

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

Address Reply to:
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155
TELEPHONE (612) 296-6671

May 26, 1978

RECEIVED
MAY 30 1978
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

Lee E. Sheehy
Office of Attorney General
Department of Administration
50 Sherburne Ave.
St. Paul, Minnesota 55155

Dear Mr. Sheehy:

In accordance with your memo of May 24, 1978, and our telephone conversation of today, I am returning to you the Commissioner's Order adopting language to remedy the deficiency pointed out in your memo and returning same for review and approval.

If you have any questions, please feel free to call.

Thank you very much for your prompt and constructive review of the matter.

Very truly yours,

PAUL G. ZERBY
Assistant Attorney General

PGZ/rl
Enc.

cc: John M. Broeker
Joseph E. Hamilton

BROEKER, HARTFELDT, HEDGES & GRANT
ATTORNEYS AT LAW

2850 METRO DRIVE-SUITE 800
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL.(612) 854-5263

JOHN M. BROEKER
WILL HARTFELDT
STEVEN R. HEDGES
DAVID A. GRANT
GEORGE L. CARLSON
ELENI P. SKEVAS
BARBARA J. BLUMER
WILLIAM J. WERNZ
ALLENE D. EVANS

June 20, 1978

RECEIVED
JUN 21 1978
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

Mr. Paul Zerby
Department of Public Welfare
4th Floor - Centennial Office Building
St. Paul, Minnesota 55155

Re: Commissioner's Order Adopting Temporary Rules
Amending DPW 49D.6.b.(1) and 49B.1.b.(2)

Dear Mr. Zerby:

This will acknowledge receipt of a copy of your letter of May 26, 1978, to Mr. Lee E. Sheehy in regard to the above. We would request from you a copy of Mr. Sheehy's Memorandum of May 24, 1978, referenced in your letter. Your prompt attention to this request would be greatly appreciated.

Thank you.

Very truly yours,

BROEKER, HARTFELDT, HEDGES & GRANT

By John M. Broeker
John M. Broeker

JMB/mt
cc: Lee E. Sheehy

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE EDWARD J. DIRKSWAGER, JR.

COMMISSIONER OF PUBLIC WELFARE

In The Matter of the Proposed Amendment to Rule 49 of the Minnesota Department of Public Welfare

COMMISSIONER'S ORDER ADOPTING TEMPORARY RULES AMENDING DPW 49 D.6.b.(1) AND 49 B.1.b.(2)

The following temporary rules are hereby adopted as authorized by Minn. Stat. § 15.0412 Subd. 5 (1977) and Minn. Stat. 256B.46 (1976):

1. DPW 49 D.6.b.(1) is amended to read as follows:

> Determination of allowance. Proprietary homes where cost reports are received after January 1, 1977, shall receive an investment allowance of nine percent of the original value of the facility for depreciation purposes.

2. DPW 49 B.1.b.(2) is amended to read as follows:

> Per-diem rates for non-proprietary facilities may include an efficiency allowance. If the facility's allowable historical cost per patient per day for the most recently completed fiscal year is less than the allowable welfare rate exclusive of Sections B.4.a. & b. and as adjusted for the lack of implementation of known cost changes, an efficiency allowance will be granted equal to the difference between the allowable historical cost and the allowable welfare rate subject to a maximum efficiency allowance of 60 cents per patient per day. For each year after the year in which the non-proprietary facility was originally purchased and there is no transfer of ownership of the facility, the efficiency allowance maximum will be increased one cent per patient per day subject to a maximum of an additional 25 cents per patient per day after 25 years. If a non-proprietary facility is operated on a lease basis, there shall not be recognized as an allowable cost for the operator any rental fee in excess of the total amount allowed for depreciation and pursuant to B.1.b.(2).
>
> This provision of the rule will be effective for rates paid non-proprietary facilities on January 1, 1978 and subsequent provided this provision of the rule is approved by HEW.

Dated: 5-26-78

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

JAMES J. HINIKER
DEPUTY COMMISSIONER

RULES REVIEW CHECKLIST

DATE RULES RECEIVED 5-10 Temporary Rule ✓

Resubmitted and Received 5/30

DUE DATE 6/6

a. Returned to Agency w/o filing w/Secy of State 5-23
b. Approved 5-30 Date Sent Back to Agency 5/31

- -

1. Rules as Adopted _____
2. Rules as Proposed _____
3. Certificate of Board's Authorizing Resolution, where applicable _____
4. Order for Hearing _____
5. Notice of Hearing _____
   (i) Sufficiency _____
6. Secretary of State's List _____
7. Certificate of Acquisition of Secretary of State's List _____
8. Affidavit of Mailing _____
   (i) At least 30 days prior to hearing _____
9. Statement of Need and Evidence _____
10. Hearing Examiner's Report _____
11. Agency's Findings of Fact _____
12. Certificate of Board's Resolution Adopting Rules, where applicable _____
13. Order Adopting _____
14. Report of Chief Hearing Examiner _____
    (i) Finding of No Substantial Change _____
    (ii) Permission to Incorporate by Reference, where applicable _____
15. Certificate of Compliance with Rulemaking Procedures _____
16. Copy of Notice of Intent to Solicit Outside Opinion, where applicable _____
17. Petition by Public, where applicable _____.

ADMIN 1000 (Rev. 1/78)

STATE OF MINNESOTA

DEPARTMENT Attorney General

Office Memorandum

TO : Paul G. Zerby
Assistant Attorney General

DATE: May 31, 1978

FROM : Lee E. Sheehy
Special Assistant
Attorney General

PHONE:

SUBJECT: Minnesota Department of Public Welfare - Rule 49 as amended, Temporary Rules Amending DPW 49 D.6.b.(1) and 49 B.1.b.(2)

The above-captioned rules are hereby approved as to form and legality.

LES:mb

420

Attorney General

Paul G. Zerby
Assistant Attorney General

May 24, 1978

Lee E. Sheehy
Special Assistant
Attorney General

296-1288

Approval of Temporary DPW Rule 49 Amendment and Addition

I am returning Temporary DPW Rule 49's proposed amendment to D.6.b.(1) and proposed addition to 1.b.(2). The amendment is hereby approved as to form and legality.

The addition to DPW 49 1.b(2) is not approved. The proposed rule fails to incorporate the provision required by Minn. Stat. § 256B.46 relating to establishing a maximum allowable cost for rental fees.

When appropriate language is added to remedy this defect, it may be returned to this office for review and approval.

I have retained a copy of all relevant documents in my office. Should you wish to discuss this matter with me, please feel free to call me at 296-1288.

LES:mb

Enclosure

420

Attorney General

Paul C. Zorby
Assistant Attorney General

May 31, 1978

Lee L. Sheehy
Special Assistant
Attorney General

Minnesota Department of Public Welfare - Rule 49 as amended
Temporary Rules Amending DPW 49 D.6.b.(1) and 49 B.1.b.(2)

The above-captioned rules are hereby approved as to form and legality.

LLS:mb

the specific data requirement for the four sections. Following receipt of that listing, the prospective applicant may elect to follow the provisions of 6 MCAR § 2.1103 H.

§2.1186 Other data filed with the application. In addition to the information required by these rules, an applicant may file additional data if it believes that such data is relevant to the director's decision.

§ 2.1191 Certificate of need modifications.

A. Issuance of a certificate of need may be made contingent upon modifications specified by the director.

B. The following changes in a facility previously certified by the director shall not require recertification:

1. capacity additions or subtractions of less than ten (10) percent of the capacity approved by the director; and

2. changes of less than two years in the in-service date.

C. If an applicant determines that a change greater or other than those specified by 6 MCAR § 2.1191 B is necessary or desirable, it shall inform the director of the desired change, accompanied by a written statement detailing the reasons for the proposed change. The director shall evaluate these reasons and within 45 days of receipt of said statement notify the applicant whether the proposed change is acceptable without recertification.

Department of Public Welfare

Proposed Temporary Rule Governing Regulations for Determining Welfare Per-Diem for Nursing Home Providers Under Title XIX Medical Assistance Program

Request for Public Comment

Notice is hereby given that the following amendment to Rule DPW 49, Rule DPW 49B, governing administration of

DPW 49

Regulations for Determining Welfare Per-Diem Rates for Nursing Home Providers Under Title XIX Medical Assistance Program, is proposed for adoption as a temporary rule as authorized by Minn. Stat. § 15.0412, subd. 5 (1977), pending completion of a full hearing and adoption of a permanent rule. Comments from interested and affected persons are requested. Comments must be received at the address given below within 20 days of the date of this publication to be considered. The temporary rule may be revised on the basis of comments received.

Comments on the proposed rule should be sent to:

Edward J. Dirkswager, Jr.
Commissioner
Minnesota Department of Public Welfare
Fourth Floor
Centennial Office Building
St. Paul, Minnesota 55155

Temporary Rule as Proposed

DPW 49 Regulations for Determining Welfare Per-Diem Rates for Nursing-Home Providers under the Title XIX Medical Assistance Program.

B.1.b.(2) Per-diem rates for non-proprietary facilities may include an efficiency allowance. If the facility's allowable historical cost per patient per day for the most recently completed fiscal year is less than the allowable welfare rate exclusive of Sections B.4.a. & b. and as adjusted for the lack of implementation of known cost changes, an efficiency allowance will be granted equal to the difference between the allowable historical cost and the allowable welfare rate subject to a maximum efficiency allowance of 60 cents per patient per day. For each year after the year in which the non-proprietary facility was originally purchased and there is no transfer of ownership of the facility, the efficiency allowance maximum will be increased one cent per patient per day subject to a maximum of an additional 25 cents per patient per day after 25 years.

This provision of the rule will be effective for rates paid non-proprietary facilities on January 1, 1978 and subsequent provided this provision of the rule is approved by HEW.

KEY: PROPOSED RULES SECTION: Underlining indicates additions to pre-existing rule language. ~~Strike outs~~ indicate deletions from pre-existing rule language. If all proposed rules in a set are totally new (i.e. non-amendatory) the entire set is printed in standard type face. RULES SECTION: Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

To Rex
Bob

Canby
Community Hospital
and Senior Haven Home
112 St. Olaf Ave. S.
CANBY, MINNESOTA 56220



DISTRICT NUMBER 1
R.J. SALMON
Administrator
PHONE
507-223-7277

April 12, 1978

Mr. Edward J. Dirkswager, Jr., Commissioner
Minnesota Department of Public Welfare
Fourth Floor
Centennial Office Building
St. Paul, MN 55155





Re: Notice of Proposed Temporary Rule
Making Pursuant to 2S.R. 1825,
April 3, 1978 regarding DPW Rule 49
Proposed Temporary Rule B.1.b(2)

Dear Commissioner:

Pursuant to Notice in the State Register we would like to provide comment on the above referenced proposed rule based upon our analysis of the rule and its resulting impact upon the reimbursement to the Canby Community Hospital and C & NC Unit.

Canby Community Hospital and C & NC Unit is operated by the Canby Community Hospital District which is a governmental nonproprietary provider of acute and long-term care services. The facility includes an acute care hospital of 27 beds with an attached 75 bed C & NC Unit which is certified by the Department as a provider for both Skilled and ICF I Nursing Care.

First, the conceptual nature of the proposed rule is plausible in that it seeks to replace, through the use of an "efficiency allowance", the prior "investment allowance" which was authorized by law pursuant to Minnesota Statute 256B and subsequently disallowed by DHEW. However, by the application of the proposed rule in conjunction with other restricting limitations contained in DPW Rule 49, the proposed rule will not fulfill its intended purpose and objective in the absence of other simultaneous changes in DPW Rule 49, which we believe can be accomplished through Rule making without further legislative changes.

Under the proposed rule change methodology (DPW 49, Section B.b.(2)), an initial "efficiency allowance" would be built into the providers historical costs for rate determination purposes. If at the end of the most recently completed fiscal year, the facility's allowable historical cost per patient day is less than the allowable welfare rate for that same period, the facility would continue to receive that difference as an

"efficiency allowance" subject to the maximum stated in the proposed rule. However, under the same methodology of the proposed rule, if the facility's allowable historical cost per patient day, as determined at the end of the fiscal year, exceeded the allowable welfare rate being paid for that same period, the efficiency allowance would be reduced or even eliminated entirely by the difference. Once reduced or eliminated, there is no method under which a provider could realistically re-establish the efficiency allowance for future years.

Thus the underlying rationale of the proposed rule (efficiency allowance) is to provide incentive and award providers who can keep costs below "budget" and thus benefit from the efficiency allowance. Herein the problem begins because under the methodology of Rule 49, a providers welfare rate is not determined on the basis of budget. Rather the welfare rate is established beginning with historical costs and adding thereto certain cost areas classified as "known cost increases" and unidentified cost increases which are limited by the provisions of Rule 49, Section B.1.C. While it is recognized that in establishing the welfare rate there must be cost increase guidelines and limitations, it must also be recognized that provider management cannot control inflation which is implied by the application of certain of the provisions contained under Section B.1.C. of the rule. To exemplify this more precisely, Section B.1.C.(1)(i) of the rule contains a limited provision for the recognition of raw food cost increases. Using this methodology of the rule since its inception, raw food costs have increased in aggregate from 1972 through 1977 approximately 58.6% according to the CPI for Minneapolis/St. Paul while during this same period DPW has allowed food cost increases aggregating approximately 27% or about one-half of the aggregate increase in food costs.

Likewise, attached C & NC Units must use the Medicare cost finding methodology in determining the welfare rate. The Medicare cost finding report is a retrospective report whereas DPW uses this methodology to determine a prospective rate, hence, if Medicare allocation factors change from the prior to most recent year causing more costs to be allocated to the C & NC Unit, this results in Medicare reducing their payment while at the same time these costs are not being recognized by DPW in the welfare rate for that same year.

To exemplify the actual effect of the proposed new rule lets examine the actual DPW rate paid and historical costs for Canby Community Hospital C & NC Unit for the last complete fiscal year 7-1-1976 through 6-30-1977. The final rate paid by the Department for this period was $20.77/day Skilled and $18.51/day ICF I. The historical costs for this same period as determined by the DPW report filed for year ending 6-30-77 was $21.00/day Skilled and $18.78 ICF I. Thus historical costs of the provider exceeded the approved welfare rate as follows:

	Skilled	ICF I
Historical Costs	$21.00	$18.78
DPW Approved Rate	- 20.77	- 18.51
	.23	.27

The historical rate on the 6-30-77 provider report includes the investment allowance authorized by the 1977 amendment to Minnesota Statute 256B.45 which is equal to 2% of the original value of the facility plus 1% per year for each year since original purchase. In the case of Canby Community Hospital and C & NC Unit the amount of this investment allowance is $14,490 which equates to $.60/day Skilled and $.54/day ICF I. Therefore, if this amount is backed out of the 6-30-77 historical costs of the provider, the provider would realize an "efficiency allowance" of $.37/day Skilled and $.27/day ICF I had this year been covered under the new proposed rule. In other words the new "efficiency allowance" would be approximately one-half of what was allowable because the DPW rate is not sufficient to cover actual historical costs under the present methodology of Rule 49. The following calculation is provided:

	Skilled	ICF I
Historical Costs	$21.00	$18.78
Less: Investment (Efficiency) Allowance	- .60	- .54
	$20.40	$18.24
Approved DPW Rate	20.77	18.51
Actual Efficiency Allow. Realized	$ .37	$ .27

Because of the limitations in Rule 49 as aforementioned, the provider would have had the allowable "efficiency allowance" reduced by approximately 50% under the application of the proposed rule during the first year. By the end of the second year, the "efficiency allowance" would be eliminated entirely and each year thereafter the providers historical costs would begin to exceed the allowable DPW rate thus resulting in losses to the provider.

As set forth above, the limitation in Rule 49 Section B.1.C.(i) for food cost increases is the major limiting factor. Based upon the DPW food cost formula, no allowance was given for known food cost increases for 1977. Thus the DPW rate which is based upon the 6-30-77 Rule 49 cost report for Canby Community Hospital and C & NC Unit does not include an amount for food cost increases. The 6-30-77 report reflects a historical food cost of $1.95 per patient day, however, the actual food costs being experienced by the provider are $2.20 per patient day which is an increase in actual food costs of $.25 per patient day. This correlates very closely to the reduction in the "efficiency allowance" as demonstrated above.

Recommendations - Based upon the potential impact of the proposed rule as set forth above we wish to recommend that the Commissioner and the Department consider the following changes in Rule 49:

1. That Section B.1.C.(1)(i) of the rule be amended and changed, through rule making simultaneously with the proposed rule, in such a manner that reflects an allowance in known cost increases for raw food costs that more appropriately reflects actual food costs.

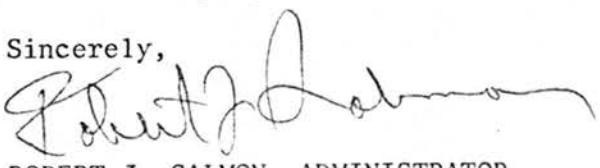
2. That Section B.1.C.(2) of the rule be amended and changed to provide for a retroactive adjustment for costs classified under Section B.1.C.(1)(j) of the rule, to C & NC Units whose unidentified costs increase more than changes in the CPI as a result of using historical medicare allocation factors, or in lieu thereof, allowing providers to budget for all known cost increases subject to a DPW recovery of overprojections as set forth in Section B.1.C.(2).

3. That in consideration of Minnesota Statutes 256B.48 which requires equalization of rates effective July 1, 1978, Section D.3.d.(13) be changed to allow bad debt expenses as allowable costs.

4. That Section D.6.a.(2) of the rule be amended and changed to provide that interest earned on funded depreciation not be required to be offset as a reduction to interest expense which is an otherwise allowable expense as provided by Section D.6.a.(1)(a) and (b). This would be consistent with regulations of Title XVIII (Medicare) which would provide simplification in reporting for C & NC Units whose attached hospital units are covered under Medicare and would also be an added incentive for all providers to prudently invest and manage their funds.

We respectfully request that these comments be given consideration at the time of the proposed temporary rule making.

Sincerely,



ROBERT J. SALMON, ADMINISTRATOR
CANBY COMMUNITY HOSPITAL AND C & NC UNIT
CANBY, MINNESOTA 56220

RJS/kv

cc: Mr. Jay Addy, Cost Analyst
Minnesota Hospital Association
2333 University Avenue S.E.
Minneapolis, Minnesota 55414

cc: Mr. William Flynn
Hamilton, Flynn & Heim
3944 IDS Center
80 South Eighth Street
Minneapolis, MN 55402

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION V
300 SOUTH WACKER DRIVE
CHICAGO, ILLINOIS 60606

HEALTH CARE FINANCING
ADMINISTRATION

February 9, 1978



Edward J. Dirkswager, Commissioner
Minnesota Department of Public Welfare
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Mr. Dirkswager:

This is to notify you that effective January 1, 1978, we have approved your State Plan Amendment, OPC-11 No. 76-37, containing the rules for reimbursement of nursing homes under Title XIX of the Social Security Act (the Minnesota Department of Public Welfare Rule 49, January 1, 1977 revision and Rule 52, the January 1, 1976 revision). You will remember that we had conditionally approved this amendment on April 22, 1977 and withdrew that approval on October 14, 1977.

The approval is being granted with the understanding that beginning January 1, 1978 you stopped paying the 2% investment allowance for non-profit institutions.

Sincerely,

George R. Holland
Acting Regional Medicaid Director

Enclosure

ADMIN. 1000

STATE OF MINNESOTA

DEPARTMENT Attorney General

Office Memorandum

TO : Lee Sheehy
Special Assistant
Attorney General

DATE: May 22, 1978

FROM : Paul G. Zerby
Assistant Attorney General

RECEIVED
MAY 22 1978
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

SUBJECT:

In accordance with our conversation regarding the Temporary Rule 49 disallowance of the 2% investment factor for nonprofit nursing homes and substitution of the incentive factor, I enclose copies of the following:

1. Copy of 41 Federal Register, No. 128, Thursday, July 1, 1976, p. 27303, the underlined portion of which disallows a profit factor to nonprofit and governmental providers.

2. Letter of October 14, 1977 from Detloff to Dirkswager indicating on p. 2 (with the item marked 5 in the margin) that the regulations preclude the payment of a return on equity to nonprofit providers.

3. Letter of November 10, 1977 from Detloff to Hiniker reiterating that the 2% investment allowance for non-proprietary homes is contrary to federal regulations and policy and that a State Plan Amendment containing such provision is not approvable.

4. Letter of December 29, 1977 from Hiniker to Bryant indicating the 2% allowance will be discontinued immediately.

5. Letter of February 9, 1978 from Holland to Dirkswager indicating that approval of the State Plan Amendment with the understanding that the 2% investment allowance for nonprofit situations is no longer being paid.

PGZ/pas
Enc.

Title 45—Public Welfare

CHAPTER II—SOCIAL AND REHABILITATION SERVICE (ASSISTANCE PROGRAMS), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PART 250—ADMINISTRATION OF MEDICAL ASSISTANCE PROGRAMS

Reimbursement on a Reasonable Cost-Related Basis for Skilled Nursing and Intermediate Care Facility Services

In the April 13, 1976, FEDERAL REGISTER (41 FR 15560), the Department published a notice of proposed rule making under title XIX of the Social Security Act, to amend Social and Rehabilitation Service regulations at 45 CFR 250.30. The proposed amendments would implement section 249(a) of Pub. L. 92–603, the Social Security Amendments of 1972. That section added section 1902(a)(13)(E) to the Act, requiring that State plans for medical assistance programs provide, "effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary."

Interested parties were given the opportunity to submit in writing on or before May 13, 1976 (subsequently extended to May 28, 1976 (41 FR 16968)), any comments, suggestions, or objections pertaining to the proposed amendments. Over 500 letters were received from a variety of sources, including 20 States, 187 long-term care facilities, 27 national or State organizations representing providers of long term care, and 270 individuals.

As a result of the Department's review of the comments, the proposed regulations have been substantially revised. The material comments received are responded to, and the changes incorporated in the final regulations are discussed, in the following analysis of the basis and purpose of these regulations. The Department considered many alternative approaches in the course of developing these regulations. A discussion of these alternatives and the reasons for rejecting them is also incorporated into the following analysis of the basis and purpose of the regulations.

LEGISLATIVE PURPOSE OF 1902(a)(13)(E)

Section 249 of Pub. L. 92–603 originated in the Senate Committee on Finance. The report of that committee, Senate Report No. 92–1230, at pp. 287–288, indicates the legislative purposes for which section 249(a) was enacted. The Senate Report notes with concern that, without any statutory requirements that payment for medical care and services in long term care facilities be on a reasonable cost-related basis, some facilities are being overpaid by Medicaid, while others are being paid too little to support the quality of care that Medicaid patients are expected to need and receive.

The Report makes clear that the Committee was concerned about the effect of both underpayment and overpayment on the quality of medical care of recipients. If facilities are underpaid, because a State's flat rate is unrealistically low or because in determining its rate the State refuses to recognize as allowable costs some of the real costs of providing the services, facilities will be under pressure to cut corners and provide lower quality care, or will be forced to make their non-Medicaid patients absorb some of the cost of Medicaid patients' care; at worst, facilities may refuse to accept Medicaid patients. If facilities are overpaid, either because the State's flat rate is unrealistically high or because the State payment formula permits reimbursement for unnecessary items such as luxury services, questionable depreciation allowances and the like, there is little incentive for providers to employ the most efficient and economical methods of providing services, with the result that the State's Medicaid dollars do not go as far as they could to provide needed medical care. When increased inflation and unemployment are already straining State welfare budgets, this is a serious consideration. The rising costs of the Medicaid program may force a State to drop optional services or the medically needy category from its plan, as some States have already done; at worst, the high prices of medical care and services in skilled nursing facilities and intermediate care facilities might be a factor in the State's decision to drop out of the Medicaid program altogether.

Congress, then, was concerned about the harmful effects on the Medicaid program of both underpayment and overpayment of providers of long-term care facility services. On the other hand, the committee was aware that application of the reasonable cost reimbursement approach of the Medicare program to payment for long-term care facility services was not entirely satisfactory; the committee noted particularly that the tremendously detailed cost finding requirements under Medicare might be unnecessarily cumbersome and expensive.

THE SECRETARY'S AUTHORITY UNDER 1902(a)(13)(E)

The committee announced that its purpose in enacting section 249 was to give States maximum possible flexibility to develop methodologies for cost finding and reasonable cost-related reimbursement, within lir ts set by the Secretary. Questions raised in many of the responses received by SRS during the comment period have indicated the necessity of clarifying the division of functions between the Secretary and the States established by the statute.

The statute requires that the States (1) use approved cost-finding methods to establish the reasonable costs of services, and (2) on the basis of such cost-finding methods, develop and use methods and procedures for payment for services on a reasonable cost-related basis. A number of the comments received expressed the mistaken view that the statute grants the Secretary authority to review, approve, and verify only the cost-finding methods, and not the methods used by the States to establish a reimbursement rate. Given the rather confusing wording of the statute, it is understandable that this misinterpretation could arise, but when the statute is read together with the Senate Finance Committee Report, there is no room for doubt that Congress intended the Secretary to have power to review, approve, and validate both the cost-finding and the reimbursement methodologies. The report reads in part, at page 287:

> The States would use acceptable *cost-finding techniques* (not necessarily those utilized for Medicare purposes) to determine reasonable reimbursement and apply to the results appropriate *methodologies for determining payment. The methods would have to be approved and validated by the Secretary.* The committee does not intend that this provision should require use of the specific Medicare reasonable cost reimbursement formula by States for purposes of reimbursing skilled nursing homes and intermediate care facilities under Medicaid, although States are free to choose this option. Rather, the States could develop other *reasonable cost-related methods of rate-setting. Whatever methodology is authorized* should include adequate procedures for auditing, as necessary, the financial records of an institution * * *. *The Secretary would be expected to validate,* on site, *a State's methodology* through sample audits. (Emphasis added.)

The language of the Committee Report makes clear that the State's methodologies for rate-setting, as well as the State's methods for cost-finding, are subject to the Secretary's approval.

A number of the comments took the mistaken view that, since under section 249 the Secretary had authority only to review and approve methodologies used by the States, he exceeded his authority in including in the proposed regulations any Federal requirements. However, it is entirely appropriate that, in the exercise of his power under section 249 to review and approve the States' cost-finding and rate-setting methodologies, the Secretary give notice to the States in the form of regulations of the criteria and conditions on which he will base his approval. In light of the concern expressed in the legislative history of section 249 about the dangers to the objectives of the Medicaid statute of either underpayment or overpayment of long-term care facilities, the Secretary, in carrying out his statutory functions of reviewing, approving, and verifying the States' methodologies, has the responsibility to seek to assure that the methodologies will in fact result in reasonable cost-related reimbursement, by establishing certain minimum standards for approval.

The legislative history of section 249(a) makes clear that, within the limits established by the statute and by regulations, the States are to have the maximum possible flexibility to develop methodologies for cost-finding and rate-setting and procedures for reimbursement. The legislative history explicitly declares that States are to be free to develop methodologies less cumbersome and expensive than those of the Medi-

care program. In light of this clear congressional purpose, the regulations have been amended to meet the objections raised in a number of comments to a variety of requirements in the proposed regulations. The purposes of the final regulations are to simplify the Federal requirements, focusing on the basic principles and standards that the States must observe in order to secure approval of their cost-finding and reimbursement methodologies and to assure validation in subsequent audits, without unnecessarily restricting the States in their choice of methodologies and standards.

ORGANIZATION OF THE FINAL REGULATIONS

The final regulations are organized around five State plan requirements established by section 1902(a)(13)(E), as amplified by its legislative history. Subsection 250.30(a)(3)(i), dealing with cost-finding and cost reporting, implements the statutory requirement that the State use cost-finding methods approved and verified by the Secretary. Subsection 250.30(a)(3)(ii), dealing with auditing, implements the requirements of the statute, as clarified in the legislative history, that the States' cost-related method of rate-setting should include adequate procedures for auditing the financial records of an institution, and that the Secretary verify a State's methodology. § 250.30(a)(3)(iii), dealing with allowable costs, implements the statutory requirement that reimbursement rates for long-term care services provided under the plan be determined on the basis of cost-finding methods approved and verified by the Secretary; this section specifies certain expense items which must be taken into account, and others which must be omitted, in the calculation of reasonable cost in an approvable cost-finding method. Section 250.30(a)(3)(iv), dealing with methods and standards for establishing a reimbursement rate, implements the statutory requirement, as clarified in the legislative history, that States develop formulas and standards for reimbursement on a reasonable cost-related basis, and that the States' method for determining such reasonable cost-related payment be approved and validated by the Secretary. Section 250.30(a)(3)(v), requiring assurance by the States that payment will be based on the principles and standards stated in these regulations and in the State plan, implements the statutory requirement that payment for long-term care facility services be on a reasonable cost-related basis.

THE MEDICARE CEILING

Many comments expressed concern at the continuation in these regulations of the Medicare ceiling on payment rates, which has been in effect since July 1, 1970.

Numerous comments urged the view that the imposition of this ceiling exceeded the Secretary's authority under section 249(a) of Pub. L. 92-603, and conflicted with the statutory intent expressed in section 249(b) that rates found acceptable for a State's Medicaid program could be adapted for use in the State's Medicare program as well.

In responding to these comments, the Department would first note that the Medicare ceiling requirement in § 250.30(b)(3)(iii) of this chapter is not new. It was published at 35 FR 10013, June 18, 1970, and became effective July 1, 1970. This requirement does not implement section 1902(a)(13)(E), but rather implements the completely separate requirement of section 1902(a)(30) that the State plan:

> provide such methods and procedures relating to the * * * payment for * * * care and services available under the plan * * * as may be necessary to * * * assure that payments * * * are not in excess of reasonable charges consistent with efficiency, economy, and quality of care.

while section 1902(a)(13)(E) requires that payment be on a reasonable cost-related basis, section 1902(a)(30) imposes the separate requirement that payment not exceed reasonable charges consistent with efficiency, economy, and quality of care. The Department has felt and continues to feel the need to place some explicit ceiling on Medicaid payment rates in order to effectuate the Congressional purpose expressed in section 1902(a)(30).

A number of comments urged that, since Medicare provides for payment of reasonable cost, to make the Medicare rates the ceilings on payments under section 1902(a)(13)(E) would be effectively to require that States pay reasonable cost or less. The fallacy contained in this analysis is the assumption that there is only one method to determine reasonable cost, and only one cost figure which is reasonable. But, to the contrary, the Department believes that a variety of cost-finding methods could be used to determine reasonable cost, which methods would produce a range of amounts representing reasonable cost. Rather than any one figure representing the reasonable cost, each figure within the acceptable range represents a reasonable cost. Based on its experience with the use of the Medicare formula, the Department believes it is appropriate to continue the assumption that a payment rate is excessive if it would result in higher payment than under Medicare in any cost-reimbursement method which determines final payment retrospectively.

The enactment of section 1902(a)(13)(E), which requires that State plans provide for reimbursement of skilled nursing facilities and intermediate care facilities on a reasonable cost-related basis, does not render superfluous section 1902(a)(30) or its implementing regulations. A State's reimbursement formula under section 1902(a)(13)(E) might be related to reasonable cost and still exceed reasonable charges, for example, if a State set a high rate of return on owners' net equity.

One comment urged that, had Congress wanted to impose an upper limit on nursing home payments calculated in relationship to payments under Medicare, it would have added a ceiling provision to section 249(a) similar to the ceiling provision in section 232 of Pub. L. 92-603, which states that payment of the reasonable cost of inpatient hospital services under Medicaid shall not exceed the amount which could be determined under Medicare as the reasonable cost of such services.

The answer to this comment is that it is equally reasonable to conclude that since at the time Congress enacted section 249, it was aware that the regulation making the Medicare cost determinations a ceiling on payment to long-term care facilities under Medicaid was already in effect, it saw no need to create such a ceiling through legislation. Indeed, Congress would have been expected to declare its objections, if any, to the existing regulatory ceiling at the time it enacted section 249. Since Congress was silent, it can reasonably be assumed that it had no such objections.

Section 249, which added section 1902(a)(13)(E) to the Medicaid statute, also added to the Medicare statute section 1861(v)(1)(E), which empowers the Secretary to provide by regulations that rates developed by a State under section 1902(a)(13)(E) may be used to reimburse providers of skilled nursing facility services under Medicare as well. A few comments argued that this provision demonstrated the Congressional intent that reimbursement under Medicare was to follow Medicaid principles, and not the reverse, and that therefore the Medicare ceiling on Medicaid reimbursement rates was no longer appropriate.

In the first place, this argument manifestly ignores the explicit language of section 249(b), which unmistakably leaves to the Secretary's discretion the decision whether to promulgate regulations allowing the use of Medicaid rates in the Medicare program, and also gives the Secretary discretion to determine on a State-by-State basis whether to allow use of such alternative rates. Second, the legislative history gives no indication that Congress was dissatisfied with the rate arrived at under the Medicare formula, but rather indicated dissatisfaction with the cumbersomeness and expense of the formula. Furthermore, as stated above, experience with use of the Medicare formula had demonstrated that the rates determined on the basis of this formula are at the upper end of the range of reasonable costs. On the basis of these factors, the Department sees no reason to interpret section 249(b) as evidence that Congress objected to the continued use of the Medicare rates as a ceiling on payment rates determined under section 249(a). On the contrary, strong evidence of Congress' continued satisfaction with the Medicare formula as a ceiling on Medicaid rates is provided in Congress' making the Medicare ceiling on Medicaid rates for inpatient hospital services a statutory requirement under section 1902(a)(13)(D) of the Act, enacted by a companion provision of the same Act of Congress, section 232 of Pub. L. 92-603.

A number of comments stated that the Medicare ceiling could not be reconciled

with the clear legislative intent that States were not to be required to use the Medicare cost reimbursement formula for payment, but were to be free to experiment with developing alternative payment methods and standards that might be simpler and less expensive. Comments emphasized that retaining the ceiling would seem to require States to employ the detailed Medicare formula at least for purposes of rate comparison, thus forcing a choice between expensive and duplicative accounting and auditing procedures or acceptance of the Medicare formula. This requirement was felt to be burdensome whether it required comparison between rates under Medicare and alternative systems on individual cost items or in the aggregate. Other comments stated that the ceiling could not be reconciled with the explicit legislative intent that states be free to set a reimbursement rate prospectively without provision for retrospective adjustment, because it would not be administratively feasible under a prospective system to apply the retrospective Medicare ceiling.

The answer to these comments is that States are not required to use Medicare's cost reports or Medicare's detailed cost-finding methods solely for purposes of rate comparison. Program Regulation Guide (MSA-PRG-19) issued June 7, 1972, and still in effect, authorizes the use of simplified formulas to determine the ceiling for facilities that do not participate in Medicare. The Guide also provides for use of a modified formula to determine the rate ceiling prospectively without the need for retrospective adjustment. Under this formula the rate comparison may be made prospectively using current unaudited costs and may be made on a sample of facilities participating in Medicaid: where the facility participates in Medicare, the Medicare interim rate, with certain adjustments, may be used as the rate ceiling.

Some comments expressed concern that the Medicare ceiling would force States to adopt the Medicare principles and standards as the only viable alternative to costly rate comparisons. The short answer to this concern is that since the Medicare ceiling went into effect six years ago, on July 1, 1970, only two States (Idaho and Alaska) have fully adopted Medicare's principles and standards, although many States do use selected Medicare principles and standards. The Department is unaware of any other States planning to drop existing systems to adopt the Medicare system.

The Department is not entirely satisfied with use of Medicare rates as the ceiling on Medicaid rates, being aware both of the cumbersomeness and expense of ascertaining the Medicare rate and of the fact that the Medicare ceiling may be so high that it is not a completely effective deterrent to the setting of excessive rates. The Department solicited proposals for alternative methods of setting the ceiling at the time Notice of Proposed Rule Making was published for these regulations. But the alternatives proposed in comments are unsatisfactory. The suggestion that the ceiling be set as a percentage of the costs recognized by a State is unsatisfactory, because it creates an incentive to increase costs. The suggestion that the Department set limits on profits that may be paid is also unsatisfactory, because it has been the Department's experience that ceilings it establishes frequently become floors as well, thus defeating their purpose. However, as a result of the above comments, the Department is discontinuing use of a Medicare ceiling in the case of States with prospective rate setting systems. Prospective rate setting systems, as defined for purposes of this regulation, involve payment rates not subject to further adjustment on the basis of the actual costs of a particular provider of long-term care services. The Department believes that the inherent cost containment potential of such limits negates the need for an additional ceiling. As part of its validation audits of State payment systems, the Department will compare States' payments under prospective methods of reimbursement with rates which would have been determined under Medicare. The results of these audits to evaluate the impact of the regulations will also be used by the Department to evaluate the need for defining a more restrictive ceiling in regulations or legislation.

In the case of retrospective payment systems (i.e., systems in which there is any retrospective determination of payment or settlement of costs), the use of a Medicare ceiling determination is continued. For ease of administration, the States may determine the upper limit based on a random sample of all long-term care facilities participating in Medicaid. The ceiling will be deemed met if the State's payment does not exceed amounts which would have been determined under Medicare in at least 90 percent of the facilities in the sample. States are equally free to continue using the present procedures for determining compliance with the Medicare ceiling in circumstances where it will continue to be applicable. Thus, the "random sample" method may be used at state option. Since this additional, optional method for determining compliance with the Medicare ceiling imposes no new burdens or requirements on the states, the Department finds that good cause exists for including this provision in these regulations in final form without prior public comment and for dispensing with notice of proposed rulemaking.

In all cases, whether a State has a prospective or retrospective payment system, any general payment limits established under Medicare pursuant to section 223 of Pub. L. 92-603 will be in effect under Medicaid on the same facility-by-facility basis as under Medicare. General payment limits are not currently in effect under Medicare, but it is anticipated that limits on payment rates for routine service costs of skilled nursing services will be promulgated in the near future. Such limits are considered by the Department to be absolute limits on what is considered reasonable costs for both skilled nursing facility and intermediate care facility services.

Other Medicare Tie-Ins

A considerable number of comments expressed concern that the numerous requirements in the proposed regulations that the State's reimbursement rate for individual cost items not exceed the Medicare rate, combined with the provision that State plans which adopted the Medicare standards and principles would have automatic approval while all other plans would be subject to review, would have the unintended effect of forcing States to adopt the Medicare formula as the only viable option. The point was well taken, and the Department has removed all requirements that the State rates not exceed Medicare rates of payment for individual cost items except for payment limits established by Medicare pursuant to section 223 of Pub. L. 92-603.

Some comments urged that States be required to adopt the Medicare principles and standards of reasonable cost reimbursement, while others urged that States be forbidden to do so. However, the legislative history leaves no doubt that Congress intended States to have the option to adopt the Medicare principles and standards, but not to require that States adopt these principles and standards.

Payment on a Reasonable Cost-Related Basis

The statute requires payment for long-term facility services provided under the plan "on a reasonable cost-related basis," rather than simply requiring payment of "reasonable costs," as in section 1902(a)(13)(D) (payment for inpatient hospital services) and section 1861(v) in title XVIII (Medicare). Since "reasonable cost-related basis" is not defined in the statute, we must look to the legislative history for its meaning.

Section 1902(a)(13)(E) was enacted to remedy what Congress perceived as the inadequacy of present systems for payment of long-term care facilities. The Senate Report expresses dissatisfaction with the flat rate payment system in general use, because it results in overpayment to some long-term care facilities, while other facilities are paid too little to support the quality of care that Medicaid patients are expected to need and receive, and because a flat rate provides no incentive to upgrade the quality of care. In light of this clearly expressed legislative concern, the statutory requirement of "payment * * * on a reasonable cost related basis" must mean that, after determining the reasonable cost on the basis of some approved method, the State must set a payment rate that it finds adequate to reimburse such reasonable costs, and could not set the rate so low that it clearly would not reimburse such reasonable costs. In other words, the State may not set the payment rate at, for example, 60 percent of reasonable costs; such a rate, although it would be within a literal definition of the words "payment on a reasonable cost related

basis," would not comport with what Congress clearly understood to be the meaning of the statutory language. For the same reason, a State would not satisfy the requirement of section 1902 (a) (13) (E) if it paid, or gave assurance to pay, the amount determined under this section to the extent that State funds are available, or to the extent that State appropriations permit. To allow a State to limit its obligation under the statute by such a provision, as some comments suggested, would permit a State to defeat a major part of Congress' purpose in enacting section 249.

On the other hand, neither does the statute require that States provide assurance that each facility will be reimbursed its reasonable costs, as some comments urged. The intent expressed in the legislative history that States be allowed the maximum possible flexibility in developing cost-related payment methods sheds light on the distinction between "reasonable cost" and "reasonable cost-related." The Senate Report declares that States need not use the Medicare reasonable cost reimbursement formula, but that they should be free to develop simpler and less expensive methodologies. The Senate Report explicitly declares that reasonable cost-related rates can be determined on a geographical or other class basis instead of on an institution-by-institution basis. The report also clearly implies that States are to be free to set the rates prospectively without provision for retrospective adjustment. A rigid requirement that a State pay to each facility the full amount of its allowable costs would bar the use of these very options that Congress meant to make available. As some comments pointed out, rates set prospectively on the basis of past experience, or set on a class basis, cannot reimburse the actual costs of each facility with the same degree of precision possible under the Medicare formula, and will inevitably result in a degree of underpayment of some facilities and overpayment of others. But the legislative history makes clear Congress' intent to give up a certain amount of precision in order to afford States the option to use simpler and less expensive methodologies.

As pointed out above in the discussion of the Medicare ceiling, there is no single acceptable method for determining reasonable cost, but rather a variety of acceptable methods; it follows from this that there is no single figure that is the reasonable cost, but rather a spectrum of figures within an acceptable range, any one of which is a reasonable cost. The Department expects that a variety of acceptable methods for determining a reasonable cost-related payment rate will be developed. The legislative history of section 249 makes clear that the States are to be allowed great freedom both to define allowable costs items and to set a value on the reasonable cost of such items, and, in addition, States are to be free in setting their reasonable cost-related payment rate to take into account, on the one hand, incentives toward efficiency and economy and, on the other hand, incentives to upgrade the quality of care and to provide for growth and improvements.

The legislative history makes clear that States may set their payment rates at the level that will reimburse only those costs which a State finds reasonable. States are not required to reimburse for luxury services, questionable allowances for depreciation, and similar items which they may reasonably choose not to recognize as "reasonable." To safeguard against overpayment a state may, for example, set the payment rate for a facility or class of facilities on the basis of the cost at the occupancy level necessary for the advantageous use of efficiencies and economies of scale.

Although the Department will not at this time promulgate rules requiring specified methods of property valuation, States are encouraged to adopt methods under which payment would not vary solely as a result of sales, whether at arms-length or otherwise, would not differ solely on the basis of whether a facility is leased or owned, and would not vary solely as a result of changes in an owner's financing arrangements. One such method was developed by the New York State Moreland Act Commission on Nursing Homes and Residential Facilities. In its publication, Reimbursement of Nursing Homes Property Costs: Pruning The Money Tree, the method is described as follows:

> In the case of proprietary facilities, amounts in lieu of real property expenses (depreciation, interest, and a return on capital investment), would be determined under the following "fair rental" system:
>
> (1) A amount equal to the equivalent of full amortization of non-land property costs over a useful life (determined in accordance with commonly accepted standards) plus a return in each of the years on the unamortized portion of such costs. The rate of return would be set at one and one-half times the rates of interest on special issues of public debt obligations issued to the federal hospital insurance trust fund averaged over a period of time specified by the State; and in addition,
>
> (2) A amount equal to the equivalent of a rental for land based on the original cost of the land adjusted annually for inflationary/deflationary trends times a rate of return not to exceed four percent per year.

Another approach has been adopted by the Minnesota Medicaid program in which depreciation paid by the program is subject to recapture upon sale or transfer of an asset. Program depreciation amounts paid are recaptured to the extent that the gain upon sale or transfer of assets is in excess of the historical cost of the assets depreciated on a straight line basis to the time of the sale or transfer. The State reduces the amount subject to recapture by one percent for each month of participation in the program.

The legislative history also makes clear that States may take into account in setting their payment rates the need to assure that adequate numbers of qualified facilities are available and willing to participate in the Medicaid program, and to provide incentives to participating facilities to upgrade the quality of care. For example, the Senate Report indicates that Congress intended States to have the option to adopt the Medicare formula, which provides for a profit for proprietary providers in the form of an allowance for a reasonable return on owner's net capital equity; the fact that this option is available indicates that States are to be free to include a similar profit factor for proprietary providers in calculating the reasonable cost-related rate. States may include as an allowable cost whatever return on owners' net equity they conclude is necessary to avoid withdrawal of capital and to attract additional capital needed for expansion. This return on owners' net equity of proprietary providers is the only item of profit that may be included as an item of allowable cost. States may conclude that such a profit factor is necessary to avoid withdrawal of capital and to attract additional capital needed for expansion. On the other hand, such a profit factor would not be an appropriate element in the calculation of the reimbursement rate for non-profit and governmental providers. At the same time, nothing in the statute or the legislative history requires payment of a profit; the only requirement is that payment be on a reasonable cost-related basis. Therefore, payment of a profit as a return on owners' net equity is optional with the States, and it would be inappropriate to require in these regulations that a State assure a profit return comparable to returns in enterprises having a corresponding risk, as some comments suggested.

The proposed regulations would have allowed rates to include flat amounts representing growth allowances and efficiency bonuses for both profit and non-profit providers. Provisions for such payments have been deleted. An efficiency bonus in the form of a lump sum payment to facilities that the state finds to have operated efficiently and economically is not a true cost item, and cannot be reconciled with the statutory mandate that payment be on a reasonable cost-related basis. Growth allowances are also impossible to reconcile with the legislative purpose of section 1902(a) (13) (E), which was to provide for payment reasonably related to actual costs incurred. Growth allowances to enable providers to finance necessary expansion, modernization, and development are not related to current costs, but rather are a form of capital financing. It would not be appropriate to seek to provide this financing under section 1902(a) (13) (E). States may allow proprietary providers a profit in the form of a rate of return on owners' net equity sufficiently high to attract needed capital investment. In addition, depreciation allowances and interest expenses may be allowable costs for all providers of long term care services.

While return on proprietary owners' net equity is the only item of profit that may be included as an allowable cost, these regulations also provide another opportunity for profit, in permitting states to set payment rates on a class basis. An efficiently operated facility that provides services under the plan at

a cost less than the class rate will in effect make a profit equal to the difference. On the other hand, a facility that is not economically operated may incur actual costs of more than the class rate; thus, a class rate can be used as an incentive for efficiency and economy. It is intended that States have great flexibility in determining classes in setting class rates, as long as their criteria for classes and rates are reasonable.

The proposed regulations would also have allowed deductions from the payment rate for operational deficiencies which were not clearly related to reasonable costs. This provision has been deleted, but the final regulations allow a state that sets prospective class rates to set for each class a second reduced rate to be paid to facilities found not to have provided the quality of service or level of care required of the class, and to adjust retroactively to such reduced rate its payments to facilities with service deficiencies. Because of the difficulty of calculating such a reduced rate that is reasonable cost-related, and to prevent its misuse as a substitute for more stringent measures against facilities that do not comply with certification standards, the regulations require that the criteria on which such rate reductions are based, and the amount of the reductions, must be set forth in the State plan and must be published for public review and comment before such rates become effective.

A final point on the meaning of the statutory requirement of "payment * * * on a reasonable cost-related basis" is that the statute and the legislative history are silent on the question of the timing of such payment. The Department in these regulations makes no requirement with respect to the time of payment such as the requirement of interim payments under Medicare. Accordingly, States are free to establish such payment schedules as they find reasonable. For example, a State may wish to withhold payment or a portion of payment pending receipt of adequate cost reports from a facility. However, the Department leaves open the possibility that it may decide at some future date, on the basis of experience under these regulations, that regulatory requirements respecting the timing of payments are necessary to effectuate fully the Congressional requirement of payment on a reasonable cost-related basis.

The ICF–SNF Differential and Supplementation Plans

The Secretary has discretion, under section 1903(h)(1) of the Act, to compute, for reimbursement purposes, a reasonable cost differential between skilled nursing facilities and intermediate care facilities.

Under this authority, the Department presently requires by regulation, at 45 CFR 250.30(b)(3)(iii)(*b*), that except as specified therein, to qualify for Federal financial participation the State must set its reimbursement rate for intermediate care facilities at least ten percent below the rate for skilled nursing facilities. As some comments pointed out, this differential is inconsistent with the requirement of the proposed regulations that States pay both skilled nursing and intermediate care facilities on a reasonable cost-related basis, as determined under the reimbursement principles and provisions of these regulations. In addition, a study of cost differentials between skilled nursing facilities and intermediate care facilities in five States (using cost data from 1971), conducted for the Department by a private consulting firm, indicates that there may be no rational basis for requiring any differential, since a substantial number of intermediate care facilities were found to have costs as high as those of skilled nursing facilities. The study concluded that inadequate data existed on which to base further conclusion on the question of whether any differential is appropriate.

Since section 1902(a)(13)(E) of the Act now requires that all long-term care facilities be paid on a reasonable cost-related basis, the calculation of rates in accordance with the regulation implementing this requirement should result in rates that reflect whatever differential, if any, is appropriate, without further need for a separate requirement for calculating the differential. Accordingly, the requirement for a differential has been deleted from the regulations.

The provisions permitting supplementation of state payments for skilled nursing facility and intermediate care facility services are deleted, since the last state plan for supplementation is scheduled to conclude as of July 1, 1976.

Cost-Reporting

A number of comments pointed out that the cost reporting requirements of the proposed regulations were unnecessarily detailed and burdensome, and would require the States to develop, at considerable expense, cost data of limited usefulness. On the basis of these comments, the regulations have been revised to make clear that the principal requirement of this paragraph is the annual submission by providers to the State of uniform cost reports conforming to certain standards set by the Secretary.

The proposed regulations required that, if the Administrator later prescribes a uniform cost report form, States must adopt that form. A number of comments objected to this requirement on the ground that it would be unreasonable to require States to adopt a Federal uniform cost report form after they had developed their own report forms at considerable expense. These points are well taken and, accordingly, this requirement has been omitted in the final regulations.

Auditing

A number of comments objected to various of the auditing requirements of the proposed regulations. The regulations have been revised to delete some unnecessarily burdensome requirements. The provision requiring a report on the number of field audits conducted has been deleted.

A number of comments urged that the regulations should not require on-site audits, but should give States the option to use other generally accepted methods for validating cost reports. However, the Department has decided to retain this requirement in the final regulations. The Department has been given a preliminary briefing on findings of the General Accounting Office to the effect that State audits of facility-reported cost data are generally lax under the provisions of the present § 250.30(a)(4), which are not specific regarding the scope and frequency of audits required. Based on such experience, on-site, full-scope audits of all facilities over a three-year period following the effective date of these regulations are deemed necessary. However, a provision has been added to the regulations exempting from this requirement States that have recently completed adequate on-site audits of all facilities.

A number of comments also objected that the requirement in the proposed regulations that overpayments found in such audits be accounted for on the SRS–OA–41 report in the quarter found was unfair, because audit findings of overpayments to facilities may be withdrawn later upon reconsideration. Despite this objection, the Department considers it necessary to retain this provision, although it has been amended to permit the State six months to resolve audit findings or to make recovery, before amounts must be reported. Where audit findings of overpayment are withdrawn in a later quarter, the SRS–OA–41 report for that quarter may be adjusted accordingly.

Opportunity for Provider Appeals and Public Comments

A number of comments wanted the regulations to assure providers more opportunities to influence the State's choice of cost-finding and rate-setting methods and payment procedures. Some comments urged that, before the regional offices approve any State plan, the public should have an opportunity to review and comment on the proposed plan and supporting cost data. However, it is considered unnecessary to make this a regulatory requirement, since an opportunity for review of all State plan material filed with Federal offices already exists under the Freedom of Information Act. Other comments argued that a State plan adopting the Medicare principles of reimbursement should not be approved unless it adopts Medicare's procedures for provider appeals of reimbursement determinations. But, since Congress clearly intended that adoption by the State of the Medicare principles and standards of reasonable cost reimbursement was to be optional, there is no basis for requiring that a State adopt the Medicare system in its entirety. However, the Department has been persuaded that some opportunity should be provided for public comment on the proposed payment rates before they become effective. The regulations have been amended accordingly. In addition, the final regulations specifically require that

an opportunity be provided for comment before any penalty provision may be included in the payment rate or rate formula.

TIMETABLE FOR IMPLEMENTATION

A considerable number of States have expressed concern regarding the timetable for implementation of these regulations. The Department is aware that, although a good number of States will be able to implement the greater part of these regulations fairly quickly, some will need a good deal of time to begin to accumulate the cost data on which to base payment rates, and none will be able to meet all the requirements as of July 1, 1976. The Department does not intend that States should be penalized for the Department's delay in publishing final regulations. Therefore, the regulations require that the initial cost-reporting period begin no later than January 1, 1977, and that States set reasonable cost-related rates no later than January 1, 1978, on the basis of cost data submitted by providers. The States are encouraged to meet each requirement of the regulations as soon as possible. Although the regulation speaks to a cost reporting period of a year, some States may set their initial rate on a cost reporting period of less than a year.

Accordingly, the proposed regulations, as modified, are hereby adopted.

Section 250.30, Part 250, Chapter II, Title 45 of the Code of Federal Regulations is revised by adding a new paragraph (a)(3), redesignating current paragraphs (a)(3) through (8) as (a)(4) through (9), amending the renumbered paragraph (a)(8); by deleting subparagraph (b)(3)(ii)(b), redesignating current subparagraphs of paragraph (b)(3) as paragraphs (b)(3) through (b)(7), and amending the renumbered paragraphs (b)(6), as follows:

§ 250.30 Reasonable charges.

(a) State plan requirements. * * *

(3) Effective July 1, 1976, provide for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost-related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary.

(i) The State plan shall prescribe requirements for cost finding and cost reporting by providers of long term care facility services under the plan. Under this requirement, the State plan shall:

(A) Specify the inclusive dates of the cost reporting year under this section, which year need not be the same for all providers of long term care facility services under the plan; and specify the beginning date of the first such cost reporting year, which shall be no later than January 1, 1977;

(B) Require that each provider of long term care facility services under the plan compile, after the close of each cost reporting year specified under paragraph (a)(3)(i)(A) of this section, an itemized list of its allowable costs under paragraph (a)(3)(iii) of this section for such cost reporting year, or for the period of participation in the plan, if less than the full cost reporting year, on the basis of generally accepted accounting principles and the accrual method of accounting, except that, for governmental institutions operated on a cash method of accounting, data based on such a method of accounting will be acceptable;

(C) Specify one cost-finding method approved by the Secretary to be used by all providers of skilled nursing facility services, and one cost-finding method approved by the Secretary to be used by all providers of intermediate care facility services, which may be the same cost-finding method for all providers of long term care facility services in the State, and require that, after the close of each cost reporting year as defined in paragraph (a)(3)(i)(A) of this section, each provider of long term care facility services under the plan shall apply such specified cost-finding method to its allowable costs determined under paragraph (a)(3)(i)(B) of this section to ascertain the costs of the various services provided by it under the plan during such cost reporting year. Cost-finding methods specified under 20 CFR 405.453(d) have been approved by the Secretary; other cost-finding methods shall be submitted to the Regional Commissioner for approval;

(D) As of the beginning date of the first cost reporting year under the plan as specified under paragraph (a)(3)(i)(A) of this section, provide for a uniform cost report form to be used by all providers of skilled nursing facility services, and a uniform cost report form to be used by all providers of intermediate care facility services, which may be the same cost report form for all providers of long term care facility services in the State, which cost report form or forms shall require an itemized list of the allowable costs, under paragraph (a)(3)(iii) of this section, and a list of the costs of the various services provided under the plan as determined on the basis of an approved cost-finding method; and require that each provider of long term care facility services under the plan report to the State agency, on the appropriate uniform cost report form, the cost data determined by the facility under paragraphs (a)(3)(i)(B) and (C) of this section, no later than three months after the close of the cost reporting year;

(E) Require that each provider of long term care facility services under the plan maintain, for a period of not less than three years following the date of submission of the cost report form to the State agency under paragraph (a)(3)(i)(D) of this section, financial and statistical records of the period covered by such cost report which are accurate and in sufficient detail to substantiate the cost data reported; and require each provider to make such records available upon demand to representatives of the State agency or of the Department;

(F) Provide that all cost reports submitted by providers under paragraph (a)(3)(i)(D) of this section shall be maintained by the State agency, pursuant to the recordkeeping and reporting requirements of § 205.60 of this chapter, for a period of not less than three years following the date of submission of such reports.

(ii) The State plan shall provide for audits to verify the accuracy and reasonableness of cost reports furnished by providers under paragraph (a)(3)(i) of this section, and shall describe the State's procedures for such audits, which shall meet generally accepted auditing standards. The adoption of audit standards set forth in Health Insurance Manual (HIM–18) issued by the Social Security Administration is recommended, but the State may establish its own standards. Under this requirement, the State plan shall:

(A) Provide procedures for analyzing and auditing the cost reports and financial records of providers and other pertinent documents, which procedures are adequate to verify:

(*1*) That only those expense items that the State has specified as allowable costs under paragraph (a)(3)(iii) of this section have been included by the provider in the computation of the costs of the various services provided by it under the plan under paragraph (a)(3)(i)(C) of this section; and

(*2*) That expenses determined under paragraph (a)(3)(i)(B) of this section, and attributed to proper items of allowable cost under paragraph (a)(3)(i)(C) of this section, have been accurately determined and attributed, and are reasonable.

(B) Provide for analysis, within six months after their submission to the State agency, of all cost reports submitted by providers under (a)(3)(i)(D) of this section to verify, to the extent possible, that the provider has complied with paragraphs (a)(3)(i)(B) and (C) of this section;

(C) Where analysis under paragraph (a)(3)(ii)(B) of this section indicates that a provider has not fully complied with paragraphs (a)(3)(ii)(A)(*1*) and (A)(*2*) of this section, provide for such further auditing of the provider's financial and statistical records or other documents as are needed;

(D) Provide for on-site audit of the financial and statistical records of each participating provider, over a three-year period beginning as of the close of the first cost reporting year as defined in paragraph (a)(3)(i)(A) of this section, during which three-year period no less than one third of the participating long term care facilities are to be audited each year. Such on-site audit shall be sufficiently comprehensive in scope to ascertain whether, in all material respects, the cost report submitted by the provider under paragraph (a)(3)(i)(D) of this section complies with paragraphs (a)(3)(ii)(A)(*1*) and (A)(*2*) of this section. The Regional Commissioner may exempt from this requirement a State which demonstrates to his satisfaction that it has in effect a continuing audit program under which it has completed on-site audits of the financial and sta-

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION V
300 SOUTH WACKER DRIVE
CHICAGO, ILLINOIS 60606

HEALTH CARE FINANCING ADMINISTRATION

October 14, 1977

Mr. Edward Dirkswager
Commissioner
Minnesota Department of Public Welfare
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Mr. Dirkswager:

Please refer to our letter of April 22, 1977 to Vera J. Likins in which we indicated our conditional approval of Minnesota's State Plan Amendment on cost-related reimbursement of nursing homes. Incidentally, we never received a reply either to this letter or the status request of August 5, 1977.

Due to extensive changes in Federal regulations which became effective July 1, 1976, our Central Office took a special interest in these plan amendments and re-reviewed them. They found additional shortcomings in your State Plan Amendment which are either contrary to 45 CFR 250.30(a)(3)(4) or require clarification:

Uniform Method of Cost Finding

(1) It is unacceptable to use one system of reimbursement for ICF-MRs and another system for all other providers. (2) It is also unacceptable to pay a flat rate to small providers. It is required by 45 CFR 250.30(a)(3)(i)(c) that the plan specify one cost finding method to be used for SNFs and one cost finding method to be used for ICFs (and these methods may be the same).

The State may establish classes (one of which may be ICF-MR) to be used in its reimbursement system; however, the same rate setting methodology must be applicable to all ICFs and/or SNFs. If a cost ceiling or overall rate ceiling is applied to one class, a ceiling established by the same method must be applied to all the other classes.

The methodology of establishing rates for small providers must be the same as the methodology used for other providers. It is unacceptable to pay small providers a class (flat) rate based on regional averages and to pay other providers a rate based on their individual costs. In addition, the ceiling limitations and other provisions of the plan must also apply to small providers.

Allowable Cost Identification

(3) The State's method of providing for a return on owners' equity must be demonstrated to be related to industry net equity data and interest costs. It should also be noted (5) that the regulations preclude the payment of a return on equity to non-profit providers.

The plan provides that costs applicable to services and facilities provided from related organizations will be recognized at the cost to the related organization or the related organization's price to outsiders. It is required by § 250.30(a)(3)(iii)(D) that costs applicable to services, facilities, and supplies furnished to a provider by a related organization shall not exceed the lower of the cost to the (6) related organization or the price of comparable services, facilities, or supplies purchased elsewhere.

(7) (4) The plan must specify what construction index will be used to adjust the limitation on the basis of depreciable assets.

Payment Determination

(8) The State must be more specific and precise concerning its reimbursement methodology. We suggest that it use examples to describe its system. Specifically, the State plan must clearly describe: a) the reimbursement methodology (prospective or retrospective), b) the specific regions which will be used, and the specific methodology for calculating regional averages (e.g., 50th percentile of per diem costs). Also, (9) since each facility uses its own fiscal year as the base year, the plan should clearly indicate when the regional averages will be calculated. Are regional averages only based on costs of facilities with a calendar year reporting system?

(10) Since providers receive prospective rates, the plan must provide for an inflation factor to account for economic conditions during the rate period.

In view of the numerous and substantial modifications required in the reimbursement standards, we are compelled to suspend our conditional approval of Transmittal IM-76-37 until the State Plan is so changed that it complies with the Federal regulations. The timetable for implementing the regulations creates a special urgency to work out these problems soon. Our staff is available for any consultations and technical assistance. Please feel free to call on us.

Sincerely yours,

Ralph A. Detloff

Ralph A. Detloff
Acting Regional Medicaid Director

Bob Lan

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION V
[illegible]
CHICAGO, ILLINOIS 60604

November 10, 1977



James J. Hiniker, Deputy Commissioner
Minnesota Department of Public Welfare
Centennial Office Building
Fourth Floor
658 Cedar Street
St. Paul, Minnesota 55155

Dear Mr. Hiniker:

This is to continue our discussion on Minnesota's plan amendment for cost-related reimbursement of nursing homes.

We would like to reiterate what we said at our November 9th meeting, namely, that the two percent investment allowance for non-proprietary homes in your Rule 49 is contrary to Federal regulations (42 CFR 450.30) and policy. Therefore a State plan amendment containing such provision is not approvable.

We hope that you will find a way to make necessary adjustments so that the plan may be approved before January 1, 1978.

Sincerely,

Ralph A. Detloff

Ralph A. Detloff
Acting Regional Medicaid Director

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

December 29, 1977

Mr. Everette Bryant
Acting Regional Medicaid Director
Health Care Financing Administration
Department of Health, Education, & Welfare
300 South Wacker Drive
Chicago, Illinois 60606

Dear Mr. Bryant:

This is in accordance with telephone conversations today concerning the Minnesota State Plan amendment covering revised requirements for reasonable cost reimbursement to Skilled Nursing Facilities and Intermediate Care Facilities. It is my understanding that Mr. Milton Dezube, Branch Chief, Institutional Reimbursements, was to inform your office that the Minnesota Plan amendment was acceptable if we discontinued allowing non-profit facilities the 2% investment allowance. This is confirmation of our acceptance of that condition and the 2% allowance to non-profit facilities will be discontinued immediately.

I am expecting written response and notice of your approval of the State Plan Transmittal #IM-76-37 which was our original transmittal.

Sincerely,

James Hiniker
Deputy Commissioner

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION V
300 SOUTH WACKER DRIVE
CHICAGO, ILLINOIS 60606

HEALTH CARE FINANCING
ADMINISTRATION

February 9, 1978

FEB 1978
RECEIVED
COMMISSIONER'S
OFFICE



Edward J. Dirkswager, Commissioner
Minnesota Department of Public Welfare
Centennial Office Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Mr. Dirkswager:

This is to notify you that effective January 1, 1978, we have approved your State Plan Amendment, OPC-11 No. 76-37, containing the rules for reimbursement of nursing homes under Title XIX of the Social Security Act (the Minnesota Department of Public Welfare Rule 49, January 1, 1977 revision and Rule 52, the January 1, 1976 revision). You will remember that we had conditionally approved this amendment on April 22, 1977 and withdrew that approval on October 14, 1977.

The approval is being granted with the understanding that beginning January 1, 1978 you stopped paying the 2% investment allowance for non-profit institutions.

Sincerely,

George R. Holland

George R. Holland
Acting Regional Medicaid Director

Enclosure

Hunker Reporter #11

STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

Due 5-17-78

Address Reply to:
DEPARTMENT OF PUBLIC WELFARE
CENTENNIAL OFFICE BUILDING
ST. PAUL, MINNESOTA 55155
TELEPHONE (612) 296-6671

May 9, 1978

RECEIVED
MAY 10 1978
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

Michael B. Miller, Esq.
Special Assistant Attorney General
Department of Administration
G 19-k Administration Building
Saint Paul, Minnesota 55155

Re: Temporary Rules DPW 49-A and 49-B

Dear Mr. Miller:

Submitted for your approval is temporary rule DPW 49-A as proposed February 27, 1978, 2 S.R. 1596. Enclosed are three copies of the rule as proposed. Also enclosed for your information are comments regarding the proposed rule by letter dated March 17, 1978 from counsel for the Minnesota Hospital Association Conference on Geriatric Care. After reviewing comments received concerning the temporary rule, the Department has decided to adopt the proposed rule without change.

Also submitted in three copies is rule DPW 49-B, a temporary rule proposed April 3, 1978 (2 S.R. 1895) in lieu of the eliminated 2% disallowance. Also enclosed for your information are comments regarding the proposed rule by letter dated April 12, 1978 from the Canby Community Hospital and C & NC unit. After reviewing comments received concerning the temporary rule, the Department has decided to adopt the proposed rule without change.

It is the Department's view that Minn. Stat. § 256B.46 (1976), coupled with the enclosed letter of February 9, 1978 from the Acting Regional Medicaid Director, provides justification for the temporary rules.

Please call me at 296-8403 if you have any questions concerning this submittal.

Very truly yours,

PAUL G. ZERBY
Assistant Attorney General

PGZ/ph
Enclosures

cc: Joseph E. Hamilton, Esq.
John Broeker, Esq.
Canby Community Hospital

Attorney General

Paul G. Zerby
Assistant Attorney General

May 24, 1978

Lee E. Sheehy
Special Assistant
Attorney General

296-1288

Approval of Temporary DPW Rule 49 Amendment and Addition

I am returning Temporary DPW Rule 49's proposed amendment to D.6.b.(1) and proposed addition to 1.b.(2). The amendment is hereby approved as to form and legality.

The addition to DPW 49 1.b(2) is not approved. The proposed rule fails to incorporate the provision required by Minn. Stat. § 256B.46 relating to establishing a maximum allowable cost for rental fees.

When appropriate language is added to remedy this defect, it may be returned to this office for review and approval.

I have retained a copy of all relevant documents in my office. Should you wish to discuss this matter with me, please feel free to call me at 296-1288.

LES:mb

Enclosure

Any compound, mixture, or preparation containing any of the following limited quantities of narcotic drugs, which shall include one or more non-narcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone,

Statutory Name	Some examples of common names, trade names, or names of products which contain a controlled substance.
(1) Not more than 100 milligrams of dihydrocodeine per 100 milliliters ~~or per 100 milliliters~~ or per 100 grams.	
(2) Not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams.	
(3) Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit.	Lomotil
(4) Not more than 15 milligrams of anhydrous morphine per 100 milliliters or per 100 grams.	Parapectolin, Donnagel P.G.
(5) Loperamide	Imodium

((f) remains unchanged.)

Department of Public Welfare

Proposed Temporary Rule Eliminating 2% Investment Allowance for Non-Proprietary Nursing Home Providers under Title XIX Medical Assistance Program

Request for Comment

Notice is hereby given that the following amendment to Rule DPW 49, Rule DPW 49A, governing administration of Regulations for Determining Welfare Per Diem Rates for Nursing Home Providers Under the Title XIX Medical Assistance Program, is proposed for adoption as a temporary rule as authorized by Minn. Stat. § 15.0412, subd. 5 (1977), pending completion of a full hearing and adoption of a permanent rule. Comments from interested and affected persons are requested. Comments must be received at the address given below within 20 days of the date of this publication to be considered. The temporary rule may be revised on the basis of comments received.

Comments on the proposed rule should be sent to:

Edward J. Dirkswager, Jr.
Commissioner
Minnesota Department of Public Welfare
Fourth Floor
Centennial Office Building
St. Paul, Minnesota 55155

Temporary Rule as Proposed

DPW 49 D.6.b.(1) is amended to read as follows:

(1) Determination of allowance. Proprietary homes where cost reports are received after January 1, 1977, shall receive an investment allowance of nine percent of the original value of the facility for depreciation purposes. ~~Non-proprietary homes whose fiscal year begins after June 30, 1977, shall receive an investment allowance of two percent of the original value.~~

LAW OFFICES

HAMILTON, FLYNN & HEIM

394 IDS CENTER • 80 SOUTH EIGHTH STREET

MINNEAPOLIS, MINNESOTA 55402

JOSEPH E. HAMILTON
WILLIAM E. FLYNN
PAUL M. HEIM

TELEPHONE
(612) 338-4200

ARE YOU HANDLING THIS?

MAR 29 1978
LEGAL
OFFICES

MAR 1978
RECEIVED
COMMISSIONER'S
OFFICE

March 17, 1978

BY MESSENGER

Commissioner Edward J. Dirkswager, Jr.
Minnesota Department of Public Welfare
Fourth Floor
Centennial Office Building
St. Paul, Minnesota 55155

Re: Department of Public Welfare Proposed Temporary Rule Eliminating the Nonproprietary Nursing Home Investment Allowance

Dear Commissioner:

Enclosed and hereby submitted with you please find the comment of the Minnesota Hospital Association Conference on Geriatric Care on the above proposed temporary rule.

If the proposed rule is not to be revised by the Department of Public Welfare on the basis of the comment enclosed, we would appreciate being informed promptly of when the proposed rule is to be submitted to the Attorney General for his review as to legality and form. We would also appreciate being informed of who in the Attorney General's office will be conducting this review.

Thank you very much for your consideration.

Very truly yours,

HAMILTON, FLYNN & HEIM

Joseph E. Hamilton

Joseph E. Hamilton

JEH:la

Enclosure

cc: Mr. Steve Rogness
Mr. James J. Hiniker
Mr. Paul G. Zerby

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE THE COMMISSIONER

OF PUBLIC WELFARE

In the Matter of the Proposed Temporary Rule Eliminating the Two Percent Investment Allowance for Nonproprietary Nursing Homes	COMMENT OF THE MINNESOTA HOSPITAL ASSOCIATION CONFERENCE ON GERIATRIC CARE

This comment is being submitted on behalf of the Minnesota Hospital Association Conference on Geriatric Care (MHA - CGC) which represents approximately 205 nonprofit nursing homes providing resident care throughout the State of Minnesota. This comment is to formally respond to the Request for Comment published in the State Register on February 27, 1978, in connection with a proposed temporary rule which would eliminate the present DPW Rule 49 two percent investment allowance for nonproprietary nursing homes.

MHA - CGC is opposed to the temporary rule proposed on February 27, 1978, on the basis of significant policy and legal grounds. The public policy grounds are perhaps best reflected in the legislative purpose of Minnesota Statutes, Section 256B.45. That Section requires that nonproprietary nursing homes receive an investment allowance, initially set at two percent, thereafter to be adjusted by the Department of Public Welfare (DPW). This is explicit legislative recognition that Minnesota nonprofit nursing homes need this item of funding to continue to provide a satisfactory level of care. This statement of State policy should not be ignored by DPW, unless and until its contravention is clearly and finally required by the Department of Health, Education and Welfare (HEW). Moreover, even at that point, there is a direct legislative mandate in Section 256B.46 to replace any disallowed investment allowance with an adequate incentive allowance. The legislative purpose expressed in these two Sections carries over to provide solid legal objections to the temporary rule proposed on February 27, 1978.

Our first legal objection is that the proposed temporary rule exceeds the statutory power accorded to the Department by Section 256B.46 of the Minnesota Statutes. That Section provides:

> "In the event that the United States government disallows the investment allowance provided for in Section 256B.45 for nonproprietary homes, the state agency shall by rule establish an incentive allowance for nonproprietary nursing homes consistent with federal requirements. The incentive allowance shall include incentives to reward efficient management and quality care."

The clear import of this statutory requirement is that the two percent nonprofit investment allowance, if disallowed, is to be immediately replaced with a financially adequate substitute. In order to comply with this statutory language, any proposal to discontinue the two percent investment allowance would have to be accompanied by a proposal for its replacement. MHA - CGC strenuously objects to the temporary rule proposed on February 27, 1978, because it makes no provision for an alternative incentive allowance as required by Section 256B.46.

We have been informed that alternative incentive allowance language is presently being developed and will soon be proposed by the Minnesota Department of Public Welfare. MHA - CGC specifically requests that at this time the Department of Public Welfare delay action to eliminate the two percent investment allowance until that action can be taken as a part of replacing the two percent allowance with a financially adequate substitute. The only type of proposed rule which we would see as being acceptable is one which ties the effective date of eliminating the two percent allowance with the effective date of its replacement.

Our second legal objection is that at this point the Department is not authorized by the Minnesota Administrative Procedure Act to promulgate a valid temporary rule. The basis for our second objection is the fact that to our knowledge there has been no showing by the Department of Public Welfare that it cannot comply with the formal rule-making procedure of Minnesota Statutes, Section 15.0412, Subdivision 4. The published notice of February 27, 1978, states that

the elimination of the two percent allowance "is proposed for adoption as a temporary rule as authorized by Minnesota Statute §15.0412, Subdivision 5(1977)". Yet, as to be expected, the standard to be met for emergency rule-making is stringent. The agency must be "directed or authorized by statute, federal law or court order to adopt, amend, suspend or repeal a rule in a manner that does not allow for compliance with Subdivision 4" of Section 15.0412. Here it is clear that this standard has not been met because there has never been a final decision of HEW that the two percent allowance has been disallowed and even if that type of decision was finally made it is not clear that it would require emergency rule-making.

We have been informed that the impetus for the Department's proposal of a temporary rule is information that DPW has received from someone in the Department of Health, Education and Welfare that HEW will disapprove that portion of the state medical assistance plan which contains the two percent investment allowance. However, in light of the mandated HEW procedure for state plan disallowance, it is clear that such information doesn't amount to a disapproval or disallowance of the Minnesota state medical assistance plan.

The Federal Social Security statute and implementing regulations establish a fairly comprehensive procedure to be followed before HEW may disapprove a part or all of a state medical assistance plan. Specifically, 42 U.S.C. §1396c requires that HEW provide "reasonable notice and opportunity for hearing to the state agency" before finding that the state plan does not comply with federal law.

This is amplified in 45 C.F.R. §§201.6 and 201.7 which establish a disallowance procedure consisting of informal discussions, a hearing, notification of withholding of payment and judicial review. It is significant to note that before HEW may disallow a state plan, a hearing must be held and before a hearing may be held, formal notice must be provided to the state agency. Moreover, the regulations point out that, "Formal notification of the date and place of the hearing does not foreclose further negotiations with the state officials." 45 C.F.R. §201.6(c).

The Department of Public Welfare has made no showing, thus far, that the steps set out above have been taken by HEW or that HEW has disallowed the nonprofit homes' investment allowance after a hearing held pursuant to Section 1396c: nor have we even seen a notification of such a hearing. In short we do not have, in any legally recognizable form, a final decision of HEW which states that the two percent allowance has been disallowed. Moreover, even if we did, it is not clear that this would require or authorize temporary rule-making. Presumably, if a temporary rule promulgated in March can operate to cure any defects back to January 1, 1978; then a formal rule promulagated within the next several months could operate to accomplish the same end. But, in any case, it is impossible to conclude that an HEW final decision requires temporary rule-making, until we have that decision.

The position of MHA - CGC as stated herein may be briefly summarized as follows. To propose the elimination of the two percent

allowance without provision for an adequate replacement is inherently unacceptable. It presents the critical risk that the two percent allowance will be quickly eliminated, but slowly replaced. It violates the clear policy and wording of Minnesota Statutes, Section 256B.46. Moreover, there has been no showing that a temporary rule is authorized or required in this matter. There has been no final decision of the Department of Health, Education and Welfare; and there is no indication that any such final decision would require temporary rule-making. Finally it does not appear to MHA - CGC that any cost or harm would be incurred by the reasonable delay of conducting formal rule-making. This would have the benefit of according to the Department of Public Welfare the opportunity to provide an effective replacement for the two percent investment allowance. Anything short of that will continue to receive the strenuous objection of nonprofit nursing homes providing resident care in Minnesota.

Dated: March 17, 1978

Respectfully submitted,

HAMILTON, FLYNN & HEIM

Joseph E. Hamilton

William E. Flynn

Attorneys for the Minnesota Hospital Association Conference on Geriatric Care

① Rule does not have lease aspect mentioned in M.S. § 256B.46

② Retroactive eff. of rule? BUT ONLY Benefits Retroactive.

③ HEW

- HEW admin appeal.