.

27. Section (III)(d)(2)(B), relating to personal property as a resource, is a reasonable restatement and clarification of the provisions of Minn. Stat. §§ 256B.06, subd. 1(8) and 256B.07. Subparagraph (i)(ee) is a restatement of Minn. Stat. § 256.935, subd. 2, and provides that prepaid burial contracts not exceeding the amount stated in the rule shall not be considered as a resource for medical assistance. Several comments were addressed to these provisions (Exs. be at 17, ad, ah, bf and bj). It was again suggested that persons requiring immediate aid be allowed to receive medical assistance immediately on condition that the non-exempt personal property be placed up for sale. (See, ¶ 26) Two counties suggested that income-producing personal property be excluded as it is under AFDC. There are several judgments to be made on this issue. Sale of income-producing property may perpetuate the

recipient's lack of resources. On the other hand, a considerable amount of cash may be tied up in such property. The Examiner believes it should not be excluded. One comment on prepaid burial contracts stated that the April, 1976 program manual required a contract with a certain funeral director and objected to the fact that it bound the client to a particular funeral director and made change difficult. The proposed rule clearly provides an alternative of creating a trust account restricted to use for payment of funeral burial costs but not restricted to a particular funeral director. Another comment (Ex. bj) stated that the 15-day period provided in Subparagraph (iii) was inadequate time to transfer excess personal property into excluded types of property. Department personnel testified that the 15-day period was based upon their experience and that they had found that it was a reasonable time for such transfers to take place and for the counties to implement the procedure. The same comment also suggested that a third alternative be added as a method of disposing of an excess; that the recipient use the excess to purchase items for personal needs. This is really a form of transferring the excess into excluded types of property and need not be listed separately.

28. Subsection (C), requiring applicants to submit a list of their assets, is an administratively reasonable way of implementing the provisions of Minn. Stat. § 256B.09 which requires the county agencies to investigate all applications. Full-scale investigations to verify all applications are simply impossible.

29. Subsection (D) is necessary and reasonable to implement the policy of Minn. Stat. § 256.98. That section makes it a crime to, among other things, knowingly aid or abet in buying or in any way disposing of the property of a recipient of assistance without the consent of the county agency. This section also recognizes court decisions holding that such transfers may not, in themselves, make the person ineligible for medical assistance, if, in fact, the property transferred is unavailable to meet the applicant's medical needs. The provision stating that money tendered to a long-term care facility shall be considered as a resource generated a number of comments (Ex. bj, be at 17 and T. 103). The

comments generally stated that the phrase was over-broad and would include any money paid or tendered in any manner to the nursing home. DPW personnel stated that it was their intention that the phrase cover money placed down as a deposit. The phrase should be modified to make that clear.

30. Subsection (E) is necessary and reasonable to clarify the interest an applicant has in jointly-held property. The Department responded to a number of comments by modifying the clause relating to joint tenancy to consider the owner as owning his pro rata share rather than one-half of the value of such property.

31. Subsection (F) is reasonable and necessary to implement the assignment of benefits provisions required under Minn. Stat. § 256B.06, subd. 1(10). The provision clarifies the requirements of the statute by requiring that the applicants notify the county of any health care coverage available to him.

32. DPW 47(III)(e), Relative responsibility, provides the mechanics to be used by the local welfare agency in determining relative responsibility under Minn. Stat. §§ 256B.14 and 256B.06. The section reasonably requires the counties to work closely with their county attorneys because of the many legal ramifications. Comments in Exs. cy and cz raised the interesting question of the right of confidentiality for minors, especially in the light of recent Supreme Court decisions saying that parental consent is not required for abortions. Planned Parenthood of Central Missouri v. Danforth, 96 S.Ct. 2831 (1976), and Bellotti v. Baird, 96 S.Ct. 2857 (1976). The question deserves the attention of the Department's attorneys, but the Examiner would note that this section deals with the eligibility of the recipient and not with the type of medical service provided. Also, those Supreme Court decisions deal primarily with the power of the parent to withhold consent for an abortion and not with whether or not parents are notified of the abortion.

33. DPW 47(III)(f), Marriage or Remarriage of Parent, follows the basic provisions of Minn. Stat. §§ 256B.14 and 256B.06, and includes income of natural and adoptive parents in determining available income. Two comments on this section (Exs. ag and ah) stated that gifts should not be considered as income. However,

the comments applied to persons in nursing homes and not to children.

34. DPW 47(III)(g), Institutional Status, is required by 45 C.F.R. § 248.60. Medical Assistance is not available, with limited exceptions, to inmates of public institutions.

35. DPW 47(III)(h) provides for a right to a hearing for any applicant or recipient aggrieved by action or inaction of welfare agencies. The provisions summarize the requirements of Laws 1976, Ch. 131 (codified Minn. Stat. § 256.045). Both the rule and the law refer to federal regulations which establish hearing procedures. That regulation is 45 C.F.R. § 205.10, and it provides a detailed list of the procedural requirements. Comments on this section (Exs. be at 18, bt and cz; T. 128) were directed at the vagueness of the term "established procedures", the right of the provider to notice of the proceedings, the continuation of benefits pending final determination, and the efficacy of notice when the recipient is incompetent (as is often the case in long-term care facilities). The point on the vagueness of pre-hearing procedures is especially well-taken. 45 C.F.R. § 205.10(a)(2) states: "Hearing procedures shall be issued and publicized by the State agency." The place to do that is within this section of DPW 47. Until such an amendment to the rules is adopted, this proposed rule should make a specific statement that the procedures provided in Minn. Stat. § 256.045, and 45 C.F.R. § 205.10 shall be followed. Without such provision, the rule is unreasonably vague. Deletion of the section entirely would be inappropriate because appeals must be allowed.

Neither the statute nor the federal regulations provide the provider any right in these appeal proceedings.

36. The Examiner concludes that the Department has demonstrated the need for and reasonableness of the provisions of DPW 47(III) except as noted in ¶¶ 24, 29 and 35.

DPW 47(IV) - GENERAL ADMINISTRATION.

37. Department personnel testified that DPW 47(IV)(a), Free Choice of Provider, was required by 45 C.F.R. § 249.20. That regulation states that the recipient may obtain the available services

from any provider. It allows, however, the State Agency to establish the fees and to set qualification standards. The rules limit the free choice to the "choice available to the local population", and, if the recipient chooses to enroll in an HMO, he is limited to the services provided by that HMO. Questions were raised as to whether there could be any restriction to local area (T. 145; Ex. be at 19). Department personnel admitted that the regulation does not appear to allow the restriction but stated that a "Federal Manual" interpreting the regulation does. The reasons given by the Department support the restriction. Primarily, the purpose of the provision is to provide or allow choices to recipients that are similar to those available to the general population and to prevent exhorbitant and unusual expenses for trips to far-away clinics. The Minnesota State Pharmaceutical Association (Ex. bh), reciting that "some HMO's in Minnesota have historically provided a substandard drug-related service requested that a proviso be added that the HMO's meet standards required of non-HMO providers. Section (V)(b)(4) states the qualifications for HMO's; it is not necessary to provide it in this section.

38. A third restriction on free choice was originally proposed: Patients in a long-term care facility could agree to be limited to a particular pharmacy with whom the facility had a contract. Several comments (Exs. bj, cy, cz) objected to this restriction. The Department withdrew this provision from the proposed rule at the hearing, stating that Laws 1976, Ch. 274, prohibited the restriction. As pointed out in Ex. bz, the correct citation is Laws 1976, Ch. 282, § 8, subd. 1(c) (codified Minn. Stat. § 256B. 48, subd. 1(c)). The recipient is still allowed to enter into such an agreement with the facility, but he is not required, or may not be required by the facility, to do so. Even though the statute is clear, it may be appropriate to include it within the rule because, according to testimony at the hearing, many people use the rule for guidance and have no access to the statutes. The Examiner suggests that the provision be retained in the rule with modifications to conform it more precisely to the statute.

39. DPW 47(IV)(b) and (c) are required by 45 C.F.R. §§ 205.60 and 205.100. Those regulations require the State Agency to maintain or supervise the maintenance of necessary records and to specify the agency that determines eligibility. Under the general plan of Chapter 256B and long-standing practice in this State, these responsibilities are placed upon the counties. One comment (Ex. be at 19) stated that the rule was too vague, delegated too much authority to the counties and that the counties would supersede Department rules in developing record-keeping methods and procedures. No basis was given for such a belief. No county agency objected to these sections.

40. Under 45 C.F.R. § 205.60(a)(1), individual records must be kept for each applicant and recipient containing certain information. DPW 47(IV)(d) restates that and then specifies records that shall be kept by the State agency, the local agencies and medical providers. The State agency will keep records necessary to administer the central disbursement system established by Laws 1976, Ch. 434, § 2. The local agencies are required to maintain records necessary for administration of the MA Program and the utilization review and control system. These requirements are vague, but no objection was made to them. Three separate requirements are placed on medical providers. They are discussed in the next findings.

41. DPW 47(IV)(d)(3)(A) requires providers to maintain records for five years that fully disclose the service provided, the medical necessity for such service, and payment claimed. The Department stated that 45 C.F.R. §§ 250.21 and 205.60 require these records and that audit requirements mandated the five-year period (T. 136). Section 250.21 states what records the provider must agree to keep and provide to the State agency. They must agree:

> "(a) To keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan and
>
> "(b) To furnish the State agency with such information, regarding any payments claimed by such [provider], . . . as the State agency may from time to time request."

Section 205.60, again, requires the State agency to maintain or supervise the maintenance of individual records containing certain information. That information includes facts essential to the determination of eligiblity and provision of services. Thus, the only provision of this section that is not expressly required by the Federal regulations is the requirement for records showing the medical necessity. However, Minn. Stat. § 256B.27, subd. 3 (as amended by Laws 1976, Ch. 188, § 3), provides:

> "The commissioner of public welfare, with the written consent of the recipient, shall be allowed access to all medical records of medical assistance recipients solely for the purposes of investigating whether or not: (a) a vendor of medical care actually provided the medical care for which a claim for reimbursement was made; or (b) the medical care was medically necessary. To the extent feasible, the commissioner shall contract with a review organization, as defined in Minnesota Statutes, Section 145.61, in determining whether or not the medical care provided was medically necessary. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of public welfare pursuant to this section." (Emphasis added)

If records showing medical necessity were not kept, the purpose of the statute would be thwarted. One comment on this section (Ex. ct) suggested that the word "medical" be deleted because some of the services provided under the program are not technically "medical," (e.g.: psychological treatment). The change is not necessary because the term as used here is just as broad as the "medical" services provided under the program.

42. DPW 47(IV)(d)(3)(B), requiring disclosure of records on request to the Department, legislative auditor and HEW is essentially a restatement of 45 C.F.R. 250.21(b) and Minn. Stat. § 256B.27, subd. 3, quoted above. The authority of the legislative auditor is not listed in the regulations or statute but is necessary for him to perform his function. Two comments (Exs. bg and an) asked for greater clarity in defining how the requests would be made and could be complied with and in specification of what records would satisfy the requirements. Both suggestions have some merit, and perhaps the rule could be amended. However, since the rule reflects the statutory language in these respects, it is reasonable in its present form. However, as pointed out in Ex.bj,

the rule does not state that recipient's consent is required prior to making the records available. That is clearly required by Minn. Stat. § 256B.27, subd. 3. Unless the rule is modified to include that qualification, it is contrary to the statute and thereby unreasonable. The provision should be modified by inserting a clause so that the rule reads, "On request, and upon being provided a copy of the recipient's written consent, make their records available. . . ." Testimony of the Minnesota State Medical Association (MSMA) (T.39), suggests that DPW 47(IV)(d)(3)(A) and (B) be modified to conform exactly to 45 C.F.R. § 250.21(a) and (b). As pointed out above, our statute adds some additional requirements to the Federal regulations, and that should be stated in the rules.

43. DPW 47(IV)(d)(3)(C) provides immunity for the provider who provides information to the State agency. Based upon MSMA testimony (T.39), the Department modified this provision to apply to information "requested" rather than "required." The provision is supposed to be a restatement of the last sentence of Minn. Stat. § 256B.27, subd. 3, quoted above. Many comments were made on this section, several directed at confidentiality in general. (Exs. aa, am, an, ap, be at 20, bg, bj and bt; T.38, 44, 50, 56, 137, 138, 143; and see Finding No. 18 above). One very well taken comment was that the proposed grant of immunity does not comport with the statute; it appears broader than the immunity granted by the statute. Some confusion is caused by the fact that this rule does not distinguish administrative and financial records from medical records. It treats both alike and, therefore, the tighter restrictions on use of medical records applies to both. This is not unreasonable because it provides greater rights of privacy to the recipient. The statute only provides immunity from civil and criminal liability for providing access to medical records to the Commissioner of Public Welfare pursuant to the section. To avoid any appearance that the rule provides greater immunity than the statute, the rule should be changed to refer to the statute or should quote the statute directly, or both. The Examiner recommends that DPW 47(IV)(d)(3)(C) be amended to read:

"(C) Not be subject to any civil or criminal liability for providing access to medical records to the commissioner of public welfare pursuant to Minn. Stat. § 256B.27."

44. The other comments on DPW 47(IV)(d)(3) fall into two main categories: Those asking for protection for providers who release information, and those concerned about the reaction of patients who know that medical information concerning them may be released to certain agencies.

The rule provides adequate protection by means of the statutory immunity and by the fact that the provider need only provide access when the written consent is shown (assuming the rule is modified as suggested in ¶ 42).

The second category is more difficult. There is no doubt that the statute authorizes, and in fact requires, the access to medical records and requires the recipient to consent. However, many doctors, especially psychiatrists, have testified or commented that this may adversely affect the patient-doctor relationship and effectiveness of treatment. The Examiner sees no easy solution to this problem. The only workable one seems to be to follow the privacy act and 45 C.F.R. § 205.50 closely. That is, clearly define the conditions for use or release of the information and so inform the applicant/recipient, and insure that agency personnel use the information properly. It may be helpful to notify the applicant/recipient that the Department is required to use professional review organizations to review medical records whenever feasible, Minn. Stat. § 256B.27, subd. 3, and that improper use by the agency, or its personnel, subjects them to civil and criminal penalties, Minn. Stat. §§ 15.166 and 15.167.

45. The provisions of DPW 47(IV)(e), Third-Party Liability, implement the provisions of Title XIX of the Social Security Act (SSA), § 1902(a)(25); 45 C.F.R. § 250.31; Laws 1975, Ch. 247; and Laws 1976, Ch. 236; all of which require the Department to identify and collect payments from parties who may be liable to pay for medical care provided to recipients. Comments on this section dealt with the possibility of recovery from third parties exceeding the cost of the provided care and what was to be done with the

overage. (Exs. aa, an, be at 21, bc and bj). The Department responded by modifying the section to require that overages from insurance payments ". . . will be forwarded to the provider." (Ex. 107). Two comments (be at 21 and bj) requested that the section be modified to make it clear that only net recoveries through court action are considered as a resource to the recipient. That may be true for determining subsequent or continuing eligiblity of the recipient, but it is not true for the particular provided care from which the liability arose. The entire amount received must be applied first to pay for the provided care.

46. Department personnel testified that DPW 47(III)(f), Identification Card, is the basic procedure used in administering the program. Cards are issued every 30 days to recipients, and these are shown to providers to prove current eligibility. One comment (Ex. bj, T.164), questioned the authority of the Department to restrict free choice of provider, as the section does, "to particular providers of specified services when necessary to prevent duplication as documented abuse of services, to prevent violation of prior authorization requirements, or to assure continuity of case." Department testimony (T.154) was that 45 C.F.R. § 249.20 "in effect authorizes the state to restrict ID cards to particular individuals and to particular vendors when continued evidence of abuse is shown." The regulation does allow DPW to set standards for providers (See, ¶ 37). Testimony by Department personnel demonstrated the need for and reasonableness of such an exception to the regulation's requirement of free choice. Abuses of the system typically occur where recipients go to separate physicians without notifying the other, or where they have prescriptions filled several times at different pharmacies. The Department must be able to control such abuses. Restricting recipients to certain providers is a reasonable means of doing so. However, Laws 1976, Ch. 131; 45 C.F.R. § 205.10(a)(5); and § (III)(h) of this rule require that the recipient be afforded the right to a hearing when aggrieved by any agency action or inaction resulting in suspension, reduction, discontinuance or termination of assistance. It would seem that the hearing requirement applies like-

wise to restrictions placed on assistance, and the rule should be modified to make that clear.

Other comments (be at 22, an, bt) address the matter of notice of termination to providers. This was of special concern where the recipient is receiving an ongoing course of treatment, and it would be medically inappropriate to discontinue the treatment. This is a matter that the provider must be alert to. If the recipient is no longer eligible, the recipient must pay for the service. The rule does reasonably provide that if the State agency makes an error, it will be responsible for payments.

47. DPW 47(IV)(g) and (h) deal with provider eligibility. Section (g) requires that providers meet federal and state standards and sign a provider agreement. Such agreements are required under 45 C.F.R. 250.21. The regulation does not require that it be in "form stipulated by DPW," (Ex. be at 22), but the requirement is not unreasonable. The rule also provides that the agreement shall be terminated if the provider fails to comply with federal and state statutes, rules, regulations and policies. Comments pointed out that this could apply to any law or regulation. The Department has therefore recommended that a qualifying phrase "pertinent to the MA program." be inserted after the word "policies". (Ex. 107) That would not be a substantial change and is appropriate. Objection to the use of the word "policies" was raised (Ex. bg, T.159 and 163) in that rule-making procedures now require all "policies" to be adopted in rule form. The objection is well-taken and the word should be deleted. Section (h) also deals with termination of providers. The MSMA argued that Minn. Stat. § 256B.064 provides the only grounds for termination (Ex. aa). The statute does not say that, and the grounds listed are reasonable. However, in response to statements at the hearing, the Department has suggested that the section be modified by removing the language quoted from § 256B.064, subd. 1, and inserting the language of § 256B.064, subd. 2. This change makes the hearing rights of the provider more clear. The second sentence of section (h) is unreasonable. This essentially requires the provider to allow a proper survey or reimbursement agency access to its records. There is clearly a need for this in order to audit

claims. But the statute under which this procedure is authorized has some restrictions. Minn. Stat. § 256B.27, subd. 3. See the discussions on confidentiality in ¶¶ 35 and 42. Unless those restrictions are stated here, the rule is unreasonable. At a minimum, DPW, or its agents, must have the affected recipient's written consent to examine medical records and the rule should so state.

48. DPW 47(IV)(i) is a general statement on prior authorization. Later provisions of the rule identify specific items and services requiring prior authorization. The Department believes that prior authorization is a reasonable means of attempting to control costs in certain high-cost areas. Federal regulations require that the State have some form of cost-control program, but, in general, leaves the form to the State. 45 C.F.R. § 250.20. There is a great deal of dispute about the effectiveness of prior authorization, but the concept is not unreasonable as long as standards are set and administrative costs of prior authorization do not exceed the cost savings. (Ex. 103) In response to statements at the hearing, the Department has suggested several changes to this section to clarify it and to provide for subsequent authorization in emergency cases (Ex. 107). The modifications reasonably meet the substantial objections raised. (See, e.g., Exs. ab, ad, ay, bd, bf, be at 23, bt and cw.) It limits prior authorization to those areas specifically enumerated in latter portions of the rule; it provides standards for making the authorization; it provides the mechanism for making requests, and it provides for emergency procedures. Specific objections to where prior authorization is required will be discussed below.

49. DPW 47(IV)(j), Utilization Control, is, in general, required by 45 C.F.R. 250.18. That regulation requires DPW to establish and implement a statewide program that safeguards against unnecessary or inappropriate utilization of care and services. That regulation also places rather specific requirements on such a program in relation to in-patient hospital and long-term care facilities. For that reason, this section was intended to apply only to such facilities. Other services are covered under other

sections. In response to comments at the hearing (T. 178), DPW suggested that the title be changed to: "Utilization Control of Inpatient Hospital Services and Services Provided in Skilled and Intermediate Care Facilities." (T.182) Such a change would not be substantial and should be made. It would remove some of the apparent inconsistencies of the section with other provisions of the rule dealing with other services. The four subsections of the section are treated separately below.

50. DPW 47(IV)(j)(1) states that "Providers shall comply with all requirements promulgated to support the statewide surveillance and utilization control program as specified by federal regulations." MAHCF objected to the term "all requirements" (Ex. be at 26), in that it does not say which requirements and appears to give DPW the power to promulgate requirements without going through rulemaking requirements. The point is well-taken, and the subsection should be modified. The requirements are specifically listed in subsection (2), and it would appear that this subsection is really an introduction. The Examiner would recommend that it be modified to read:

> "(1) A statewide surveillance and utilization program is established. Such program shall include:"

Paragraphs (A) and (B) then describe the major provisions of the program as required by 45 C.F.R. § 250.18(a)(1)(i) and (ii).

51. DPW 47(IV)(j)(2) places certain requirements on all inpatient facilities. One comment (Ex. be at 27), pointed out (without objecting) that the requirements of establishing an extensive utilization control program did not apply equally to all providers; just inpatient facilities. That is true, but it is not unreasonable. First, that is what the federal regulations require; second, controls on other providers are provided by other means. Further, inpatient service is a high-cost area, and some form of special control is not unreasonable. All of the requirements listed are specifically required by 45 C.F.R. §§ 250.18 or 250.19. The only comments on the requirements were addressed to paragraphs (C) and (D), dealing with physician certification and recertification. Paragraph (C) requires that a physician's certification of medical necessity be obtained at the time of the recipient's

admission or when the potential recipient applies for Medical Assistance. Paragraph (D) requires recertification every 60 days. DPW based the requirements on 45 C.F.R. § 250.18 (a)(2). That regulation expressly requires certification at those times.

The Minnesota Academy of Family Physicians argued that prior certification was not authorized (T.47). However, the objection was apparently based upon a misreading of the paragraph (T.48). The paragraph does not require prior authorization by someone other than the certifying physician. The other comment (Ex. be at 27), said that the 60-day recertification was inconsistent with other portions of the rule dealing with recertification of medical care. The cited portions all require certification at 60 days or less or deal with matters other than certifying the need for services on an inpatient basis. Thus, they are not inconsistent. Most important, however, is the fact that the requirements are expressly stated in 45 C.F.R. § 250.18(a)(2). They are thus reasonable and necessary.

52. DPW 47(IV)(j)(3) provides that all long-term care facilities shall provide for review of necessity of admission and continued stay of recipients and for review by DPW of the recommendations for admission. These provisions are required by 45 C.F.R. §§ 250.19 and 250.18(a)(1)(i). MAHCF points out that long-term care facilities cannot make determinations of necessity (the physician does that), and so, they should not be saddled with this responsibility. The rule, and the regulations, do not require the facility to make the review. But they reasonably require the facility to insure that the determinations are made because it is in the best position to do so.

53. DPW 47(IV)(j)(4) states the duties of DPW under the utilitization control program. These duties are prescribed by 45 C.F.R. §§ 250.23, 250.24, 250.18(b) and 250.18(c). Subsections (B) and (C) are virtual quotations from 45 C.F.R. 250.18(b) and (c), but they are unreasonable because they are contrary to the rule-making requirements of Minnesota law. Subsection (B) purports to allow DPW to establish methods and procedures to implement the control program. Subsection (C) allows it to establish

written criteria to evaluate the appropriateness and quality of care and services provided by the MA program. Methods, procedures and criteria are clearly "rules" under Minn. Stat. Ch. 15, and must be adopted under the procedures specified in that chapter. The Federal regulations do not imply any authority to avoid rule-making procedures. DPW frequently disavowed any intent to circumvent rulemaking procedures during the hearing. That intent must be made clear by modifying or deleting these two subsections. Methods, procedures and criteria which are not already specified in other parts of the rule may be adopted in subsequent rule-making proceedings.

54. DPW 47(IV)(k) allows for payment for transportation of recipients only when furnished by an enrolled medical provider licensed by the Department of Health or when prior authorization has been given by the local agency. In the former case, payment will be made by the MA program. In the latter case, payment will be made by the local agency. DPW 47(V)(b)(18)(A) has a similar provision but relates to the MA program portion only. The provisions appear inconsistent at first reading. However, it is necessary to set forth the provision on local agencies' authority in this part of the rule on administration because funding is through the local Medicaid administrative account. The apparent inconsistency may be cleared up by modifying the first sentence to read, "The MA program shall pay for transportation through the centralized system only in accordance with section (V)(b)(18)(A)." MAHCF (T.18) stated that the provision may be self-defeating. That is, facilities may choose to have recipients transported by the generally more expensive transportation providers if they cannot get prior authorization to use a cheaper means. The clarified provisions on subsequent approval in emergency situations should alleviate the problem to some extent. One comment (Ex. bj) points out that it would be a waste of staff time to require prior authorization for every taxicab trip. The Examiner agrees; DPW has given no justification for applying prior authorization in this case, and the provision has, thus, not been shown to be reasonable. Comments on the reasonableness of limiting centralized payment to enrolled

providers will be discussed with section (V)(b)(18)(A).

55. With the exceptions noted in ¶¶ 42, 43, 46, 47, 50, 53 and 54, DPW has demonstrated the need for and reasonableness of DPW 47 (IV).

DPW 47(V) - SERVICES UNDER THE MEDICAL ASSISTANCE PROGRAM

56. DPW 47(V)(a) lists 19 items which are specifically not covered by the MA program.

(1) Those paid for by the recipient. This prevents double payments to providers.

(2) Medications dispensed by physicians that could reasonably be dispensed by a pharmacy. This is necessary to insure high quality and because physicians should not ethically be involved in a profit on drugs they prescribe. Lastly, pharmacies are generally better stocked with generic equivalents and are able to dispense the least expensive medication. The paragraph should reference § (V)(b)(14), which creates an exception to this rule.

(3) Items where required prior authorization is not requested or has been denied. This is necessary to enforce the specific prior authorization requirements of the rule.

(4) Autopsies, (5) missed appointments, (7) routine reports, (8) investigational or research procedures, (9) illegal operations and procedures, (13) cosmetic surgery, (14) weight-reduction except in certain circumstances, and (19) duplicate services. All are items which are not necessary or in which no service is provided.

(6) Telephone conversations with the recipient. This is needed to insure quality care; any meaningful treatment must be face to face.

(10) Artificial insemination and (17) reversal of voluntary sterilization procedures are, according to DPW (T. 246, 247), "inconsistent with the MA program's aim of reducing financial dependency of recipients." No justification was given for that goal, though it seems apparent. However, the Examiner doubts the legality of interfering with the recipient's right to have children. DPW, itself, recognizes this right and its possible medical necessity because it will pay for correction of non-voluntary sterilization. DPW has failed to demonstrate that prohibiting these specific procedures is necessary or reasonable. Items (10) and (17) should be deleted from the list of non-covered services.

(11) Transsexual surgery is not generally available to members of the public because of its expense and is not generally recognized in this state as medically necessary. One comment (Ex. bk) argued that there may be circumstances where transsexual surgery can be shown to be medically necessary and that it should, at least, be a subject of prior authorization. Assuming that is true, the complete prohibition is not unreasonable because it is a procedure that is not available to the general public.

(12) Aversion therapy is covered by another program.

(15) Billing charges and (16) mileage expenses of providers are items that, according to DPW, should be included in the charge for the service and not billed separately. This is necessary to control the cost of the basic service. The reasonableness of not allowing separate mileage charges was questioned (Ex. be at 28 and cw), because it would discourage providers from making trips to provide necessary services (e.g., physical therapists going to rural areas where they are needed.) Whereas physicians may charge more for out-of-office services (and such is reflected in DPW's maximum rates), physical therapists do not. Dr. Johnson from DPW thought that the Department's fee schedule made provision for out-of-office services by practitioners other than physicians. Separate payment for mileage is not provided by Medicare or insurance carriers. The rule is not unreasonable, but DPW should consider reviewing the cost-effectiveness of the provision. As to billing charges, MAHCF argued that this was unfair to long-term care facilities who are required to bill through services of other providers. The Examiner would note that these facilities' administrative expenses are reimbursed under special rules (e.g., DPW 49).

(18) Services to inmates are specifically excluded by Federal regulation.

57. DPW 47(V)(b)(1) describes covered inpatient hospital services. The definition of inpatient service is that stated in 45 C.F.R. § 249.10(b)(1). Paragraph (A) provides that inpatient service of marginal medical necessity must receive prior authorization. Hospitals were concerned that "marginal medical necessity" was too vague (T. 251). Dr. Johnson said that he, too, would like a better term, but there was none available. "Medical necessity" is a term of art which defies more precise definition. The section also prohibits reimbursement for leave days quite simply because no service is provided.

58. DPW 47(V)(b)(2) describes covered long-term care facility services simply as those services provided in various defined long-term care facilities. It then defines different types of facilities, gives general limits on payments and requires annual reports to DPW. The definition of skilled nursing facilities (SNF) requires that such facility be "certified" as meeting Medicare requirements. DPW personnel stated that certification was required by section 1902(a)(28) of the Social Security Act (T.186 and 262). However, that section says a SNF must satisfy the Medicare require-

ments. This was of great concern to the nursing homes because most are not certified under both Medicare and Medicaid (T. 184). The paragraph is unreasonable and should be modified to comport squarely with § 1902(a)(28). It would be reasonable to provide that the authority for verifying satisfaction of the requirements is the Department of Health and that certification by the Secretary of HEW under Title XVIII is deemed to be satisfaction of the requirements (See SSA § 1910(a)).

Most of the definition of Intermediate Care Facility (ICF) is taken from the SSA § 1905(c), but the rule further defines ICF-Nursing Home, ICF-Boarding Care Home, ICF-Mentally Retarded and ICF-Chemically Dependent. DPW testified that these definitions were inserted because HEW, at a prior Rule 47 hearing, had requested such clarification. These definitions are provided for convenience because of differences in program licenses. The remaining definitions of types of facilities are taken from the Federal regulations (T. 263-264)

Paragraph (E) says that DPW will establish written criteria for determining levels of required nursing care. Such "criteria" will quite clearly be rules. This statement is not justified until such rules are adopted. MAHCF questioned whether DPW should adopt such criteria at all (Ex. be at 31). Those comments should be considered if DPW intends to take any action in the future.

MAHCF said the term "facilities" was vague in Paragraph (F). (Ex. be at 32) The Examiner disagrees; this entire subsection relates to the long-term care facilities listed in the introductory paragraph. The limitations on payments listed in (F)(ii) are taken from 45 C.F.R. 248.4 and 248.50. MAHCF points out a typographical error (Ex. be at 32). It should preclude payments for an individual who is under 65 and a patient in an institution for TB or mental diseases, not or.

The report requirement of Paragraph (G) is required by Minn. Stat. § 256B.30. MAHCF asked for an explicit statement that a Rule 49 or Rule 52 cost report satisfies the requirement (Ex. be at 32). That is the current policy (T. 265-266). It would be reasonable to state this in the rule.

59. DPW 47(V)(b)(3) describes covered physician services and reasonably defines them as those provided by or under the supervision of a licensed physician or osteopath.

60. DPW 47(V)(b)(3)(A) lists items which may be covered if prior authorization is given. There was little comment on the first three items: services aimed at weight reduction, procedures of questionable medical necessity and removal of a tattoo. The last two items raised a lot of comment: services in excess of 30 days of inpatient psychiatric treatment per year and and services in excess of ten hourly psychiatric sessions per year. Several comments (a form letter) simply said that the rule discriminates against psychiatrists and their patients and must be be rejected. (Exs. bm, bp, br, bs, bu, bv, bw, bx, by, ca, cb, cc, cd, ch, cj, ck, cm, co, cp, cq and ct). It is, no doubt, discriminatory. The relevant question is whether the discrimination is illegal or unreasonable. DPW justified the requirements on several grounds (T. 269-274). First, cost. In 1975, 12-15% of all moneys paid to acute care hospitals involved only a psychiatric diagnosis. That does not include payments to other providers related to inpatient services or cases where there was a diagnosis in addition to the psychiatric diagnosis. Second, the fact that almost half the recipients with stays over 30 days are AFDC recipients (as opposed to 21% who are recipients because of a disability), and that less than one-half of diagnoses were psychosis, alcoholism and chemical dependencies, indicate that equally effective and much cheaper therapeutic services could often be rendered. Third, the DPW Psychiatric Advisory Committee supports these provisions. Fourth, psychiatric diagnosis is clearly the largest expense item of all inpatient hospital diagnosis. Fifth, even with this provision, Minnesota remains among the most liberal states in providing psychiatric services. Sixth, no other third-party payer (e.g., insurance carriers) provides comparable benefits. Seventh, the limits can be exceeded with prior authorization. Comments by psychiatrists and medical association were on both sides of the issue (Exs. aa, am, ao, ap, ar, ax, ay, bi, bl, bn, bo, bq, bz, ce, cf, cg, ci, cl, cn, ct). Many of those opposing prior author-

ization by DPW agreed that some form of peer review was necessary and useful, but felt that the function was adequately performed by utilization review committees. Prior authorization, at least as it previously existed, was so slow and administratively burdensome that it interfered with ongoing therapy. Objection was also made to the fact that, in the past, authorization had been denied when requested, or at least therapy was restricted in some manner different from that requested by the treating psychiatrist. The legal arguments against this form of prior authorization are best stated in Ex. bd and in Mr. Getts' hearing presentation (T. 284-311). Both Mr. Getts and DPW base their positions, at least partially, on 45 C.F.R. 249.10(a)(5)(i), which requires DPW to specify the amount and duration services that will be provided under the MA program. It states in part:

> "Such items must be sufficient in amount, duration and scope to reasonably achieve their purpose. . . . [T]he 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."

This provision does not prohibit prior authorization; it allows it because prior authorization is a means of determining medical necessity. The rule does not arbitrarily limit the services provided. They are freely allowed to a certain amount and then subject to review. Other methods of control may also be reasonable and DPW may change its approach at some future date. However, the evidence presented demonstrates that the prior authorization requirements of the rule are not unreasonable.

61. DPW 47(V)(b)(3)(B) lists limitations that are applied to physician services. It provides for family psychiatric sessions and psychotherapy because early intervention is a cost-effective way to prevent later emotional problems. It also provides for chemotherapy on an extended basis because such treatment can provide for successful outpatient management of certain individuals. Several psychiatrists stated that this rule, especially when combined with the prior authorization requirements, encouraged treatment by drugs which could, in many cases, be less effective

than nonsomatic treatment. It doesn't do that; it merely makes extended chemotherapy available. Whether DPW's review panel encourages such treatment is a separate matter.

62. DPW 47(V)(b)(4) provides that the MA program will pay for HMO fees of recipients who are enrollees. The HMO's are excluded from the service limitations of the rule because they are controlled by the HMO contract. No comment was made on this subsection. The Examiner would recommend that the words "as are all other providers" be deleted from the last sentence. Someone might read that as excusing all providers from the limitations. That was not intended.

63. DPW 47(V)(b)(5) provides for services provided by other licensed practitioners and applies to chiropractors, podiatrists, vision care centers, psychologists, nurse-midwives, osteopaths not licensed to practice medicine and surgery, and public health nurses. Minn. Stat. § 256B.02, subd. 8(14), requires that payments be made under the MA program for "Any other medical or remedial care licensed and recognized under state law." This section lists those providers not covered elsewhere.

64. DPW 47(V)(b)(5)(A) limits payment to chiropractors for manual manipulation of the spine as required by 45 C.F.R. 249.10 (b)(6). It places a limit of six treatments per month and 24 per year on chiropractic treatments. Further treatments may be given with prior authorization. The Minnesota Chiropractic Association questioned this provision because it was unsure as to prior authorization procedures and who would make the review (Ex. cu). DPW made the following statement justifying the limits imposed.

> "The limitations that are suggested in the proposed Rule are based upon the Department's best judgment with the built-in protection that additional treatments will be authorized if deemed necessary. The Department intends to employ on a consultant basis appropriately qualified doctors of chiropractic to assist in making these judgments of necessity." (T. 313)

There is no evidence demonstrating that the limits imposed are reasonable or that prior authorization is appropriate. However, the Examiner believes that notice can be taken that 24 treatments per year with no more than six per month is an extremely liberal amount, especially since the Association did not

object to the number. The fact that review will be by doctors of chiropractic seems to satisfy the question that was raised. The Association also questioned whether payment would be made for diagnostic and laboratory measures (e.g., Xrays) used in diagnosing the patient or only for the treatment itself. The rule should be clarified on this point, see ¶ 87.

65. DPW 47(V)(b)(5)(B) covers podiatrists and imposes a limit of 12 treatments per year and three per month without prior authorization. There was no objection to this provision, and it appears to be reasonable. This paragraph also provides that certain podiatry services will not be covered for recipients in long-term care facilities. These are the simpler procedures that should be administered by the facilities' personnel, and it is reasonable to exclude them from services provided by a podiatrist.

66. DPW 47(V)(b)(5)(C) covers vision care and lists several specific items that require prior authorization because they may be of questionable medical necessity or less expensive alternatives may exist. Principally, cosmetic services are listed and are excluded entirely because they are not medically necessary. The limitations are reasonable in the professional judgment of the optometrist consultant to the MA program (T. 317), and no objection was made to them.

67. DPW 47(V)(b)(5)(D) covers psychologists and provides the same limits as are imposed on psychiatric treatments. The justification of the limits is the same. The Minnesota Psychological Association generally supported the rule, though it did recommend modifying the numbers somewhat (Ex. ct). Again, the limits provided are not unreasonable.

68. DPW 47(V)(b)(5)(E) allows payments to public health nurses only for (1) health assessment and screening; (2) health promotion and prevention counseling; and (3) early periodic screening, diagnosis and treatment (EPSDT). This is essentially a clarification of the services required by Minn. Stat. § 256B.02, subd. 7 (Supp. 1975), but it does not include the 1976 amendments to the section (Laws 1976, C. 312). The change is not effective until July, 1977, but it may be wise to include it now (Ex. bj).

The Department of Health points out that the section is not entirely accurate and recommends some amendments to make the section comport with the law (Ex. cy). The comments are well-taken and should be considered for inclusion.

69. DPW 47(V)(b)(6) defines outpatient hospital services as they are defined in 45 C.F.R. § 249.10(b)(2). That is, items or services furnished on an outpatient basis by or under the direction of a physician or dentist. The Minnesota Psychological Association asked that psychologists be included (Ex. ct). However, the definition is straight out of the Federal regulation. The rule requires prior authorization for kidney dialysis, hemodialysis back-up service, and supplemental and tube feedings. These are either high-expense items, reimbursable only in Federally certified facilities, or of questionable medical necessity. Prior authorization is also required for physician and dental services which require prior authorization under other sections. This is necessary to prevent circumventing the rule. Baby foods and diapers are excluded completely because they are not a medical necessity, and if needed, are provided through income maintenance programs. Employees' salaries are excluded because these are included in the hospital's costs and reimbursed as such.

70. DPW 47(V)(b)(7) covers clinic services. This includes family planning agencies and is necessary because 90% Federal financial participation is available to the State for such services under SSA § 1903(a)(5). The definition is broader than just family planning agencies and includes any medical care provided to outpatient recipients other than in a hospital outpatient facility by a physician or dentist. Again, psychologists asked to be included in the definition (Ex. ct), but, as above, the definition is that provided in 45 C.F.R. 249.10(b)(9).

Several comments recommended that adult day care be included in the MA program (Ex. cv. cx, cy, cz). This, generally, is a cost-effective alternative to nursing homes for many recipients. As pointed out by the Department of Health (Ex. cy), inclusion of such service may be clarified by modification of this section or

section (V)(b)(11), Rehabilitative and Therapeutic Services. DPW should consider such a modification.

71. DPW 47(V)(b)(8) covers home health care services and is taken directly from 45 C.F.R. § 249.10(b)(7). Homemaker services and social services are excluded because they are not medical items. The Department of Health thought that it would be an unnecessary expense and duplication of effort for DPW to make the determination that a home health agency meets the Title XVIII requirements.(Ex. cy). Since the Department of Health does the certification for Title XVIII, it would seem more reasonable that they also approve non-certified agencies for DPW. The Federal regulation does not say that DPW itself must make the determination, and Minn. Stat. § 144.072 authorizes the Board of Health to make these determinations. The words, "state agency", in (V)(b)(8)(B) should be changed to "Department of Health." Some further modifications may be necessary if the Department of Health has not implemented the certification program (See, ¶ 77).

72. DPW 47(V)(b)(9) covers medical supplies. The State is not required to provide medical supplies by Federal regulations, but it is allowed to under 45 C.F.R. 249.10(b)(7)(iii) which provides for necessary medical supplies prescribed by a physician for use in the home of the recipient. The services provided here are somewhat broader, however, in that medical supplies may be prescribed by any licensed medical practitioner within the scope of his profession and may be supplied to individuals who are residents of long-term care facilities (though reimbursement is to the supply provider, not the facility).

73. DPW 47(V)(b)(9)(E) requires prior authorization for medical supplies in certain instances. First, when the cost exceeds the "performance agreement" limitations. "Performance agreements" are not defined, and probably should be. They are apparently provider agreements containing certain standards (T. 192-193, Ex. be at 34). Second, items not listed in the "Formulary". (Listed items do not need prior authorization.) It is a good idea to list items which do not require prior authorization, but such a "formulary" would appear to be a "rule" as that term is defined

because it states and implements a policy of general and future effect. Therefore, the subparagraphs referring to the formulary are not enforceable as a "rule" and should be deleted.

74. DPW 47(V)(b)(9)(E)(v) and F(vi) deal with medical supplies for residents of long-term care facilities and authorize payments to the supplier (not the facility) when: (1) such supplies are not covered by the facility's per diem rate; (2) it is necessary for the particular recipient, and (3) "the need is identified in the team conference and documented in the recipient's plan of care." Question was raised about the term "team conference" (T. 333-334, Ex. be at 35), and it was agreed that it was possibly confusing. The words "in the team conference" should be deleted. The MAHCF also argued that the rule discriminated against long-term care facilities vis-a-vis hospitals which may be reimbursed directly for medical supplies (Ex. be at 34). The rule is not unreasonable; the facilities are now informed that they must require the supplier to bill DPW directly for unique supplies.

75. DPW 47(V)(b)(9)(F)(i) and (iii) list several specific items that are excluded from coverage. They are items that DPW considers not to be manufactured primarily for medical purposes (T. 330) Apparently, they are defined as non-medical items under Title XVIII (Ex. 106). Many comments point out that in particular cases, many of the items may be medically necessary (Exs. ak, aq, as, aw, bf, bj, be at 35 and db). DPW further justifies these exclusions by pointing out that welfare recipients are provided funds by other programs to purchase these "not primarily-medical" items. The Examiner would request that DPW review the other programs to determine if, in fact, such payments are made for medically related items over and above subsistence payments. The exclusion of these items is not unreasonable, but it may be better in some cases to allow them under prior authorization if more expensive services can thereby be avoided.

76. DPW 47(V)(b)(10) covers private duty nursing services and reflects the requirements of 45 C.F.R. § 249.10(b)(7), (8) and (17). No comments were made on this section. Payment is reasonably provided whenever private duty nursing is required and other facilities are not available or capable of providing the

necessary service.

77. DPW 47(V)(b)(11), Rehabilitative and Therapeutic Services, first addresses provision of such services in long-term facilities. It defines "physical therapy", "qualified physical therapist", "occupational therapy", "qualified occupational therapist", "services for individuals with speech, hearing and language disorders", "qualified speech pathologist" and "qualified audiologist" as they are defined in 45 C.F.R. 249.10(b)(11). One comment (Ex. aw), addressed the requirement of American Speech and Hearing Association certification for speech pathologists and audiologists, stating that there are "more prestigious" bodies. Even if that is so, the Federal regulation provides the requirements. The rule requires that a physical therapist have a Minnesota Certificate of Registration. The Board of Health has authority to issue such certifications, but has yet to implement the program (Ex. be at 35, T. 211). The rule should be modified to delete the requirement or reworded to make the requirement effective after the Board of Health begins such licensing.

78. DPW 47(V)(b)(11)(A)(iv) defines restorative therapy and specialized maintenance therapy. The definitions were supported by the Minnesota Chapter of the American Physical Therapy Association (Ex. cw). The MAHCF argued that the word "specialized" was too narrow because federal regulations require health facilities to make restorative and maintenance therapy available where necessary (Ex. be at 36). "Specialized" in this rule seems to connote only that it is designed for a particular patient, and it is not unreasonable.

79. DPW 47(V)(b)(11)(A)(v) provides that the facility shall bill DPW on behalf of the person or facility providing the therapy. If the therapist is under contract, it is a straight bill-through. If the rehabilitative personnel are employees, a limiting formula is applied that prorates the salary, by "treatment sessions", between treatments provided to recipients and non-recipients. This formula is DPW's effort to reflect current costs of the facility and the appropriate share of that cost to be borne by the MA program (T. 343). The formula provides that:

"If Medical Assistance reimbursement [for qualified rehabilitative personnel] exceeds the percentage of salary related to treatment sessions provided to Medical Assistance recipients, the excess amount shall be applied to and, therefor, reduce the 'General and Administration' expenses on the health facility cost report submitted by the respective facility." (The bracketed words were suggested as a non-substantial change by DPW.)

In other words, a facility bills and is paid for rehabilitative services according to DPW's schedule of fees. At the end of the fiscal year, any payments exceeding the prorated salary costs are included in the calculation of the following year's per diem rate, reducing that rate. Nursing homes stated that this would be a disincentive for them to provide in-house therapy (Ex aj, az, ba). Instead of providing in-house therapists where they can possibly make a profit if costs are held below DPW's fee schedule (or risk a loss if costs are high), facilities will choose the no-risk (and no profit or loss) alternative of using contract therapists or hospital and outpatient rehabilitative services. The MAHCF argues that the high cost of these alternatives is contrary to the cost-effectiveness goals of the MA program (Ex. da). One comment (Ex. aj) points out that in-house therapists, because of their proximity to the patients, discover cases where therapy is needed and thus tend to generate more treatments. This makes for healthier patients and may or may not reduce overall costs. The proposed rule will, quite clearly, control costs associated with in-house therapists and, therefore, is not unreasonable in that respect. It's overall impact on health care should, however, be reconsidered.

80. DPW 47(V)(b)(11)(A)(vi) lists 16 items for which long-term care facilities cannot separately charge the MA program. Most flow from foregoing definitions; e.g., services rendered by non-qualified personnel, nursing services, services not ordered by by a physician. MAHCF states that the exclusion of non-ordered screening procedures conflicts with § (V)(b)(11)(A)(iv)(aa) which requires the physician to assess the need for restorative therapy "after consultations with qualified rehabilitative personnel." MAHCF reads it as requiring a qualified rehabilitative therapist to initially screen the patient before consulting with the physi-

cian. (Ex. be at 36) That is not what it says. MAHCF also points out that the requirement of 30-day physician review is contrary to § (IV)(j)(2)(D) requiring physician recertification of medical necessity every 60 days. The provision should be consistent throughout the rule. The same requirement appears in (V)(b)(ll)(B)(iv)(ii). Subsections (ii) and (ll) deal with improper physician orders' for services not reasonable or necessary or related to the patient's condition or disability. The facility is in a difficult position here. It must follow a physician's order, and yet it may not be reimbursed if the services it provides are not necessary or reasonable. Nevertheless, the MA program can only pay for necessary medical services and the rule is not unreasonable. Subsection (mm) requires 90-day review by the medical consultant, facility utilization review committee or local welfare agency. DPW stated at the hearing that the last option was to be used only if the preceding ones were not available (T. 366-367). The rule should so state so that administration is uniform by all the counties.

8. DPW 47(V)(b)(ll)(B) covers rehabilitative and therapeutic services provided by independent practitioners. The rule defines the various types of qualified practitioners and the comments of Finding No. 77 apply here.

82. DPW 47(V)(b)(ll)(B)(iv) lists non-covered services. It says that only services provided in the practitioner's office or the patient's home are covered as independent practitioner services. This caused a great deal of confusion, because some people thought this excluded services rendered in other facilities (Exs. aw and cw). When read with the other sections, it can be seen that services provided at other facilities are billed through those facilities; the practitioner does not bill the MA program directly. Nevertheless, when this subsection is read in a vacuum, it appears to exclude completely contract services by independent practitioners and is, therefore, unreasonably vague and confusing. The defect may be cured by non-substantial change. The Examiner would recommend that a new paragraph (v) be added to subsection (B) which provides that:

"(v) The following services of independent practitioners must be billed through the contracting or employing facility, agency, or person and will not be reimbursed directly to the practitioner:"

Subparagraphs (V)(b)(11)(B)(iv)(aa) and (hh) should then be moved to this new paragraph. Subparagraph (V)(b)(11)(B)(iv)(ff) should be deleted because it says the same thing as (aa).

83. DPW 47(V)(b)(11)(C) covers rehabilitation agencies. DPW relied heavily upon Medicare regulations and guidelines in writing this section because that is where experience in this area lies. Rehabilitation agency is only defined as an agency certified as such. While this is not unreasonable, a definition of such agencies should be provided which would clarify the type of agencies contemplated. Definitions of types of service, qualifications of practitioners and limitations are similar to those provided in subsections (A) and (B).

84. DPW 47(V)(b)(12) covers dental services as defined in 45 C.F.R. § 249.10(b)(10). The MA program pays for all emergency care on basic medically necessary oral health needs. DPW added the words "medically necessary" at the hearing because they had been unintentially omitted in the proposed rule (T. 385). Nine specific items are listed that require prior authorization. Dentistry lends itself well to prior authorization because of the availability of alternatives. The Minnesota Dental Association suggested that a priority system be used instead of prior authorization (Ex. bt). The rule would be amended to rank various types of treatments and DPW would periodically publish a bulletin stating what level would be covered based upon moneys available at that point. This approach is interesting, but contrary to the overall approach of the rule in providing medically necessary services. The method of the proposed rule is not unreasonable. The section also provides some reasonable limits and exclusions on dental services (T. 388-393). MAHCF raised the only objection (Ex. be at 38). As they pointed out at the hearing, the subparagraph limiting visits to nursing home residents to three per diagnosis also limits the number of visits by the patient to the dentist's office. This was not intended (T. 396) and should be corrected

by a non-substantial change. MAHCF also argues that the subparagraph discriminates against nursing home residents because no limit is placed on visits to a patient's home (Ex. be at 35). The subparagraph should also be modified to clarify DPW's intent on this issue. It would not be unreasonable to exclude home visits entirely because of their high cost. Such cost is mitigated or justified in the case of nursing homes and hospitals where the dentist may visit a number of patients or where patients are generally less able to get to the dentist's office.

85. DPW 47(V)(b)(13), other laboratory and X-ray services, reasonably defines such services as they are defined in 45 C.F.R. 249.10(b)(3). No objection or comment was made on this section.

86. DPW 47(V)(b)(14) covers pharmacy services. It defines "pharmacy" according to state law, and "prescribed drugs" according to 45 C.F.R. 249.10(b)(12)(i). A medical practitioner may dispense the drugs he prescribes if no pharmacy is located in the local trade area. This is the "reasonable" exception to the prohibition on such services stated in § (V)(a)(2). The section also provides that DPW may limit payment to drugs listed in a formulary, "if such action is deemed necessary for proper administration of the program." Almost half of the states use a formulary system (T. 349). As presently written, this provision unreasonably and illegally authorizes DPW to circumvent the rule-making process and indicates something DPW might do in the future. It must be deleted from the proposed rule.

The rule requires that prescriptions be kept for five years. The Minnesota State Pharmaceutical Association (MSPA) points out that the pharmacy law only requires two years (Ex. bh). However, this is the general record-keeping requirement of the MA program discussed above. (¶ 41) MSPA also requested that the five refill limit not apply to nursing homes where monthly review of medication is already required. The suggestion is reasonable and DPW should consider it. MAHCF objected to three of the items that are excluded under pharmacy services (Ex. be at 38-39). First, biologicals provided directly to the recipient. DPW justified this as items which should be administered by a physician and billed

on his invoice. MAHCF states that many recipients receive injections of biologicals (e.g., insulin) from other than a physician, and there should be reimbursement for the medication. The point is well-taken, and the term "biological" should be more narrowly defined so that it clearly applies only to those medications which should be administered directly by a physician. Second, medications for weight control. In certain cases, weight control treatment may receive prior authorization, and this section should be consistent with the exception provided in § (V)(a)(14). Third, hypoallergenic foods. MAHCF says many nursing home patients require such foods and allowing them only for children under two is unfair discrimination. DPW stated that nutritional services are not covered under the MA program, but that exceptions are made (T. 401). No justification was given for excepting groups by age and, thus, DPW has failed to demonstrate that the rule is reasonable. These foods should be excluded entirely or should be subject to prior approval for all recipients.

87. DPW 47(V)(b)(15), other diagnostic, screening preventive and rehabilitative services are defined as required by 45 C.F.R. § 249.10(b)(13). The entire section is subject to prior authorization because, as far as DPW knows, no services are rendered under this section, and if there are, they should be identified (T. 406). The Examiner would point out that this section could be read to apply to certain practitioners, such as chiropractors, who are limited to certain treatments, but who must perform certain diagnostic procedures to determine the proper treatment. In such cases, prior authorization would not be appropriate.

88. DPW 47(V)(b)(16) covers early periodic screening, diagnosis and treatment (EPSDT) as required by 45 C.F.R. §§ 249.10(a)(3)(iv) and 205.146(c). This program is required to avoid loss of federal funding.

89. DPW 47(V)(b)(17) provides that the program will pay health insurance premiums for recipients that the state agency determines to be cost-effective. No objection was made to this provision. Insurance may, in many cases, be cheaper than direct payment to providers.

90. DPW 47(V)(b)(18), other medical care, lists services that are not covered elsewhere and is similar to 45 C.F.R. § 249.10 (b)(17). It provides for transportation, emergency hospital services even where the hospital is not qualified, personal care services, whole blood and the Crippled Children services program.

Transportation will be paid out of the centralized system only to enrolled transportation providers. That is what § 249.10 (b)(17)(i)(B) allows. If transportation is furnished by non-enrolled providers, it may be paid through the local agency's administrative account. (See Finding No. 54).

91. DPW 47(V)(b)(19) covers Mental Health Centers and is included under the authority of 45 C.F.R. 249.10(b)(6) which allows medical and other remedial care recognized by state law. Mental Health Centers are authorized by Minn. Stat. §§ 245.61-249.69, and Minn. Rule DPW 28. There are no objections to this section.

92. The Examiner concludes that DPW has demonstrated the need for and reasonableness of Minn. Rule 47(V), with the exceptions noted in ¶¶ 58, 62, 64, 65, 68, 71, 73, 74, 77, 80, 82, 84 and 86. Most of the unreasonable provisions may be corrected by nonsubstantial modifications.

MINN. RULE DPW 47(VI) - REIMBURSEMENT

93. DPW 47(VI)(a) is entitled "Maximum Allowable Charges" and generally provides that the MA program will pay the lesser of the provider's usual and customary fee or DPW's "maximum allowable charge." DPW originally proposed a slight amendment to the existing rule (DPW 47(s)), but withdrew this amendment and will leave § (s) unamended but renumbered (VI)(a) (Ex. 107). The maximum allowable charges are not part of the rule (T. 203-205), though DPW did testify as to how they are determined (T. 424-426). In order for these maximum charges to be enforced, the rule must either spell them out or provide a description of the mechanical method of computing them (if there is one). (Ex. be at 39).

94. DPW 47(VI)(b) and (c) covers payments and billing procedures and restates many of the requirements of the federal re-

gulations and prior sections of the rule. There were a number of comments on these sections. MAHCF correctly points out that the term "employer" is inappropriate for an institution or agency that contracts with the provider and "bill through" for the provider's services. (Ex. be at 39). The provision should be reworded. MAHCF also points out that Title XVIII standards do not generally apply to the MA program (Ex. be at 39). DPW agreed that they do not apply universally (T.428-429). Therefore, the words "the Title XVIII standards or" should be deleted from the last sentence of section (b). If Title XVIII standards do apply, they will still be included in the remaining phrase, "limits required by federal law and regulations". The Minnesota Hospital Association objected to some of the billing procedures requiring providers to submit "necessary forms" and "diagnosis and procedure codes deemed necessary" as vague and allowing circumvention of rule-making procedures (Ex. bg). The Examiner disagrees. These are matters of administrative detail that would be impractical to set forth. They do not implement any policies. The Medical Association objected to the requirement that providers accept assignments on Medicare billings and bill Medicare prior to billing the MA program (Ex. an). DPW reasonably justified this as the only feasible method of administering the program (Ex. 27). One clinic requested that DPW place a time limit on itself for payment (Ex. af).

95. DPW 47(VI)(d) states DPW's authority to recover funds erroneously or fraudulently obtained by providers. No comment or objection was made on this section.

96. The Examiner concludes that DPW has demonstrated the need for and reasonableness of DPW 47(VI), except that "DPW's maximum allowable charge" must be better defined.

MINN. RULE DPW 47(VII) - MISCELLANEOUS

97. DPW 47(VII)(a) originally provided that the existing DPW 47 "is hereby repealed." Everything that is relevant in the existing rule has been restated or modified in the proposed amendments. DPW suggested a modification in its posthearing comment (Ex. 107) that would add the proviso, "except Section (s) which now becomes (VI)(a)." Because (VI)(a) has been modified to restate

the old section (s), this modification is not necessary.

98. DPW 47(VII)(b) allows DPW to insert the effective date. This is not unreasonable, but if DPW desires the rule to be effective 20 days after publication, the provision may be omitted entirely.

OTHER COMMENTS

99. Comments were made on the need for a fiscal impact statement under Laws 1975, Ch. 434, § 22. That is a procedural requirement that may be fulfilled after the hearing (Ex. be at 9, da). The Examiner suggests that DPW review the fiscal impact of the rule in final form before deciding whether such a statement is necessary.

100. MAHCF also requested that provisions be made in the rule for appointment of guardians for incompetent recipients (Exs. be at 4, cs). Because several areas of the rule require consent or agreement of the recipient, many problems arise if the recipient is incompetent; especially for providers such as nursing homes. DPW's attention is directed to the cited comments for consideration of possible modifications to the proposed rule.

101. The Examiner has attempted to analyze and understand every comment that has been offered during these proceedings. Some comments that appeared to be repetitious, irrelevant or clearly contrary to the MA program designs have not been referenced in this Report. There were several ideas presented that could be included in future amendments which DPW should consider.

RECOMMENDATION

Having found and concluded that the Department of Public Welfare has fulfilled all procedural requirements of law and rule and demonstrated its statutory authority to adopt the proposed rule and, with the exceptions noted, the need for and reasonableness of the proposed rule, the Hearing Examiner recommends:

That the proposed rule be modified as suggested, and that so modified, it be adopted.

Dated this 11th day of January, 1977.

STEVE M. MIHALCHICK
Hearing Examiner

BROEKER, HEDGES & GRANT
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420



RECEIVED
JUN 30 1977
Dept. of Administration

Mr. Michael Miller
Special Assistant Attorney General
Department of Administration
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT 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.

REPORT OF THE CHIEF HEARING EXAMINER

WHEREAS, hearings were held on June 1, 2 and 25, 1976, before Steve M. Mihalchick, a Hearing Examiner of the State Office of Hearing Examiners, on the above-entitled matter in compliance with Minn. Stat. §15.0412, Subd. 4; and

WHEREAS, the Report of Hearing Examiner made pursuant to Minn. Stat. §15.052, Subd. 3, was issued to the Commissioner of Public Welfare on January 11, 1977; and

WHEREAS, the Commissioner of Public Welfare has now determined to adopt rules pursuant to Minn. Stat. §15.0412, Subd. 4; and

WHEREAS, the Commissioner of Public Welfare has submitted said rules to the Chief Hearing Examiner for review pursuant to Minn. Stat. §15.052, Subd. 4, and Rule HE 107 on February 16, 1977; and

WHEREAS, the Commissioner of Public Welfare has notified the Chief Hearing Examiner of unintentional omissions in the final proposed rules by letter of February 17, 1977, which require minor modifications to be made;

THEREUPON, the Chief Hearing Examiner now finds that the final proposed rules, as modified, are not substantially different from those proposed at the public hearing and that the Department of Public Welfare has met all requirements of Minn. Stat. §15.0412, Subd. 4.

PLEASE TAKE NOTICE, that upon receipt of this Report, the Department of Public Welfare has the responsibility of submitting the complete hearing record and the rules as adopted by the Department to the Attorney General and to publish in the State Register, all pursuant to Minn. Stat. §15.0412, Subd. 4.

Dated this 18th day of February, 1977.

Duane R. Harves

DUANE R. HARVES
Chief Hearing Examiner

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE EDWARD J. DIRKSWAGER, JR.

ACTING COMMISSIONER OF WELFARE

In the Matter of the Proposed Amendments to Rule 47 of the Rules of the Minnesota Department of Public Welfare

ORDER ADOPTING RULES AFTER RESUBMISSION BY ATTORNEY GENERAL

The procedural history of the above-captioned rule-making proceeding is fully set forth in the Order Adopting Rules of former Commissioner of Public Welfare, Vera J. Likins, dated July 5, 1977, which is on file in these proceedings.

After submission of the proposed amendments to Rule 47 for the review of the Attorney General pursuant to the aforementioned Order, the Attorney General returned the proposed amendments to the Minnesota Department of Public Welfare in order for the Department to consider revisions of certain provisions of Rule 47. These provisions, Minn. Rules DPW 47D.4.b.1.; 47E.2.1.2.d.; 47F. 1.a.; and 47F.1.a.6 have been reviewed in light of the comments of the Attorney General and are hereby resubmitted for further review of the Attorney General.

NOW THEREFORE, IT IS ORDERED that the Acting Commissioner hereby adopts and incorporates the Findings set forth in the Order of Vera J. Likins dated July 5, 1977, with the exceptions of those Findings relating to the above referenced provisions of Minn. Rule DPW 47, and as to those provisions, makes the following:

FINDINGS

1. The insubstantial change incorporated into the provisions of Minn. Rule DPW 47D.4.b.1. meets the recommendations and concerns expressed by the Attorney General by clarifying the nature of the records which must be maintained by local welfare agencies.

2. The provisions of Minn. Rule DPW 47E.2.1.2.d. now accurately reflect the recommendation made by the Hearing Examiner in Para. 84 of his Findings.

3. Insubstantial changes in the provisions of Minn. Rule DPW 47F.1.a. and 6. remove any concern that the Department of Public Welfare is attempting to implement payment provisions absent the utilization of the fee schedules for certain services as provided in Minn. Stat. § 256B.05. Such schedules will have to be implemented in the course of subsequent rule-making hearings.

IT IS FURTHER ORDERED that the Acting Commissioner hereby adopts the proposed amendments to Rule 47 of the Rules of the Minnesota Department of Public Welfare so that from and after this date of August 1, 1977, said Rule 47 shall read in its entirety as set forth in the attached Exhibit A, pursuant to the authority vested in me, and pursuant to Minnesota Statutes Chapters 15 and 256B.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Edward J. Dirkswager, Jr.
Acting Commissioner

STATE OF MINNESOTA
OFFICE OF THE ATTORNEY GENERAL
ST. PAUL 55155

WARREN SPANNAUS
ATTORNEY GENERAL

TELEPHONE
(612) 296-6196

October 27, 1977

Mr. James B. Swanson
President
Minnesota Association of
Health Care Facilities
Suite 431, 2850 Metro Drive
Minneapolis, Minnesota 55420

Dear Mr. Swanson:

Attorney General Warren Spannaus and I have discussed your recent inquiry and he has asked me to respond.

In the matter you inquire about, which was the review of DPW Rule 47, the law firm representing the Minnesota Association of Health Care Facilities and Lake Ridge Health Care Center was permitted to submit its views on two occasions. The statute governing review of rules by this office requires that objections to rules be taken only on the first submission; however, because of the interest expressed by Ms. Baerwald, I accepted comments from her on the second as well as first submission of this rule. She apparently contends that an opportunity to comment was denied on the third submission of the rule to this office. Clearly, there is no legal basis for comment at that time.

I hope that this explanation satisfactorily answers your inquiry.

Very truly yours,

Michael B. Miller

Michael B. Miller
Special Assistant
Attorney General

MBM:mb

cc: Warren Spannaus
Attorney General

Kay E. Baerwald

BROEKER, HARTFELDT, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL. (612) 854-5263

SUITE 434, HAMM BUILDING
SAINT PAUL, MINNESOTA 55102
TEL. (612) 222-0708

JOHN M. BROEKER
WILL HARTFELDT
STEVEN R. HEDGES
DAVID A. GRANT
KATHRYN E. BAERWALD
GEORGE L. CARLSON
ELENI P. SKEVAS

September 13, 1977

Mr. Michael Miller
Special Assistant Attorney General
Department of Administration
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

Re: Department of Public Welfare Rule 47

Dear Mr. Miller:

We have just been informed that Department of Public Welfare Rule 47 was published in the September 6, 1977 Minnesota State Register and thus becoming in effect on September 12, 1977. On June 29, 1977 we specifically requested that we be notified at such time as any amendments to the Rule were forwarded to you by the Department of Public Welfare as we requested the opportunity to make comments on the amendments to Rule 47. We received no notification from the Attorney General despite our request to be notified. We are presently reviewing Rule 47 as published in the State Register and will be discussing the matter with our client as to whether any further action should be taken.

Very truly yours,

BROEKER, HARTFELDT, HEDGES & GRANT

By Kay Baerwald
Kathryn E. Baerwald

KEB:dlr

cc: James Swanson
J. I. Green
Rick Carter

BROEKER, HARTFELDT, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
SUITE 434, HAMM BUILDING
SAINT PAUL, MINNESOTA 55102



Mr. Michael Miller
Special Assistant Attorney General
Department of Administration
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

Mail File

ADMIN 1000

STATE OF MINNESOTA

DEPARTMENT Attorney General

Office Memorandum

TO : Thomas H. Jenson
Special Assistant
ATTORNEY GENERAL

DATE:

FROM : Michael B. Miller
Special Assistant
ATTORNEY GENERAL

PHONE:

SUBJECT: Department of Welfare Rule 47

Proposed	Adopted	
47 I.b.	47 A.2	This rule is vague; it allows for procedures not specifically covered by the rule itself.
47 II. j. 47 IV d. 3	47 B.10 47 D.4c.	These rules are problematicin that the consent to release of medical forms by patients is only secured as to the Department of Public Welfare, but release is made available to all participating agencies.
47 III.d.1.c.	47 C.4.a.3	This rule is improper as including the income of minors, whic

298 Attorney General

Thomas H. Jenson
Special Assistant
Attorney General
Department of Welfare

April 29, 1977

296-4692

Michael B. Miller
Special Assistant
Attorney General
G-19K State Administration Building

Department of Welfare Rule 47

Returned herewith is the above-captioned rule. This rule is not approved for the following reasons:

Proposed	Adopted	
47I.b.	47A.2.	This rule is vague; it allows for procedures not specifically covered by the rule itself.
47II.j. 47IV.d.3	47B.10 47D.4c.	These rules are problematic in that the consent to release of medical forms by patients is only secured as to the Department of Public Welfare, but release is made available to all participating agencies.
47III.d.1.c.	47C.4.a.3	This rule is improper as including the income of minors, which is in opposition to Minnesota Statutes § 256B.14.
47III.h.	47C.8.a.	This rule leaves "established procedures" undefined.
47IV.d.	47D.4.b.1.	This rule leaves the record keeping requirement vague.
47IV.i.	47D.9.	The amended rule sets out criteria upon which the Department may rely in making discretionary decisions, but allows establishment of undefined "methods and procedures".
47V.b.1.2.	47E.2.1.2.d.	This rule fails to clarify, as pointed out in Hearing Examiner's Report paragraph 84, that reimbursable visits to a dentist's office are not limited to three.

Proposed	Adopted	
47VI.a.	47F.1.a. & b.	This rule fails to set out a means of computation as required by Minnesota Statutes § 256B.05, Subdivisions 2 and 3 and Code of Federal Regulations 250.30(a)(1).

Two procedural problems are also noted. First, Chapter 434 of the Laws of 1975 requires that where the fiscal impact of a rule is in excess of $100,000, that a statement to this effect be made and filed with the House Appropriations and Senate Finance Committees. Since the Department of Welfare did not make an estimate of the fiscal impact of this rule as a whole, it is impossible to ascertain from the record whether or not the $100,000 figure is exceeded by this rule.

Finally, the Department of Welfare should adopt its own Findings of Fact, which were informally set out in a letter from the Commissioner of Welfare to the Chief Hearing Examiner.

MBM/sr

Enclosures

Attorney General

Marianne D. Short
Special Assistant
Attorney General
Department of Welfare

August 17, 1977

296-4692

Michael B. Miller
Special Assistant
Attorney General

Rule 47

The above-captioned rule is returned herewith for revisor of §§ 47D.4.b.1 and 2. These sections require more specificity as to documentation required by DPW.

MBM:mb

Enclosure

ADMIN 1000

STATE OF MINNESOTA

DEPARTMENT Attorney General

Office Memorandum



TO : Thomas Jensen
Special Assistant
Attorney General
Department of Welfare

DATE: July 15, 1977

FROM : Michael B. Miller
Special Assistant
Attorney General
G-19K Administration Building

PHONE: 296-4692

SUBJECT: Department of Welfare Rule 47

Enclosed please find the above-captioned rule. This rule is returned to the agency for further revision in the following respects:

1. Rule 47D.4.b.1. is the same as originally submitted and returned to the agency.

2. Rule 47E.2.1.2.d. was apparently changed by mistake to have the opposite effect of the recommendation of the Hearing Examiner in ¶ 84.

3. Rule 47F.1.a. and 6. do not appear to differ significantly from the originally submitted versions.

Revision of these three sections (assuming no substantial change) should make the rule proper and adequate for filing.

MBM/sr

Enclosures

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE EDWARD J. DIRKSWAGER, JR.

ACTING COMMISSIONER OF WELFARE

In the Matter of the Proposed Amendments to Rule 47 of the Rules of the Minnesota Department of Public Welfare

ORDER ADOPTING RULES AFTER RESUBMISSION BY ATTORNEY GENERAL

The procedural history of the above-captioned rule-making proceeding is fully set forth in the Order Adopting Rules of former Commissioner of Public Welfare, Vera J. Likins, dated July 5, 1977, which is on file in these proceedings.

After submission of the proposed amendments to Rule 47 for the review of the Attorney General pursuant to the aforementioned Order, the Attorney General returned the proposed amendments to the Minnesota Department of Public Welfare on July 15, 1977, in order for the Department to consider revisions of certain provisions of Rule 47. Minn. Rules DPW 47D.4.b.1., 47E.2.1.2.d., and 47F.1.a. and b. were reviewed in light of the comments of the Attorney General and were resubmitted for further review of the Attorney General. On August 17, 1977, the Attorney General returned the proposed amendments to the Minnesota Department of Public Welfare in order for the Department to consider revision of Minn. Rules DPW 47D.4.b.1. That provision has been reviewed and is hereby resubmitted for further review of the Attorney General.

NOW THEREFORE, IT IS ORDERED that the Acting Commissioner hereby adopts and incorporates the Findings set forth in the Order of Vera J. Likins dated July 5, 1977, and in the Order dated August 1, 1977, with the exceptions of those Findings relating to the above referenced provision of Minn. Rule DPW 47, and as to that provision, makes the following:

FINDING

1. The insubstantial change incorporated into the provisions of Minn. Rule DPW 47D.4.b.1. and 2. meets the recommendations and concerns expressed by the Attorney General by clarifying the nature of the records which must be maintained by local welfare agencies.

IT IS FURTHER ORDERED that the Acting Commissioner hereby adopts the proposed amendments to Rule 47 of the Rules of the Minnesota Department of Public Welfare so that from and after this date of August 18, 1977, said Rule 47 shall read in its entirety as set forth in the attached Exhibit A, pursuant to the authority vested in me, and pursuant to Minnesota Statutes Chapters 15 and 256B.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Edward J. Dirkswager, Jr.
Acting Commissioner

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
AUG 19 1977
Joan Anderson Growe
Secretary of State

9:30 A.M.

ADOPTED

Minn. Rule DPW 47 -- Medical Assistance

A. Introduction

1. 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.

2. The Commissioner of Public Welfare may issue instructional bulletins and manual material to the local welfare agencies and vendors of medical care and services to clarify and implement the provisions of this rule and may prescribe forms to be used in administration of the MA program.

3. 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.

4. 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.

5. 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, on all applicants/recipients under the MA program, and on the state agency.

6. The official State Plan is the submitted and approved federal document which indicates those options covered by Minnesota Statutes.

7. This rule specifically includes by reference any federal laws or regulations or state laws pertaining to the Minnesota Medical Assistance program, and any provision of this rule which is inconsistent with those laws and regulations is superseded thereby.

B. Application for Medical Assistance

1. Definitions

a. "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.

b. "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.

2. 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. In such cases, the local agency shall promptly advise the applicant of the MA program's eligibility requirements. (deleted)

3. Each application form shall be signed by the applicant or the applicant's responsible relative, legal guardian or authorized representative (or where incompetent or incapacitated, by someone acting responsibly for him).

4. 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 eligibility for Medical Assistance. All eligibility conditions shall be met within these time limits. Where a delay is necessary because necessary information cannot be obtained within the time limits, the applicant shall be notified in writing of the delay and shall be advised of his right to appeal such delay.

5. 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.

6. 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. 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.

7. 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.

8. 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:

a. Social Security numbers (as provided under (9) below) of all individuals applying for or receiving Medical Assistance and the parents of dependent children.

b. The applicant's income and property holdings.

c. Any other information affecting eligibility as deemed necessary under the circumstances of each particular case.

9. 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.

a. 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.

b. 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.

10. 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. Local welfare agencies shall inform all applicants that their medical records may be released to the state agency, the local welfare agency, the Minnesota Department of Health, the U.S. Department of Health, Education and Welfare, and the PSRO. No person shall be eligible for medical assistance unless he has authorized in writing the Commissioner of Public Welfare to examine all personal medical records developed while receiving medical assistance for the sole purpose of investigating whether or not a vendor has submitted a claim for reimbursement, cost report or rate application which the vendor knows to be false in whole or in part.

11. 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. 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. All other individuals not specified herein shall file a separate Medical Assistance application.

12. 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.

13. The county in which the applicant resides at the time of application for Medical Assistance is the county of financial responsibility. Continuous receipt of assistance will continue financial responsibility in that county.

C. Eligibility Factors Under the Medical Assistance Program

1. Age

a. 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.

b. 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 inpatient psychiatric hospital services), or 65 years of age or older.

c. 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.

2. Residence

a. "Residence" or "abode": Where a person lives and intends to remain.

b. 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).

c. 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. An agricultural migrant who meets all other eligibility requirements and who has an abode in another state shall be eligible for Medical Assistance. 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.

d. 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:

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

(2) Where the health of the individual would be endangered if the care and services are postponed until he returns to Minnesota;

(3) Where his health would be endangered if he attempted to return to Minnesota in order to receive medical care.

e. Medical care and services will be provided outside Minnesota to eligible residents of this state in the following situations:

(1) When it is general practice for residents of Minnesota to use medical resources beyond the borders of this state; or

(2) 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.

f. 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.

3. Citizenship and Alienage

a. 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:

(1) A citizen of the United States; or

(2) An alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

4. Income and Resources

a. Income

(1) 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.

(2) 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 relatives responsible under statutes expect to receive from all sources during the year.

(3) In determining eligibility for Medical Assistance for children under 18 years of age, the local welfare agency must consider all income of parents, and all income of children under 18 years of age who are in the home and on whose behalf application for medical assistance is made. Eligibility of individuals between 18 and 21 years of age shall be determined either separately or as part of a family unit.

(4) Definitions

(a) "Income": Any benefit received by or available to a Medical Assistance applicant/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, including non-cash items provided free of cost, is considered a resource to be evaluated in determining the need of Medical Assistance applicants/recipients.

(b) "Net income": The amount left after deducting allowable expenses and income disregards.

(c) "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.

(d) "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.

(5) The following employment expenses are to be deducted in determining net earned income:

(a) Mandatory retirement fund deductions.

(b) Transportation costs to and from work based on the actual cost of public transportation or car-pool payments, or 13¢ 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).

(c) Cost of work uniforms.

(d) FICA and SMI payments.

(e) Federal and state income taxes withheld.

(f) Union dues.

(g) Professional association dues required for employment.

(h) Health insurance premiums.

(i) Cost of tools and equipment used on the job.

(j) One dollar per day for the cost of meals eaten during employment hours (unless the recipient can establish actual higher work-related meal expenses that are necessary and reasonable).

(k) Public liability insurance required by the employer when an automobile is used in employment and the cost is not compensated by the employer.

(6) Rental income is considered unearned income.

(7) 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, except when specifically exempted by federal law.

(8) 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.

(9) Income that is within the legal maxima of the MA program is not to be considered in determining the amount of payments made for medical services, except in long term care facility, 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. 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. 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.

(10) 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.

(11) Persons receiving a maintenance grant under the AFDC or MSA programs shall be automatically eligible for Medical Assistance.

(12) 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:

(a) "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.

(i) "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.

(ii) "Medical obligations" are amounts owed any eligible provider for medical care, services or supplies which are covered under the MA program.

(b) Spend-down applies only to income.

(c) Spend-down is computed by the local welfare agency and is a condition of eligibility.

(i) Spend-down is computed by first determining the current and anticipated annual income of the applicant and his responsible relatives under state law.

(ii) The amount protected under state law is subtracted to determine the amount of anticipated annual income available to meet medical obligations.

(iii) This amount is reduced by one-half to indicate the anticipated income available during the next six (6) months.

(d) 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.

(i) For the purpose of spend-down only, "third-party" means anyone other than the applicant/recipient or his responsible relatives.

(e) The amount of spend-down shall be paid or incurred prior to establishing eligibility for Medical Assistance, except in those instances where a continuing spend-down exists.

(i) "Continuing spend-down" means the spend-down requirement is met on a monthly basis rather than on a six-month basis.

(aa) Continuing spend-down is limited to institutionalized individuals and those special situations individually approved by the state agency.

(f) 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.

b. Resources

(1) 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. "Equity" shall be the assessed tax value minus any encumbrance against the property.

(a) 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.

(i) 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:

(aa) 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.

(bb) The circumstances and conditions under which the excess equity in real property was waived shall be examined periodically (at least annually) for changes in current market value, opportunity for sale or mortgage, or other pertinent factors.

(2) Personal property. Medical Assistance may be available to any individual whose cash or liquid assets do not exceed the limits established by state law.

(a) Under the MA program, the following items are exempted in determining the value of personal property owned by the applicant/recipient:

(i) Household goods and furniture presently used in the applicant's/recipient's residence.

(ii) Wearing apparel.

(iii) 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).

(iv) Burial plots.

(v) 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.

(b) 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.

(c) 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:

(i) Transfers the excess to an excluded type of property; or

(ii) Uses the excess to repay the local welfare agency and/or state agency for Medical Assistance already received.

(d) 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.

(3) 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.

(4) 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. If a person tenders any amount of money as a deposit to a long term care facility within three years immediately preceding his application for Medical Assistance, or while receiving such assistance, all such deposits shall be considered a resource in determining such person's eligibility for Medical Assistance.

(a) The following provisions shall govern property transfers as they affect potential eligibility under the MA program:

(i) 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.

(ii) 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.

(iii) 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.

(iv) The information required by (ii) and the efforts made to reacquire the property mandated by (iii), shall be entered in the applicant/recipient's case record with the appropriate eligibility determination.

(v) 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.

(vi) 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.

(5) Types of property ownership. The owner of property in joint tenancy shall be considered as owning his pro-rata share 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.

(6) Assignment of benefits. 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.

5. 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.

a. 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:

(1) 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.

(a) 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.

(2) 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.

(3) 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.

6. Marriage or Remarriage of Parent. In the event that a parent with dependent children under 18 years of age marries or 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:

a. 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.

b. 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.

c. All other income and resources available to the MA applicants/recipients 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.

d. 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.

e. 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.

7. 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.

a. Definitions

(1) "Inmate": A person who is being involuntarily retained and who is living in the institution.

(2) "Public institution": A facility that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(3) "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.

(4) "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.

(5) "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.

8. Termination of Medical Assistance

a. Medical Assistance applicants and recipients have the right to a fair hearing when aggrieved by action or inaction of the local and/or state welfare agencies. Such hearings shall be conducted in accordance with procedures established by and consistent with applicable state law and federal regulations. The aggrieved applicant/recipient shall submit a written request for a hearing to the state or local welfare agency, whichever is appropriate. A local welfare referee shall conduct a hearing on the matter and shall issue a ruling affirming, reversing or modifying the action or decision of the local agency. The ruling of the local welfare referee shall be binding upon the local agency and the aggrieved party unless appeal is taken to the state agency. If appeal is taken directly to the state agency, a state welfare referee shall conduct a hearing on the matter and shall recommend an order to the Commissioner of Public Welfare. In appeals to the state agency from rulings of local welfare referees, the hearing may be limited, upon stipulation of the parties, to a review of the record of the local welfare referee. The Commissioner of Public Welfare shall issue an order on the matter to the local agency and the applicant/recipient. Any order so issued shall be conclusive upon the parties unless appeal is taken to District Court. Termination of Medical Assistance may be effected only at the end of the month, except in the case of the death of the recipient.

(1) 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, B.4, supra].

(2) 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.

(3) 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.

D. General Administration

1. 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.

a. Free choice is limited by the choice available to the local population.

b. 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.

c. No long term care facility shall be eligible to receive medical assistance payments unless it agrees in writing that it will refrain from requiring any resident of the facility to utilize a vendor of health care services who is a licensed physician or pharmacist chosen by the facility.

2. 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:

a. Verify current individual eligibility for the MA program.

b. Justify that payment for long term care facility services was correctly made.

c. Record individual eligibility for levels of care or other federal regulatory requirements as prescribed by the state agency.

3. 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:

a. Late or inaccurate redeterminations of eligibility.

b. Non-compliance with utilization review and control requirements [See, D. 10, infra].

c. Inaccurate or incomplete record-keeping or failure to satisfy other written requirements [See, D.4.b, infra].

d. Failure to submit accurate information on recipient eligibility to DPW.

4. Records. The state and local welfare agencies and all medical providers shall maintain separate medical and/or fiscal records.

a. The state agency shall:

(1) Keep records necessary for a centralized disbursement system which maximizes federal financial participation [FFP];

(2) Maintain a recipient eligibility file based on information supplied by the county of service;

(3) Maintain records on all eligible providers; and

(4) Maintain an information retrieval system for necessary statistical reports and/or audits of payment.

b. Local welfare agencies shall:

(1) Maintain eligibility records prescribed by DPW as necessary or advisable for administration of the MA program; and

(2) Maintain necessary records relevant to DPW's utilization review and control system.

c. Medical providers participating in the MA program shall:

(1) 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;

(2) On request, and upon being provided a copy of the recipient's written consent, make their records available to DPW, the state Legislative Auditor and the Department of Health, Education and Welfare (or representatives of those agencies) in order to justify all payments made to such provider and the propriety of all services rendered by such provider under the MA program;

(3) Not be subject to any civil or criminal liability for providing access to medical records to the commissioner of public welfare pursuant to Minn. Stat. Chapter 256B.

5. Third-Party Liability. The term "third-party" as used herein includes, but is not limited to, insurance companies, (including HMOs); other governmental programs such as Medicare; Worker'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 and any overage will be forwarded to the provider of service. 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.

a. The local welfare agency shall:

(1) 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

(2) As provided under state law, file its verified lien statements within one year from the date the last item of medical care was furnished.

b. The state agency shall:

(1) Seek recovery of all third-party liability benefits;

(2) Distinguish between third-party liability which is a current resource and one which is not current, based on the following considerations:

(a) 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.

(b) 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.

(3) File its verified lien statement within one year from the date the last item of medical care was furnished; and

(4) Refrain from withholding payment on behalf of an otherwise eligible recipient when third party liability cannot be readily determined or collected.

6. 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. Nothing in this rule shall be construed as requiring a provider to provide services to a recipient who fails to present a currently valid ID card. A provider may contact the local welfare agency for verification of current eligibility 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. Such restrictions on the use of ID cards shall be subject to the fair hearing requirements of applicable state law and federal regulations [See, C.8.a., supra]. 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 90 days overdue, or when the special four month AFDC extended medical periods terminate in accordance with applicable federal regulations. 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. The state agency shall be fully responsible for payments made on behalf of ineligible individuals due to state processing error.

7. 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 and regulations (deleted) 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.

8. Qualification of Eligible Providers. The state agency shall determine the eligibility of each provider of medical care, services and supplies. Any medical vendor who, on request, and upon being provided a copy of the recipient's written consent, refuses to allow a proper survey and/or reimbursement agency access to its records, shall become an ineligible provider upon written notification from DPW. The Commissioner may terminate

payments under Chapter 256B to any person or facility providing medical assistance which under applicable federal law or regulation, has been determined to be ineligible for payments under Title XIX of the Social Security Act. Any vendor of medical care who submits to the state agency a claim for reimbursement, a cost report, or a rate application which he knows to be false in whole or in part shall be declared ineligible for further payments of medical assistance funds by the commissioner of public welfare. The commissioner shall determine the time period of ineligibility and any conditions for reinstatement of eligibility. No vendor of medical care shall be declared ineligible without prior notice and an opportunity for a hearing, pursuant to Minnesota Statutes, Chapter 15, on the commissioner's proposed action.

9. Prior Authorization. The state agency shall establish and implement methods and procedures for prior authorization of certain items of care and services covered under the MA program. Services and items of care which must receive prior authorization are so indicated in Sections E.2.a. thru E.2.s, infra. The state agency shall provide vendors of medical care with designated forms to be used in making prior authorization requests. The vendor shall submit the contemplated charge and sufficient information to allow a reasonable evaluation of the request. The state agency shall send a form to the provider indicating whether the requested authorization has been approved or denied. The state agency shall use the following criteria in evaluating prior authorization requests in order to:

a. Safeguard against the unnecessary or inappropriate utilization of care and services;

b. Safeguard against excess payments;

c. Assess the quality and timeliness of such services;

d. Determine if less expensive alternative medical care, services or supplies are usable;

e. Promote the most effective and appropriate use of available services and facilities; and

f. Attempt to rectify misutilization practices of providers, recipients and institutions.

Emergency services maybe covered under the MA program even if the required prior authorization was not obtained. In order to be covered, the provider shall attach to the invoice an explanation of the circumstances under which the services were provided and why such services should be classified as emergency care. The state agency shall reimburse only those services usually requiring prior authorization for which emergency status is established.

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.

10. Utilization Control

a. A statewide surveillance and utilization control program is established subject to applicable federal law and regulations. Such program shall include:

(1) 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.

(2) 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.

b. Utilization Control of Inpatient Hospital Services and Services Provided in Skilled and Intermediate Care Facilities. Under this surveillance and utilization control program, all inpatient facilities shall:

(1) Have in effect a written utilization review plan which meets the requirements of applicable state law and federal regulations;

(2) 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;

(3) 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;

(4) Obtain physician recertification at least every 60 days thereafter that such services continue to be medically necessary;

(5) Develop written plans of care in accordance with applicable state law and federal regulations; and

(6) 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.

c. 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:

(1) 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.

(2) Review by the state agency (or its designee) of the recommendations for admission, in accordance with applicable federal regulations.

d. Under the surveillance and utilization control program, the state agency shall:

(1) 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. (deleted)

11. Transportation. The MA program shall pay for transportation through the centralized payment system only in accordance with Section E.2.r.(1), infra. However, local welfare agencies may approve and pay for transportation when furnished by someone other than an enrolled medical provider. Such service must receive prior authorization and shall be reimbursable from the local welfare agency's medical assistance administrative account.

E. Services Under the Medical Assistance Program

1. The following services are not covered under the MA program:

a. Medical services or supplies paid for directly by the recipient.

b. Medications dispensed by a physician that could reasonably be obtained from a licensed pharmacy [See, E.2.m., infra].

c. Medical services or supplies where the requisite prior authorization was not submitted or was denied.

d. Autopsies.

e. Missed appointments.

f. Telephone calls or other non face-to-face communication between the provider and the recipient.

g. Routine reports (e.g., Social Security, insurance) unless requested by the state agency.

h. Investigational surgery or procedures (e.g., research efforts not clearly essential to the patient's health).

i. Illegal operations and other procedures prohibited by law.

j. Artificial insemination.

k. Transsexual surgery.

l. Aversion therapy (including cash payments from recipients) unless provided in accordance with Minn. Rule DPW 39.

m. Cosmetic surgery aimed at beautification only.

n. Weight reduction programs unless:

(1) The program treats a medical condition causing obesity; or

(2) Obesity interferes with the health, well-being or employability of the recipient.

o. Billing charges.

p. Mileage charged by eligible providers.

q. Reversal of voluntary sterilization procedures.

r. 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).

s. Duplication of services by more than one provider without appropriate medical referrals.

2. The following services are covered under the MA program:

a. 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.

(1) The following inpatient hospitalization services must receive prior authorization:

(a) Medical care of marginal medical necessity.

(2) The following limitations apply to inpatient hospital services:

(a) Private room - must be certified by a licensed physician as medically necessary, unless the private room rate does not exceed the semi-private room rate in that hospital.

(b) 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.

(3) The following inpatient hospital services are not covered under the MA program:

(a) Leave days, leaves-of-absence and reserved beds as defined under federal regulations.

typo (b). 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.

(1) "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:

(a) Certified by MDH 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

(b) Which meets the requirements of applicable federal regulations.

(2) "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:

(a) 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;

(b) 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

(c) Meets such standards of safety and sanitation as mandated by federal regulations.

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/nursing home" means services provided in an ICF-NH. An "ICF-NH" is an institution licensed as a nursing home and which meet each of the conditions described above. "Intermediate care facility services/boarding care home" means services provided in an ICF-BCH or which could be provided in an ICF-BCH. An "ICF-BCH" 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.

(3) "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:

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

(b) 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

(c) 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.

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

(a) "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.

(b) "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.

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

(d) "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.

(e) 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.

(f) 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.

(5) Levels of care. Reserved for future use.

(6) General limitations.

(a) 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.

(b) 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] or a resident of an intermediate care facility) or any individual who has not attained 65 years of age and 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.

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

(d) Payment will be made to facilities only in accordance with applicable federal reimbursement formula regulations.

(7) 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:

(a) An annual statement of income and expenditures;

(b) A complete statement of fees and charges;

(c) 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

(d) The names of all owners of interest in the facility as defined in (c), 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.

A Rule 49 or Rule 52 cost report shall satisfy this requirement. 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.

c. 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.

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

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

(b) 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.

(c) Removal of tattoo.

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

(e) Individual hourly sessions with a psychiatrist licensed to practice medicine in the U.S. or Canada in excess of ten (10) per calendar year.

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

(a) The MA program will pay for up to 10 hourly sessions with a psychiatrist licensed to practice medicine in the U.S. or Canada per calendar year for any eligible recipient.

(b) The MA program will pay for up to 26 additional hourly sessions with a psychiatrist licensed to practice medicine in the U.S. or Canada per calendar year when all of the following conditions exist:

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

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

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

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

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

(ii) No more than 52 sessions take place within a twelve month period.

(d) The MA program will pay for family 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, E.2.c.(2)(b), supra.]

(e) 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.

d. Health Maintenance Organizations [HMO]. Health Maintenance Organizations are organizations licensed by the state which provide comprehensive health care to a voluntarily enrolled population in a specified geographic area. The MA program shall reimburse participating HMOs through a pre-negotiated and fixed per capita payment determined in accordance with applicable federal regulations made on behalf of enrolled recipients. HMOs 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. 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 (deleted) under this rule.

e. 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, nurse-midwives, osteopaths not licensed to practice medicine and surgery and by public health nurses. Limitations on the number of treatments pertain to each eligible recipient per calendar year.

(1) 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:

(a) 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.

(b) 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.

(c) Payment is limited to 6 treatments per month and 24 treatments per calendar year for each eligible recipient. Treatment in excess of these maxima must receive prior authorization.

(d) <u>The MA program shall not cover x-rays nor any other diagnostic or laboratory procedure provided by a chiropractor.</u>

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

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

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

(i) Total office and outpatient visits.

(ii) Total home or long term care facility visits.

(iii) Hospital visits.

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

(d) The following podiatry services are not covered under the MA program for long term care facility patients:

(i) Ordinary foot hygiene.

(ii) Use of skin creams to maintain skin tone.

(iii) Normal trimming of nails and other services that can reasonably and safely be performed by LTC facility personnel.

(3) 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.

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

(i) Contact lenses:

(aa) Supplemental contact lens evaluation.

(bb) Contact lens check-up.

(cc) Spherical lens fitting (single vision).

(dd) Cylindrical, lenticular, aphakic or prism ballast lenses.

(ee) Keratoconus lenses.

(ff) Cosmetic lenses (disfigurement only).

(gg) Fitting previous contact lens wearer.

(hh) Soft contact lens fitting.

(ii) Fitting monocular patient.

(ii) Custom-fit prosthetic eye.

(iii) Amblyopia therapy.

(aa) "Amblyopia" includes all test procedures necessary for classification and determination of expecteds.

(iv) Strabismus therapy.

(aa) "Strabismus" includes all test procedures necessary for classification, degree of squint and determination of expecteds.

(v) Vision therapy-supplemental evaluation and report.

(vi) More than one (1) pair of eyeglasses in any single 12 month period.

(vii) Photochromatic lenses: Must be accompanied by a statement of medical necessity.

(viii) Sunglasses: Must be accompanied by statement of medical necessity.

(ix) Lens coating-surface or edge.

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

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

(aa) Contact lenses prescribed for reasons other than aphakia, keratoconus, aniseikonia or marked acuity improvement over spectacle correction.

(bb) Replacement of lenses or frames due to a recipient's personal preference for a change of style or color.

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

(4) Psychologists. Eligible providers are individuals currently licensed by the Minnesota Board of Examiners of Psychologists to practice as licensed psychologists or licensed consulting psychologists in the appropriate service areas.

(a) The following psychological services must receive prior authorization:

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

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

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

(ii) The MA program will pay for up to 26 additional hourly sessions with a licensed psychologist 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 family psychotherapy of two family members as needed for up to two hours per week for a twenty week period. [When more than two family members are involved, See, E.2.e.(4)(b), supra.]

(iv) 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.

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

(i) Medical supplies and equipment.

(5) Public health nurses. A "public health nurse" is a registered nurse who is licensed as a professional nurse and certified by the State Board of Health as a public health nurse. The MA program limits payment for public health nurses to the following services:

(a) Health assessment and screening.

(b) Health promotion and preventive counseling.

(c) EPSDT screening if approved by the Minnesota Department of Health.

(d) Health care services provided at the residence of the patient if the services are performed by a public health nurse and the nurse indicates in a statement submitted under oath that the services were actually provided.

f. 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.

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

(a) Kidney dialysis not covered by Medicare.

(b) Oral surgery (except in emergencies).

(c) Hemodialysis back-up service.

(d) Supplemental and tube feedings for patients who have special nutritional needs.

(e) All physician services which must receive prior authorization [See, E.2.c.(1), supra].

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

(a) 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.

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

(a) Hypoallergenic foods; babyfoods.

(b) Diapers.

(c) 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.

g. 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. Family planning agencies or centers are considered "clinics" under this definition.

(1) "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.

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

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

(ii) 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.

h. Home health care services.

(1) "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:

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

(b) 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.

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

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

(2) 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 Department of Health to currently meet the requirements of applicable federal regulations. The following home health care services are not covered under the MA program:

(a) Homemaker services.

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

i. Medical supplies. The term "medical supplies" as used herein includes the most cost effective non-durable medical supplies, durable medical equipment, prostheses, orthoses and oxygen. Medical supplies must be prescribed by a physician or other licensed medical practitioner within the scope of his profession as defined by state law. Medical supplies must be necessary and reasonable for the treatment or diagnosis of an illness or injury or to improve the functioning of a malformed body member.

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

(2) "Durable medical equipment": Equipment which can withstand repeated 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).

(3) "Prostheses" and "orthoses": Replacement, corrective or supportive devices 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.

(4) The MA program pays for oxygen and any equipment necessary for administration of oxygen (or other than nasal catheters and positive pressure breathing apparatus) when prescribed by a licensed physician so long as prior authorization is obtained.

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 pay for supplies essential to the effective use of medically necessary durable equipment.

Eligible providers include those individuals or agencies who supply and/or service medical supplies. Medical supply and hearing aid dealers must complete a "Performance Agreement" to be eligible to participate in the MA program. Performance agreement as used herein means a written agreement between a provider of service and the state agency, as required by federal regulations.

(5) The following medical supplies must receive prior authorization:

(a) Non-durable medical supplies, when:

(i) The cost exceeds the performance agreement limitations:

^(deleted)

(b) Durable medical equipment, when:

(i) The purchase, projected cumulative rental, repair or maintenance cost exceeds the performance agreement limitation;

^(deleted)

(c) Prostheses and orthoses, when:

(i) The purchase, projected cumulative rental, or repair cost exceeds the performance agreement limitations;

(ii) The order is for an indwelling catheter (which requires a diagnosis of permanent urinary incontinence) or

(iii) The order is for a hearing aid, repairs to hearing aids when the costs of parts and labor exceeds the performance agreement limitations, repairs under the limitations, 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.

(d) Oxygen and any equipment necessary for the administration of oxygen, except in documented emergencies.

(e) Medical supplies for recipients who are residents of long term care facilities may be authorized under the following conditions:

(i) The cost of a specific item cannot be covered in the per diem rate; and

(ii) The item is necessary for the continuous care and exclusive use of this recipient to meet an unusual medical need; and

(iii) The need is identified ~~and~~ (deleted) documented in the recipient's plan of care.

(6) The following items are not covered under the MA program:

(a) Equipment primarily and customarily used for non-medical purposes, i.e.:

(i) Air conditioners.

(ii) Food blenders.

(iii) Exercycles.

(iv) Orthopedic mattresses.

(v) Dehumidifiers.

(vi) Humidifiers.

(vii) Air filters.

(viii) Auto modifications.

(ix) Books.

(x) TV sets.

(xi) Bicycles.

(xii) Household items.

(xiii) Safety bars.

(xiv) Training equipment.

(b) Comfort or convenience items (i.e., electric beds, elevators, waterbeds, cushion lift chairs).

(c) Stock orthopedic shoes unless attached to a leg brace.

(d) Medical equipment and supplies for recipients who are residents of long term care facilities, except as provided in E.2. i (4)(e), supra.

(e) The three follow-up visits per year at the hearing aid dealer's office or service center specified in the Hearing Aid Performance Agreement.

(f) Reimbursement to long term care facilities for any medical equipment or supplies other than allowed under Minn. Rules DPW 49 and 52.

j. 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.

(1) The MA program pays for private duty nursing services only:

(a) When ordered in writing by the patient's primary physician or consulting physician;

(b) In hospitals having no intensive care unit capable of meeting the patient's needs;

(c) 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.

(d) If the private duty nurse is not a member of the patient's family.

k. 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.

(1) Rehabilitative and therapeutic services in long term care facilities. Such services must be provided in accordance with applicable federal regulations, state law and DPW rules.

(a) "Physical therapy": Those services prescribed by a physician and provided to a patient by a qualified physical therapist. In addition, other qualified rehabilitative personnel, including physical therapy assistants, physical therapy aides, and physical therapy orderlies may assist the physical therapist in performing physical therapy services and in the performance of duties that do not require a qualified physical therapist's knowledge and skill. The full responsibility for the patient's 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. A "qualified physical therapist" is a graduate of a school of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, and who has a valid Minnesota certificate of registration (as soon as such certificate is available from the Minnesota Department of Health).

(b) "Occupational therapy": Those services prescribed by a physician and provided to a patient by a qualified occupational therapist. In addition, other qualified rehabilitative personnel, including occupational therapy assistants, occupational therapy aides, and occupational therapy orderlies may assist the occupational therapist in performing occupational therapy services and in the performance of duties that do not require a qualified occupational therapist's knowledge and skill. The full responsibility for the patient's 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. A "qualified occupational therapist" is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and/or who is registered by the American Occupational Therapy Association.

(c) "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.

(d) Specialized rehabilitative service requirements -- inpatient and outpatient.

(i) 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.

(ii) 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.

(e) Billing and reimbursement.

(i) 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.

(ii) Reimbursement to qualified rehabilitative personnel (including rehabilitative assistants and aides) under contract with a facility: Each facility shall bill the MA program on behalf of qualified rehabilitative personnel providing services under contract to it.

(iii) Reimbursement to qualified rehabilitative personnel (including supervised rehabilitative assistants and aides) 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:

(aa) 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 and/or modalities provided to one patient during one session.

(bb) 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.

(cc) Multiply the resulting percentage by the salary of the employee. "Salary" means all direct costs related to employment. 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.

(f) 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:

(i) Services authorized by a physician but not documented in the patient's medical record.

(ii) Services provided by unsupervised 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.

(iii) Rehabilitative services provided by nursing personnel.

(iv) Services for personal comfort.

(v) Services of qualified rehabilitative personnel related to training or consultation of facility staff.

(vi) Activities programs.

(vii) Services of a rehabilitative nature provided by living unit personnel, qualified mental retardation professionals, direct care staff, and training or habilitational personnel.

(viii) Screening procedures not ordered by a physician.

(ix) Services not reasonable and necessary to the treatment of the patient's condition.

(x) Services provided without written orders of the patient's attending physician.

(xi) 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.

(xii) Services of a preventive or maintenance nature when physician orders do not relate such services to the patient's disabilities.

(xiii) Physical therapy services not authorized after the initial 90-day service period by an independent medical consultant or the facility's utilization review committee, or through the local welfare agency's approved review plan only if authorization by an independent medical consultant or the utilization committee is not possible.

(xiv) Outpatient services provided by a facility not certified as an outpatient provider.

(xv) Outpatient services provided off the facility's premises.

(xvi) Services billed for by any source other than the skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

(2) 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. Such services must be provided in accordance with applicable federal regulations, state law and DPW rules.

(a) "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.

(b) "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.

(c) "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 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 (as soon as such certificate is available from the Minnesota Department of Health), and has been certified as an independent practitioner by the Minnesota Department of Health.

(d) The following services are not covered as independent practitioner services under the MA program:

(i) 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.

(ii) Services which are not physician prescribed.

(iii) Any service authorized by a physician but not documented in the clinical record of the patient.

(iv) Training or consultation provided by a speech pathologist, audiologist or physical therapist to an agency, facility or other institution.

(v) Screening procedures not physician authorized.

(vi) 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.

(e) The following services of independent practitioners must be billed through the contracting or employing facility, agency, or person and will not be reimbursed directly to the practitioner:

(i) 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.

(ii) Services of a speech pathologist, audiologist or physical therapist employed and salaried by physicians.

(3) Rehabilitation agencies: An agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, a rehabilitation agency must provide physical therapy or speech pathology services, and a rehabilitation program which in addition to physical therapy or speech pathology services, includes social or vocational adjustment services. 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 in accordance with applicable federal regulations, state law and DPW rules and defined as follows:

(a) "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.

(b) "Psychological services": Those services provided to a patient by a psychologist licensed to practice in the appropriate service areas, when medically necessary.

(c) "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.

(d) "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.

(e) "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.

(f) "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.

(g) "Special services": Physician-ordered and monitored evaluations, classes, clinics or programs provided to patients generally by a rehabilitation team.

(h) The MA program will reimburse for services provided only by the following qualified personnel:

(i) 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.

(ii) 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.

(iii) 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.

(iv) Physical therapists. 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.

(v) Occupational therapists. A qualified occupational therapist is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association, and/or who is registered by the American Occupational Therapy Association.

(vi) 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.

(i) Rehabilitation agencies -- non-covered services include:

(i) Services provided without physician orders (excluding psychological services).

(ii) Psychosocial services provided by a social worker when a licensed physician does not assume professional and administrative responsibility for such services.

(iii) Services authorized by a physician but not documented in the patient's clinical record.

(iv) Services provided in day activity centers which are subsidiaries of rehabilitation agencies.

1. 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 (medically necessary). "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.

(1) The following dental services and procedures must receive prior authorization:

(a) Pedodontics (only when the secondary tooth has completed two-thirds of its development).

(b) Hospitalization for dental treatment.

(c) Periodontics.

(d) Root canal therapy (molars only and only if more than one needs treatment).

(e) Gold restorations and/or inlays (including cast non-precious and semi-precious metals).

(f) Fixed prosthodontics.

(g) Orthodontics.

(h) Surgical services except emergencies and alveolectomies.

(i) Removal of impacted teeth.

(2) The following are limitations on the MA dental program:

(a) Oral hygiene instruction - 1 time only.

(b) Dentures (any type) - 1 per 5 year period, except under special circumstances and only then if prior authorization is received. Dentures that

are lost and/or destroyed by recipient negligence will not be replaced during such 5 year period.

(c) Relines or rebase - 1 every 3 years, except under special circumstances and only then if prior authorization is received.

(d) Patients in hospitals or long term care facilities -- 3 visits to the hospital or facility 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.)

(3) The following services are not covered under the MA dental program:

(a) Additional clasps for partial dentures.

(b) Bases.

(c) Sealants.

(d) Local anesthetics when billed as a separate procedure.

(e) Toothbrushes and/or other hygiene aids.

(f) Services provided to a recipient in his home.

m. 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.

n. 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 D.1., supra. ^(deleted)

(1) The following are service limitations of the MA pharmacy program:

(a) 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, D.4.c., supra].

(b) Telephone orders, where legal, must be reduced to writing with the name of the prescribing physician shown and must be signed by the pharmacist.

(c) Prescription refills:

(i) The prescriber must indicate, either verbally or by specification on the original prescription, approval for refilling the prescription.

(ii) 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, except when the patient is in a long term care facility where no such limit shall exist.

(iii) 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.

(d) 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.

(2) The following services must receive prior authorization:

(a) 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. ^(deleted)

(3) The following items are not covered under the MA pharmacy program:

(a) 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.

(b) Cosmetic products (including hypoallergenic cosmetics).

(c) Toiletries (non-medicated soaps, body lotions, powders) used for personal cleaning and grooming.

(d) Oral antiseptics.

(e) Dentifrices and other dental hygiene equipment and supplies.

(f) Throat lozenges.

(g) Contact lens wetting solutions and cleaners.

(h) Investigational drugs.

(i) Biologicals (i.e., vaccines, serums, toxoids) <u>generally considered inappropriate for self-administration.</u>

(j) Amphetamines, amphetamine derivates and any other Drug Enforcement Agency Schedule II anorexient agents for weight control purposes, <u>except as provided in E.1.n., supra.</u>

(k) Nutritional services:

(i) Modified diets consisting of conventional foods.

(ii) Salt and sugar substitutes; salt or sugar-free specialty food and beverage products.

(iii) Baby foods.

(iv) Hypoallergenic foods [See, E.2.n(2), supra].

(v) Alcholic beverages.

(l) 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.

o. Other diagnostic, screening, preventive and rehabilitative services. The MA program provides for these services as described herein.

(1) "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.

(2) "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.

(3) "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.

(4) "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.

p. 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.

(1) In order to comply with federal and state EPSDT requirements, local welfare agencies shall:

(a) Notify in writing on an annual basis all recipients eligible for EPSDT services about the existence of such services;

(b) Provide or arrange for provision of screening services when they are requested;

(c) Arrange for needed corrective treatment; and

(d) Maintain adequate EPSDT records and report activities as required by federal and state agencies.

(2) In order to comply with federal and state EPSDT requirements, providers shall:

(a) Follow required EPSDT billing/reporting procedures;

(b) Adhere to free choice of provider policy when making referrals for recipients.

q. Health care insurance premiums. The MA program shall pay health insurance premiums determined by the state agency to be cost-effective, for:

(1) 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.

(2) Supplemental medical insurance [SMI] on a buy-in basis for eligible recipients covered under Title XVIII of the Social Security Act.

(3) Such other insurance programs as the state agency may approve for eligible recipients.

r. Other medical care. The MA program shall pay for other necessary medical and/or remedial care as follows:

(1) Transportation only when furnished by an enrolled medical provider licensed by the Minnesota Department of Health [See, D.7., supra].

(a) The following services rendered by medical transportation providers are not covered under the MA program:

(i) Any routine service determined by the local welfare agency not to be medically necessary.

(ii) Ambulance service in cases where another means of transportation would have sufficed.

(2) 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.

(3) 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.

(4) 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.

(5) Crippled children services program [CCS]. Pursuant to a co-operative 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 diagnosis, 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.

s. Mental health centers. "Mental health centers" are centers currently receiving grant-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 psychiatrist licensed to practice medicine in the U.S. or Canada or a 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.

(1) 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 [See, E.2.c(1) and (2) and E.2.e(4), supra].

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

(a) Community planning.

(b) Community consultation; program consultation.

(c) Program and service monitoring and evaluation.

(d) Public information and education.

(e) Resource development.

(f) Training and education.

F. Reimbursement

1. 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.

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. 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 an agency, institution or group pursuant to a contract with an approved provider only if required under a written contract between the provider and the agency, institution or group. 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. DPW shall limit payments to (deleted) the limits required by federal law and regulation to be used in state administration of the MA program.

3. 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. 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. 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:

a. Providers submit all necessary forms and reports to the appropriate state or local welfare agency.

b. All prior authorization requirements are fulfilled.

c. Providers bill for care or services rendered on prescribed forms according to state agency instructions.

(1) 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.

d. Providers shall bill the state agency directly, except as follows:

(1) 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.

(2) If a provider of service who is eligible to accept Medicare assignments wishes to be paid by the MA program, such provider shall accept assignments on Medicare billings and shall bill Medicare prior to billing the MA program.

4. 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.

G. Miscellaneous

1. Former Minn. Rule DPW 47, is hereby repealed.

(deleted)

ADMIN. 1000

STATE OF MINNESOTA

DEPARTMENT Attorney General

Office Memorandum

TO : Michael B. Miller
Special Assistant Attorney General

DATE: 7-1-77

FROM : Thomas H. Jensen
Special Assistant Attorney General

SUBJECT: Department of Public Welfare Rule 47

Enclosed for your review, please find the above referenced rule as adopted by the Commissioner and the Commissioner's Order adopting the rule, which includes her findings of fact.

As you will note, changes (which DPW believes to be insubstantial in nature) have been made to those provisions of Rule 47 which you initially found objectionable. There are four exhibits to the Commissioner's Order. Exhibit A is the text of Rule 47 as originally proposed. Exhibt B is the Report of the Hearing Examiner. Exhibit C is the text of the Rule as originally "adopted" by DPW; Exhibit D is the text of Rule 47 as adopted pursuant to the attached Order of the Commissioner.

As you will recall, nine provisions of Rule 49 were determined to be infirm. See, your memo to me of April 29, 1977. In a nutshell, here is what DPW has done with those provisions:

OK 1. 47 A. 2. [47 I. b. as originally proposed]: This provision has been deleted from the rule as adopted. See Commissioner's Finding No. 2.

OK 2. 47 B.10 [47 II j]; 47 D.4.c. [47 IV. d. 3]. Both of these provisions have been reworded to meet your expressed concerns. The provisions as they now read appear on pages 4 and 21 of the rule as adopted. (Ex. D.) See also, Commissioner's Findings 4 and 9 respectively.

OK 3. 47 C. 4. a. 3 [47III. h.]. This provision, relating to income of minors, has been clarified. See, page 7 of the rule as adopted (Ex. D) and Commissioner's Finding 6.

OK

4. 47 C. 8. a. [47 IV. d.]. The provision now clarifies the term "established procedures" through incorporation of an insubstantial change. See, page 18 of the rule as adopted; Commissioner's Finding 7.

no change

5. 47 D. 4. b. 1 [47 IV. d.]. See page 21 of the rule as adopted (Ex. D). No specific finding is made on this provision since the change made adopts a recommendation of the Hearing Examiner. See, Commissioner's Finding 1.

OK

6. 47 D. 9. [47 IV. i.] The objectionable language relating to establishment of "methods and practices" has been deleted. See, page 24 of the rule as adopted (Ex. D.) and Commissioner's Finding 10.

check HE Rept. makes change to opposite

7. 47 E. 2 1. 2. d. [47 V. b. 1. 2.] has been clarified to conform to the recommendation set forth in ¶ 84 of the Hearing Examiner's Report. See, page 57 of the rule as adopted (Ex. D).

check HE rept. - no apparent change

8. 47 F. 1. a. & b. [47 VI. a.] have been clarified and essentially incorporate recommendations of the Hearing Examiner. Those provisions appear on page 65 of the rule as adopted (Ex. D).

Also, a specific finding as to the applicability of the fiscal impact statement requirement of Minn. Laws 1975 Ch. 434 has been made. As you will note, DPW has determined that such a statement is unnecessary in this case.

necessary at hearing? No — just b/c rules go into effect

I would be happy to send over all of the hearing exhibits, etc., if you feel that is necessary for your review. I did not do so because you have already reviewed those files in some detail.

Please let me know if you need any more information, any of the hearing exhibits, etc.

Thank you.

THJ:lp

Attach.

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS

COMMISSIONER OF WELFARE

In the Matter of the Proposed Amendments to Rule 47 of the Rules of the Minnesota Department of Public Welfare

ORDER ADOPTING RULES

The above captioned matter came on for hearing before Steve M. Mihalchick, Hearing Examiner, who was appointed by the Chief Hearing Examiner after proper notice as required by Minn. Stat. § 15.0412 was served on all persons, associations and other interested groups registered with the Secretary of State for that purpose.

At said hearing, proposed amendments to Minn. Rule DPW 47 were considered as originally proposed as shown in Exhibit A attached hereto. The following persons appeared for the Department of Public Welfare (DPW): James Hiniker, Deputy Commissioner; Robert Baird, Assistant Commissioner; Roger Johnson, M.D.; Russell Roberts, D.D.D.; John Bush, R.Ph.; Wyllis Akre, O.D.; Bradley Stoneking; Tom Gaylord; Charlene Seavey; Jean Morley; Warren Nyhus; Irving Bernstein, M.D.; Thomas L. Fabel, Deputy Attorney General; Thomas H. Jensen, Special Assistant Attorney General.

Public speakers at the hearing were: John Broeker and Kathrine E. Baerwald, attorneys representing the Minnesota Association of Health Care Facilities (MAHCF); Dr. Richard Anonsen, President, Minnesota State Medical Association; Dr. Frederick Walter, President, Minnesota Academy of Family Physicians; Carl Gustafson, Administrative Director of the Foundation for Health Care Evaluation; Howard Kelly, Hennepin County Welfare Department; Pamela Parker, Executive Director, Nursing Home Residents Advisory Council; Fred Sattler, representing the Minnesota Hospital Association; Harry LeMieux, President, Minnesota Association of Health Care Facilities; Kay Roberts, physical therapist; Philip Getts, attorney, representing certain psychiatrists; Ben Kubes, physical therapist.

Included in the record are some 120 DPW exhibits and 80 public exhibits and comments.

The hearing on the proposed amendments to Minn. Rule DPW 47 began on June 1, 1976, and continued on June 2 and June 25, 1976, until all interested persons had an opportunity to be heard. Based upon the proceedings as indicated in the Report of the Hearing Examiner, dated January 11, 1977, a copy of which is attached as exhibit B hereto, the Hearing Examiner made Findings of Fact, Conclusions and Recommendations.

Pursuant to Minn. Stat. § 15.0412, subd. 4, the Report of the Hearing Examiner was made available to all affected persons for over ten days subsequent to the date of the Report. Thereafter, the rule as adopted (Exhibit C hereto) was forwarded for the review of the Attorney General as provided by law and certain of its provisions were not approved. The reasons stated by the Attorney General for disapproval of certain provisions of Rule 47 have been considered by DPW and, as more fully appears herein, the concerns expressed by the Attorney General can be met with insubstantial changes which have been incorporated into the Rule as herein adopted (Exhibit D hereto).

After affording interested persons an opportunity to present written and/or oral statements, having reviewed all of the testimony, having considered all of the evidence adduced, having considered the Report of the Hearing Examiner, the Report of the Attorney General, and upon all of the proceedings and testimony herein and applicable statutory standards or criteria, and having determined the need for the above captioned rules and the reasonableness thereof;

NOW, THEREFORE, IT IS ORDERED that the Commissioner hereby adopts and incorporates herein the Report of the Hearing Examiner, dated January 11, 1977, to the following extent:

FINDINGS

1. Except as noted below, all Findings of Fact of the Hearing Examiner are adopted and incorporated in full. In cases where the Hearing Examiner suggested changes in proposed Rule 47, all of the changes suggested in his herein adopted Findings of Fact are of an insubstantial nature and have been incorporated in Minn. Rule DPW 47 as adopted. (References to Rule 47 herein shall be to the Rule as adopted; provisions of the rule as originally proposed shall be referenced in brackets).

2. Finding of Fact 11, relating to Rule 47 A. 2. [47 I.b. as proposed] is rejected. Public comments and the Attorney General questioned DPW's authority to issue "policy" or "instructional" bulletins relating to the Medical Assistant program; therefore Rule 47 A. 2. [47 I.b.] has been removed from the Rule as adopted and no finding on that issue is necessary.

3. Finding of Fact 14 is rejected and the following Finding is adopted in lieu thereof:

> 14. The Department has demonstrated the need for and reasonableness of DPW 47 A. [47 I].

4. Finding of Fact 18 is adopted, but with the following additional language:

> 18. * * *
>
> The insubstantial change incorporated into the provisions of 47 B. 10 [47 II. j.] meets the recommendations of both the Hearing Examiner and the Attorney General.

5. Finding of Fact 20 is rejected and the following Finding is substituted in lieu thereof:

> 20. DPW has demonstrated the need for and reasonableness of all provisions of DPW 47 B. [47 II].

6. Finding of Fact 24 is adopted, but with the following additional language:

> 24. * * *
>
> The insubstantial change incorporated into the provisions of 47 C. 4. a. 3 [47 III. d. 1. c.] meets the recommendations of both the Hearing Examiner and the Attorney General and as adopted, the provision accurately reflects the law.

7. Finding of Fact 35 is adopted, but with the following additional language:

> 35. * * *
>
> The insubstantial change incorporated into the provisions of 47 C. 8. a. [47 III. h.] meets the recommendations of

both the Hearing Examiner and the Attorney General.

8. Finding of Fact 36 is rejected and the following Finding is adopted in lieu thereof:

> 36. DPW has demonstrated the need for and reasonableness of the provisions of DPW 47 C. [47 III].

9. Finding of Fact 44 is adopted, but with the following additional language:

> 44. * * *
>
> The insubstantial change incorporated into the provisions of 47 D. 4. c. [47 IV. d. 3.] meets the recommendations of both the Hearing Examiner and the Attorney General.

10. Finding of Fact 48 is adopted, but with the following additional language:

> 48. * * *
>
> The deletion of references to the establishment and implementation of "methods and practices" from 47 D. 9 [47 IV. i.] is an insubstantial change in that provision which meets the concerns of the Attorney General.

11. Finding of Fact 56 (10) is rejected and the following Finding is adopted in lieu thereof:

> 56(10). Artificial insemination and reversal of voluntary sterilization procedures are not medically necessary. DPW is required by state law and the provisions of 45 CFR § 250.18 to safeguard against unnecessary or inappropriate utilization of care and services. Since the two aforementioned procedures are not medically necessary, they cannot be reimbursed with Medical Assistance funds.

12. Finding of Fact 92 is rejected and the following Finding is adopted in lieu thereof:

> 92. DPW has demonstrated the need for and reasonableness of Minn. Rule 47 E [47 V.].

13. Finding of Fact 96 is rejected and the following Finding is adopted in lieu thereof:

> 96 DPW has demonstrated the need for and reasonableness of DPW 47 F [DPW 47 VI].

14. Finding of Fact 97 is rejected. Since the Rule as adopted specifically reserves Rule 47 F. 4. from repeal, no specific finding in lieu of Finding 97 is considered necessary.

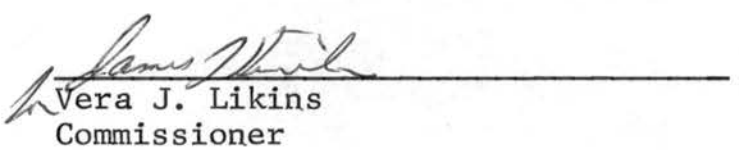
15. Finding of Fact 99 is rejected and the following Finding is adopted in lieu thereof:

> 99. As was noted at the public hearing on Rule 47, (see, e.g. Tr. Vol III at 20-21) DPW has considered the financial impact of the amendments to Rule 47 herein adopted. DPW has concluded that Rule 47 as adopted will not result in increased expenditures of $100,000 or more in the administration of the Medical Assistance program. Therefore, no fiscal impact statement is necessary. See, Minn. Laws 1975 Ch. 434.

16. The matters discussed in Finding of Fact 100 have been considered by DPW as suggested by the Hearing Examiner; for the present, at least, the suggestions contained therein are rejected.

IT IS FURTHER ORDERED that the Commissioner hereby adopts the proposed amendments to Rule 47 of the Rule of the Minnesota Department of Public Welfare so that from and after this day of July 5, 1977, said Rule 47 shall read in its entirety as set forth in the attached Exhibit D, pursuant to the authority vested in me, pursuant to Minnesota Statutes Chapters 15 and 256B.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE



Vera J. Likins
Commissioner

objections: X 1 - changes must go to hearing

X 2 - No fiscal impact (See my rept. of 4/24)

X 3 - No find/fact

X ~~✓~~ 4 - N/disp vague language (47A.2, 47D.9, ~~& dropped?~~ canc. dropped?) no change (47D.4.b.1)

X 5 - Fed. Law w/ complied w/ on release of med. info. (47CFR 205.50 req. release only to sources w/ confidentiality)

X 6 - "max allow. charges" & "cust. fees" undefined 47F(1)(a)+(b)

check 7. 256B.05 violated as n/ est. ~~@~~ pmt. rates for services

opposite ? 8. 47.E.2.1.2.d. - limits dental visits to 3 - n/ what was called for by rejection of old rule - should be subject of hearing -

~~///~~

BROEKER, HARTFELDT, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL. (612) 854-5263

SUITE 434, HAMM BUILDING
SAINT PAUL, MINNESOTA 55102
TEL. (612) 222-0708

JOHN M. BROEKER
WILL HARTFELDT
STEVEN R. HEDGES
DAVID A. GRANT
KATHRYN E. BAERWALD
GEORGE L. CARLSON
ELENI P. SKEVAS

July 12, 1977

Mr. Michael B. Miller
Special Assistant Attorney General
G-19K State Administration Building
50 Sherburne Street
Saint Paul, Minnesota 55155

Re: In the Matter of the Amendments to Rule 47 of the Minnesota Department of Public Welfare - Adopted Rules

Dear Mr. Miller:

On behalf of our client, the Minnesota Association of Health Care Facilities, we wish to comment on the above-referenced Rule, presented to you on or about July 5, 1977, by the Department of Public Welfare for review as to form and legality as required by Minn. Stat. §15.0412, subd. 4 and Atty. Gen. 305.

By way of chronology, the following events have occurred to date:

	ITEM	DATE
1.	Hearing on proposed Amendment to Rule 47 proposed by the Minnesota Department of Public Welfare (hereinafter referred to as "Department").	November 19, 1975
2.	Adopted Amendments.	April 30, 1976
3.	Second Hearing on proposed Amendment to Rule 47 proposed by the Department.	June 1, 2 and 25, 1976

4.	Report of Hearing Examiner.	January 11, 1977
5.	Letter adopting Rule 47 with certain changes signed by Commissioner Vera J. Likins (hereinafter referred to as "Commissioner").	February 15, 1977
6.	Report of Chief Hearing Examiner.	February 18, 1977
7.	Report of Attorney General Disapproving Rule 47.	April 29, 1977
8.	Revised Adopted Rule 47 Submitted to the Attorney General	July 5, 1977

Our comments herein are not intended to be all inclusive in terms of all challenges which could be made to the form and legality of the revised Rule 47 amendments. Rather, we have chosen to highlight some comments, with the expectation that, on behalf of the Attorney General, you will be reviewing the entire hearing record and other documents filed to date in this matter to cover all matters pertaining to form and legality. We have already filed several documents on behalf of the Minnesota Association of Health Care Facilities which have been included as exhibits to the hearing record and correspondence to the Chief Hearing Examiner.

Our comments herein will be divided into general comments affecting the overall legality of the revised Rule 47 amendments and specific comments on the individual items at issue. Acceptance of our general comments as to legality will obviate the need to review the specific comments on individual items.

II - GENERAL COMMENTS

1. There is no provision in the Minnesota Administrative Procedures Act or other law to permit the Department to adopt Revised Adopted Rule 47. Under the Administrative Procedures Act, Rules of the Attorney General, and Rules of the Office of Hearing Examiners, a rule must be approved, disapproved, returned to the Agency for revision or returned to the Agency for public hearing. On April 29, 1977, the Attorney General disapproved the Rule; it was not resubmitted for revision. Therefore, the Department has no authority to presently revise the Rule and submit it again to the Attorney General. However,

even if revision is permitted, the failure of Revised Adopted Rule 47 to comply with applicable law prohibits its being approved by the Attorney General and adopted by the Department.

Under Minn. Stat. §15.0412, subd. 4 and Atty. Gen. 305, the Attorney General is required to review all agency rules for form and legality. Such review was made by the Attorney General on April 29, 1977, and the Rule was not approved. The statute and rules further provide that, if the Attorney General disapproves the rule,

> " . . . he shall state in writing his reasons therefor, and the rule shall not be filed in the office of the secretary, nor published . . . ." Minn. Stat. §15.0412, subd. 4. [Emphasis supplied.]

Publication of a proposed rule is required prior to its becoming effective. Minn. Stat. §15.0412, subd. 4; Atty. Gen. 305. Because a rule disapproved by the Attorney General cannot be published, it therefore cannot become law. Rather, it must again be submitted to the agency and the public for further hearing. Further, no provisions are made in the Administrative Procedures Act, Rules of the Office of Hearing Examiners, or Rules of the Attorney General for adoption of a rule by an agency following disapproval by the Attorney General other than by a new rule-making procedure commenced by a new Notice of Hearing.

The purpose of the Administrative Procedures Act is to ensure that those individuals affected by actions of state agencies be fully informed of and participate in the making of rules governing them. To permit the Department to adopt rules already disapproved by the Attorney General would make a mockery of the whole rule-making procedure.

2. In his report, the Attorney General disapproved Rule 47 because, among other reasons, the Department failed to follow proper rule-making procedures. The Department is required to file a fiscal note where the impact of the rule is in excess of $100,000. As the Attorney General stated, because no such estimate was made and filed with the appropriate legislative committee, "it is impossible to ascertain from the record whether or not the $100,000 figure is exceeded by this rule." April 29, 1977 Report of the Attorney General.

The Department still has not made any showing as required by Chapter 434, Laws 1975 as to whether the $100,000 limit will be exceeded. Further, the Department failed to comply with Minn. Stat. §15.0412, subd. 7, requiring the Department to file a statement of the

agency's

> "reasonable estimate of the total cost to all local public bodies in the state to implement the rule for the two years immediately following adoption of the rule if the estimated total cost exceeds $100,000 in either of the two years".

As county welfare agencies are "local public bodies" and are directly financially impacted by Rule 47 in implementing Medical Assistance, the above estimate would have to be made by the Department if the impact exceeds $100,000 as provided above. Because the record does not contain any fiscal information upon which to determine if the statutory limit is exceeded, the Rule must be disapproved for failure of the Department to follow statutory requirements. Atty. Gen. 305(b).

The Attorney General also disapproved the Rule for the Department's failure to adopt Findings of Fact as required by Atty. Gen. 302(h). No such Findings have been adopted. Therefore, the Rule must be disapproved pursuant to Atty. Gen. 305(b) for violation of proper rule-making procedure and no portion of it can be adopted without meeting all procedural requirements.

III - SPECIFIC COMMENTS

Although we believe the above General Comments to be dispositive of the matter, the following Specific Comments address certain amendments made by the Department to Rule 47 if the revision of the Rule is permitted. Certain amendments have been grouped together for discussion purposes.

1. Many of the Attorney General's comments were aimed at provisions found by the Attorney General to be "vague" or permitting the Department to adopt or establish procedures not covered by the Rule. In making its amendments to Rule 47, the Department failed to address the issues raised by either dropping the objectionable language (47A.2, 47D.9) or making no changes at all (47D.4.b.1.).

Revised Adopted Rule 47 therefore continues to contain vague and thus legally improper provisions, as well as fails to spell out in the Rule all procedures to be followed by the Department as required by Minn. Stat. §15.0411, et seq. and Atty. Gen. 305. Therefore, the Rule must again be disapproved by the Attorney General.

2. Changes made to those portions of Rule 47 related to release of medical information (47B.10, 47D.4.c.) still fail to comply with federal law. See letter of March 8, 1977, page 10, from the undersigned to Michael B. Miller, as well as letter to the Commissioner, dated June 22, 1976, from the undersigned. Federal regulations require the safeguarding of information once in the hands of the Department and prohibit the release of information to any entity not having certain confidentiality standards. 45 CFR, §205.50. These requirements have not been met in Rule 47.

Therefore, Rule 47 cannot be approved as to form and legality by the Attorney General. Atty. Gen. 305.

3. Revised Adopted Rule 47, in responding to the Attorney General's disapproval of 47F.1.a. and b., has been modified by deleting those portions of the Rule. Yet, the following sections of the Rule still reference and rely upon the now undefined terms of "maximum allowable charges" and "usual and customary fees." Rule 47 also continues to violate Minn. Stat. §256B.05, subds. 2 and 3 and 45 CFR §250.30(a)(1) by failing to set out the schedule of maximum fees and the methods used for establishing payment rates for each service provided. See also March 8, 1977 letter.

Therefore, because Rule 47 is in clear violation of state and federal law, it cannot be approved for form and legality by the Attorney General.

4. 47E.2.1.2.d. now limits the number of visits to a health care facility by a dentist to three rather than simply clarifying the fact that reimbursable visits to the dentist's office are not limited to three as stated in the Attorney General's Report of April 29, 1977. Such is a substantial change made in the Rule and must be submitted to public hearing. Such a change cannot be made by the Department at this stage of the rule-making process. A change limiting dentist visits would "invite reaction at the hearing" (HE 108(4)) and thus must be submitted for hearing. The Rule should be disapproved by the Attorney General.

For the reasons above stated, Rule 47 as revised and adopted by the Department should be disapproved.

Should you have any questions concerning the contents of this letter, please contact the undersigned. During the month of July, I can be reached at the St. Paul office listed above.

Very truly yours,

BROEKER, HARTFELDT, HEDGES & GRANT

By Kathryn E. Baerwald
Kathryn E. Baerwald

KEB:sb

cc: Mr. ~~Steve~~ Tom KEB Jensen
Mr. Steve Mihalchick

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE VERA J. LIKINS

COMMISSIONER OF WELFARE

In the Matter of the Proposed Amendments to Rule 47 of the Rules of the Minnesota Department of Public Welfare

ORDER ADOPTING RULES

The above captioned matter came on for hearing before Steve M. Mihalchick, Hearing Examiner, who was appointed by the Chief Hearing Examiner after proper notice as required by Minn. Stat. § 15.0412 was served on all persons, associations and other interested groups registered with the Secretary of State for that purpose.

At said hearing, proposed amendments to Minn. Rule DPW 47 were considered as originally proposed as shown in Exhibit A attached hereto. The following persons appeared for the Department of Public Welfare (DPW): James Hiniker, Deputy Commissioner; Robert Baird, Assistant Commissioner; Roger Johnson, M.D.; Russell Roberts, D.D.D.; John Bush, R.Ph.; Wyllis Akre, O.D.; Bradley Stoneking; Tom Gaylord; Charlene Seavey; Jean Morley; Warren Nyhus; Irving Bernstein, M.D.; Thomas L. Fabel, Deputy Attorney General; Thomas H. Jensen, Special Assistant Attorney General.

Public speakers at the hearing were: John Broeker and Kathrine E. Baerwald, attorneys representing the Minnesota Association of Health Care Facilities (MAHCF); Dr. Richard Anonsen, President, Minnesota State Medical Association; Dr. Frederick Walter, President, Minnesota Academy of Family Physicians; Carl Gustafson, Administrative Director of the Foundation for Health Care Evaluation; Howard Kelly, Hennepin County Welfare Department; Pamela Parker, Executive Director, Nursing Home Residents Advisory Council; Fred Sattler, representing the Minnesota Hospital Association; Harry LeMieux, President, Minnesota Association of Health Care Facilities; Kay Roberts, physical therapist; Philip Getts, attorney, representing certain psychiatrists; Ben Kubes, physical therapist.

Included in the record are some 120 DPW exhibits and 80 public exhibits and comments.

The hearing on the proposed amendments to Minn. Rule DPW 47 began on June 1, 1976, and continued on June 2 and June 25, 1976, until all interested persons had an opportunity to be heard. Based upon the proceedings as indicated in the Report of the Hearing Examiner, dated January 11, 1977, a copy of which is attached as exhibit B hereto, the Hearing Examiner made Findings of Fact, Conclusions and Recommendations.

Pursuant to Minn. Stat. § 15.0412, subd. 4, the Report of the Hearing Examiner was made available to all affected persons for over ten days subsequent to the date of the Report. Thereafter, the rule as adopted (Exhibit C hereto) was forwarded for the review of the Attorney General as provided by law and certain of its provisions were not approved. The reasons stated by the Attorney General for disapproval of certain provisions of Rule 47 have been considered by DPW and, as more fully appears herein, the concerns expressed by the Attorney General can be met with insubstantial changes which have been incorporated into the Rule as herein adopted.

After affording interested persons an opportunity to present written and/or oral statements, having reviewed all of the testimony, having considered all of the evidence adduced, having considered the Report of the Hearing Examiner, the Report of the Attorney General, and upon all of the proceedings and testimony herein and applicable statutory standards or criteria, and having determined the need for the above captioned rules and the reasonableness thereof;

NOW, THEREFORE, IT IS ORDERED that the Commissioner hereby adopts and incorporates herein the Report of the Hearing Examiner, dated January 11, 1977, to the following extent:

FINDINGS

1. Except as noted below, all Findings of Fact of the Hearing Examiner are adopted and incorporated in full. In cases where the Hearing Examiner suggested changes in proposed Rule 47, all of the changes suggested in his herein adopted Findings of Fact are of an insubstantial nature and have been incorporated in Minn. Rule DPW 47 as adopted. (References to Rule 47 herein shall be to the Rule as adopted; provisions of the rule as originally proposed shall be referenced in brackets).

2. Finding of Fact 11, relating to Rule 47 A. 2. [47 I.b. as proposed] is rejected. Public comments and the Attorney General questioned DPW's authority to issue "policy" or "instructional" bulletins relating to the Medical Assistant program; therefore Rule 47 A. 2. [47 I.b.] has been removed from the Rule as adopted and no finding on that issue is necessary.

3. Finding of Fact 14 is rejected and the following Finding is adopted in lieu thereof:

> 14. The Department has demonstrated the need for and reasonableness of DPW 47 A. [47 I].

4. Finding of Fact 18 is adopted, but with the following additional language:

> 18. * * *
>
> The insubstantial change incorporated into the provisions of 47 B. 10 [47 II. j.] meets the recommendations of both the Hearing Examiner and the Attorney General.

5. Finding of Fact 20 is rejected and the following Finding is substituted in lieu thereof:

> 20. DPW has demonstrated the need for and reasonableness of all provisions of DPW 47 B. [47 II].

6. Finding of Fact 24 is adopted, but with the following additional language:

> 24. * * *
>
> The insubstantial change incorporated into the provisions of 47 C. 4. a. 3 [47 III. d. 1. c.] meets the recommendations of both the Hearing Examiner and the Attorney General and as adopted, the provision accurately reflects the law.

7. Finding of Fact 35 is adopted, but with the following additional language:

> 35. * * *
>
> The insubstantial change incorporated into the provisions of 47 C. 8. a. [47 III. h.] meets the recommendations of

both the Hearing Examiner and the Attorney General.

8. Finding of Fact 36 is rejected and the following Finding is adopted in lieu thereof:

> 36. DPW has demonstrated the need for and reasonableness of the provisions of DPW 47 C. [47 III].

9. Finding of Fact 44 is adopted, but with the following additional language:

> 44. * * *
>
> The insubstantial change incorporated into the provisions of 47 D. 4. c. [47 IV. d. 3.] meets the recommendations of both the Hearing Examiner and the Attorney General.

10. Finding of Fact 48 is adopted, but with the following additional language:

> 48. * * *
>
> The deletion of references to the establishment and implementation of "methods and practices" from 47 D. 9 [47 IV. i.] is an insubstantial change in that provision which meets the concerns of the Attorney General.

11. Finding of Fact 56 (10) is rejected and the following Finding is adopted in lieu thereof:

> 56(10). Artificial insemination and reversal of voluntary sterilization procedures are not medically necessary. DPW is required by state law and the provisions of 45 CFR § 250.18 to safeguard against unnecessary or inappropriate utilization of care and services. Since the two aforementioned procedures are not medically necessary, they cannot be reimbursed with Medical Assistance funds.

12. Finding of Fact 92 is rejected and the following Finding is adopted in lieu thereof:

> 92. DPW has demonstrated the need for and reasonableness of Minn. Rule 47 E [47 V.].

13. Finding of Fact 96 is rejected and the following Finding is adopted in lieu thereof:

> 96 DPW has demonstrated the need for and reasonableness of DPW 47 F [DPW 47 VI].

14. Finding of Fact 97 is rejected. Since the Rule as adopted specifically reserves Rule 47 F. 4. from repeal, no specific finding in lieu of Finding 97 is considered necessary.

15. Finding of Fact 99 is rejected and the following Finding is adopted in lieu thereof:

> 99. As was noted at the public hearing on Rule 47, (see, e.g. Tr. Vol III at 20-21) DPW has considered the financial impact of the amendments to Rule 47 herein adopted. DPW has concluded that Rule 47 as adopted will not result in increased expenditures of $100,000 or more in the administration of the Medical Assistance program. Therefore, no fiscal impact statement is necessary. See, Minn. Laws 1975 Ch. 434.

16. The matters discussed in Finding of Fact 100 have been considered by DPW as suggested by the Hearing Examiner; for the present, at least, the suggestions contained therein are rejected.

IT IS FURTHER ORDERED that the Commissioner hereby adopts the proposed amendments to Rule 47 of the Rule of the Minnesota Department of Public Welfare so that from and after this day of July 5, 1977, said Rule 47 shall read in its entirety as set forth in the attached Exhibit D, pursuant to the authority vested in me, pursuant to Minnesota Statutes Chapters 15 and 256B.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

_____

Vera J. Likins
Commissioner

Attorney General

Michael B. Miller
Special Assistant Attorney General

7-1-77

Thomas H. Jensen
Special Assistant Attorney General

Department of Public Welfare Rule 47

Enclosed for your review, please find the above referenced rule as adopted by the Commissioner and the Commissioner's Order adopting the rule, which includes her findings of fact.

As you will note, changes (which DPW believes to be insubstantial in nature) have been made to those provisions of Rule 47 which you initially found objectionable. There are four exhibits to the Commissioner's Order. Exhibit A is the text of Rule 47 as originally proposed. Exhibt B is the Report of the Hearing Examiner. Exhibit C is the text of the Rule as originally "adopted" by DPW; Exhibit D is the text of Rule 47 as adopted pursuant to the attached Order of the Commissioner.

As you will recall, nine provisions of Rule 49 were determined to be infirm. See, your memo to me of April 29, 1977. In a nutshell, here is what DPW has done with those provisions:

1. 47 A. Z. [47 I. b. as originally proposed]: This provision has been deleted from the rule as adopted. See Commissioner's Finding No. 2.

2. 47 B.10 [47 II j]; 47 D.4.c. [47 IV. d. 3]. Both of these provisions have been reworded to meet your expressed concerns. The provisions as they now read appear on pages 4 and 21 of the rule as adopted. (Ex. D.) See also, Commissioner's Findings 4 and 9 respectively.

3. 47 C. 4. a. 3 [47III. h.]. This provision, relating to income of minors, has been clarified. See, page 7 of the rule as adopted (Ex. D) and Commissioner's Finding 6.

4. 47 C. 8. a. [47 IV. d.]. The provision now clarifies the term "established procedures" through incorporation of an insubstantial change. See, page 18 of the rule as adopted; Commissioner's Finding 7.

5. 47 D. 4. b. 1 [47 IV. d.]. See page 21 of the rule as adopted (Ex. D). No specific finding is made on this provision since the change made adopts a recommendation of the Hearing Examiner. See, Commissioner's Finding 1.

6. 47 D. 9. [47 IV. i.] The objectionable language relating to establishment of "methods and practices" has been deleted. See, page 24 of the rule as adopted (Ex. D.) and Commissioner's Finding 10.

7. 47 E. 2 1. a. d. [47 V. b. 1. 2.[has been clarified to conform to the recommendation set forth in ¶ 84 of the Hearing Examiner's Report. See, page 57 of the rule as adopted (Ex. D).

8. 47 F. 1. a. & b. [47 VI. a.] have been clarified and eseentially incorporate recommendations of the Hearing Examiner. Those provisions appear on page 65 of the rule as adopted (Ex. D).

Also, a specific finding as to the applicability of the fiscal impact statement requirement of Minn. Laws 1975 Ch. 434 has been made. As you will note, DPW has determined that such a statement is unnecessary in this case.

I would be happy to send over all of the hearing exhibits, etc., if you feel that is necessary for your review. I did not do so because you have already reviewed those file in some detail.

Please let me know if you need any more information, any of the hearing exhibits, etc.

Thank you.

THJ:lp

Attach.

BROEKER, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL. (612) 854-5263

JOHN M. BROEKER
STEVEN R. HEDGES
DAVID A. GRANT
KATHRYN E. BAERWALD
GEORGE L. CARLSON
ELENI P. SKEVAS

June 29, 1977

Mr. Michael Miller
Special Assistant Attorney General
Department of Administration
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

Re: Department of Public Welfare Rule 47

Dear Mr. Miller:

Following up on our letter of May 25, 1977, we wish to specifically request on behalf of our client, the Minnesota Association of Health Care Facilities, that we be notified at such time as any amendments to said rule are forwarded to you by the Department of Public Welfare. As indicated in our letter of May 25, 1977, we request the opportunity to make comments on the amendments to Rule 47 submitted to the Attorney General for review.

Thank you.

Very truly yours,

BROEKER, HEDGES & GRANT

By Kathryn E. Baerwald
Kathryn E. Baerwald

KEB:gsr

BROEKER, HARTFELDT, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL. (612) 854-5263

SUITE 434, HAMM BUILDING
SAINT PAUL, MINNESOTA 55102
TEL. (612) 222-0708

JOHN M. BROEKER
WILL HARTFELDT
STEVEN R. HEDGES
DAVID A. GRANT
KATHRYN E. BAERWALD
GEORGE L. CARLSON
ELENI P. SKEVAS

July 21, 1977

Mr. Michael Miller
Special Assistant Attorney General
Department of Administration
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

Re: Proposed Department of Public Welfare Rule 47

Dear Mr. Miller:

We are in receipt of your memorandum of July 15, 1977 returning the above-referenced rule to the Department of Public Welfare for revision. On behalf of our client, the Minnesota Association of Health Care Facilities, we hereby request that you inform the undersigned when the Department of Public Welfare resubmits Rule 47 to you for review as to form and legality for the purpose of giving our client the opportunity to comment on the revised rule.

Thank you.

Very truly yours,

BROEKER, HARTFELDT, HEDGES & GRANT

By Kathryn E. Baerwald
Kathryn E. Baerwald

KEB:jlh

cc: Mr. Thomas Jensen
Mr. James B. Swanson
Mr. Rick Carter

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Dept. of Administration

BROEKER, HARTFELDT, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
SUITE 434, HAMM BUILDING
SAINT PAUL, MINNESOTA 55102

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Mr. Michael Miller
Special Assistant Attorney General
Department of Administration
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

Attorney General

Thomas H. Jenson
Special Assistant
Attorney General
Department of Welfare

April 29, 1977

296-4692

Michael B. Miller
Special Assistant
Attorney General
G-19K State Administration Building

Department of Welfare Rule 47

Returned herewith is the above-captioned rule. This rule is not approved for the following reasons:

Proposed	Adopted	
47I.b.	47A.2.	This rule is vague; it allows for procedures not specifically covered by the rule itself.
47II.j. 47IV.d.3	47B.10 47D.4c.	These rules are problematic in that the consent to release of medical forms by patients is only secured as to the Department of Public Welfare, but release is made available to all participating agencies.
47III.d.1.c.	47C.4.a.3	This rule is improper as including the income of minors, which is in opposition to Minnesota Statutes § 256B.14.
47III.h.	47C.8.a.	This rule leaves "established procedures" undefined.
47IV.d.	47D.4.b.1.	This rule leaves the record keeping requirement vague.
47IV.i.	47D.9.	The amended rule sets out criteria upon which the Department may rely in making discretionary decisions, but allows establishment of undefined "methods and procedures".
47V.b.1.2.	47E.2.1.2.d.	This rule fails to clarify, as pointed out in Hearing Examiner's Report paragraph 84, that reimbursable visits to a dentist's office are not limited to three.

Proposed	Adopted	
47VI.a.	47F.1.a. & b.	This rule fails to set out a means of computation as required by Minnesota Statutes § 256B.05, Subdivisions 2 and 3 and Code of Federal Regulations 250.30(a)(1).

Two procedural problems are also noted. First, Chapter 434 of the Laws of 1975 requires that where the fiscal impact of a rule is in excess of $100,000, that a statement to this effect be made and filed with the House Appropriations and Senate Finance Committees. Since the Department of Welfare did not make an estimate of the fiscal impact of this rule as a whole, it is impossible to ascertain from the record whether or not the $100,000 figure is exceeded by this rule.

Finally, the Department of Welfare should adopt its own Findings of Fact, which were informally set out in a letter from the Commissioner of Welfare to the Chief Hearing Examiner.

MBM/sr

Enclosures

BROEKER, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL. (612) 854-5263

JOHN M. BROEKER
STEVEN R. HEDGES
DAVID A. GRANT
KATHRYN E. BAERWALD
GEORGE L. CARLSON
ELENI P. SKEVAS

March 11, 1977

Mr. Michael B. Miller
Special Assistant Attorney General
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

Re: Department of Public Welfare Rule 47

Dear Mr. Miller:

Upon review of our letter of March 8, 1977, we have noted a typographical error on page 4, the second line of the last paragraph of comment 3. "Statement" of Fact should instead read "Findings" of Fact.

Thank you.

Very truly yours,

BROEKER, HEDGES & GRANT

By Kathryn E. Baerwald
Kathryn E. Baerwald

KEB:gsr

cc: Mr. J. Swanson
Mr. J.I. Green
Mr. S. Mihalchick
Mr. T. Jensen
MAHCF Ad Hoc Committee

BROEKER, HEDGES & GRANT
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420



Mr. Michael B. Miller
Special Assistant Attorney General
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

Mike Miller

February 7, 1977

Mr. Arthur Shuster
President, Lake Ridge
Health Care Center
2727 N. Victoria Street
St. Paul, Minnesota 55113

Dear Mr. Shuster:

Attorney General Warren Spannaus and I have discussed your recent letter to this office concerning reimbursement of physical therapists pursuant to proposed DPW Rule 47. He has asked that I respond to your letter.

As you undoubtedly know, the subject of reimbursement for physical therapy services was the subject of much discussion at the hearing on Rule 47 this past summer. The decision to reimburse physical therapists in the manner now provided in proposed Rule 47 was based upon the Department of Welfare's determination that the specified method of payment is the best way to utilize available medical assistance funds in reimbursing physical therapists.

As you point out in your letter, however, there are certainly arguments to be made on both sides of the question. This office, as you know, reviews all rules and regulations prior to the time they become effective. In order to insure that your concerns are taken into account at that time, I am taking the liberty of sending a copy of your letter to the person on our staff who will review Rule 47 for form and legality.

I hope this procedure will satisfy your concerns. If you have any further questions or comments please do not hesitate to contact me.

Very truly yours,

Thomas H. Jensen
Special Assistant
Attorney General

THJ:lp

bl. cc: Mike Miller

LAKE RIDGE --- HEALTH CARE CENTER

2727 NORTH VICTORIA ST. PAUL, MINNESOTA 55113 • PHONE 483-5431

(1.)

January 21, 1977

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JAN 24 1977
ATTORNEY GENERAL
102 STATE CAPITOL
ST. PAUL, MINN. 55101

Mr. Warren Spannus
Attorney General
State of Minnesota
State Capital
St. Paul, MN 55155

RE: Department of Public Welfare Rule 47-Physical Therapy

Dear Warren:

I am writing to you to call your attention to the physical therapy provisions of the above rule which are being promulgated by the Department of Public Welfare. These provisions are unfair, discriminatory and in the long run will cost the State of Minnesota more taxpayer dollars. In addition, such provisions will be to the detriment of the patient or resident of some health care facilities such as Lake Ridge.

Specifically, the Department of Public Welfare proposal, which has gone to public hearing but which has not yet become law, provides that an outside physical therapist working on a consultant or contract basis with a health care facility will be reimbursed at a different or higher rate for caring for welfare recipients than will a salaried therapist employed by a facility. The restrictions in the rule for salaried therapists are of such a nature that only a portion of the direct salary of the therapists will be reimbursed by the welfare program which may well cause a facility to not be able to offer therapy to residents or patients. If residents or patients are sent to hospitals or to other places for therapy, not only will the cost be higher to the state but the health and welfare of the individual patients or residents may be jeopardized by having to send such patients or residents outside the premises for therapy treatment.

In his report the hearing examiner, who heard the Rule 47 proposal, upheld this discrimination, but with a recommendation that the Department of Public Welfare consider the rule's overall impact on health care. The hearing examiner specifically stated that in-house physical therapy "makes for healthier patients." The health and well-being of residents and patients should be the primary concern under the Medical Assistance Program.

The hearing examiner makes no findings that the rule in its present form will reduce or even control overall costs for therapy. In fact, costs will increase. Transportation costs plus much greater costs to receive physical therapy at hospitals at the "usual and customary" fee will cause a much greater cost to the state.

Our attorney informs us that the discrimination between salaried therapists and outside therapists being proposed by Rule 47 may well be illegal. There has been no showing whatsoever of any justification for different treatment of a salaried therapist as opposed to an outside therapist.

At the time of the public hearing we submitted comments to the hearing examiner on this matter. A copy of our letter of June 16, 1976, is enclosed herewith.

I sincerely hope that you will be able to understand and appreciate our position on this matter and to help obtain some justice for equal treatment of all therapists under Rule 47 for purposes of welfare reimbursement. Our legal counsel informs me that the rule will be reviewed by the Attorney General's office and that the Attorney General's office can make a determination on the "legality" of the proposed rule. Of course, I would be happy to discuss this with you further if you desire. However, I will be out of town for over a month due to the fact that I have to take care of my health. Should you desire to discuss this in more detail, please call my secretary, Sharon Eagle, and she will have the proper person get in touch with you.

With best personal regards, I remain.

Very truly yours,

LAKE RIDGE HEALTH CARE CENTER

Arthur Shuster
President

AS/se
Enclosure
cc: John Broeker, Attorney

LAKE RIDGE --- HEALTH CARE CENTER

2727 NORTH VICTORIA ST. PAUL, MINNESOTA 55113 • PHONE 483-5431

June 16, 1976

Ms. Vera Likins, Commissioner
Minnesota State Department of Public Welfare
Fourth Floor, Centennial Office Building
St. Paul, MN 55155

RE: Public Hearing on Rule 47 Amendments

Dear Ms. Likins:

This letter is being submitted to the Department of Public Welfare with the request that it be made part of the hearing record for proposed Department of Public Welfare Rule 47 amendments, which were subject to public hearing on June 1 and 2, 1976 and which we understand have been continued to June 25, 1976. Our comments are directed to that part of Rule 47 concerned with reimbursement for physical therapy offered to nursing home residents, specifically residents cared for at Lake Ridge.

Even though several changes have been made in proposed Rule 47, relating to physical therapy, between hearings held in November and the present hearings, there are still changes which should be considered. Rule 47, as currently proposed, still works a considerable hardship on nursing homes which maintain a salaried in-house physical therapy department and therapist as opposed to using outside physical therapists working on a consulting agreement. The latter are reimbursed on the basis of "usual and customary" charges under proposed Rule 47 while the former are reimbursed on a much more restrictive payment schedule. We are informed by legal counsel that this discrimination may well be illegal. However, herein we would like to address the practical problem of such an arrangement.

With the restrictions contained in Rule 47 for salaried in-house therapists, a facility such as Lake Ridge Health Care Center with a salaried therapist could not adequately protect itself from possible risks from operating a physical therapy program, including risks from litigation and related matters. A facility operating under Rule 47 with a salaried therapist presumably can include in its Rule 49 cost statement certain indirect costs relating to physical therapy, such as the welfare portion of equipment costs, utilities, and costs related to space. There is no method of reimbursement, however,

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ATTORNEY GENERAL
102 STATE CAPITOL
ST. PAUL, MINN. 55101

for costs that are not specifically covered, making it undesirable for a nursing home such as ours to continue to provide physical therapy services.

Further, Lake Ridge Health Care Center uses a salaried therapist and is at its regional maximum rate under Rule 49, it is doubtful whether our facility would implement a program of physical therapy or continue such a program with a salaried therapist, realizing that we would not be reimbursed for our costs. Since physical therapy is not required in a nursing home, it would be easy to discontinue our therapy program and send our residents or patients outside for therapy at a much greater cost to the State and County. These problems could be avoided by placing facilities such as ours, with salaried physical therapists on the same reimbursement schedule which is being proposed for physical therapists working with a facility on a consulting agreement.

The reimbursement formula proposed for salaried physical therapists could subject a facility to considerable losses, which losses would vary depending upon the number of patients receiving physical therapy who are on welfare. Any incentive to provide therapy services is further reduced by proposed Rule 47's requirement that any excess medical assistance reimbursement must be applied to reduce the "General and Administration" expenses on the facility's Rule 49 cost statement. Thus, Lake Ridge Health Care Center only stands to lose under this system. If the facility is able to provide quality physical therapy at a lower cost, it is penalized by having excess reimbursement amounts reduce other permissible general and administration costs. If, on the other hand, the costs for treatment for medical assistance recipients exceed the medical assistance percentage of therapy treatments as applied to salaried personnel amounts, the facility will be be fully reimbursed for services rendered to medical assistance recipients. As already indicated, if the facility is at or near the regional maximum under Rule 49, these problems are compounded.

If Rule 47 goes into effect in its proposed form, Lake Ridge Health Care Center may have no choice but to curtail their physical therapy department for welfare patients. As already noted, we would be forced to send our welfare patients and residents requiring physical therapy services to nearby hospitals or physical therapy centers at a much greater cost to the State and with higher emotional costs to the patients and residents who cannot be treated on the premises. As established on the hearing record in November, the cost to the State for providing this out-of facility service could be six or seven times as much as present

costs, since hospitals generally charge higher physical therapy rates and since transportation to and from the hospital, etc. would have to be covered by the medical assistance program.

In the interests of economy, good patient care and ready availability of good therapy services, we request that the proposed restrictions on physical therapy rendered by salaried personnel in long term care facilities be dropped from Rule 47 and that the present reimbursement system for physical therapy or a substantial equivalent be retained. If this is not done, the patient and the taxpayer will be the primary losers.

I would be happy to comment further on these matters if you so desire. Thank you.

Very truly yours,

LAKE RIDGE HEALTH CARE CENTER

Arthur Shuster
President

AS/se

BROEKER, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL. (612) 854-5263

JOHN M. BROEKER
STEVEN R. HEDGES
DAVID A. GRANT
KATHRYN E. BAERWALD
GEORGE L. CARLSON
ELENI P. SKEVAS

March 2, 1977

Mr. Michael B. Miller
Special Assistant Attorney General
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

Re: Proposed DPW Rule 47

Dear Mr. Miller:

This letter is to confirm our telephone conversation of today, March 2, 1977, regarding our meeting scheduled for Monday, March 7, 1977 at 10:00 o'clock A.M. On behalf of the Minnesota Association of Health Care Facilities, the undersigned law firm will present its comments on Proposed DPW Rule 47 at that time.

Thank you.

Very truly yours,

BROEKER, HEDGES & GRANT

By Kathryn E. Baerwald
Kathryn E. Baerwald

KEB:gsr

cc: Mr. J.I. Green
Mr. James Swanson

BROEKER, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL. (612) 854-5263

JOHN M. BROEKER
STEVEN R. HEDGES
DAVID A. GRANT
KATHRYN E. BAERWALD
GEORGE L. CARLSON
ELENI P. SKEVAS

February 24, 1977

Mr. Michael Miller
Administration Division
Attorney Generals Office
State Capitol Building
St. Paul, Minnesota 55101

Re: Proposed Department of Public Welfare
Rule 47

Dear Mr. Miller:

The undersigned law firm has been retained by the Minnesota Association of Health Care Facilities to represent it in the promulgation of the Department of Public Welfare Rule 47. We hereby request that the undersigned be notified at the time that the Chief Hearing Examiner's report on proposed Rule 47 is forwarded to the Attorney General's office for final review pursuant to the Minnesota Administrative Procedures Act. We understand that there is a twenty day period within which interested parties may make comments to the Attorney General on the proposed rule. It is anticipated that the Minnesota Association of Health Care Facilities may wish to make comments at that time.

Should you have any questions, please feel free to contact the undersigned.

Yours very truly,

BROEKER, HEDGES & GRANT

By Kathryn E. Baerwald
Kathryn E. Baerwald

KEB/jlh

BROEKER, HEDGES & GRANT
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420



Mr. Michael B. Miller
Special Assistant Attorney General
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

BROEKER, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL. (612) 854-5263

JOHN M. BROEKER
STEVEN R. HEDGES
DAVID A. GRANT
KATHRYN E. BAERWALD
GEORGE L. CARLSON
ELENI P. SKEVAS

February 28, 1977

Mr. Michael B. Miller
Special Assistant Attorney General
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

Re: Proposed Department of Public Welfare Rule 47

Dear Mr. Miller:

This letter is a follow-up to our conversation of this morning regarding the above-referenced matter. It is our understanding that the undersigned as counsel for the Minnesota Association of Health Care Facilities may be granted an extension in making our comments to Proposed Rule 47 should we be unable to obtain a copy of the rule as amended promptly. We will be contacting you should an extension be required and also as to arranging a meeting to discuss our comments on Proposed Rule 47.

Should you have any questions, please do not hesitate to contact the undersigned.

Very truly yours,

BROEKER, HEDGES & GRANT

By Kathryn E. Baerwald
Kathryn E. Baerwald

KEB:gsr

cc: Mr. J.I. Green
Mr. James Swanson

BROEKER, HEDGES & GRANT
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420



Mr. Michael B. Miller
Special Assistant Attorney General
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

C.1

BROEKER, HEDGES & GRANT
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420



Mr. Michael Miller
Administration Division
Attorney Generals Office
State Capitol Building
St. Paul, Minnesota 55101

(3) Data concerning payments for medical assistance under title XIX on behalf of recipients subject to sampling under the medical assistance program; and

(4) A comprehensive plan for analysis of and corrective action on the findings of each sampling period provided for in paragraph (c) of this section, no later than 135 days after the end of each sampling period.

(c) There shall be a sampling period from July 1, 1975 to September 30, 1975, and sampling periods of 6 months each thereafter commencing October 1, 1975, to collect the data referred to in paragraph (b)(2) and (3) of this section. Such data shall be submitted to SRS no later than 120 days after the end of each sampling period.

[40 FR 27221, June 27, 1975]

§ 250.30 Reasonable charges.

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

(1) Include a description of the policy and the methods to be used in establishing payment rates for each type of care or service listed in section 1905(a) of the Act that is included in the State's medical assistance program.

(2) Provide for payment of the reasonable cost of inpatient hospital services as determined in accordance with methods and standards, consistent with the provisions of section 1122 of the Social Security Act for participating States, which shall be developed by the State and approved in advance of implementation by the Regional Commissioner, Social and Rehabilitation Service. Under this requirement:

(i) Plans for payment of reasonable cost will be approved which adopt the title XVIII standards and principles described in 20 CFR 405.402–405.455 (excluding the inpatient routine nursing salary cost differential). However, with respect to cost reporting periods beginning after December 31, 1973, payments to hospitals for inpatient services shall be based on the lesser of the reasonable cost of services or the customary charges to the general public for such services, or, in the case of public hospitals rendering services free of or at a nominal charge, on the basis of fair compensation for such services, in accordance with the provisions of title XVIII regulations.

(ii) For other plans, criteria for approval will include:

(*a*) Incentives for efficiency and economy;

(*b*) Reimbursement on a reasonable cost basis;

(*c*) Reimbursement not to exceed that which would be produced through the application of the title XVIII standards and principles of reimbursement, as modified under paragraph (a)(2)(i) of this section;

(*d*) Assurance of adequate participation of hospitals and availability of hospitals services of high quality to title XIX recipients;

(*e*) Adequate documentation for evaluation of experience under the State's approved reimbursement plan.

State title XIX agencies are encouraged to involve representative provider organizations in the development of such plans and to work closely with title V grantees, the Social Security Administration, and other Governmental purchasers of hospital care in an attempt to achieve coordination in reimbursement methods within States.

(iii) Plans for payment of reasonable cost will not be approved under which payment for inpatient hospital services exceeds the amount which would be determined as reasonable cost using the title XVIII standards and principles described in 20 CFR 405.402–405.455 (excluding the inpatient routine nursing salary cost differential) as modified under paragraph (a)(2)(i) of this section.

(3) Provide that payments for care or service are not in excess of the upper limits described in paragraph (b) of this section.

(4) Provide that the single State agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or service, or fee plus costs of materials.

(5) Provide assurance that the State agency has access to data identifying the maximum charges allowed and that such data will be made available to the Secretary of Health, Education, and Welfare upon request.

(6) Provide that fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the

plan at least to the extent these are available to the general population.

(7) Provide that participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure, except that, with respect to payment for care furnished in skilled nursing facilities and services in intermediate care facilities, existing supplementation programs are permitted where the State has determined and advised the Secretary of Health, Education, and Welfare that its payments for such care or services furnished under the plan are less than the reasonable cost of such care or services permitted under Federal regulations, and the State has, prior to January 1, 1971, in the case of skilled nursing facilities, and the effective date of these regulations, in the case of intermediate care facilities, provided the Secretary with a plan for phasing out such supplementation within a reasonable period after the applicable date.

(8) Provide that any increase in a payment structure that applies to individual practitioner services shall be documented in State manuals or other official files by:

(i) An estimate of the percentile of the range of customary charges to which the revised payment structure equates and a description of the methods used in arriving at the estimate.

(ii) An estimate of the composite average percentage increase of the revised fee structure over its predecessor.

Criteria for meeting Federal requirements pertaining to such payment structures are set forth in paragraph (b) (3) (i) (A) of this section.

(b) *Upper limits.* The upper limits for payments for care and services under a medical assistance plan are as follows: The State agency may pay less than the upper limits. These upper limits do not apply to payments made under the State plan for deductibles and coinsurance imposed under title XVIII of the Social Security Act. Such payments may be made up to the reasonable charge under title XVIII. A State which pays for reserved beds in long term care facilities pursuant to paragraph (d) of this section may set payment rates for such reserved beds in an amount less than the rate paid for care in the facility if it is determined by the State that a differential exists between the cost of reserving a bed and the cost of providing care.

(1) *Inpatient hospital services.* The upper limits for payment shall not exceed the payment which would be determined as reasonable cost using the title XVIII standards and principles described in 20 CFR 405.402–405.455 (excluding the inpatient routine nursing salary cost differential). However, with respect to cost reporting periods beginning after December 31, 1973, payments to hospitals for inpatient services shall be based on the lesser of the reasonable cost of services or the customary charges to the general public for such services, or, in the case of public hospitals rendering services free of or at a nominal charge, on the basis of fair compensation for such services, in accordance with the provisions of title XVIII regulations.

(2) *Drugs.* The upper limit for payment for prescribed drugs—whether legend items (for which a prescription is required under Federal law) or non-legend items—shall be based on the lower of the cost of the drug (as determined in accordance with paragraph (b) (2) (ii) or (iii) of ths section) plus a dispensing fee established by the State, or the provider's usual and customary charge to the general public.

(i) In establishing the dispensing fee, States should take into account the results of surveys of costs of pharmacy operation. States shall periodically conduct such surveys of pharmacy operational data including such components as overhead, professional services and profits.

(*a*) The dispensing fee may vary according to the size and location of the pharmacy and according to whether the dispensing is done by a physician or by an outpatient drug department of an institution and according to whether the drug is a legend or a non-legend item.

(*b*) The dispensing fee may also vary for prescribed drugs furnished to title XIX recipients in an institutional setting by a pharmacy employing a unit dose system. In such instances the dispensing fee may be either: (*1*) An amount added to the cost of each unit dose furnished by the pharmacy or (2) a daily or monthly capitation rate per resident for whom prescribed drugs are being furnished. In either case, the dispensing fee is added to the ingredient cost of the prescribed drug which is actually consumed.

(ii) For each multiple source drug designated by the Pharmaceutical Reim-

bursement Board and published in the FEDERAL REGISTER, cost will be limited to the lowest of (*a*) the maximum allowable cost established by the Board for such drug, and published in the FEDERAL REGISTER, or (*b*) the estimated acquisition cost (as defined in paragraph (b)(2)(iii)), or (*c*) the provider's usual and customary charge to the general public; except that such limitation shall not apply in any case where a physician certifies in his own handwriting that in his medical judgment a specific brand is medically necessary for a particular patient. The form and procedure for the certification shall be prescribed by the State. An example of an acceptable certification would be the notation "brand necessary." A procedure for checking a box on a form will not constitute an acceptable certification. At the discretion of the State, the certification may be retained by the provider rather than submitted with the claim form with the understanding that it will be available for inspection by the State and by the Department of Health, Education, and Welfare.

(iii) For all other prescribed drugs, cost shall not exceed an upper limit established by the State. This shall be the State's closest estimate of the price generally and currently paid by providers. Such estimates shall be based on the package size of drugs most frequently purchased by providers. To aid States in making cost estimates, the Department will make available information on a current basis on acquisition costs of the most frequently purchased package size of drugs. These data will cover the majority of the most frequently prescribed drugs.

(iv) The upper limits governing reimbursement by State agencies to providers of prescribed drugs specified in this section shall also apply in cases where prescribed drugs are furnished as part of skilled nursing facility or intermediate care facility services or under prepaid capitation arrangements. Contracts between the State agency and the underwriter, carrier, foundation, health maintenance organization or other insurers containing the terms of such prepaid capitation arrangements shall include a provision imposing the same upper limits for reimbursement or prescribed drugs as are imposed by paragraph (b)(2) of this section on the State agency.

(3) *Other services*—(i) *Noninstitutional services*—(A) *Payments to individual practitioners.* (This applies to services of doctors of medicine, dentistry, osteopathy, and podiatry. At the option of the State, other individual practitioner services may be included.) A payment structure will meet Federal requirements if (as documented in State manuals or other official files):

(*1*) Payment to the individual practitioner is limited to the lowest of

(*i*) His actual charge for service;

(*ii*) The median of his charge for a given service derived from claims processed or from claims for services rendered during all of the calendar year preceding the start of the fiscal year in which the determination is made; or

(*iii*) His reasonable charge recognized under part B, title XVIII.

(2) In no case may payment exceed the highest of

(*i*) Beginning July 1, 1971, the 75th percentile of the range of weighted customary charges in the same localities established under title XVIII during the calendar year preceding the fiscal year in which the determination is made;

(*ii*) The prevailing charge recognized under part B, title XVIII, for similar services in the same locality on December 31, 1970 and found acceptable by the Secretary; or

(*iii*) The prevailing reasonable charge recognized under part B, title XVIII.

(B) *Other noninstitutional services.* The upper limits for payment shall be customary charges which are reasonable The prevailing charges in the locality for comparable services under comparable circumstances shall set the upper limits for payments. In reviewing prevailing charges for reasonableness, the State agency should consider the combined payments received by providers (for furnishing comparable services under comparable circumstances) from the carriers under part B, title XVIII of the Act and beneficiaries under such title, and the combined payments received from other third-party insuring organizations and their regular policy holders and subscribers, using whichever of these criteria or other criteria are appropriate to the specific provider service.

(ii) *Skilled nursing home services, outpatient hospital services, and clinic services.* Customary charges which are reasonable. Schedules of payments established by the State agency shall not exceed the combined payments received by providers (for furnishing comparable services under comparable circum-

practitioners. (This applies to
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steopathy, and podiatry. At the
of the State, other individual
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stances) from the intermediaries or carriers under title XVIII and beneficiaries under title XVIII of the Social Security Act. Schedules will be acceptable if within the upper limits either on a facility by facility basis or on the basis of average payments according to a reasonable classification of facilities based on levels of care. (In case of providers which are not participating under title XVIII, a financial audit of the facilities to apply the title XVIII–A reimbursement principles is not required but the State shall establish schedules of charges which are consistent with the intent that upper limits do not exceed amounts paid under title XVIII–A for similar services.)

(iii) *Intermediate care facility services.* (*a*) Customary charges which are reasonable. Schedules of payments established by the State agency shall not exceed an upper limit determined in accordance with the principles of reimbursement for provider costs under Part A of title XVIII of the Act. (A financial audit of the facilities to apply the title XVIII–A reimbursement principles is not required but the State shall establish schedules of payments which are consistent with the intent that upper limits do not exceed amount which would be paid using title XVIII–A principles and methods of cost reimbursement for similar service.)

(*b*) (*1*) Federal financial participation is not available for expenditures under the State plan for payments to intermediate care facilities, except for institutions for the mentally retarded and persons with related conditions which are exempted from this requirement, for any calendar quarter which are in excess of that amount which reflects a reasonable differential on a Statewide basis between average per diem amounts paid under the State plan for intermediate care facility services and the Statewide average per diem amounts paid under the State plan for skilled nursing facility services. Such reasonable differential shall reflect a lower rate of reimbursement for intermediate care.

(2) The differential shall be computed by determining the dollar amount of difference between the average amount paid per inpatient day under the State plan for skilled nursing facility services and the average amount paid per inpatient day under the State plan for intermediate care facility services, regardless of the basis for reimbursement, whether a flat rate, a negotiated rate, or a cost-related rate.

(3) In no case shall the statewide differential computed in accordance with paragraph (b)(3)(iii)(b)(2) be less than 10 percent of the statewide skilled nursing facility rate except as provided in paragraph (b)(3)(iii)(b)(5).

(4) States must report each quarter on the Quarterly Statement of Expenditures (Form SRS–OA–41) separately for skilled nursing facility services and intermediate care facility services, the total amount paid during the quarter for services, the number of inpatient days of services paid for during the quarter, and the average amount paid per inpatient day for services during the quarter. The single State agency shall have on file adequate records to substantiate the quarterly statement of expenditures.

(5) The Administrator may approve a State's request for a cost differential of less than 10 percent if he determines that such differential is reasonable. A State requesting approval of a cost differential of less than 10 percent must submit cost-related data to demonstrate that such lesser differential is reasonable. The Administrator in approving a cost differential of less than 10 percent will indicate the period for which such differential is approved.

(4) *Prepaid capitation arrangements* The upper limit for payment for services provided on a prepaid capitation basis shall be established by ascertaining what other third parties are paying for comparable services under comparable circumstances. The cost for providing a given scope of services to a given number of individuals under a capitation arrangement shall not exceed the cost of providing the same services while paying for them under the requirements imposed for specific provider services.

(c) *Waiver of experiments.* Any limitations on reimbursement imposed by the provisions of this section may be waived by the Secretary with respect to experiments conducted under the provisions of section 402, Public Law 90–428, Incentives for Economy Experimentation.

(d) *Federal financial participation.*—(1) *General* Federal financial participation is available for payments within the upper limits described in paragraph (b) of this section, in accordance with the provisions of the State plan.

(2) *Payments during recipient's absence from long term care facility.* (i)

58–006—75——16

Federal financial participation is available in vendor payments which are necessary to reserve a bed in a long term care facility (skilled nursing facility, intermediate care facility, tuberculosis or mental hospital, or chronic care part of a general hospital facility) for a recipient during a temporary absence in a hospital for an acute condition or for therapeutically indicated home visits (defined to include visits with relatives and friends, and leaves to participate in State-approved therapeutic or rehabilitative programs).

(*a*) The following conditions will be met in any instance in which a bed is reserved;

(*1*) The State plan provides for such payments:

(2) Payment is made only for those days during which there is a likelihood that the reserved bed would otherwise be required for occupancy by some other patient. Determinations as to whether there is a likelihood that a bed is otherwise required for occupancy shall be based on analysis of current facility occupancy patterns in the locality and other pertinent data; and

(*b*) The following conditions will be met when a bed is reserved in a long term care facility because of the recipient's hospitalization for an acute condition:

(*1*) The single State agency has approved the recipient's hospitalization for an acute condition prior to each period of hospitalization during which a bed in another facility has been reserved. In case of an emergency admission such authorization will be obtained as soon as possible after admission.

(*2*) The single State agency has approved the bed reservation for the recipient prior to each period of hospitalization. In case of an emergency admission such authorization will be obtained as soon as possible after admission.

(*3*) The patient intends to return to the same facility after hospitalization.

(*4*) The hospital provides a discharge plan for the recipient.

(*c*) In the case of therapeutic home visits, the patient's plan of care provides for such visits.

(ii) Federal financial participation in the cost of reserving a bed for purposes of paragraph (d) (2) of this section is available for (*a*) periods of hospitalization for acute conditions not to exceed 15 days per any single hospital stay and for (*b*) therapeutically indicated home visits not to exceed 3 days per visit nor six such visits per patient during any 12-month period, limited to two visits in any calendar quarter. The limitations do not apply in the case of patients in institutions for the mentally retarded or persons with related conditions (see § 249.13(a) (1) (xi) (E) of this chapter). Where the limitations for therapeutic visits interfere with a State approved therapeutic or rehabilitative program, the State agency may submit a request for special limits to the Regional Commissioner. In addition, the State shall obtain, and submit to the Regional Commissioner as requested, data on long-term care recipients who make home visits.

[34 F.R. 1244, Jan. 25, 1969, as amended at 35 F.R. 10013, June 18, 1970; 36 F.R. 12621, July 2, 1971; 36 F.R. 21591, Nov. 11, 1971; 39 FR 2235, Jan. 17, 1974; 39 FR 21135, June 19, 1974; 39 FR 28288, Aug. 6, 1974; 39 FR 31639, Aug. 30, 1974; 39 FR 43632, Dec. 17, 1974; 40 FR 14598, Apr. 1, 1975; 40 FR 15388, Apr. 7, 1975; 40 FR 34519, Aug. 15, 1975]

NOTE: For interim policy published in uncodified form, see 34 F.R. 11098, July 1, 1969.

EFFECTIVE DATE NOTE: § 250.30(b) (2) is effective Apr. 26, 1976.

Subpart A—General

§ 250.31 Payments for medical services and care by a third party.

(a) *Requirements for State Plans.* A State plan for medical assistance under title XIX, Social Security Act, must provide that:

(1) The State or local agency will take reasonable measures to ascertain any legal liability of third parties arising after March 31, 1968, for the medical care and services included under the plan, the need for which arises out of injury, disease, or disability of applicants for or recipients of medical assistance.

(2) The State or local agency, in determining whether medical assistance is payable, will treat any third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time.

(3) The State or local agency will not withhold payment in behalf of an eligible individual because of the liability of a third party when such liability or the amount thereof cannot be currently established or is not currently available to pay the individual's medical expense.

(4) The State or loca
reimbursement from a
assistance provided wh
bility is established a
granted and in any oth
the liability of a third p
was not treated as a cu

(b) *Federal Financ*
The State may claim
participation in expend
assistance made in acc
provisions for conside
and resources in the ap
Accordingly, since the l
party is considered as
State may not include
claimed, payments mad
and services rendered r
out of injury, disease, or
extent that: (1) The th
constituted a current r
disregarded when such
made, (2) the agency fa
sonable steps to collec
from a third party wh
subsequently establish
agency received funds i
in satisfying his liabilit
The Federal Governme
pro rata share of any
instances representing
from third parties, if F
tion has been claimed.

(c) For purposes of
term "third party" incl
ual, institution, corpo
private agency who is o
pay all or part of the
injury, disease or disab
cant or recipient of me

[34 F.R. 752, Jan. 17, 1969]

§ 250.41 Consultative s institutions.

(a) *State plan requi*
plan for medical assis
XIX of the Social Se
provide for consulta
health agencies and o
agencies of the State to
ing homes, home health
and laboratories in ord
facilities to:

(1) Qualify for pay
Social Security Act, i
and XVIII of the Act;

(2) Establish and ma
records as may be n
proper and efficient a
the Act; and

(3) Provide informati
termine payments due

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FEB 16 1977
OFFICE OF HEARING EXAMINERS

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

February 15, 1977

Duane Harves, Chief Hearing Examiner
Office of Hearing Examiners
1745 University Avenue
St. Paul, Minnesota 55104

Dear Mr. Harves:

Re: Minnesota Rule DPW 47 - Medical Assistance
DPW-76-006-SM

The Department has carefully reviewed each of the comments and proposed changes made by Mr. Steve M. Mihalchick, Hearing Examiner, before whom the public hearing on Minnesota Rule DPW 47 was held. We found his comments and suggestions to be most helpful and have therefore included all but a few of them in the adopted rule.

Before explaining in detail the revisions made by the Department to the rule as first proposed, I would like to make some general comments. Mr. Mihalchick suggested that specific sections of Federal regulations and State and Federal statutes be explicitly referenced in the rule. Such reference would afford interested individuals ready access to these statutes and regulations. After careful consideration the Department has declined to reference specific sections of statutes and regulations in DPW 47. Such reference would require the Department to amend the rule every time any referenced statute or regulation was amended or revised. Therefore the adopted rule refers to "applicable regulations and statutes" and in some sections to Minn. Stat. §256B or to Title 45 of the Code of Federal Regulations. Such reference should enable interested individuals to locate the relevant sections with a minimum of difficulty.

The Hearing Examiner objected to the provision of DPW 47 A.3. that proposed limiting medical assistance to persons having a demonstrated need for such services. The Department agrees with the Hearing Examiner that such limitations are unnecessarily confusing and has stricken the phrase from the rule as adopted. The same objection was raised to DPW 47 B.10. as being broader than that required by statute and lacking necessary definitions for release of information. In order to remedy these defects, the Department has reworded the rule to include the statutory language of Minnesota Laws 1976 Ch. 188, subd. 3, as suggested.

A question was raised as to the accuracy of paragraphs d. and e. of DPW 47 C.2. defining residence. The Department has reviewed these paragraphs and finds that they

accurately state the requirements of Federal regulations, State law and Court decisions.

The Hearing Examiner criticized the language of DPW 47 C.4.a.(3) as not conforming with applicable state law. Accordingly, the Department has modified the rule to remedy this defect in language. The Department has also revised DPW 47 C.4.b.(4) to clarify the status of money paid as a deposit to a long term care facility.

The Hearing Examiner took exception to the language of DPW 47 C.8.a. for being unreasonably vague. The proposed rule attempted to incorporate by reference all Federal regulations and State law relevant to fair hearing requirements and procedures. Because these requirements and procedures are outlined in great detail in Title 45 and in Minn. Stat. §256, the Department did not include them in DPW 47. However, in response to the Hearing Examiner's concern, the Department has revised this section of the rule to include a summary of the requirements and procedures concerned with fair hearings, and also to state that all requirements of Federal regulations and State law will be followed.

The Hearing Examiner suggested that DPW 47 D.1.c. be amended to include the language of Minnesota Laws 1976, Ch. 282, sec. 8, regarding free choice of provider. The Department approves of such revision and has modified DPW 47 accordingly.

The Hearing Examiner disapproved of DPW 47 D.4.c. unless modified to include the requirement of Minn. Stat. § 256B.27, subd. 3. It is currently the policy of the Department to present a provider with a copy of the recipient's signed consent when requesting the provider's records. The Department therefore concurs with the Hearing Examiner's suggested phrase and has inserted it into DPW 47 D.4.c.(2) as appropriate. In addition, the Department has accepted the Hearing Examiner's proposal to amend DPW 47 D.4.c.(3) to incorporate the language of applicable State law.

The Hearing Examiner suggested that DPW 47 D.6. be amended to specify that the fair hearing requirement applies to restrictions placed on use of Medical Assistance identification cards. While the Department believes that DPW 47 C.8. adequately states the requirements for fair hearings, we have amended DPW 47 D.6. to explicitly apply all fair hearing requirements to restrictions placed on recipient identification cards.

In accordance with the Hearing Examiner's objections to inclusion of the word "policies" in DPW 47 D.7., the Department has stricken the word from the rule as adopted. In addition, the Department has extensively reworded DPW 47 D.8. to add the statutory language of Minn. Stat. § 256B to the section of the rule concerned with provider eligibility.

In the course of amending DPW 47, the Department discovered an error in Section D.9. prior authorization. In the fourth sentence the phrase "completed charges" was inadvertently substituted in place of "contemplated charges". As the latter term is correct, and as the change is not substantial, the Department has inserted the appropriate word.

The Hearing Examiner suggested several changes to DPW 47 D.10. utilization control. The first proposal would modify the first sentence of subsection a. The Department has no objection to this modification and has reworded the sentence accordingly.

The Hearing Examiner next recommended that the title of DPW 47 D.10. be amended to limit this section of the rule to utilization control of inpatient hospital and skilled and intermediate care facility services only. The Department believes that such change would be inappropriate because 45 CFR § 250.18 requires the Department to establish and implement a utilization control program for all services furnished under the Medical Assistance program. However, as subsection b. of DPW 47 D.10. deals specifically with utilization control in hospitals and skilled and intermediate care facilities, the Department has added a descriptive title to subsection b. to clarify the scope of the utilization control program provided thereunder. Finally, the Hearing Examiner strongly objected to subsections (2) and (3) of DPW 47 D.10.d. as being unreasonable because contrary to the rule-making requirements of State law. In order to assure full compliance with all requirements of Minn. Stat. § 15, the Department has deleted the subsections in question from the adopted rule. When surveillance and utilization control methods, procedures and criteria are developed, they will be adopted in accordance with all requirements of State law.

The Hearing Examiner proposed a modification to DPW 47 D.11. in order to remedy an apparent inconsistency between two provisions of the rule dealing with transportation services. The Department agrees that the language of the proposed rule was somewhat confusing and therefore accepts the rewording suggested by the Hearing Examiner. However, the Department cannot agree with the Hearing Examiner's conclusion that the requirement that certain transportation services receive prior authorization is unreasonable. 45 CFR § 249.10(b)(17)(i)(A) specifically authorizes payment for transportation "when determined by the agency to be necessary in the individual case". The purpose of the prior authorization process is to make such determination before services are rendered. Without some workable procedure to determine necessity in advance of providing the service, we believe that the Department would be in violation of governing Federal regulations.

The Hearing Examiner suggested that DPW 47 E.1.b. reference E.2.n. which creates an exception to provision of medications under the rule. The adopted rule has been duly referenced.

The Hearing Examiner expressed doubt about the legality and reasonableness of the prohibition against Medical Assistance payment for artificial insemination and reversal of voluntary sterilization [See, DPW 47 E.1.j. and q.]. The Department has considered these objections and has concluded that there is no substantial basis for belief that such services are medically necessary. Because 45 CFR § 250.18 requires the Department to safeguard against unnecessary or inappropriate utilization of care and services, the Department has determined that artificial insemination and reversal of voluntary sterilization shall not be reimbursable with Medical Assistance funds.

In DPW 47 E.2.b.(1)(a) the Hearing Examiner proposed a modification so that this section will comport squarely with § 1902(a)(28) of the Social Security Act. The Department accepts this recommendation and has reworded the rule accordingly. The Hearing Examiner also suggested deletion of section E.2.b.(5) in its entirety until the rule-making requirements of Minn. Stat. § 15 are carried out. The Department has deleted the paragraph as suggested, reserving it for future use.

The Hearing Examiner correctly pointed out a typographical error in DPW 47 E.2.b.(6)(b) wherein payment should be precluded for an individual who is under 65 and a patient in an institution for tuberculosis or mental diseases. The appropriate correction has been made.

DPW E.2.b.(7) requires each facility licensed by State law to submit an annual financial report to the Department. As it is the policy of the Department to accept a Rule 49 or Rule 52 cost report as satisfaction of this requirement, the Hearing Examiner recommended that this policy be explicitly stated in DPW 47. This recommendation has been accepted and the rule modified appropriately.

The Hearing Examiner expressed concern that the words "as are all other providers" in DPW 47 E.2.d. might mislead someone into believing that all providers are excused from the limitations provided in DPW 47. As the intention of the rule is to excuse only contracted HMOs, the Department has deleted these words in order to prevent any possible confusion.

Federal regulation limit reimbursable chiropractic services to manual manipulation of the spine only. DPW 47 E.2.e.(1)(b) states that Medical Assistance reimbursement is so limited. However, the Hearing Examiner requested that the rule be modified in order to expressly state that Medical Assistance funds shall not be used to reimburse chiropractors for x-rays nor any other diagnostic or laboratory procedure provided. Therefore the Department added subsection E.2.e.(1)(d) to clarify this point.

As suggested by the Hearing Examiner, the Department modified DPW 47 E.2.e.(5) in order to include the 1976 amendments regarding services provided by public health nurses. Also, the Department accepted the Hearing Examiner's recommendation that a qualified home health agency is one determined by the Minnesota Department of Health to meet the requirements of applicable Federal regulations (DPW 47 E.2.h.(2)).

The Hearing Examiner raised some objections to provisions of DPW 47 E.2.i. Medical Supplies. In subsection (4) the Department was asked to define "performance agreements". In subsections (5)(a) and (b) the Hearing Examiner objected to reference to a "formulary" as being in violation of the rule-making process. In subsection (5)(e) the Hearing Examiner suggested deletion of the words "in the team conference" to avoid confusion over their meaning. The Department has accepted these comments and modified DPW 47 accordingly.

DPW 47 E.2.k. is concerned with provision of rehabilitative and therapeutic services. The Hearing Examiner proposed several changes within this section, all of which have been incorporated into the rule. Therefore, in subsections (1)(a) and (2)(c) the Department has added the provision that a physical therapist shall obtain a valid Minnesota certificate of registration "as soon as such certificate is available from the Minnesota Department of Health". In subsection (1)(f)(xiii) the rule specifies that the local welfare agency may authorize physical therapy services beyond the initial 90 days only if authorization by an independent medical consultant or the facility's utilization review committee is not possible. To provide the requested definition of Rehab. agencies in subd. (3), the Medicare definition in 20 CFR § 405. 1702(h) was inserted. Finally, the Hearing Examiner suggested that a new paragraph be added following subsection (2)(d) to clarify reimbursement procedures for services of independent practitioners under contract to or employed by an agency or facility. The Department accepted the Hearing Examiner's proposed language, added subsection (2)(e), moved paragraphs E.2.k.(2)(d)(i) and (viii) under (2)(e) and deleted subsection (2)(d)(vi) because it became duplicated by (2)(e).

The Hearing Examiner suggested two changes to DPW 47 E.2.l. covering dental services. These changes would specify that the limit of 3 visits per diagnosis applies only to

visits by the dentist to a hospital or facility, and would exclude services provided by a dentist to a recipient in his home. Both of these suggestions would help clarify DPW 47 and have been accepted by the Department for inclusion in the rule.

The section of DPW 47 covering pharmacy services, E.2.n., requires some changes in order to satisfy the Hearing Examiner's objections. The last sentence in the first paragraph, referring to a formulary, has been deleted from the rule. The five (5) refill limitation in subsection (1)(c)(ii) has been modified to not apply to residents of long term care facilities. In subsection (3)(i) "biologicals" have been further defined as those serums, toxoids and vaccines "generally considered inappropriate for self-administration". Subsection (3)(j) has been cross-referenced to DPW 47 E.1.n. as suggested by the Hearing Examiner.

The Hearing Examiner asked that DPW 47 F.1. either spell out the Medical Assistance program's maximum allowable charges, or describe the mechanical method used to compute those maximums. The Department has seriously considered this suggestion but believes that section F.1.b. of the rule as proposed already provides a description of the methods used to establish maximum allowable charges. The language of DPW 47 F.1. was adopted in accordance with all requirements of Minn. Stat. § 15 and became effective May 28, 1976. Therefore the Department believes that the Hearing Examiner's objection to this paragraph of proposed DPW 47 is not well taken and should not be accepted.

The Hearing Examiner proposed two changes to DPW 47 F.2. in order to improve the language of the paragraph. Accordingly, the reference to a provider's "employer" has been replaced with reference to "an agency, institution or group pursuant to a contract with an approved provider". Also as suggested, the reference to the Title XVIII standards has been deleted.

As the Department desires DPW 47 to be effective 20 days after publication in the State Register, the reference in section G to an effective date has been removed.

The adopted rule has been typed in the format required for publication in the State Register. Because DPW 47 is essentially a new rule rather than an amendment to an existing rule, it has been typed in the format required for a new rule. However, in order to assist you in reviewing the changes made by the Department between the rule as proposed and as adopted, we have indicated all changes in red on the attached copy of adopted DPW 47.

Yours respectfully,

Vera J. Likins

Vera J. Likins
Commissioner

(1) WORK

Notice - re cit. of stat. auth.

S/N - def.? See Ex B 91 - cured by 23 day interim

* 47 I B - "instr." manuals? - Adopted 47 D 2 drop "implement"

✓ 47 I C (e)? - Strike " have demonstrated the need for such services"

Last sent. ✓ 47 II b - delete " one cond. of eligibility is a demonstrated need for medical care + service"

✓ 47 II j → delete " and other appropriate agencies"

✓ → Rule as proposed falls short of defining cond of info release & of info. Consent req'd by stat. is less broad than rule — rule ∴ bad unless called for by Fed. Law 45 CFR 250.21

#24 *? 47 III d 1 C - must be modified to comply w/ stat. (incl. non-cash income) C 4 a 3 ↓ child prot.

✓ ⊘ 47 III d 2 D • change phrase "cover money" to "dispose"

* 47 III h - define "Est. procedures"

[8a - adopted - still bad]

✓ 47 IV a - conform letter to stat (see #38) deleted

* 47 III d - record keeping req't vague D 461 - still vague

✓ 47 IV d - rule must include ind. consent before info release

✓ 47 IV d 3 b - add lang - in #42 p. 16 HEReg

✓ 47 IV d 3 c - grant of immunity broader than stat. 356 B 27 - see rec. @ bottom of p. 16 HEReg.

✓ 47 IV g - delete "policies"

✓ 47 IV h - 2nd sent. of prop. rule unreas.

47 DG ✓ 47 IV h - must have written consent to examine med. records

*47 II i - out ✓ 47 IV j i - language on middle of p. 21

✓ 47 IV j 4 - avoids rulemaking req'ts (as proposed)

✓ 47 IV k - should read as in middle of p. 23

agency just. rule * 47 IV k - prior ~~justifies~~ auth. for transp. w/ justified by record

2 - NOTES

222-4383
↳ Surplus Store

dept says inappropriate ? * 47 II A (10) + (17) - omit legality of reg. re childbirth

✓ 47 II b 2 f;; change "or" to "and"

A62 ✓ 47 II b 4 - delete "as are all other providers" from last sent.

✓ 47 II b 5 A - clarification as per As 64 + 87

✓ 47 II b 8 B - change "state agency" to dept of Health

✓ 47 II b 9 C - delete As referring to "formulary"

"as soon as avail." ? ✓ 47 II b 11 - delete req't of cert. by bd. of health

✓ 47 II b 11 A - restate as per A80 p. 36 - last sent.

✓ 47 II b 11 B iv - rec. new ¶ as on top of p. 37 HCR + deletion of As mentioned there

said changed but didn't ? * 47 II b 12 - deletion @ bottom of p. 37 HCR A84 - ok if clarify that dentist's office visits limited to 3

A86 ✓ 47 II b 14 - delete ". if such action nec. for adm. of program"

✓ - define "biological" - so applies only to med. adm. dir. by physician

" ✓ - delete exception of groups by age - exclude such foods

A87 ✓ 47 II b 15 - any services shown or enumerated

** A93 stat.!! * 47 VII a - rule must spell out mech. changes or define method for computing them

A94 ✓ 47 VII b + c - replace word "employer" + delete "the Title XVIII Stds"

X · Fiscal impact statement - should be filed?

· Dept. FF

· S/N

3/7/77 Also - no FF by dept. - just 5 page rule.

Meeting w/ Kay Baerwald re Rule 47 SPW

① 2 obj. to whole rule
A. no fiscal impact statement (see ch. 43 laws 75 § 22

↓

since rule is justified on fiscal grounds, this seems imp.

↓

Procedural

record was going to be reviewed for $100M impact, but has not been done

✓ B. Statement of Need - no reasons for various provisions of rules.
obj. to in June '76 - HE said cured by 23 day delay between 2 hearing days → all Tr. of 2nd day

② F.I. - reimbursement - w/ speed usual + cust. or SPW max
Pt 93 + 96 HE Dept. - should spell out or set formula
- see p. 3 of Silvis letter

* She says violates 256 B. 05 subs 2+3
↓
calls for est. of schedule of max. charges

also 45 CFR 250.30
↓
agency must spell out methods of est. pmt.

This rule allows rulemaking by allowing later est. of sched. w/o APA procedure -

They say "neg. fee" = sched.
She says must be formula or sched.

Rule as adopted satisfies MS but not CFR

✓ ① C.8. - termination. → See MS 256.045 + 45 CFR 205.10 - rule must set out hearing + appeal procedure. We found orig. rule deficient.

③ E.2.b.1.a. - "skilled nursing facil" = 1 cert. as ~~skilled~~ meeting reqts of Title 19

says can't dep. on Dept of Health

should be std. for cert. (incl. some of 18 by ref.)

④ Med. Supplies - obj.: uncond. discrim. against some inpatient + long term care facil. (no reimb. for certain equip. where others do get it -- no rational dist. between need of patient in one inst. vs. another)

E.2.i. (med. suppl.)

E.2.k. (rehab. services)

staff services of i.t. in house care facil. - formula under Rule 47. No restr. on hosp. therapy in hosp's or by ind. practitioner

Rule is non-cost effective obj. in Tr.

want both reimbursed same way - one is now direct & other is ~~for~~ by pmt. to equip. provider.

wants all treated alike

E.2.k.2.d. → defn. of ind. prac. is vague

③ Prior auth. + util control → Rule now lets dept. est. stds. by decree rather than APA procedure

D.9 D.10

correct? Rule sets out criteria (not allows est. of "methods + procedures")

Fed. regs. call for agency to set out criteria. W/done for inpatients facilities (HE obj. to this as circumventing APA - dept's deletions do not correct this)

⑥ Release of med. records

B.10. → See P10 letter → 45 CFR 205.50

D.4.c. → 45 CFR 205.50

D.8. - releasing providers - rule says must do @ request by DPW. 2-3 sentences added after hearing - says subst. change would give CDPW power to declare provider ineligible + provide subs for reimbursement

Right (3) → requires st. agency to define info released - must req. confid. by agency + have same std. of confid. as DPW

3/17/77 Tom Jensen - meeting on Rule 47

① (A) Fiscal impact - 1) Says n/a over 100,000
2) Says see Simmons test. - rule will result in savings - est hard to do

(B) S/Need - will get back to me on this q.

② - Says hard to give est. in advance
Says tied in to medicaid + ∴ reas. stds.
Opposite is est. of fee schedules --
can't do 250.30 - says "discr. of
He says they follow Medicare stds. policy + methods + in comp. or est

③ Says only way to know if Title 8+19 stds are met is by Dept of Health Cert
- what is her compl. ? -

④ Med. supplies - small % of facil. population actually needs equip. - dept. says better to depr. equip. than get pmt.

Can get reimbursed to extent that it is used for ind. on med. assistance

Hosp., on other hand - has need for equip for greater % of pop.

⑤ Rule sets limits (by hours of psych help, for ex.) by rel stds. Says that's enough.
Supp. by record -

⑥ Fed. regs require release - says need not be more spec
Says complies w/ HE dept.

Letter #8 → says don't want to pay for therapists used on non-med. assist. recipients

↓

reg. showing that services actually are provided to recipients -

#12 - letter - Tom says n/ pay them w/o documentation

256B.064

Release of Med records - recipient must consent in order to submit bill

#13 — Intent of dept. was to make it a cl. 15 cont. case.

BROEKER, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 504
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL. (612) 854-5263

JOHN M. BROEKER
STEVEN R. HEDGES
DAVID A. GRANT
KATHRYN E. BAERWALD
GEORGE L. CARLSON
ELENI P. SKEVAS

March 8, 1977

Mr. Michael B. Miller
Special Assistant Attorney General
State Administration Building
50 Sherburne Street
St. Paul, Minnesota 55155

Re: Department of Public Welfare Rule 47

Dear Mr. Miller:

The undersigned law firm has been retained by the Minnesota Association of Health Care Facilities to present its comments on Department of Public Welfare Rule 47. At the June 1 and 2, 1976 hearing, the Department of Public Welfare presented "Proposed" Rule 47. After review by the Hearing Examiner, the Rule was amended, in part, and presented to the Chief Hearing Examiner. That version of Rule 47 provided to the Chief Hearing Examiner will be referred to as "Adopted" Rule 47 as distinguished from "Proposed" Rule 47.

On June 22, 1976, the Minnesota Association of Health Care Facilities (hereinafter referred to as "MAHCF") filed its comments with the Hearing Examiner as part of the hearing record herein. Additional comments were filed by MAHCF during the 20-day period in which the hearing record was open for public comment upon conclusion of the hearing on June 25, 1976. These comments will address primarily issues raised by the Report of the Hearing Examiner dated January 11, 1977 and Adopted Rule 47. These comments are filed to object to the form and legality of certain portions of Adopted Department of Public Welfare Rule 47 and to oppose the enactment of certain portions thereof into law. Minn. Stat. §15.0412; Atty. Gen. 305.

1. Fiscal Impact. At ¶99 of his Report, the Hearing Examiner suggested that the Department of Public Welfare review "the fiscal impact of the rule in final form before deciding" whether the Department should file a fiscal note as required by Laws 1975, Chapter 434, Section 22. That statute reads as follows:

> "Notwithstanding any other law to the contrary, the departments of health, public

> welfare, and corrections shall not put into effect any rule, regulation, or standard, which has a fiscal impact in excess of $100,000 annually without first providing the house appropriations and senate finance committees with a fiscal note."

In its Report, the Department of Public Welfare does not address the question of the fiscal note.

At the June, 1976 public hearing, the Department of Public Welfare was requested to state for the record the fiscal impact of the various provisions of Proposed Rule 47. The Department responded by stating that the financial impact of the various provisions would be addressed as each provision was discussed rather than in one statement at the beginning or at the end of the hearing. However, at no time during the public hearing was the financial impact of Proposed Rule 47 discussed other than in the most vague and general terms. The only discussion of financial impact of Proposed Rule 47 was in terms of the Medical Assistance program in Minnesota as it currently exists and to show the rising costs of Medical Assistance payments both in Minnesota and in other states over the last ten years. Nothing was stated as to exactly how Department of Public Welfare Rule 47 would impact upon the amount of Medical Assistance payment expended by the state. If, in fact, the Department of Public Welfare has determined that Proposed Rule 47 has an impact of less than $100,000 annually, then no fiscal impact note is required as such, but it would be of importance to still note the cost of the changes since many portions of Rule 47 are being justified on cost grounds. However, if the Department of Public Welfare has failed to make any determinations of the fiscal impact of Proposed Rule 47, then it is in violation of Chapter 434, Laws 1975. If no fiscal study has been done, the Department of Public Welfare is required to do such a study to determine whether or not a fiscal note is required under applicable state law. Until such time as the Department clearly shows that a fiscal note is or is not required, Proposed Rule 47 is out of compliance with Laws 1975, Chapter 434 and thus must be struck as a whole as being illegal for failing to comply with mandatory statutory requirements for Department of Public Welfare regulations.

#1

2. Statement of Need. In its June, 1976 comments, MAHCF objected to the Statement of Need filed by the Department of Public Welfare regarding Proposed Rule 47. In ¶7 of his Report, the Hearing Examiner stated that the Statement of Need's purpose is to allow "persons who may wish to contest proposed rules the opportunity to prepare a rebuttal." He then continued by stating that any defects in the Statement

of Need were cured by the 23-day recess in the hearings and that interested persons had not only the chance to see the Statement of Need but also to hear the entire "case-in-chief" of the Department of Public Welfare.

The Statement of Need as supplied by the Department of Public Welfare was inadequate as it contained little more than a list of the changes which were proposed and merely indexed the contents of Proposed Rule 47. Rule Atty. Gen. 302(g) requires that the Statement of Need "contain a recitation of the reasons which support a finding of need for the rules . . . A general statement of statutory implementation will not suffice." When one reviews the Statement of Need in light of those requirements, it is clear that the Statement of Need did not fulfill those criteria. Further, the Statement of Need could not be cured by the 23-day recess in the hearings. The purpose of the Statement of Need is to permit individuals to prepare their rebuttal to the contents of the proposed Rule. While the Statement of Need may have been cured for those individuals who attended the first full two days of the hearing, such is only a very small percentage of persons affected by Proposed Rule 47. Most persons affected by the Rule or potentially affected by it did not have the chance to hear the Department's "case-in-chief" and thus could not submit a knowledgeable rebuttal or commentary to the proposed Rule. Therefore, Proposed Rule 47 is out of compliance with applicable law governing rule making and should be striken.

3. Department of Public Welfare Report. The Department of Public Welfare submitted a five page letter to the Chief Hearing Examiner on February 16, 1977 as its Report on Rule 47, and an additional letter on February 17, 1977 relating to two miscellaneous matters. To the best of our knowledge, no Findings of Fact were submitted by the Department of Public Welfare as required by Atty. Gen. 302(h). The five page letter, even if intended by the Department of Public Welfare to be its "Findings of Fact" does not comply with Atty. Gen. 302(h) which states as follows:

> "The Findings of Fact must contain that which the agency finds to be fact which supports the reasons or need for the rules adopted."

Clearly, a mere recitation of what amendments were made to the Rule is not a statement of the facts supporting "the reasons or need" for the Rule. Further, the Department of Public Welfare does not show that the record supports the Rule as adopted. Atty. Gen. 303(c). Therefore, Rule 47 should not be approved as to form and legality by the Attorney General pursuant to Atty. Gen. 305(b).

In addition, the February 16, 1977 letter does not address all of the recommendations by the Hearing Examiner. For example, the

Hearing Examiner states that the Department of Public Welfare should consider providing guardians for incompetent Medical Assistance recipients. ¶100 of Hearing Examiner Report. This is especially important in light of requirements that Medical Assistance recipients give consent to the release of their records. (See comments on release of records, infra.) See also the following paragraphs of the Hearing Examiner Report:

¶42 Requests for disclosure of records
¶56(15) Mileage expenses
¶73 Listing of items requiring prior authorization
¶75 Payment for certain supplies
¶79 Cost of rehabilitative therapy
¶80 Consistency of periods of time for physician review.

All of the above are of great concern to MAHCF but were not addressed by the Department of Public Welfare despite the recommendations of the Hearing Examiner.

Therefore, MAHCF objects to Rule 47 because of the inadequate or non-existent Statement of Fact and because of the Department of Public Welfare's failure to address many issues raised by the Hearing Examiner.

4. Rule Making Outside of the Minnesota Administrative Procedures Act. As noted in specific comments, infra, Rule 47 would permit the Department of Public Welfare to establish "rules" outside of the requirements of Chapter 15 of the Minnesota Statutes. These comments have attempted to note each such instance of the apparent grant of rule making authority but there may well be other instances thereof contained in the Adopted Rules. Therefore, MAHCF objects to the legality of Rule 47 as being in violation of Minn. Stat. §15.0411 et seq.

At the time of the June, 1976 hearing, Rule 47(F)(1) read as follows:

> "DPW's'maximum allowable charge' as used herein means the charge established in accordance with requirements of applicable federal regulations."

In its adopted version of the Rule, the Department did in fact make changes in the Rule and restated the Rule as adopted after the first Rule 47 hearing held in November, 1975. The Department's assertion that the Rule as adopted does in fact describe the method of computation is incorrect. The Rule does not spell out the "applicable federal regulations" which prescribe the maximum allowable charge. The Rule states that there is to be a "negotiated fee" but no procedures are established for medical providers to follow in negotiating the fee.

Further, Proposed Rule 47(F)(1)(b) is out of compliance with Minn. Stat. §256B.05, subd. 3, which states as follows:

> ". . . [T]he commissioner of public welfare shall establish a schedule of maximum allowances to be paid by the state on behalf of recipients of medical assistance toward fees charged for services rendered such medical assistance recipients." [Emphasis supplied.]

By the above-quoted statute, the Department of Public Welfare is mandated by state law to spell out the maximum allowable charges. The statute requires that a schedule of such charges be established by the commissioner. A mere statement that a maximum allowable charge is a "negotiated fee between DPW and provider groups" does not meet the statutory directives cited above. Further, after the November, 1975 hearing on Rule 47, the Department of Public Welfare repealed all of its schedule of maximum allowances. Therefore, since that time, the Department has been in violation of Minn. Stat. §256B.05, subd. 3 which requires that such a schedule of maximum allowances be established. Subdivision 3 was undoubtedly enacted by the legislature to implement subd. 2 of Minn. Stat. §256B.05 which states that county welfare departments shall not pay "a fee or charge for medical, dental, surgical, hospital, nursing, licensed nursing home care, medicine, or medical supplies in excess of the schedules of maximum fees and charges as established by the state agency." [Emphasis supplied.] Such schedules come within the statutory definition of a "rule" found in Minn. Stat. §15.0411, subd. 3 as they are a "statement of general applicability and future effect." Therefore, such schedules must be promulgated pursuant to Chapter 15 of the Minnesota Statutes.

Federal regulations also mandate that the Department of Public Welfare must specifically spell out the methods used for establishing payment rates for each type of service provided. 45 CFR §250.30(a)(1). Specific requirements for reimbursement of various types of services are found in 45 CFR §250.30(a)(2) through (a)(9) and §250.30(b) through (d). None of these requirements are fulfilled in Rule 47(F) and it is therefore illegal for failure to meet required conditions of statutory authority and federal law. Atty. Gen. 305(b)(2).

5. Reimbursement. Department of Public Welfare Rule 47(F)(1) relates to maximum allowable charges. The Hearing Examiner in his Report states at ¶¶93 and 96 that the phrase "maximum allowable charges" must be defined in such a manner so as to either "spell them out or provide a description of the mechanical means of computing them (if there is one)." In its Report, the Department of Public Welfare stated as follows:

> "The Hearing Examiner asked that DPW 47(F)(1) either spell out the Medical Assistance

program's maximum allowable charges, or describe the mechanical method used to compute those maximums. The Department has seriously considered this suggestion but believes that section (F)(1)(b) of the rule as proposed already provides a description of the methods used to establish maximum allowable charges. The language of DPW Rule 47(F)(1) was adopted in accordance with all requirements of Minn. Stat. §15 and became effective May 28, 1976. Therefore the Department believes that the Hearing Examiner's objection to this paragraph of proposed DPW 47 is not well taken and should not be accepted."

6. Long Term Care Facility Services. Department of Public Welfare Rule 47(E)(2)(b)(1)(a) states that a skilled nursing facility is a facility "certified by MDH as meeting the requirements of Title XVIII of the Social Security Act . . . ." At the time of the public hearing, it was noted that certification under Title XVIII is not required for participation in the Medical Assistance program. The Medical Assistance regulations, at 45 CFR §249.33(a)(1)(i), which implement Title XIX (Medical Assistance), incorporate by reference the requirements of Title XVIII but do not require certification as a Title XVIII facility. Section 1902(a)(28) of the Social Security Act explicitly states that skilled nursing facilities participating in the Title XIX program must satisfy the requirements of Title XVIII but need not be certified as such. Therefore, Department of Public Welfare Rule 47 (E)(2)(b)(1)(a) must be amended to conform with Section 1902(a)(28) and federal regulations.

7. Medical Supplies. Rule 47(E)(2)(i) deals with medical supplies in general. Rule 47(E)(2)(i)(5)(e) and Rule 47(E)(2)(i)(6)(f) deal specifically with medical supplies in long term care facilities. When read together (5)(e) and (6)(f) prohibit reimbursement to long term care facilities governed by Department of Public Welfare Rules 49 and 52 for all specialized (durable) medical equipment. However, other long term care facilities, hospitals, and similar institutions may be reimbursed for specialized medical equipment under Rule 47. This is an unlawful, unconstitutional discrimination against certain long term care facilities and cannot be permitted pursuant to Atty. Gen. 305(b)(2)(dd).

A basic right guaranteed to all persons is that of equal protection of the law under the Fourteenth Amendment to the United States Constitution and the Minnesota Constitution. It is clear that a

governmental body cannot "arbitrarily discriminate between members of the same class . . . ." State v. Comer, 207 Minn. 93, 290 N.W. 434, 435 (1940). The Equal Protection Clauses of the Minnesota and United States Constitutions also require that:

> "All those within the general class of that activity [regulated] must be treated the same unless reasonable and substantial grounds for differentiation exist." 290 N.W. at 435.

There is no reason for permitting reimbursement for specialized medical supplies to certain inpatient facilities and not to others. See also City of Saint Paul v. Dalsin, 245 Minn. 325, 71 N.W.2d 855 (1955).

In State v. Comer, cited above, the Minnesota State Board of Health's licensing policies were under consideration. The licensing statute required all places of "refreshment" to have a license to sell soft drinks, whereas a general merchandise store did not need such a license if the soft drinks were sold and delivered to the customer in the original container. The defendant therein operated a gasoline station and also sold bottled soft drinks. In finding that the gasoline station qualified under the exemption for general merchandise stores, the Court stated as follows:

> "An exemption differentiating in treatment without substance to fortify it is violative of the equal protection of the laws [citations omitted]. Likewise it is offensive to Art. 4, §§33, 34, of the state constitution." 290 N.W. at 436. [Emphasis supplied.]

The Court looked at the reasons for exempting certain stores from the coverage of the licensure requirement and for the licensure requirement itself. The reason for the license was to protect the health of the citizens of the state. The Court found that the state's interest in protecting the health of its citizens was served equally well when bottled soft drinks in the original container were sold at gasoline stations or at general merchandise or grocery stores.

In Rule 47 and the Medical Assistance program, the state is providing quality care to the citizens and, at the same time, doing so in a cost-effective manner. The Department of Public Welfare provided no reasons why certain inpatient facilities may be reimbursed for specialized medical equipment and other facilities cannot. Either all inpatient facilities should be reimbursed for specialized medical equipment or none should be. In all cases, the need for the equipment is based on the needs and health of the patients and residents, not the

kind of facility in which they reside. Therefore, Rule 47(E)(2)(i) illegally discriminates between inpatient facilities and MAHCF objects to the legality thereof.

8. Rehabilitative and Therapeutic Services. At the time of the public hearing, MAHCF strongly urged that the Department reconsider its policies, as incorporated in the Rule, for reimbursement for "in-house" rehabilitative and therapeutic services. MAHCF cited numerous examples of the non-cost effectiveness of the Rule. Many facilities may well be forced to close in-house physical therapy departments and thus provide such services on a contract basis or not provide such services in the facility at all. In the latter cases, the Medical Assistance program would incur greatly increased costs not only in terms of money but also in reduction of care given to the Medical Assistance recipients. The Hearing Examiner recommended that the Department reconsider its reimbursement policies in ¶79 of his Report but such was not addressed in the Report of the Department of Public Welfare. No basis or reasons supporting a finding of need have been provided by the Department of Public Welfare, as is required in Atty. Gen. 302(g), in its Statement of Need for a reimbursement system which provides such high disincentives to the provision of in-house physical therapy. Therefore, since this provision was unsupported by the Department of Public Welfare and is contrary to the purposes of the Medical Assistance program in providing good medical care at reasonable cost, it should not be approved by the Attorney General's office. Atty. Gen. 305.

No limits are placed on the cost of in-house physical therapy at other inpatient facilities, such as hospitals. As with medical supplies, Rule 47 unconstitutionally discriminates between certain long term care facilities and other inpatient facilities and medical providers. Therefore, Rule 47(E)(2)(k) must be disapproved pursuant to Atty. Gen. 305 (b)(2)(dd). In addition, Rule 47(E)(2)(k) has "no reasonable relationship to statutory purposes." (Atty. Gen. 305(b)(2)(cc)) because it will result in higher overall cost to the Medical Assistance program.

In ¶82 of his Report, the Hearing Examiner states that Department of Public Welfare Rule 47(E)(2)(k)(2)(d) is unreasonable because it is vague and confusing. The intent of the change made in Adopted Rule 47 was to make explicit that rehabilitative services provided by independent practitioners in long term care facilities are reimbursable under the Medical Assistance program. However, the changes made do not address the objection of the Hearing Examiner. Section (d)(i) states that independent practitioner services provided by an independent practitioner "not maintaining at his own expense an office or office space and the necessary equipment to provide an adequate treatment program" will not be covered under the Medical Assistance program. This would still appear to prohibit reimbursement for independent practitioner services

in long term care facilities if the practitioner did not maintain a separate completely equipped office. Therefore, (d)(i) should be amended to note the exception in Rule 47(E)(2)(k)(2)(e) or else the Rule remains unreasonable as found by the Hearing Examiner.

9. Prior Authorization and Utilization Control. The Department of Public Welfare amended Department of Public Welfare Rule 47(D)(9) dealing with prior authorization to clarify certain aspects thereof. However, in Exhibit 107, provided by the Department of Public Welfare to the Hearing Examiner subsequent to the June, 1976 hearings, it was stated that the Department would provide standards for the making of prior authorization. No such standards were added to that portion of the Rule dealing with prior authorization. "Standards" for the granting or denying of prior authorization come within the statutory definition of a rule. Minn. Stat. §15.0411, subd. 3. Unless such standards are provided by rule, Rule 47 conflicts with relevant law and is illegal. Atty. Gen. 305(b)(2)(bb).

That portion of Adopted Rule 47 relating to utilization control does not comply with federal Medical Assistance regulations governing utilization control. Rule 47(D)(10)(a) simply restates what is found in 45 CFR §250.18(a)(1)(i) and (ii). 45 CFR §250.18 goes on to provide in §§(b) and (c) that the state agency is to provide written criteria to be used in the implementation of its utilization control program. Although the federal regulation states that copies of such procedures are to be made available by the state agency responsible for Medical Assistance, clearly such criteria for utilization control are in the nature of rules as defined in Chapter 15 of the Minnesota Statutes. Simply stating that the program is going to include "an on-going evaluation of the necessity for the quality and timeliness of the services" and a "post-payment review process" is not enough to satisfy the requirements of federal regulations that the Department provide written criteria in implementing its utilization control program as well as the requirements of the Minnesota Administrative Procedure Act which mandate that all such "criteria" be promulgated properly under Minnesota law. Therefore, that portion of Department of Public Welfare Rule 47 dealing with utilization control cannot be adopted until it complies with the requirements of state and federal law. Atty. Gen. 305(b)(2)(aa), (bb). This is even more clearly shown by the fact that the Hearing Examiner required the deletion of certain portions of Rule 47(D)(10) which would have allowed the Department the ability to establish rules for utilization control by merely adopting written procedures. Although the Department states in its report at the top of page 3 that at such time as the utilization control and surveillance criteria are developed they will be adopted in accordance with all the requirements of Minnesota law, Department of Public Welfare Rule 47 still remains out of compliance with federal regulations which require that such criteria be adopted by the agency.

10. Release of Medical Records. Section (B)(10) of Adopted Rule 47 permits the release of medical records to various governmental and review agencies. The comparable provision of Proposed Rule 47 provided that "[l]ocal welfare agencies shall obtain written consent to release this information to these agencies." The Hearing Examiner, at ¶18 of his Report, objected to that particular provision of the Proposed Rule because the consent required by the Proposed Rule was broader than that authorized by Laws 1976, Chapter 188, Section 3. Said statute requires applicants to authorize the release of medical records to the Commissioner of Public Welfare for the sole purpose of investigating "whether or not a vendor has submitted a claim for reimbursement, report or rate application which the vendor knows to be false in whole or in part." Adopted Rule 47 deleted the sentence to which the Hearing Examiner objected and inserted instead the language found in Laws 1976, Chapter 188, Section 3, codified as Minn. Stat. §256B.27, subd. 4. However, the change made by the Department of Public Welfare does not squarely address the unreasonableness of the regulation as found by the Hearing Examiner.

As amended, Adopted Rule 47(B)(10) does not require written consent for release of records to entities other than the Department of Public Welfare even though it requires that Medical Assistance applicants or recipients be notified that their records can be released to such entities. The Hearing Examiner's objection was not about the consent to release records to other entities assuming such is authorized by relevant law, but rather was about the fact that Rule 47 does not comply with applicable law for the release of records.

The Hearing Examiner cited 45 CFR §205.50 which requires that, "pursuant to a state statute, the use or disclosure of information concerning applicants or recipients will be limited to purposes directly connected with administration of the MA program." Hearing Examiner Report at ¶18. However, Minn. Stat. §256B.27 only relates to the release of records to the Department of Public Welfare. Further, 45 CFR §205.50 requires that the state agency administering the Medical Assistance program clearly define the information that is to be safeguarded and the manner in which it is to be used or disclosed. 45 CFR §205.50 also states that information can only be released to agencies or entities having a similar requirement of confidentiality as is imposed on agencies directly administering the Medical Assistance program. Rule 47 would permit the release of records to entities that may or may not meet such standards. (See also Rule 47(D)(4)(c)(2).)

Therefore, Adopted Rule 47(B)(10) conflicts with relevant law and should not be approved as to its legality pursuant to Atty. Gen. 305(b).

11. Release of Records by Medical Providers. Section (D)(4)(c) obligates medical providers to make available medical records to the Department of Public Welfare, the state legislative auditor, the Department of Health, Education and Welfare, or representatives of such agencies. This is undoubtedly meant as a parallel provision to (B)(10) which notifies Medical Assistance recipients that their records may be released to various governmental agencies and requires the written consent for the release of such documents to the Department of Public Welfare. Although changes were made in Adopted Rule 47 to comply with certain findings of the Hearing Examiner that (D)(4)(c) was unreasonable in not providing that the recipient's written consent was required prior to the release of the records (Hearing Examiner Report at ¶¶42-44), Adopted Rule 47 does not comply with applicable state statutes and federal regulations governing release of records and confidentiality of medical records. As previously stated, 45 CFR §205.50 places strict obligations on the state and federal agencies receiving medical records as to the use and disclosure of such records. It is nowhere provided in Rule 47 that those agencies to whom the records are released comply with the procedures required under 45 CFR §205.50. Thus, unless Rule 47 clearly defines the conditions for the use of or release by providers of medical information and other information relating to the recipient and also clearly spells out and insures the proper usage of such records by agency personnel, the Rule is illegal for failing to comply with governing federal regulations and cannot be approved as to its legality. Atty. Gen. 305(b)(2).

12. Qualification of Eligible Providers. The Department of Public Welfare amended Rule 47(D)(8) as a result of the recommendations of the Hearing Examiner at ¶47 of his Report. The change made which requires the written consent of the recipient prior to release of medical records is unclear, however. The Rule as amended, reads as follows:

> "Any medical vendor who, on request, and upon being provided a copy of the recipient's written consent, refuses to allow a proper survey and/or reimbursement agency access to its records, shall become an ineligible provider upon written notification from DPW." [Emphasis supplied.]

The rule does not explicitly state that the recipient is consenting to the release of records. Assuming that the release relates to medical records, it is not in conformity with Minn. Stat. §256B.27, subd. 3, which strictly limits written consent for the release of medical records for the purposes of investigating whether or not:

> "(a) a vendor of medical care actually provided the medical care for which a

> claim for reimbursement was made; or
> (b) the medical care was medically necessary."

Adopted Rule 47 does not comply with federal regulations cited above regarding release of records to government agencies. Further, the Rule does not define what is meant by a "proper survey and/or reimbursement agency." Therefore, Rule 47 exceeds the statutory authority of the Department of Public Welfare and thus should not be adopted into law.

Proposed Rule 47(D)(8) dealt solely with the release of records to the Department for the determination of whether or not services were properly provided. However, the Department has added extensively to Rule 47(D)(8) as submitted to the Chief Hearing Examiner and the Attorney General. The following has been added to Rule 47(D)(8) without any showing of necessity by the Department of Public Welfare, any Statement of Need, and also without notice to the public:

> "Any vendor of medical care who submits to the state agency a claim for reimbursement, a cost report, or a rate application which he knows to be false in whole or in part shall be declared ineligible for further payments of medical assistance funds by the commissioner of public welfare. The commissioner shall determine the time period of ineligibility and any conditions for reinstatement of eligibility. No vendor of medical care shall be declared ineligible without prior notice and an opportunity for a hearing, pursuant to Minnesota Statutes, Chapter 15, on the commissioner's proposed action."

This portion of Proposed Rule 47 cannot be adopted into law. It was not provided to the public at the time of public hearing as required by HE 102(a) and Minn. Stat. §15.0412, which clearly states that the entire rule must be presented at the time of the public hearing. No "affirmative presentation of facts establishing the need for and reasonableness" of the Rule was made by the Department of Public Welfare. Minn. Stat. §15.0412, subd. 4. This addition to Rule 47 constitutes a substantial change in the Rule, requiring a public hearing. Atty. Gen. 304; HE 108; Minn. Stat. §15.052, subd. 4. No authority is cited for the proposition that it is up to the discretion of the commissioner to determine the time period of ineligibility for Medical Assistance as well as the discretion vested solely in the commissioner to determine the conditions for reinstatement of eligibility. Clearly, the

Department has acted illegally in attempting to include provisions in Rule 47 which have not been submitted to the public for comment and review. This must be disapproved as to both form and legality. Atty. Gen. 305(b).

13. Hearings Upon Termination of Medical Assistance. In Section (C)(8)(a) Adopted Rule 47 addresses the question of hearing procedures upon termination of Medical Assistance. These procedures are also referenced in Section (D)(6), in which it is stated that the hearing requirements must be referenced on the recipient's identification card. The Hearing Examiner's Report, at ¶35, states that those provisions of Proposed Rule 47 relating to hearing procedures are "unreasonably vague" but that deletion is inappropriate because appeals must be provided for under the Rule. See Minn. Stat. §256.045 and 45 CFR §205.10. An objection was made at the time of the public hearing to the vagueness of the term "established procedures". The Hearing Examiner stated that the Rule could not refer to nebulous procedures because federal regulations require that "hearing procedures shall be issued and publicized by the State agency." 45 CFR §205.10(a)(2). Further, the Minnesota Administrative Procedure Act, at §15.0411, requires that such procedures be properly promulgated because they are in the nature of rules.

In its adopted version of Rule 47, the Department of Public Welfare merely changed the phrase "established procedures" to "procedures established by and consistent with applicable law and federal regulations." The Rule then went on to delineate the hearing procedure, but such delineation is woefully inadequate when it is compared to the strict requirements found in Minn. Stat. §256B.045 and 45 CFR §205.10 (a)(2). The Department of Public Welfare cannot be permitted to circumvent the requirements of both state and federal law. Therefore, those portions of Adopted Rule 47 dealing with hearing rights of Medical Assistance applicants and recipients must be amended to strictly comply with state and federal hearing procedures as well as the State Administrative Procedure Act and disapproved pursuant to Atty. Gen. 305(b)(2).

14. Conclusion. MAHCF objects to Rule 47 for the reasons stated herein and requests that the Attorney General not approve the Rule as to form and legality.

Very truly yours,

BROEKER, HEDGES & GRANT

By Kathryn E. Baerwald
Kathryn E. Baerwald

KEB:gsr
cc: Mr. J. Swanson
Mr. J.I. Green
Mr. S. Mihalchick
Mr. T. Jensen
MAHCF Ad Hoc Committee

ADMIN. 1000

STATE OF MINNESOTA

DEPARTMENT Attorney General

Office Memorandum

TO : Mike Miller
Special Assistant
Attorney General
G-19 Administration Building

DATE: March 18, 1977

FROM : Thomas H. Jensen

Tom

SUBJECT: The Enclosed.

Mike:

As you requested, please find enclosed a copy of 45 C.F.R. §250.30.

THJ

/ph

Enclosure

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF RULES OF THE DEPARTMENT OF PUBLIC WELFARE GOVERNING ADMINISTRATION OF THE MEDICAL ASSISTANCE PROGRAM

ORDER ADOPTING RULES

The above-entitled matter came on for hearing before Steve Mihalchick, Hearing Examiner, Office of Hearing Examiners of the State of Minnesota on the First day of June, 1976, at 8:30 A.M. in the State Office Building Auditorium, St. Paul, Minnesota, after proper notice required by M.S. 1974, Section 15.0412 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 continued the need for the above captioned rules and the reasonableness thereof.

NOW, THEREFORE, IT IS ORDERED that this rule with the minor corrections confirmed in my letter of February 17, 1977, is adopted this 18th day of February, 1977, pursuant to authority vested in me by M.S. 256D.04(2) and Minnesota Laws 1975, Chapter 437, Article II.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

VERA J. LIKINS
STATE WELFARE COMMISSIONER

Outline

	Problem	Proposed Rule	Adopted Rule
1.	Vagueness; procedures not covered specifically with a rule	47 I B	47 A 2
2	Improper as including income of minors in distinction to 256B.14	47 III d 1(c)	47 C 4 a 3
3.	Leaves "established procedures" undefined	47 III h	47 C 8 a
4.	Record keeping req't vague	47 IV d	47 D 4 b 1
5.	Same as #1 & { amended rule sets out criteria and allows use of "methods + procedures"	47 IV i	47 D 9
6.	Fails to clarify, as pointed out in HE 7184, that visits to dentists office n/ltd. to 3.	47 V b 12	47 E 2 I. 2 d
7.	Rule must set out a means of computation, acc. to 256B.05, sub {2 3 + .05	47 VI a	47 F 1 a + b
8.	~~Do not call for sufficient explanation to applicant~~ waiver: ~~and~~ uniformity in all agencies - consent as to all agencies, n/just DPW, before release to any agency	{ 47 II; 47 IV d 3 ~~47 V b 1~~	{ 47 B 10 47 D 4 c ~~4 D 6~~

Letter should be dept. F/F

Problem of fiscal impact

STATEMENT OF COMPLIANCE WITH

MANUAL OF RULE MAKING PROCEDURES

I, Special Assistant Attorney General Thomas H. Jensen, do hereby declare that I have examined proposed rule DPW 47 and all related documents and that, based upon them and my personal familiarity with the applicable procedures, the Manual of Rule Making Procedures has been followed. Any exceptions are noted below.

Thomas H. Jensen

THOMAS H. JENSEN

Dated: 2/22/77

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

RECEIVED
FEB 18 1977
OFFICE OF HEARING EXAMINERS

February 17, 1977

Duane Harves, Chief Hearing Examiner
Office of Hearing Examiners
1745 University Avenue
St. Paul, Minnesota 55104

Dear Mr. Harves:

Re: Minnesota Rule DPW 47
DPW-76-006-SM

In my letter to you dated February 15, 1977, I explained the changes made by the Department to DPW 47 as first proposed. It has now come to my attention that the adopted rule contains some unintentional omissions which I would like to hereby correct.

DPW 47 D.7. discusses agreements with providers. Subsequent to the June, 1976 public hearing on the proposed rule, Deputy Commissioner Hiniker sent a memorandum to Mr. Mihalchick in which the Department suggested a modification to this section. The Department's suggestion was to insert the phrase "pertinent to the MA program" in the sentence beginning "Failure by the provider to comply with...." so that the entire sentence will read, "Failure by the provider to comply with federal and state statutes, rules and regulations pertinent to the MA program shall result in termination of the provider agreement, ineligibility to receive MA program reimbursement and, where appropriate, action to recover Medical Assistance funds." As this phrase was accidentally omitted from the adopted rule, I would like to reinsert it at this time.

Similarly in section E.2.1. dental services, the Department suggested addition of the words "medically necessary" to the first sentence. The sentence would then read, "The MA program pays for all emergency care and basic medically necessary oral health needs." I request that the omitted words be put in the adopted rule.

In his report to the Department, Mr. Mihalchick asked us to specify in section E.2.e. that MA funds shall not be used to reimburse chiropractors for x-rays or any other diagnostic or laboratory procedure provided. The adopted rule was duly modified. The basis for limiting chiropractic reimbursement to manual manipulation of the spine is 45 CFR § 249.10(b)(6)(ii) which explicitly limits reimbursement to "treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State."

Finally, in my February 15 memo I explained why the Department believes it necessary to require prior authorization for certain medical transportation services. I referred to 45 CFR § 249.10 (b)(17)(i)(A) which authorizes MA payment when such services are determined by the Department to be necessary. At the

June, 1976 public hearing, Mr. Warren Nyhus discussed the legal basis permitting MA reimbursement for medical transportation provided by non-licensed vendors. He specifically referred to 45 CFR § 249.10(b)(17). Mr. Nyhus' comments are on page 228 of the transcript of the public hearing.

Yours respectfully,

Vera J. Likins

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

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 27th day of April, 1976, that a public hearing on proposed amendments to Minn. Rule DPW 47 be held in the State Office Building Auditorium, Wabasha Street (between Aurora and Fuller), St. Paul, Minnesota, on Tuesday, June 1, 1976, 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

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 29th day of April, 1976, 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.

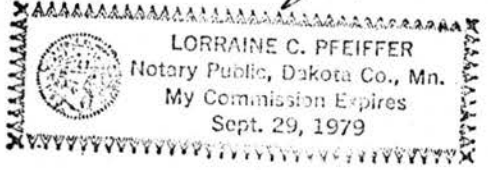
3) That on the 29th day of April, 1976, at 1:00 P.M., in response to the above request, the Secretary of State provided her with such a list, a copy of which is attached hereto and incorporated by reference.

Further affiant sayeth not.

Irene R. Goldman
IRENE R. GOLDMAN

Subscribed to and sworn to before
me this 30th day of April, 1976

Lorraine C. Pfeiffer



PUBLIC WELFARE

Allin, Kent, Welfare Advocacy Unit, 370 Selby Avenue, St. Paul, MN 55102

Anoka Co. Comprehensive Health Dept., Courthouse, Anoka, MN 55303

Blade, Joe, Mpls. Star, 425 Portland Ave., Mpls MN

Community Mental Health Bd. of the Northern Pines Mental Health Ct., 103-105 1st St. S.E. Little Falls, MN 56345

Curtis E. Louis (Dr.) Prof. Education U M, Morris, MN 56267

Dale, Randy L., Immanuel-St. Joseph Hospital, Mankato, MN 56001

Damon Corp., Att: B.G. Goodman, 115 4th Ave, Needham Heights, MA 02194

Deephaven Montessori School, Inc., 188 S. Circle A Drive, Wayzata, MN 55391

Friesen, Miller A., Hiawatha Valley Mental Health Ct., Box 619, Winona 55987

Goldberg, Paula, 5315 James Ave. S., Mpls 55419

Henn Cty Family Day Care Ass., 404 E. 48th St., Mpls 55409

Hiawatha Valley Mental Health Center, 76 E. 4th St., Winona 55987

Kurtz, Kirsten (Mrs.) 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, Att: H.L. Paulsen, 2414 Park Ave S., Mpls 55404

Minneapolis & Henn Cty Mental Health Clinic, 619 S 5th St, Mpls 55415

MN Assn. for Ed. of Young Children, Rm 373 S. Griggs Midway, 1821 Univ. St. Paul 55104

MN Legislative Comm of Blind, 1605 Eustis, St. Paul, MN 55108

MN Recipients Alliance, 116 E. 32nd St., Mpls 55404

MN State Pharmaceutical Ass. 2388 Univ Ave, St. Paul 55104

MN Valley Soc. Adaptation Center, Att: M.Jones, 100 Freeman Dr., St. Peter 56082

Mitchell, Malcolm, Met Health Bd, 300 Metro Sq. Bldg. 7th & Robt, St. Paul

Moratzka, Timothy, 1304 Vermillion St., Hastings, MN 55033

Neff, Walter S. (Dr.) Virginia, MN 55792

Northland Mental Health Center, 415 S. Pokegema, Grand Rapids 55744

N.W. Mental Health Center, Inc., Box 603, Crookston, MN 56716

Public Relief, Bd of Public Welfare, Att: Dir Jensen, 250 S. 4th St., Mpls 554

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 Ct., Att: Dr. Howard C. Reid, 510 Beltrami, Bemidji, MN

Usher, Janice, Isanti Co. Public Health Nursing Serv., 237 SW 2nd, Cambridge 55008

Veterans Affairs, Veterans Service Bldg, St. Paul 55155

Welfare Rights Organization, Stephen Parsons, 1118 Newton Ave N. Mpls 55411

West Central Mental Health Center, 323 W. 6th St. Willmar 56201

TATE VERN 3M CO
3M CENTER 220/6W
ST PAUL MN
55101

THOMPSON CONRAD
1107 23RD ST NW
ROCHESTER MN
55901

THOMPSON HESSIAN ET AL
1500 MIDWEST PLAZA BLDG
MPLS MN
55402

TIMESAVERS INC ATT R S VOLD
5270 HANSON COURT
MPLS MN
55422

TOUCHE ROSS & CO K H STOCKE
780 NORTHSTAR CNTR
MPLS MN
55402

TWIN CITY RETAIL DRUGGIST AS
2388 UNIV AVE
ST PAUL MN
55104

UNION STOCK YARDS
ATTN PRES
SO ST PAUL MN
55075

VANDERVOORT T J MET WASTE
350 METRO SQUARE BLDG
ST PAUL MN
55101

VAN CLEVE JOHN H
2101 HENN AVE
MPLS MN
55405

N DRAKE STEPHEN R
353
ELICAN RAPID MN
56572

VAN EVERA MUNDT ET AL
700 TORREY BLDG
DULUTH MN
55802

VERRILL JOHN E
DEPT SECONDARY ED UOF M
DULUTH MN
55812

VILLAGE OF WOODBURY
2100 RADIO DRIVE
WOODBURY MN
55042

VOLDNESS PERRY
IDS 8TH & MARQUETTE
MPLS MN
55402

VOSS REV GORDON O
11120 NE 7TH ST
BLAINE MN
55434

VOS LEROY
2137 BURNS AVE
ST PAUL MN
55119

WALD JEAN
5746 SANDER DR
MPLS MN
55417

WALTERS THOS H
4510 W 77TH ST STE 235
MPLS MN
55435

WANQUIST ALLEN
RM 252 FEDERAL BLDG
ST PAUL MN
55101

WELK G V NORTHERN STATES
414 NICOLLET MALL
MPLS MN
55401

WELLINGTON R R SKELLY OIL
PO BOX 1650
TULSA OK
102

WESTIN CHAS W
220 MEDICAL ARTS BLDG
DULUTH MN
55802

WHITING RALPH
555 WABASHA SUITE 204
ST PAUL MN
55102

WHITLOCK A G
ECON LAB OSBORN BLDG
ST PAUL MN
55102

WILCOX J PATRICK
1220 NORTHERN FED BLDG
ST PAUL MN
55102

WM.MITCHEL COLLEGE LAW LIB.
2100 SUMMIT AVE.
ST.PAUL MN
55105

WILEY ENTERPRISES
101 5TH AVE SE
OSSEO MN
55369

WILLIAMS THOS W
4915 W 35TH ST
MPLS MN
55416

WILSON R GARY PPG INDUSTR
1 GATEWAY CENTER
PITTSBURGH PA
15222

WIS FEEDER PIG MARKET CO-OP

FRANCIS CREEK WI

WOLKERSTORTER THEODORE
676 17TH AVE NW
NEW BRIGHTON MN
55112

WOZNIAK D D
401 FIRST FED BLDG
ST PAUL MN
55101

WYANT CLINTON W ATTY

ATKIN MN
56431

Mortimer C. Watson
5824 France Ave So.
Edina, Mn. 55410

YOUNG TODD P
555 WABASHA STE 215
ST PAUL MN
55102

CHAMBERLAIN JOHN L
PO BOX 241
MPLS MN
55440

CHERCHES CHRIS CITY MGR
5005 MTKA BLVD
ST LOUIS PARK MN
55416

CHRISTIAN SCI COMM ON PUB
1821 UNIV AVE SUITE 271
ST PAUL MN
55104

CHRISTIANSEN FREDRIK
RM 505 CAPITOL SQ BLDG
ST PAUL MN
55155

CHRYSALIS CENTER FOR WOMEN
2104 STEVENS AVE S
MPLS MN
55404

CITY CLERK
386 CITY HALL
ST PAUL MN
55102

CITIZENS LEAGUE
530 SYNDICATE BLDG
MPLS MN
55402

CITY OF ROBBINSDALE
C LARSON 4221 LAKE RD
ROBBINSDALE MN
55422

CLARKSON J.B.
2350 I.D.S. CENTER
MINNEAPOLIS MN
55402

CLAUSEN PHILLIP
2307 STANDISH ST
ST PAUL MN
55108

CLAWSON CONNIE
HELP CT 317-17TH AV SE
MPLS MN

COLEMAN NICHOLAS D
700 LINWOOD AVE
ST PAUL MN
55105

COLLIN LAURENCE
2
[redacted]NTI MN
5[redacted]0

COMMUNITY DESIGN CENTER
118 E 26TH ST
MPLS MN
55404

CONCORDIA COLLEGE
DEAN
MOORHEAD MN
56560

CONSUMER SERVICES DEPT CO
5TH FLR METRO SQ BLDG
ST PAUL MN
55101

COUNTY ATTYS COUNCIL
95 SHERBURNE AVE S203
ST PAUL MN
55103

CRAVEN NORMAN
10637 THOMAS AVE S
BLOOMINGTON MN
55431

CROW WING CO PLANNING & ADV
COURT HOUSE
BRAINERD MN
56401

CUSHMAN J S DAYTON HUDSON
700 NICOLLET MALL
MPLS MN
55402

DAHLKE LOIS M
118 S EAGLE ST
BELLE PLAINE MN
56011

DAILEY THOMAS ECONOMICS LAB
370 WABASHA ST
ST PAUL MN
55102

DANKERS, KENNETH
1200 WEST FOURTH STREET
RED WING MN
55066

DANIELSON RODNEY L
418 AUDITORIUM
ST PAUL MN
55102

DAYTON CHAS SIERRA CLUB
800 MIDLAND BANK BLDG
MPLS MN
55401

DEVELOP DISABILITIES PROGRAM
STATE PLAN 101 CAP SQ
ST PAUL MN
55155

DICKINSON MRS JOANNE
BOX 1065
MARSHALL MN
56258

[redacted]L JOHN
2[redacted] KENWOOD PKWY
ST PAUL MN
55105

DISPATCH PIONEER PRESS
PRESS RM STATE CAPITOL
ST PAUL MN
55101

DORSEY MARQUART
2400 1ST NATL BANK BLDG
MPLS MN
55402

DOUGLAS BELL ET AL
2212 AM.NATL BK BLDG
ST PAUL MN
55102

DOW CHEMICAL
47 BLDG
MIDLAND MI
48640

DOYTON MAURICE, MET SEWER BD
350 METRO SQ BLDG
ST PAUL MN
55101

DUDLEY E H
RT 7 BOX 122
EXCELSIOR MN
55331

DUNN OLIVER PLUMBERS LOC
708 SO 10TH ST
MPLS MN
55404

DZUGAN KEN ST PAUL PLANNING
421 WABASHA ST
ST PAUL MN
55102

EBELING EDWARD H.
161 W. MAIN
PERHAM MN
56573

ELDER DR JAMES B
11140 WASHBURN AVE SO
BLOOMINGTON MN
55431

ELDRED R W ARMOUR & CO
UNION STOCK YARDS
SO ST PAUL MN
55075

ELMER EDWIN W
2901 PLEASANT AVE
MPLS MN
55408

EMERICK RICHARD A
1908 IDS CENTER
MPLS MN
55402

ENGELBRECHT DOUGLAS
809 RANGE ST
NO MANKATO MN
56001

ASSN RESIDENCES FOR RETARDED
459 RICE SUITE 301
ST PAUL MN
55103

AUTOMOBILE MFRS ASSN INC
55 SHERBURNE AVE
ST PAUL MN
55103

BABCOCK LOCHER NELSON ET
118 E MAIN ST
ANOKA MN
55303

BADALICH JOHN P
2025 THOMPSON AVE
SO ST PAUL MN
55075

BARRETT FRED
ST LOUIS CO COURT HOUSE
DULUTH MN

BARTHOLOW HAROLD E FIRE CHF
2600 109 AVE N W
COON RAPIDS MN
55433

BATES DENNIS
446 STATE OFF BLDG
ST PAUL MN
55155

BECK PAT
953 HYACINTH AVE
ST PAUL MN
55106

BECKLIN ROBERT C
447 N W 4TH
CAMBRIDGE MN
55008

BEECHER EVERETT
10 10 1ST ST SO
HOPKINS MN

BEGALKA D REV
212 N ELK ST
BELLE PLAINE MN
56011

BEMIDJI STATE COLLEGE
ACEMENT BUR.J.C.BRADY
MIDJI MN
01

BENSONI PETER USW OF AM.
609 PROVIDENCE BLDG.
DULUTH MN

BERGERUD ALF
300 ROANOKE BLDG
MPLS MN
55402

BERGSETH THOMAS
1011 NICOLLET MALL
MPLS MN
55403

BERGUSON & LOFGREN MN GAS
700 LINDEN W
MPLS MN
55403

BEST FLANAGAN ET AL
4040 IDS CENTER
MPLS MN
55402

BEUTEL ROBERT
2200 SILVER LAKE RD
NEW BRIGHTON MN
55112

RIEKE DAVID R
PO BOX 509
TH RV FALLS 7(
56701

BLOMQUIST BARRY L

NORTH BRANCH MN
55056

BLOOMINGTON CITY CLERK
2215 W OLD SHAKOPEE RD
BLOOMINGTON MN
55431

BOLTON MALCOLM
422 ALDRICH AVE NO
MPLS MN
55405

BREHL JAMES W
332 HAMM BLDG
ST PAUL MN
55102

BRIGGS & MORGAN - B F FRIEL
2200 W 1ST NATL BK BLDG
ST PAUL MN
55101

BRIGHAM E M III
RR4
RED WING MN
55066

BROEKER JOHN
2850METRO DR. SUITE 504
BLOOMINGTON MN
55420

BROOKS WILLIAM F JR
854 MIDLAND BK BLDG
MPLS MN
55401

WN D M GOODRIDGE PUB SCH
DIST #561
GOODRIDGE MN
56725

BROWN H D
4961 KINGSBERRY LANE
MINNETONKA MN
55343

BRUBACHER RICHARD COMM ADM
208 ADM BLDG
ST PAUL MN
55101

BRUNING C.R.DEPT.CLINIC.E
BURTON HALL
MPLS. MN
55455

BUCHHOLTZ CHARLES
5044 BRENT AVE E
INV GRV HTS MN
55075

BURGER ALBERT
600 DEGREE OF HONOR BLD
ST PAUL MN
55101

BUR.ENGR.IND.DIV. MR.KIBIGER
219 N. 2ND ST.
MPLS. MN

BUR NATL AFFAIRS INC
1231 25TH ST NW
WASHINGTON DC
20037

BUSCH NOEL
3131 FERNBROOK LANE N
MPLS MN
55441

CABLE COMM SYST-H SARRAZIN
BOX 777
HECTOR MN
55342

CAIN RUTH
730 E 38TH ST
MPLS MN
55407

CAIRNS JOHN A
47TH FLR IDS CENTER
MPLS MN
55402

CAPITOL NEWS SERVICE
BOX 17035
ST PAUL MN
55117

CARLSON CARL L
7516 80TH ST S
COTTAGE GROVE MN
55016

CARLSON VERNE E
BOX 755 CITY HALL
WILLMAR MN
56201

JAIN NIRMAL ENIV PROCESS
1220 GLENWOOD AVE
MPLS MN
55405

JENOS INC
525 LAKE AVE SO
DULUTH MN
55801

JENSEN ARTHUR,CITY CLK
2215 W OLD SHAKOPEE RD
BLOOMINGTON MN
55431

JENSEN CARL A
127 E MAIN ST
SLEEPY EYE MN
56085

JENSEN MRS GAYNOLD
111 WEST 107TH ST
MPLS MN
55420

JOHANSEN BUS SERV INC
19 DAYTON RD
CHAMPLIN MN
55316

JOHNSON & SANDERSON
ST MARYS HOSPITAL
ROCHESTER MN
55901

JOHNSON CLARENCE IBEW LU
3615 37TH AVE S
MPLS MN
55406

JOHNSON LEROY
9939 BLUEBIRD ST NW
COON RAPIDS MN
55433

JOHNSON M.D. FRUNDT & FRUNDT

BLUE EARTH MN
56013

JOHNSON LANCE J
265 S LAFAYETTE RD
ST PAUL MN
55107

KABLE RICHARD W

[redacted]HEL MN
[redacted]06

KAVANEY RICHARD
1220 NORTHERN FED BLDG
ST PAUL MN
55102

KEABLE MIKE
909 6TH AVE N
ST CLOUD MN
56301

KEENAN RICHARD J
4444 IDS BLDG
MPLS MN
55402

KEILY DANILE
3549 V2 PLEASANT AVE
MPLS MN
55408

KIMBALL ROBERT
647 CAPITOL SQ BLDG
ST PAUL MN
55101

KJERVIK DIANE
4302 POWEL HALL U OF M
MPLS MN

KLOSTER MARION PEAVEY CO
730 2ND AVE S
MPLS MN
55402

KLUZ STEVEN J
1910 1ST NATL BK BLDG
MPLS MN
55402

KNAPP J A
RM 3 CAPITOL
ST PAUL MN
5515

KNOPP TIMOTHY
COLLEGE FORESTRY U OF M
ST PAUL MN
55108

KNUTSON DR KEITH,BIOLOGY
ST CLOUD STATE
ST CLOUD MN
56301

KNUTSON R N GRANNIS ETAL
F J SCHULT BLDG
ST ST PAUL MN
55075

KNVDSON ROBT
4375 BROWNDALE AVE
MPLS MN
55424

KOLLER MR & MRS ERWIN A
1568 DULUTH ST
ST PAUL MN
55108

KOPP MRS VERNON
2050 65TH ST E
INVER GR HGHT MN
55075

[redacted]MER ERNEST W
[redacted] DELAWARE ST SE
MPLS MN
55440

KROEGER CHARLES
122 NW 7TH STREET
FARIBAULT MN
55021

KRONLOKKEN J E
10048 NORD RD
BLOOMINGTON MN
55437

KROON H CLIFTON
210 E WALNUT
MANKATO MN
56001

KUHL CARL
4421 4TH ST NE
COL HEIGHTS MN
55421

KVB ENGINEERING INC
600 S CO RD 18
MPLS MN
55426

LABELLE JUANITA MRS
5816 AQUILA AVE NO
NEW HOPE MN
55428

LAKE SUPERIOR INDUSTRIAL BUR
828 FIRST AM. BK. BLDG.
DULUTH MN
55802

LANAHAN E F - SIBLEY CO
184 E 6TH ST
ST PAUL MN
55101

LANGVIN DAVID
7500 80TH ST S
COTTAGE GROVE MN
55016

LANSING & OAKES
400 SIBLEY ST
ST PAUL MN
55101

LAPP LAZAR LAURIE ET AL
1200 BUILDERS EXCHANGE
MINNEAPOLIS MN
55402

LARSON C L
3800 MINNEHAHA AVE SO
MPLS MN
55406

LARSON HANS P DIV HOSP SERV
717 DELAWARE ST SE
MPLS MN
55440

LEAGUE MN MUNIC
300 HANOVER 480 CEDAR
ST PAUL MN
55101

LOCKNER GARY
R R 1 BOX 23
BAUDETTE MN
56623

LOOS CALVIN J
6809 LYNDALE AVE SO
MPLS MN
55423

LOWE DOUG
2701 N LEXINGTON AVE
ROSEVILLE MN
55113

LYNCH DONALD SIBLEY CO
184 E 6TH ST
ST PAUL MN
55102

MCDONALD PHILIP M
2077 SELBY AVE
ST PAUL MN
55104

MCFADDEN G H DISPATCH-PRESS
55 E 4TH ST
ST PAUL MN
55101

MCKIBBON MRS SHIRLEY
11 EVERGREEN LN
BABBITT MN
55706

MCLELLAN LARKIN
215 ADM BLDG ST CAPITOL
ST PAUL MN
55101

MALONE E I COMM LABOR & INDU
444 LAFAYETTE RD 5TH FL
ST PAUL MN
55101

MANKATO STAT STUDENT SENA
CENTENNIAL STUDENT UN
MANKATO MN
56001

MANKATO STATE STUDENT ASSN
58 MANKATO COLLEGE
[redacted]NKATO MN
[redacted]001

MANTHEY T J PICKANDS MATHER
1100 SUPERIOR AVE
CLEVELAND OH
44114

MARRINAN MARGARET M
1117 COMMERCE BLDG
ST PAUL MN
55101

MASTOR & MATTSON LTD
315 PEAVEY BLDG
MPLS MN
55402

MAUL WARREN E
320 S 4TH ST
MPLS MN
55415

MAYO FOUNDATION G ORWOLL
200 FIRST AVE NW
ROCHESTER MN
55901

MECCA
867 GRAND AVE
ST PAUL MN
55105

MEIEROTTO, JOAN
1794 SO LEXINGTON
ST PAUL MN
55118

MERRITT GRANT POLLUTION CONT
1935 W CO RD 32
ROSEVILLE MN
55113

MET TFR MEN ASSN A ROSENTHAL
1821 UNIV AVE
ST PAUL MN
55104

METROPOLITAN COUNCIL LIBRARY
300 METRO SQUARE
ST PAUL MN
55155

MEYER HERBERT
10824 ZENITH AVE S
BLOOMINGTON MN
55431

MIDLAND GLASS- HD SPURLING
PO BOX 69
SHAKOPEE MN
55379

MILLER RICHARD A
1020 PLYMOUTH BLDG
MPLS MN
55402

MILLER TOM
2311 PILLSBURY AVE S
MPLS MN
55404

MINN RETAIL FED INS
131 METRO SP
ST PAUL MN
55101

[redacted]S CHAMBER COMM TRANSP DPT
[redacted] S 5TH ST
MPLS MN
55402

MPLS CITY ATTORNEY
325M CITY HALL
MPLS MN
55415

MPLS STAR PRESS ROOM
STATE CAPITOL
ST PAUL MN
55101

MPLS TRIBUNE CITY DESK
425 PORTLAND AVE
MPLS MN
55415

MIDLAND GLASS-HD SPURLING
PO BOX 69
SHAKOPEE MN
55379

MILLER PAUL J PHARMACY SERV
ST MARYS HOSP
ROCHESTER MN
55901

MINN APT ASSN
GRIGGS-MIDWAY BLDG
ST PAUL MN
55104

MN. ASN.C&IND H.D.PETERSO
480 CEDAR ST.
ST.PAUL MN
55101

MN AFL-CIO L.O. LASHOMB
175 AURORA
ST PAUL MN
55103

MN.BD OF NURSING
717 DELAWARE ST SE
MPLS MN
55414

MN SOC SERV ASS J HOOD
614 PORTLAND
ST PAUL MN
55102

MN STATE SER BLIND-K NATA
1745 UNIVERSITY AVE
ST PAUL MN
55104

MINN ASPHALT PAVEMENT ASSN
555 WABASHA RM 209
ST PAUL MN
55102

MINN ASSN COOPERATIVES
55 SHERBURNE AVE
ST PAUL MN
55103

MINN ASSN ELEC COOPERATIVES
4901 W 77TH ST
MPLS MN
55435

MINN. ASSN. PET RETAILERS
1115 2ND AVE. SO.
MINNEAPOLIS MN
55403

MINN COUNCIL STATE EMP NO 6
475 RICE ST
ST PAUL MN
55103

MINN DEPT HEALTH J C MCKASY
717 DELAWARE S E
MPLS MN
55440

MINN DENTAL HYGIENISTS
5041 YVONNE TERRACE
MPLS MN
55436

MINN ENV LAW INST INC
PO BOX 15076 COMM STA
MPLS MN
55415

MINN FARMERS UNION PRES OFF
1275 UNIV AVE
ST PAUL MN
55104

MINN FOOD RETAILERS ASSN
555 WABASHA
ST PAUL MN
55101

MINN HEREFORD-LJ SCHAFER

BUFFALO LAKE MN
55314

MINN. HOTEL & MTR. ASSN
2001 UNIVERSITY AVE
ST PAUL MN

MINN HOUSING INST N T CARTER
7801 METRO PKWY
MPLS MN
55420

MINN HWYS MANAGEMENT SERVICE
407 HWY BLDG
ST PAUL MN
55101

MINN LAND USE COMMITTEE
4344 IDS CENTER
MPLS MN
55402

MINN LP GAS ASSN
7515 WAYZATA BLVD 106
MPLS MN
55426

MINNE MINE CREDIT UNION
00 HUDSON PK S 100
PAUL MN
119

MINN.MTR.TRANSP. .J.N.DENN
1821 UNIV.
ST.PAUL MN
55104

MINN PETROLEUM COUNCIL
1020 NORTHERN FED BLDG
ST PAUL MN
55102

MINN POULTRY & HATCHERY A
BOX 158
MADELIA MN
56062

MN REP STATE CENTRAL COMM
555 WABASHA AVE
ST PAUL MN
55102

MINN RESTAURANT ASSN
2001 UNIVERSITY AVE.
ST PAUL MN 55
104

MINN RETAIL HARDWARE ASSN
3033 EXCELSIOR BLVD 313
MPLS MN
55416

MINN SOCIETY ARCHITECTS A
NW NATL BK BLDG
ST PAUL MN
55101

MINN SOC CERTIFIED PUB ACCTS
1102 WESLEY TEMPLE BLDG
MPLS MN
55403

MINN STATE BAR ASSN
100 MINN FED BLDG
MPLS MN
55402

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 STATE MED ASSN
375 JACKSON ST
ST PAUL MN
55101

MINN STATE RETIREMENT SYSTEM
529 JACKSON ST
ST PAUL MN
55101

MINN TEAMSTERS CREDIT UNION
2021 HENN AVE E
MPLS MN
55413

MINN TBR PRODUCERS ASSN
200 CHRISTIE BLDG
DULUTH MN
55802

NN.TURKEY GROWERS ASSN
83 UNIV AVE
ST PAUL MN
55114

MINN VETERANS MED ASSN
2175 W HWY 36
ROSEVILLE MN
55113

MINN WATER RESOURCES BD
RM 206 555 WABASHA ST
ST PAUL MN
55102

MINN-WISC BOUNDARY AREA C
600 2ND ST
HUDSON WI
54016

MN ELECTRICAL ASSN
3100 HUMBOLT SO
MPLS MN
55408

MN PUB INT RESEARCH GROUP
3036 UNIV AVE SE
MPLS MN
55414

MOFFITT R C
RM 301 M MPLS CITYHALL
MPLS MN
55415

MOOD R BLOOMINGTON HLTH D
10200 PENN SO
BLOOMINGTON MN
55431

MOONEY, MICHAEL A.
BOX 903, ST.JOHN'S UNIV
COLLEGEVILLE MN
56321

MORTON BUILDINGS INC
R #1
FOLEY MN
56329

MPIRG
BOX 45 ST MARYS COLLEGE
WINONA MN
55987

MUCK THOS R
160 STATE OFF BLDG
ST PAUL MN
55155

MURPHY DIANA E
4200 IDS-LINDQUIST VENN
MPLS MN
55402

NASS GEO V HENN CO GEN HOSP
5TH AND PORTLAND AVE
MPLS MN
55415

NATL CAR RENTAL ATT D MIT
5501 GREEN VALLEY DR
MPLS MN
55437

NEDELL HAROLD - MEINEKE
6300 W LOOP S SUITE 200
BELLAIRE TX
77401

NEREN MADONNA
376 NEAL AVE S
AFTON MN
55001

NEUMAN RALPH W
RT 2 BOX 125
EMBARRASS MN
55732

NIELSEN STOCK & BLACKBURN
415 730 BLDG
MPLS MN

NO SUB MONTESSORI-S SADDLER
2487 HELEN COURT
NO ST PAUL MN
55109

NORTH CENTRAL ELEC ASSN
PO BOX 202
BATTLE LAKE MN
56515

NW COUNTRY ELEVATOR ASSN
802 GRAIN EXCH BLDG
MPLS MN
55415

NURSING HOME ADMRS BD EXA
RM 340 717 DELAWARE SE
MPLS MN
55414

NUTTER JULIA
743 W MONTANA
ST PAUL MN
55117

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

O'BRIEN J.DENNIS
1100 1ST NATL.BANK BLDG
MINNEAPOLIS MN
55402

OFFICE OF THE GOVERNOR
) STATE CAPITOL
PAUL MN
5101

OLD COLONY GAS & OIL COMPANY
17TH AVE N AT 2ND ST
MPLS MN
55411

OLOFSON ARTHUR MBO & MAINC
927 SOO LINE BLDG
MPLS MN
55402

OSTRUM DONALD E
PO BOX 33163
COON RAPIDS MN
55433

OTTER TAIL POWER CO.
215 S. CASCADE ST.
FERGUS FALLS MN
56537

PATTISON ORVIS
BOX 645
WILLMAR MN
56201

PAYNE COL ALVIN

DEGRAFF MN
56233

PAYNE WM B
2400 FIRST NATL BK BLDG
MPLS MN
55402

PETERSON JOHN W
510 NW BK BLDG
ST PAUL MN
55101

PETERSON GARY
854 MIDLAND BK BLDG
MPLS MN
55401

PFEIFER AND SHULTZ, INC
1433 UTICA AVE S
MPLS MN
55416

PHAR MFGRS ASSN WM D PATTON
1155 15TH ST NW
WASHINGTON DC DC
20005

PHILLIPS LEGISLATIVE SERVICE
459 RICE ST
ST PAUL MN
55103

PINNETTI NICK M HALEY & ASS.
40 CENTRAL PARK S
NEW YORK NY
10019

POPOVICH PETER S
314 MINN BLDG
ST PAUL MN
55101

RTER LYLE O

TRACY MN
56175

PORT AUTH CITY OF ST PAUL
330 MINNESOTA BLDG
ST PAUL MN
55101

PORTER DAVID
3212 LONGFELLOW AVE S
MPLS MN
55407

POSS DONALD G
6301 SHINGLE CREEK PKWY
BROOKLYN CTR MN
55430

POYZER ROBT
BOX 675
FERGUS FALLS MN
56357

PRAUSE JOS.C.
2220 105TH AVE.N.W.
COON RAPIDS MN
55433

PROCTOR&GAMBLE L THEOHAROUS
IVORYDALE TECH CENTER
CINCINNATI OH
45217

PULSCHER RBT SPRINGSTED I
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

RAMSEY CO MEDICAL SOCIETY
1500 LOWRY MEDICAL BLDG
ST PAUL MN
55102

RAUENHORST CORP-C ANDERSON
7900 XERXES S. S-2200
MPLS MN
55431

REAGAN MICHAEL
% MINN LEARNING CTR
BRAINERD MN
56401

REARDON MRS HELEN
1125 S E 6TH ST
WILLMAR MN
56201

RENQUIST ARTHUR NSP CO
414 NICOLLET MALL
MPLS MN
55401

RICHARDSON THOS
7851 METRO PKWY S 103
MPLS MN
55420

RICHARDS MONTGOMERY ET AL
1430 RAND TOWER
MPLS MN
55402

ROE DAVID
175 AURORA
ST PAUL MN
55103

ROBBIE JOSEPH
904 CARGILL BLDG NO CTR
MPLS MN
55402

ROBERTS DAVID E
1260 NW NATL BK BLDG
ST PAUL MN
55101

ROSS ALFRED
6356 WARE RD
LINO LAKES MN
55014

RUDY FLOYD
118 AVE C
CLOQUET MN
55720

SAN SIMEON DEVELOP CORP
OLD 1ST STATE BK BLDG
PAYNESVILLE MN

SANFORD S M
7000 PORTLAND AVE
RICHFIELD MN
55423

SATHRE, HARVEY
375 MARION STREET
ST PAUL MN
55103

SAX DOVE & STENSON
1 ENDICOTT BLDG
PAUL MN
101

ST PAUL ASSN PLBG HTG MECH
614 AM NATL BK
ST PAUL MN

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

SCARBOROUGH WILLIAM
DIV.ED. U.M.
MORRIS MN
56267

SCHLICHT REV ROBT
611 W MAIN ST
BELLE PLAINE MN
56011

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

SCHMIDT LARRY WCCO-TV NEWS
50 S 9TH ST
MPLS MN
55402

SCHNEIDER MAHLON
GREEN GIANT
LESUEUR MN
56058

SCHUTZ LINDA
RM 328 CAPITOL BLDG
ST PAUL MN
55155

SCHWARTAU NEAL METH HOSP
201 W CENTER ST
ROCHESTER MN
55901

SCHWERMAN EARL JR
1535 8TH AVE SE
ROCHESTER MN
55901

SCHWINN ROBT.P.
1400 SOO LINE BLDG.
MPLS. MN
55402

SCHNEIDER & NEESER
706 1ST ST SO PO BX 876
WILLMAR MN
56201

SCHROEDER ALFRED H
2172 CARROLL AVE
ST PAUL MN
55104

LECTVISION INC FR VALENTIN
5 PARK AVE
NEW YORK NY
10017

SENATE COUN OFF ROOM 24
STATE CAPITOL
ST PAUL MN
55101

SENATE FINANCE COMMITTEE
113 STATE CAPITOL
ST PAUL MN
55101

SENATE GOV OP COMM
RM 303 STATE CAPITOL
ST PAUL MN
55155

SHABATURA EUGENE H
2833 LAKE AVE SO
DULUTH MN
55811

SHARP BOB
4125 HIGHWOOD RD
ST LOUIS PK MN
55416

SHAW ROBERT M
616 MOBIL OIL BLDG
MPLS MN
55402

SHELL OIL CO. W.A. ROQUET
ONE SHELL PLAZA BX 2463
HOUSTON TX
77001

SITE ENGINEERS INC
900 REDWELL LANE
APPLE VALLEY MN
55124

SLOCUM CHARLES A
1203 IDS TOWER
MPLS MN
55402

SMERIKA WN.
BOISE CASCADE PAPERS
INTL FALLS MN
56649

SMITH MICHAEL
1423 NEWTON AVE N
MPLS MN
55411

SNELL LYN
BOX 314
EDEN VALLEY MN
55329

SNYDER ROBERT W
248 CO B U OF M
ST PAUL MN
55101

SODERBERG HAROLD J
1500 MIDWEST PLAZA BLDG
MPLS MN
55402

SODERMAN ANTHONY
152 S PLAZA BLDG
MPLS MN
55416

HAROLD J WESTIN CONSTRUCTORS
45 E 8TH ST
ST PAUL MN
55101

HARVEY MICHAEL
1390 W M HAHA PKWY
MPLS MN
55409

HALLBERG LEE & MCCABE
4927 34TH AVE S
MPLS MN
55417

HAUN DR J W GEN MILLS
PO BOX 1113
MPLS MN
55440

HAYES, THOMAS W
700 SELLWOOD BLG
DULUTH MN
55812

HEALTH MANPOWER C LARSON
717 DELAWARE ST SE
MPLS MN
55440

HENTHORN GARY WOODSTOCK
7365 LANDAU DR
BLOOMINGTON MN
55438

HART PATRICK V
112 E LIBERTY BOX 3271
MANKATO MN
56001

HARTFELDT WILL
434 HAMM BLDG
ST PAUL MN
55102

HAVEN ROBT TWIN TN TREATMENT
1706 UNIV AVE
ST PAUL MN
55104

HEAD & TRUHN
1007 SOO LINE BLDG
MPLS MN
55402

HEANEY BILL
30 W SUPERIOR ST
DULUTH MN
55802

HEARING EX.OFF. M GREENBERG
5 UNIV AVE
PAUL MN
104

HEIM PAUL
1320 SOO LINE BLDG
MPLS MN
55402

HEINTZ MARY ELLEN
PO BOX 599
CINCINNATI OH
45201

HEISENFELT WM
BOX 516
BEMIDJI MN
56601

HENDRICKSON A WM
100 FREEMAN DRIVE
ST PETER MN
56082

HICHINGER-MARK PLANNING
421 WABASHA ST
ST PAUL MN
55102

HILL JIM ASSOC.MILK PROD.
7850 METRO PARKWAY
MINNEAPOLIS MN
55420

HINRICHSEN PATRICK
MANKATO FREE PRESS
MANKATO MN
56001

HOLDAHL SCOTT
380 N BLDG GRAIN EXCH
MPLS MN
55415

HOLEY GEO AERONAUTICS
DOWNTOWN AIRPORT
ST PAUL MN
55107

HOLMES EUSTIS ET AL
4610 IDS CENTER
MPLS MN
55402

HOPKINS WM.B. DIR.MISCCA
3915 GOLDEN VALLEY ROAD
GOLDEN VALLEY MN
55422

HORNER WALDORF - KAZIUKEWICZ
PO BOX 3260
ST PAUL MN
55165

HOULE MELVIN
881 W HWY 96
SHOREVIEW MN
55112

HOUSE APPROPRIATIONS COMM
RM 109 STATE CAPITOL
ST PAUL MN
55101

HOUSE ED STANDING SUB COM
RM 109 STATE CAPITOL
ST PAUL MN
55101

USE RESEARCH
M 17 STATE CAPITOL
ST PAUL MN
55155

HULSTRAND ANDERSON & LARSON
PO BOX 130
WILLMAR MN
56201

HULTMAN WARREN R
C/O BARBAROSSA R3
OSSEO MN
55369

HUMAN RIGHTS
200 CAPITOL SQ BLDG
ST PAUL MN
55101

HUMAN SERVICES
414 LAFFAYETTE RD 5THFL
ST PAUL MN
55101

HUNT JAMES P JR
11470 GALTIER DR
BURNSVILLE MN
55378

HUTCHISON R.M. ANOKA CO.COMP
COURT HOUSE
ANOKA MN
55303

HYDROLOGIST
CHIPPEWA NATL FOREST
CASS LAKE MN
56633

HYLAND DEAN
1501 W 50TH ST
MPLS MN
55419

ILLINGWORTH ROBERT C
6750 FRANCE AVE S RM290
MPLS MN

INGEBRIGTSEN DR K H
23 SE 4TH ST
MPLS MN
55414

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

INTERSTATE POWER RW STEELE
1000 MAIN ST
DUBUQUE IA
52001

IUOE LOC 49 CHAS SWENSON
2580 UNIV AVE
ST PAUL MN
55101

ESSE KENNETH
4801 W 50TH ST
EDINA MN
55424

ETHICS COMM
RM 410 STATE OFF BLDG
ST PAUL MN
55155

EVANS CHAS.L. PRENTICE-HALL
ENGELWOOD CLIFFS
NEW JERSEY

EVERETT JERRY NW PETRO AS
512 NICOLLET MALL RM917
MPLS MN
55402

EWALD DOUGLAS MINN HOSP ASSN
2333 UNIV AVE SE
MPLS MN
55414

EWING MRS WM
42 ASTAR RD
BABBITT MN
55706

FAEGRE & BENSON ATTN LIBR
1300 NW BANK BLDG
MPLS MN
55402

FARMERS ELEVATOR ASSN
852 GRAIN EXCH BLDG
MPLS MN
55415

FARRELL FRANK BUR NOR
RM 1180 176 E 5TH ST
ST PAUL MN
55101

FFLHABER R S
W 1ST NATL BANK BLDG
ST PAUL MN
55101

FILTER LOREN
BOX 36
BRITT MN
55701

FINLEY JAMES F
[illegible] MINN BLDG
[illegible] PAUL MN
[illegible]01

FINNEGAN J.R.
55 E. 4TH
ST.PAUL MN
55101

FITZGERALD DR BOB
3007 LYNDALE AVE SO
MPLS MN
55408

FLADLAND CLINTON MN L&P B
796 RAYMOND AVE
ST PAUL MN
55114

FLEMING FREDERICK A
1860 HIGHLAND PARKWAY
ST PAUL MN
55116

FLADLAND CLINT MN L&P BUR
795 RAYMOND AVE
ST PAUL MN
55114

FORBES GORDON MINN RRS ASSN
203 HANOVER 480 CEDAR
ST PAUL MN
55101

FORSBERG AGR SERV
518 SUMMIT AVE
NEW ULM MN
56073

FOX W.E. LINDQUIST & VENNUM
4200 IDSCTR 80 S.8TH ST
MINNEAPOLIS MN
55402

FRANKLIN ROBERT B MPLS TRIB
426 PORTLAND
MPLS MN
55415

FREDIN CONRAD M
811 FIRST NATL BK BLDG
DULUTH MN
55802

FREDRIKSON BYRON ET AL
47TH FLR IDS CENTER M
PLS MN
55402

F W WOOLWORTH CO
3316 W 66TH ST
EDINA MN
55424

GALVIN M J JR
W2162 1ST NATL BK BLDG
ST PAUL MN
55101

GARDNER HDW - R A JOHNSON
515 WASHINGTON AVE N
MPLS MN
55401

G[illegible]ERT K L
2[illegible] GRAIN EXCH
MPLS MN
55415

GEO A HORMEL & CO LAW DEPT
PO BOX 800
AUSTIN MN
55912

GIEL DAVID
RM B-28 STATE CAPITOL
ST PAUL MN
55155

GLEESON MICHAEL
909 SOC SC BLDG U OF M
MPLS MN
55455

GLEN. HILLS HOSP.R.VAN HAUER
3901 GOLDEN VALLEY RD.
MPLS. MN
55422

GODIN RALPH J
3824 47TH AVE SO
MPLS MN
55406

GOODMAN DF TEL CABLE TV
302 E SUPERIOR
DULUTH MN
55802

GRAHAM THOS H
854 MIDLAND BK BLDG
MPLS MN
55401

GRANATH MARVIN -HONEYWELL
2701 4TH AVE SO
MPLS MN
55408

GREATER MET AREA HOSPITALITY
5152 CEDAR AVE S
MPLS MN
55417

GREEN DEL CITY MGR
BLOOMINGTON CITY HALL
BLOOMINGTON MN
55431

GREEN GARY J
41 SHERBURNE AVE
ST PAUL MN
55102

GREEN JANET
9773 N SHORE DR
DULUTH MN
55804

GRUMMERT REV DONALD
1435 ADAMS ST
MPLS MN
55413

GUSTAFSON DAN-LABOR TEMPLE
312 CENTRAL
MPLS MN
55414

GUSTAFSON WALLACE
BOX 567
WILLMAR MN
56201

STATE REGISTER,MORROW S.
203,95 SHERBURNE
ST PAUL MN
55103

STD AM LIFE & ANNUITY CO
3801 W 50TH ST
MPLS MN
55410

STEELWORKERS CREDIT UNION
BOX 250
BABBITT MN
55706

STOLPESTAD BROWN & SMITH
1550 NW BK BLDG
ST PAUL MN
55101

STUPKA & MOREM
MIDTOWN BLDG
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

SUSSEL CO.ATTN:TED SCHWEN
1850 COMO AVE.
ST PAUL MN
55108

SWANSON BURT E
W-2162 1ST NATL BK BLDG
ST PAUL MN
55101

SWANSON DALE
P O BOX 339
FOREST LAKE MN
55025

SWANSON GERALD H
212 CITY HALL
ROCHESTER MN
55901

SWEITZER R L HONEYWELL IN
2701 4TH AVE S
MPLS MN
55408

TATE VERN 3M CO
3M CENTER 220/6W
ST PAUL MN
55101

THOMPSON CONRAD
1107 23RD ST NW
ROCHESTER MN
55901

THOMPSON HESSIAN ET AL
1500 MIDWEST PLAZA BLDG
MPLS MN
55402

TIMESAVERS INC ATT R S VOLD
5270 HANSON COURT
MPLS MN
55422

TOUCHE ROSS & CO K H STOCKE
780 NORTHSTAR CNTR
MPLS MN
55402

TWIN CITY RETAIL DRUGGIST AS
2388 UNIV AVE
ST PAUL MN
55104

UNION STOCK YARDS
ATTN PRES
SO ST PAUL MN
55075

VANDERVOORT T J MET WASTE
350 METRO SQUARE BLDG
ST PAUL MN
55101

VAN CLEVE JOHN H
2101 HENN AVE
MPLS MN
55405

VAN DRAKE STEPHEN R
BOX 353
PELICAN RAPID MN
56572

VAN EVERA MUNDT ET AL
700 TORREY BLDG
DULUTH MN
55802

VERRILL JOHN E
DEPT SECONDARY ED UOF M .
DULUTH MN
55812

VILLAGE OF WOODBURY
2100 RADIO DRIVE
WOODBURY MN
55042

[redacted]LDNESS PERRY
[redacted] 8TH & MARQUETTE
[redacted]PLS MN
55402

VOSS REV GORDON O
11120 NE 7TH ST
BLAINE MN
55434

VOS LEROY
2137 BURNS AVE
ST PAUL MN
55119

WALD JEAN
5746 SANDER DR
MPLS MN
55417

WALTERS THOS H
4510 W 77TH ST STE 235
MPLS MN
55435

WANQUIST ALLEN
RM 252 FEDERAL BLDG
ST PAUL MN
55101

WELK G V NORTHERN STATES
414 NICOLLET MALL
MPLS MN
55401

WELLINGTON R R SKELLY OIL
PO BOX 1650
TULSA OK
75102

WESTIN CHAS W
220 MEDICAL ARTS BLDG
DULUTH MN
55802

WHITING RALPH
555 WABASHA SUITE 204
ST PAUL MN
55102

WHITLOCK A G
ECON LAB OSBORN BLDG
ST PAUL MN
55102

WILCOX J PATRICK
1220 NORTHERN FED BLDG
ST PAUL MN
55102

WM.MITCHEL COLLEGE LAW LIB.
2100 SUMMIT AVE.
ST.PAUL MN
55105

WILEY ENTERPRISES
101 5TH AVE SE
OSSEO MN
55369

WILLIAMS THOS W
4915 W 35TH ST
MPLS MN
55416

ALBERT,AA CALDER CORP
366 JACKSON ST
ST PAUL MN
55101

ALLENDORF MARSHALL
220 GRAIN EX 400 S 4TH
MPLS MN
55415

AMER CAMPING ASSN
3639-21/2 ST N.E.
MPLS MN
55418

AM INST PROF GEOLOGISTS
2201 PRINCETON AVE
ST PAUL MN
55105

ANCHOR BLOCK COMPANY
PO BOX 3360
ST PAUL MN
55165

ANDERSON GRAHAM
951 E HENN
MPLS MN
55414

ANDERSON HERBERT
418 8TH ST. SO.
VIRGINIA MN
55792

ANDERSON HAROLD
BOX 3047
MANKATO MN
56001

ANDERSON JAMES
7703 NORMANDALE RD
MPLS MN
55435

ANDERSON MARY
4425 RUTLEDGE AVE
EDINA MN
55436

ANDERSON STANFORD P
14600 MINNETONKA BLVD
MINNETONKA MN
55343

ANTHONY DICK WDSM RADIO
230 E SUPR ST
DULUTH MN
55102

ARNOLD ROBERT MESPA
41 SHERBURNE
ST PAUL MN
55103

ARROWHEAD REGIONAL DEV COMM
200 ARROWHEAD PLACE
DULUTH MN
55802

ARVER JOHN A
2467 COHANCY
ST PAUL MN
55113

ASMUSSEN,DENNIS,MPIRG
3036 UNIV AVE SE
MPLS MN
55414

ASSOCIATED GEN CONTROF MN
48 E 8TH STREET
ST PAUL MN
55101

ASSOCIATED INDUST OF MPLS
NATIONAL BLDG
MPLS MN
55402

ASSN OF MINN COUNTIES
55 SHERBURNE AVE #203
ST PAUL MN
55103

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 30th day of April, 1976, 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 30th day of April, 1976

Lorraine C. Pfeiffer

LORRAINE C. PFEIFFER
Notary Public, Dakota Co., Mn.
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

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 State Office Building Auditorium, Wabasha Street (between Aurora and Fuller), St. Paul, Minnesota, on Tuesday, June 1, 1976, 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 engaged for pay or other consideration for the purpose of 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. It is expected that 125 people will attend this public hearing and that sixteen (16) hours will be needed to conduct the hearing.

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 55175. Additional copies will be available at the door on the date of the hearing.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

DATED: April 27, 1976

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

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 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. The subdivision entitled "Mental Health Centers" [V(b)(19)] is added to the proposed rule in order to more accurately define and delineate such services.

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. 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(d)] is added to the proposed rule.

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

Vera J. Likins

Vera J. Likins
Commissioner

DATED: May 5, 1976

ADMIN 1000

STATE OF MINNESOTA

DEPARTMENT Public Welfare

Office Memorandum

TO : Duane Harves
Chief Hearing Examiner

DATE: May 6, 1976

FROM : Irene Goldman
Medical Assistance Policy Specialist
Medical Assistance Program

PHONE: 7666

SUBJECT: Names of Agency Personnel Who Will Testify at the Hearing on Minn. Rule DPW 47.

The following personnel will represent the Department of Public Welfare at the June 1 Public Hearing on Minn. Rule DPW 47:

James Hiniker
Robert Baird
Roger Johnson, M.D.
Russell Roberts, D.D.S.
John Bush, R.Ph.
Wyllis Akre, M.D.
Bradley Stoneking
Tom Gaylord
Charlene Seavey
Jean Morley
Warren Nyhus
Irving Bernstein, M.D.

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ADMIN 1000

STATE OF MINNESOTA

DEPARTMENT Public Welfare

Office Memorandum

TO : Duane Harves
Chief Hearing Examiner

DATE: May 6, 1976

FROM : Irene Goldman
Medical Assistance Policy Specialist
Medical Assistance Program

PHONE: 7666

SUBJECT: Evidence to be presented at the public hearing on Minn. Rule DPW 47.

In accordance with the requirements of HE 103(i), attached are lists of evidence to be presented at the June 1, 1976 public hearing on Minn. Rule DPW 47. The evidence includes citations to federal and state statutes, newspaper articles, professional publications and books, and official correspondence between the Department and other state and federal agencies. In compliance with HE103(i) we will notify you of any additional evidence to be presented at the hearing.

3

Title 45 of the Code of Federal Regulations:

205.35	Methods of Administration
205.60	Reports and Maintenance of Records
205.100	Sing State Agency
206.10	Application, Determination of Eligibility and Furnishing of
248.3	State Plan Requirements on Financial Eligibility
248.30	Age
248.40	Residence
248.50	Citizenship
248.60	Institutional Status
249.10	Amount, Duration, Scope (a)(5)(i) specifications and limit (b) Conditions for FFP - Types of Service (c) Limitations (d) General provisions
249.12	Standards for ICF including ICF-MR at present
249.13	ICF-MR by 1977
249.20	Free Choice
249.31	Prohibition against re-assignment
249.33	Standards for payment - SNF and ICF
250.18	Utilization Control
250.19	Utilization Review
250.20	FFP - Reduction
250.21	Agreements with Providers
250.23	PMR)
250.24	IPR) Health Department Contract
250.30	Reasonable Charges
250.31	Payment by Third Party
250.80	Fraud
250.90	Claims Processing

250. 23 24

Sections of the Social Security Act

/ Sec 1902(a)(4)(A)	Methods of Administration	relate to 45 CFR
(6)	Reports required to be submitted	
(17)	Include reasonable standards	
(23)	Free choice of provider	
(25)	Third Party Liability	
(26)	Medical Review (PMR)	
(27)	Agreements with providers	
(28)	SNF - Payments	
(30)	Provide methods - procedures UR	
(31)	IPR-ICF	
(32)	Prohib - assignments	
(33)	Standards and Contract (with Health)	
(34)	Retro coverage	
(b)	No plan can be approved if --	

/	Sec. 1903(g)(1)	Reduction of FFP - Failure to do UC
	(i)	Restriction if excessive payment
/	1904	Operation of State Plan
/	1905(f)	SNF
	(g)	Chiropractors
/	1909(a)	Penalties - recipient
	(b)	Penalties - provider
	(c)	Penalties - facilities

Minnesota Statutes

4	Section 256B.04	Duties - New subd 10
	256B041	Centralized disbursement
	256B.042	Third Party Liability (76 amend)
	256B.04 subd.	The Commissioner's authority to establish fee maximum
	256B.06	Eligibility conditions
	256B.064	Ineligible provider
	256B.065	Social Security Amend - Comm. Comply - avoid loss of FFP
	256B.08	Application
	256B.09	Investigation re eligibility of applicant
	..14	Relative responsibility
	.17	Transfer of Property
	.18	Methods of Administration
	.21	Change of residence
	.22	Compliance with Social Security Act
	.27	MA cost reports
	.36	Special Allowance MR
	.37	Private Insurance
	.39	Avoidance of duplicate payments
	.121	Treble damages
4	Section 256.98	Wrongfully obtaining assistance; theft

2 Minnesota State Plan for Medical Assistance

Minnesota M.A. Caseload, Average Grant and Gross Cost Trends Fiscal Years 1966 thru 1975

8 H.F. No. 1743 Chapter No. 434 Appropriations Act

6 Minn. Stats., Chapter 15 Administrative Procedures Act

Commerce Clearing House, Medicare and Medicaid Guide

21

27,707	Conn. - Injunction Against Medicaid Cutbacks
27,221	Durable Medical Equipment -- Screening list
27,289	Medicaid - HMO Enrollees
27,343	Ohio - Coverage of Elective Abortions
27,384	California - Receipt of Health Care Under False Declarations
27,457	Pennsylvania - Abortions
27,469	Medicare and Medicaid SNF Health and Safety Standards Compliance
27,483	Medicaid Penalty for State Failure to Effectively Control Utilization of Institutional Services
27,491	New York - Removal of SNF Patients from Nursing Facilities without Hearing
27,503	SNF Conditions of Participation - Physician Visits - Medical Records

69th Legislature

5 S.F. No. 55 State Government - Unemployed and Underemployed Persons, Chapter 2

23 Letter from Raymond F. McKenna, Director, Ohio Dept. of Public Welfare to Commissioner Likins, dated April 6, 1976, regarding program cutbacks in the Ohio Medicaid Program.

22 Congressional Record - Senate, June 3, 1975, "A Look at Medicaid and Medicare", S9345-50.

14 From Other State Capitols

5-1-76	Pennsylvania - welfare reform - 30 reforms figured to save some 40 million.
3-1-76	Wisconsin - a bill to tighten state control over Medicaid program - reducing the liquid asset limits.
2-1-76	Tennessee - state supplemental appropriation needed to rescue the financially ailing Medicaid program ($12 million).
	Court order prevented a 10% cut.
1-1-76	Maryland - Because of inflation and swelling Medicaid rools - cut 12 million from 7 kinds of services (inpatient hospital, podiatry, vision care, medical transportation, medical supplies and durable equipment).
	New Jersey - Major reforms in Medicaid.
	New York - Reductions in welfare spending are among proposals by Governor Carey.
12-1-75	Virginia - Cutbacks needed and accomplished to prevent (head off) Medicaid budget deficits.
9-1-75	Montana - Montana Supreme Court allowed the State Dept. of Social and Rehab services to adopt an emergency rule curtailing the MA Program.

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96 "Great Medicaid Scandal" Time 105:55 My 26 '75.

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? 98 Holahan, John, Financing Health Care for the Poor: the Medicaid Experience.

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90 Turner, Judith Axler, "Health Report/HEW Publishes Regulations Designed to Cut Drug Costs", National Journal Reports, August 8, 1975, pp. 112-116.

25 Newspaper Articles

Medicaid in Minnesota: (series)		
	1. St. Paul Sunday Pioneer Press	11-9-75
	2. St. Paul Dispatch	11-10-75
	3. St. Paul Dispatch	11-11-75
	4. St. Paul Dispatch	11-12-75
	5. St. Paul Dispatch	11-13-75
Los Angeles Paper:	U.S. Identifies 207 Doctors Who Got 100,000 or More in Medical Fees	12-1-75
Washington Post:	Medical Fraud Charged	2-16-76
Chicago Tribune:	Medicare Labs Fraud Put at 3 Million	2-17-76
Sacramento Bee:	Defects in Health System	1-24-76
	Report Jars Chief of Medi-Cal	1-24-76
Atlanta Constitution:	Medicaid Patients to Pay $1 to See Doctor	11-20-75
	Panel Okays Medicaid Cuts	10-16-75
Minneapolis Star:	207 Drs. Paid 100,000 by Medicaid	10-31-76
St. Paul Pioneer Press:	Penalty Heldup in Mn. Medicaid Case	9-4-75
	Medicare Charges Up January 1	10-1-75
	Medicaid Caseload Puts Dr. in Public Eye	11-2-75
Milwaukee Journal:	Million in Medicaid Squandered, State Says	2-1-76
Minneapolis Star:	Auditors Sent Back to Illinois	11-14-75
Minneapolis Tribune:	Penalties Suspended for Mn. 9 States in Medicaid Case	9-4-75
Chicago Tribune:	More Medical Suspensions	4-2-76
	State Medicaid Rings Slush Fund Revealed	3-12-76
	Probers Charge State Agency Hid Medicaid Fraud	12-17-75
	11 More Doctors Suspended	2-17-76
	Walker is Warned of Medicaid Crisis	8-8-75
	Walker Blamed for Welfare Waste	11-14-75

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15 Tally of inpatient psychiatric days accumulated by Medicaid recipients during the first third of 1976 (January 1 through April 30, 1976).

16 Table of 1975 inpatient hospital costs and lengths-of-stay for certain psychiatric diagnoses.

17 Table of 100 most common diagnoses for Medicaid recipients, indicating total days, average days, average charge per day and average charge per person.

26 Minutes of the October 30, 1975, meeting of the Committee on Mental Health.

26 Minutes of the Medical Assistance Psychiatric Advisory Committee meeting on January 29, 1976; February 26, 1976; March 18, 1976; April 29, 1976.

23 Michigan Medical Assistance Program, AllProvider Bulletin No. 11 - Governor's Executive Order 1975-12 discussing reimbursement curtailment in the Michigan M.A. Program.

12 Table of 1975 Minnesota M.A. payments by type of provider

21 Memo from Paul Farseth to Warren Nyhus discussing certain sections of the proposed rule dealing with assignment of Medicare payments, billing on prescribed forms according to Department instructions and services not covered by the M.A. program.

STATE OF MINNESOTA

DEPARTMENT Public Welfare

Office Memorandum

TO : Steve Mihalchick, Hearing Examiner

DATE: May 14, 1976

FROM : Irene Goldman
Medical Assistance Policy Specialist
Medical Assistance Program

PHONE: 7666

SUBJECT: Additional Evidence to be Presented at the Public Hearing on Minn. Rule DPW 47

The Department of Public Welfare will present the evidence listed below at the June 1, 1976, public hearing on Minn. Rule DPW 47. This evidence is in addition to that previously filed with your office on May 6, 1976. If any additional evidence becomes known to us, we will so notify you immediately.

13 Table of Minn. M.A. Caseload, Average Grant and Gross Cost Trends Fiscal Years 1966 through 1975.

10 Minn. Rule DPW 49.

25 Blade, Joe, "Homes nurse profits best, author says", Mpls. Star, May 25, 1974.

19 Comptroller General of the United States, Report to the Congress: Improvement Needed in the Administration of the Program to Provide Medicare Benefits for Welfare Recipients, August 14, 1973.

18 ----------More Needs to be Done to Assure that Physician's Services - Paid for by Medicare - are Necessary, August 2, 1972.

25 Curtin, Sharon, "Tender Loving Greed in the Nursing Home Industry", Mpls Tribune, May 5, 1974.

69 "Medicare and Medicaid After Ten Years", Editoral Research Reports, July 18, 1975, pp. 525-542.

86 "Stricter Controls Needed to Regulate Surgical Procedures", Modern Health Care, Vol. 49, Nov. 1, 1975.

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STATE OF MINNESOTA

DEPARTMENT Public Welfare

Office Memorandum

TO : Steve Mihalchick, Hearing Examiner

DATE: May 27, 1976

FROM : Irene Goldman
Medical Assistance Policy Specialist
Medical Assistance Program

PHONE: 7666

SUBJECT: Additional Evidence to be Presented at the Public Hearing on Minn. Rule DPW 47

The Department of Public Welfare will present the evidence listed below at the June 1, 1976 public hearing on Minn. Rule DPW 47. This evidence is in addition to that previously filed with your office on May 6 and May 14, 1976.

7 Ch. 188 M.A. claims for reimbursement
8 Ch 434 Appropriations

Comptroller General of the U.S., Report to the Human Resources Task Force House Committee on the Budget: History of the Rising Costs of the
20 Medicare and Medicaid Programs and Attempts to Control these Costs, 1966-1975, Feb. 11, 1976.

37 Brian, Earl, M.D., "Medi-Cal Criticisms in Perspective", Medical Care, Vol. XIII, No. 4, April 1975, pp. 360-364.

38 Brian, Earl M.D. and Stephen F. Gibbens, "Medi-Cal Patients: How do Physicians Compare them with other Patients ?", Medical Care, Vol. XII, No. 11, November 1974, pp. 918-927.

43 "California's Medi-Cal Copayment Experiment", Medical Care, Vol. XII, No. 12 December, 1974, pp. 1051-1058.

44 Chodoff, Paul, M.D., "The Effect of Third-Party Payment on the Practice of Psychotherapy", American Journal of Psychiatry, 129:5, Nov. 1972, 52-57.

53 Fein, Rashi, Ph.D., "Some Health Policy Issues: One Economist's View", Public Health Reports, Vol.90, No. 5, Sept.-Oct. 1975, pp. 387-392.

59 Hopkins, Carl E., et.al., "Cost-Sharing and Prior Authorization Effects on Medicaid Services in California: Part II: The Providers' Reactions", Medical Care, Vol. XIII, No. 8, Aug. 1975, pp. 643-647.

71 Morehead, Mildred A., "A Practical Approach to Quality Control of Health Care Services", American Journal of Public Health, Vol. 66, No. 1, Jan. 1976, p. 17.

87 Stuart, Bruce and Ronald Stockton, "Control and the Utilization of Medical Services", Milbank Memorial Fund Quarterly, Summer 1973, pp. 341-394.

9 Minn. Rule DPW 47
11 Minn. Rule DPW 52

STATE OF MINNESOTA

DEPARTMENT Public Welfare

Office Memorandum

TO : Steve Mihalchick
Hearing Examiner

DATE: July 14, 1976

FROM : Jim Hiniker
Deputy Commissioner

SUBJECT: Rule 47

The Department has conducted a preliminary review of the written and oral testimony on proposed Minn. Rule DPW 47. At this time I would like to suggest several changes to the proposed rule which reflect some comments contained in the testimony. I would also like to state that, in accordance with Laws 1975, Chapter 434, Section 22, the Department estimates the fiscal impact of this proposed rule to be minimal, therefore making a fiscal note unnecessary. The minimum fiscal impact is anticipated because the proposed rule reflects the current practices and maximum allowable charges of the Department.

I submit the following changes to proposed Minn. Rule DPW 47:

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1 (I) (b) The Commissioner of Public Welfare may issue ~~policy~~ instructional bulletins and manual material to the local welfare agencies and vendors of medical care and services to clarify and implement the provisions of this rule and may prescribe forms to be used in administration of the MA program.

EXPLANATION: Certain interested parties, including the Minnesota Association of Health Care Facilities, expressed concern that § I (b) of proposed Rule 47, as originally drafted, authorized the issuance of "policy bulletins" on subjects which must be addressed through the rule making procedures of Minn. Stat. ch. 15 (Supp. 1975). As the Department noted at the public hearings on proposed Rule 47, it fully recognizes that agency statements of the nature defined in Minn. Stat. § 15.0411, subd. 3 (Supp. 1975)

must be promulgated pursuant to the rule making procedures established by the Administrative Procedure Act. Thus, while it was never the Department's intent to issue a "policy bulletin" which was in substance a "rule", the expressed concerns on that subject prompted the Department ot make the above change in § I (b) of the proposed rule in order to clarify the fact that the section should not be interpreted as authorizing the issuance of any materials which must be made the subject of rule-making hearings.

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3 (II) (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. Local welfare agencies shall inform all applicants that their medical records may be released to the state agency, the local welfare agency, the Minnesota Department of Health, the U.S. Department of Health, Education and Welfare, ~~and~~ the PSRO and other appropriate agencies. Local welfare agencies shall obtain the applicant's written consent ~~to~~ releasing this information to these agencies and making such release a condition of eligibility for Medical Assistance.

EXPLANATION: The above referenced changes in § (II) (j) of proposed Rule 47 are based upon testimony submitted by the Minnesota State Medical Association at the June 1, 1976, public hearing. See generally Transcript of the Proceedings 36-39. Upon review of the Medical Association's testimony, the Department has concluded that the minor changes in § (II) (j) which are reflected above are of merit and should be implemented.

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9 (III)(d)(2) (E) Types of property ownership. The owner of property in joint tenancy shall be considered as owning ~~one-half~~ his pro-rata share 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.

EXPLANATION: The above change in § (III)(d)(2) (E) of proposed Rule 47 is based upon the testimony of the Minnesota Association of Health Care Facilities. See, Letter to Commissioner Likins (June 22, 1976) at 18. The Department agrees that the change suggested by that organization is an improvement in the text of § (III)(d)(2) (E).

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13 (IV)(d)(3) (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~~ requested by the state agency in the administration of the MA program.

13 (IV) (e) Third-Party Liability. The term "third-party" as used herein includes, but is not limited to, insurance companies, (including HMOs); 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 ~~up-to-the-liability-of-the-MA~~

~~program.~~ and any overage will be forwarded to the provider of service. 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.

EXPLANATION: The above changes in §§ (IV)(d)(3)(C) and (IV)(e) of proposed Rule 47 are based upon the testimony of the Minnesota State Medical Association. See, Transcript of the Proceedings at 39, 40-41. Upon review of that testimony, the Department has concluded that the textual changes proposed by the Medical Association should, to the extent reflected above, be adopted for the reasons given at the public hearing.

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14 (IV) (g) Agreement 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 pertinent to the MA program 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.

EXPLANATION: Inclusion of the phrase "pertinent to the MA program" in § (IV)(g) of proposed Rule 47 resolves any possible misunderstanding as to the grounds upon which provider agreements can be terminated.

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14 (IV) (h) Qualification of Eligible Providers. The state agency shall determine the 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. ~~The Commissioner is authorized to terminate payments under Chapter 256B to any person or facility providing medical assistance which under applicable federal law or regulation, has been finally determined to be ineligible for payments under Title XIX of the Social Security Act.~~ Any vendor of medical care who submits to the state agency a claim for reimbursement, a cost report, or a rate application which he knows to be false in whole or in part shall be declared ineligible for further payments of MA funds by the Commissioner of Public Welfare. The Commissioner shall determine the time period of ineligibility and any conditions for reinstatement of eligibility. No vendor of medical care shall be declared ineligible without prior notice and an opportunity for a hearing, pursuant to Minn. Stat., Chapter 15, on the Commissioner's proposed action.

EXPLANATION: The new language in § (IV)(h) of proposed Rule 47 has been added in order to bring the text of § (IV)(h) into closer conformity with the provisions of Minn. Laws 1976 ch. 188, § 1.

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15 (IV)(i) ~~Prior-Authorization.--The-state-agency-shall establish-and-implement-methods-and-practices for-prior-authorization-of-these-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-of-service-is-to-be-furnished by-providers-whose-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:~~

Prior Authorization. The state agency shall establish and implement methods and procedures for prior authorization of certain items of care and services covered under the MA program. Services and items of care which must receive prior authorization are so indicated in Sections V(b)(1) thru (19), infra.

The state agency shall provide vendors of medical care with designated forms to be used in making prior authorization requests. The vendor shall submit the completed charge and sufficient information to allow a reasonable evaluation of the request. The state agency shall send a form to the provider indicating whether the requested authorization has been approved or denied.

The state agency shall use the following criteria in evaluating prior authorization requests in order to:

(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.

Emergency services maybe covered under the MA program even if the required prior authorization was not obtained. In order to be covered, the provider shall attach to the invoice an explanation of the circumstances under which the services were provided and why such services should be classified as emergency care. The state agency shall reimburse only those services usually requiring prior authorization for which emergency status is established.

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.~~

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.~~

EXPLANATION: The prior authorization requirements of proposed Rule 47 have been the subject of both written and oral testimony. The Department's authority to require prior authorization in appropriate circumstances has been well established. See, e.g., Department Exhibit 103 and the authorities cited therein. In addition, the need for the prior authorization requirements of proposed Rule 47 has been well documented. See, e.g., Transcript of the Proceedings at 115-118, 216-218. Thus, the Department remains committed to the concept of prior authorization as set forth in proposed Rule 47.

The changes in § (IV)(i) set forth above are based primarily upon the testimony of the Minnesota Association of Health Care Facilities and the Minnesota Hospital Association. Both of those organizations expressed concern that the "introductory" material concerning prior authorization contained in proposed Rule 47 was vague and, in some instances, confusing. The Minnesota Hospital Association also expressed concern about the operation of the prior authorization requirements of proposed Rule 47 in emergency situations.

The textual changes in § (IV)(i) which have been proposed by the Department are designed to respond to the concerns expressed by the two aforementioned organizations and others.

The Department believes its suggested revisions add clarity to § (IV)(i) and establish a practical procedure for compliance with prior authorization in emergency circumstances.

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37 (VI)(a) (2) DPW's "maximum allowable charge" as used herein means ~~the charge established in accordance with requirements of applicable federal regulations~~ 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.

EXPLANATION: The Department's proposed change in § (VI)(a)(z) is designed to clarify the manner in which maximum allowable charges are to be determined. The proposed change in § (VI)(a)(2) does no more than restate the concept originally set forth in that section in a more precise manner.

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38 (VII) (a) Former Minn. Rule DPW 47 is hereby repealed except Section (S) which now becomes VI (a).

EXPLANATION: The retention of § (VI) (a) of present Rule 47, which deals with the subject of usual and customary fees, is desirable in order to insure clarity and completeness in the fee provisions of proposed Rule 47.

STATEMENT OF COMPLIANCE WITH

MANUAL OF RULE MAKING PROCEDURES

I, Special Assistant Attorney General Thomas H. Jensen, do hereby declare that I have examined proposed rule DPW 47 and all related documents and that, based upon them and my personal familiarity with the applicable procedures, the Manual of Rule Making Procedures has been followed. Any exceptions are noted below.

_____

THOMAS H. JENSEN

Dated:

PROPOSED

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 and implement the provisions of this rule and may prescribe forms to be used in administration of the MA program.

(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, and who have a demonstrated need for such 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, on all applicants/recipients under the MA program, and on the state agency.

(f) The official State Plan is the submitted and approved federal document which indicates those options covered by Minnesota Statutes.

(g) This rule specifically includes by reference any federal laws or regulations or state laws pertaining to the Minnesota Medical Assistance program, and any provision of this rule which is inconsistent with those laws and regulations is superseded thereby.

(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 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. In such cases, the local agency shall promptly advise the applicant of the MA program's eligibility requirements. One condition of eligibility is a demonstrated need for medical care and services.

(c) Each application form shall be signed by the applicant or the applicant's responsible relative, legal guardian or authorized representative (or where incompetent or incapacitated, by someone acting responsibly for him).

(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 eligibility for Medical Assistance. All eligibility conditions shall be met within these time limits. Where a delay is necessary because necessary information cannot be obtained within the time limits, the applicant shall be notified in writing of the delay and shall be advised of his right to appeal such delay.

(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. 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.

(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 and obtain written consent 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. Local welfare agencies shall inform all applicants that their medical records may be released to the state agency, the local welfare agency, the Minnesota Department of Health, the U.S. Department of Health, Education and Welfare, and the PSRO. Local welfare agencies shall obtain written consent to release this information to these agencies.

(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. 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. 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) The county in which the applicant resides at the time of application for Medical Assistance is the county of financial responsibility. Continuous receipt of assistance will continue financial responsibility in that county.

(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 inpatient psychiatric hospital services), or 65 years of age or older.

(3) 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.

(b) Residence

(1) "Residence" or "abode": Where a person lives and intends to remain.

(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. An agricultural migrant who meets all other eligibility requirements and who has an abode in another state shall be eligible for Medical Assistance. 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.

(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 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.

(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 relatives responsible under statutes 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 all income of children under 18 years of age who are in the home. Eligibility of individuals between 18 and 21 years of age shall be determined either separately or as part of a family unit.

(D) Definitions

(i) "Income": Any benefit received by or available to a Medical Assistance applicant/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, including non-cash items provided free of cost, is considered a resource to be evaluated in determining the need of Medical Assistance applicants/recipients.

(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 13¢ 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 that are necessary and reasonable).

(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, except when specifically exempted by federal law.

(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 not to be considered in determining the amount of payments made for medical services, except in long term care facility, 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. 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. 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 available 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 spend-down 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. "Equity" shall be the assessed tax value minus any encumbrance against the property.

(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 (at least annually) 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. If a person tenders any amount of money to a long term care facility within three years immediately preceeding his application for Medical Assistance, or while receiving such assistance, all such deposits shall be considered a resource in determining such person's eligibility for Medical Assistance.

(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. 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.

(F) Assignment of benefits. Each applicant or recipient shall as a condition of eligibility:

(i) 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

(ii) 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.

(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) Marriage or Remarriage of Parent. In the event that a parent with dependent children under 18 years of age marries or 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 MA applicants/recipients 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 involuntarily 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 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, 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.

(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 DPW's utilization review and control system.

(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 Auditor and the Department of Health, Education and Welfare (or representatives of those agencies) in order to justify all payments made to such provider and the propriety of all services rendered by such provider 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 HMOs); 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 up to the liability of the MA program. 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) 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 one year from the date the last item of medical care was furnished.

(2) 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 one year 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. Nothing in this rule shall be construed as requiring a provider to provide services to a recipient who fails to present a currently valid ID card. A provider may contact the local welfare agency for verification of current eligibility 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 90 days overdue, or when the special four month AFDC extended medical periods terminate in accordance with applicable federal regulations. 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. 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 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. The Commissioner is authorized to terminate payments under Chapter 256B to any person or facility providing medical assistance which under applicable federal law or regulation, has been finally determined to be ineligible for payments under Title XIX of the Social Security Act.

(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 federal 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).

(k) Transportation. The MA program shall pay for transportation only when furnished by an enrolled medical provider licensed by the Minnesota Department of Health. However, local welfare agencies may approve and pay for transportation when furnished by someone other than an enrolled medical provider. Such service must receive prior authorization and shall be reimbursable from the local welfare agency's medical assistance administrative account.

(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 submitted 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) unless requested by the state agency.
(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) unless provided in accordance with Minn. Rule DPW 39.
(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).
(19) Duplication of services by more than one provider without appropriate medical referrals.

(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) Medical care 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, unless the private room rate does not exceed the semi-private room rate in that hospital.

(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.

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/nursing home" means services provided in an ICF-NH. An "ICF-NH" is an institution licensed as a nursing home and which meet each of the conditions described above. "Intermediate care facility services/boarding care home" means services provided in an ICF-BCH or which could be provided in an ICF-BCH. An "ICF-BCH" 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) Levels of care. 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.

(iv) Payment will be made to facilities only in accordance with applicable federal reimbursement formula regulations.

(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 psychiatrist licensed to practice medicine in the U.S. or Canada 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 psychiatrist licensed to practice medicine in the U.S. or Canada per calendar year for any eligible recipient.

(ii) The MA program will pay for up to 26 additional hourly sessions with a psychiatrist licensed to practice medicine in the U.S. or Canada 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 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.

(4) Health Maintenance Organizations [HMO]. Health Maintenance Organizations are organizations licensed by the state which provide comprehensive health care to a voluntarily enrolled population in a specified geographic area. The MA program shall reimburse participating HMOs through a pre-negotiated and fixed per capita payment determined in accordance with applicable federal regulations made on behalf of enrolled recipients. HMOs 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. 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.

(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, nurse-midwives, osteopaths not licensed to practice medicine and surgery and by public health nurses. 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 6 treatments per month and 24 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 long term care 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 long term care facility 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 long term care facility 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 lens evaluation.
(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) Strabismus 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, aniseikonia 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 psychologists or licensed consulting psychologists in the appropriate service areas.

(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:

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

(bb) The MA program will pay for up to 26 additional hourly sessions with a licensed psychologist per calendar year when all of the

following conditions exist:

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

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

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

(cc) The MA program will pay for family psychotherapy of two family members 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)(5)(D)(ii), supra.]

(dd) 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.

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

(aa) Medical supplies and equipment.

(E) Public health nurses. A "public health nurse" is a registered nurse who is licensed as a professional nurse and certified by the State Board of Health as a public health nurse. The MA program limits payment for public health nurses to the following services:

(i) Health assessment and screening.
(ii) Health promotion and preventive counseling.
(iii) EPSDT screening if approved by the Minnesota Department of Health.

(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. Family planning agencies or centers are considered "clinics" under this definition.

(A) "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 the most cost effective non-durable medical supplies, durable medical equipment, prostheses, orthoses and oxygen. Medical Supplies must be prescribed by a physician or other licensed medical practitioner within the scope of his profession as defined by State law. Medical Supplies must be necessary and reasonable for the treatment or diagnosis of an illness or injury or to improve the functioning of a malformed body member.

(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 repeated 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 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 (or other than nasal catheters and positive pressure breathing apparatus) when prescribed by a licensed physician so long as prior authorization is obtained.

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 pay for supplies essential to the effective use of medically necessary durable equipment.

Eligible providers include those individuals or agencies who supply and/or service medical supplies. Medical supply and hearing aid dealers must complete a "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 exceeds the performance agreement limitations; 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 cost exceeds the performance agreement limitation; 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 cost exceeds the performance agreement limitations;

(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 the performance agreement limitations, repairs under the limitations, 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, except in documented emergencies.

(v) Medical supplies for recipients who are residents of long term care facilities may be authorized under the following conditions:

(aa) The cost of a specific item cannot be covered in the per diem rate; and

(bb) The item is necessary for the continuous care and exclusive use of this recipient to meet an unusual medical need; and

(cc) The need is identified in the team conference and documented in the recipient's plan of care.

(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) Dehumidifiers.
(ff) Humidifiers.
(gg) Air filters.
(hh) Auto modifications.

(ii) Books.
(jj) TV sets.
(kk) Bicycles.
(ll) Household items.
(mm) Safety bars.
(nn) Training equipment.

(ii) Comfort or convenience items (i.e., electric beds, elevators, waterbeds, cushion lift chairs).

(iii) Stock orthopedic shoes unless attached to a leg brace.

(iv) Medical equipment and supplies for recipients who are residents of long term care facilities, except as provided in V(b)(9)(E)(v), supra.

(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 equipment or 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. Such services must be provided in accordance with applicable federal regulations, state law and DPW rules.

(i) "Physical therapy": Those services prescribed by a physician and provided to a patient by a qualified physical therapist. In addition, other qualified rehabilitative personnel, including physical therapy assistants, physical therapy aides, and physical therapy orderlies may assist the physical therapist in performing physical therapy services and in the performance of duties that do not require a qualified physical therapist's knowledge and skill. The full responsibility for the patient's 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. A "qualified physical therapist" is a

graduate of a school of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, and who has a valid Minnesota certifcate of registration.

(ii) "Occupational therapy": Those services prescribed by a physician and provided to a patient by a qualified occupational therapist. In addition, other qualified rehabilitative personnel, including occupational therapy assistants, occupational therapy aides, and occupational therapy orderlies may assist the occupational therapist in performing occupational therapy services and in the performance of duties that do not require a qualified occupational therapist's knowledge and skill. The full responsibility for the patient's 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. A "qualified occupational therapist" is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy 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) 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.

(v) 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.

(bb) Reimbursement to qualified rehabilitative personnel (including rehabilitative assistants and aides) under contract with a facility: Each facility shall bill the MA program on behalf of qualified rehabilitative personnel providing services under contract to it.

(cc) Reimbursement to qualified rehabilitative personnel (including supervised rehabilitative assistants and aides) 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 and/or modalities 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. "Salary" means all direct costs related to employment. 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.

(vi) 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 unsupervised 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 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.

(ll) Services of a preventive or maintenance nature when physician orders do not relate such services to the patient's disabilities.

(mm) 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.

(nn) Outpatient services provided by a facility not certified as an outpatient provider.

(oo) Outpatient services provided off the facility's premises.

(pp) 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. Such services must be provided in accordance with applicable federal regulations, state law and DPW rules.

(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 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.

(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 in accordance with applicable federal regulations, state law and DPW rules 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 in the appropriate service areas, when medically necessary.

(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 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 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.

(ee) Occupational therapists. A qualified occupational therapist is a graduate of a school of occupational therapy approved by the Council on Medical Education of the American Medical Association and the American Occupational Therapy 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) Rehabilitation agencies -- non-covered services include:

(aa) Services provided without physician orders (excluding psychological services).

(bb) Psychosocial services provided by a social worker when a licensed physician does not assume professional and administrative responsibility for such services.

(cc) Services authorized by a physician but not documented in the patient's clinical record.

(dd) 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 (only when the secondary tooth has completed two-thirds of its development).

(ii) Hospitalization for dental treatment.

(iii) Periodontics.

(iv) Root canal therapy (molars only and only if more than one needs treatment).

(v) Gold restorations and/or inlays (including cast non-precious and semi-precious metals).

(vi) Fixed prosthodontics.

(vii) Orthodontics.

(ix) Surgical services except emergencies and alveolectomies.

(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. Dentures that are lost and/or destroyed by recipient negligence will not be replaced during such 5 year period.

(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 when billed as a separate procedure.
(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 trace 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.

(B) In order to comply with federal and state EPSDT requirements, providers shall:

(i) Follow required EPSDT billing/reporting procedures;

(ii) Adhere to free choice of provider policy when making referrals for recipients.

(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.

(19) Mental health centers. "Mental health centers" are centers currently receiving grant-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 psychiatrist licensed to practice medicine in the U.S. or Canada or a 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.

(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 [See, (V)(b)(3)(A)&(B) and (V)(b)(5)(D), supra].

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

(i) Community planning.
(ii) Community consultation; program consultation.
(iii) Program and service monitoring and evaluation.
(iv) Public information and education.
(v) Resource development.
(vi) Training and education.

(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. DPW shall limit payments to the Title XVIII standards or the limits required by federal law and regulation to be used in state administration of the MA program.

(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. 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. 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 a provider of service who is eligible to accept Medicare assignments wishes to be paid by the MA program, such provider shall accept assignments on Medicare billings and shall bill Medicare prior to billing the MA program.

(d) 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 M A 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, is hereby repealed.
(b) The effective date of this rule is_____.