

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File No. 1265

05-0009, 085d

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 4-11-86
DATE FOR REVIEW
DATE DUE 4-25-86

Adopted w/a hearing
Adopted w/o hearing
~~Temporary~~ rule emergency

Approved 4/25/86 Disapproved Returned to Agency

Resubmitted Due
Approved Disapproved Returned to Agency

Date filed w/Secretary of State 4-28-86 Revisor approved disapproved

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✓ Rule as Adopted - Note: there are two sets promulgated in this Rulemaking

✓ Rule as Proposed

✓ Order Adopting 4.11.86. Date combined with FF

✓ Notice of Intent to Solicit Outside Opinion SR. 1.6.86. " 1.27.86

✓ Order for rulemaking
N/A date of Hearing

N/A Certificate of Board's Authorizing Resolution

✓ Notice of rulemaking
✓ Sufficiency

✓ Affidavit of Mailing Notice or rulemaking
2.26.86 At least ~~30~~ days prior to ~~hearing~~/adoption
Affidavit of Additional Mailing 25

✓ Mailing list Certificate

✓ Publication in State Register
3.3.86 At least ~~30~~/20 25 days prior to ~~hearing~~/adoption

N/A Hearing Examiner's Report

Chief Hearing Examiner's Report(s)
Approving H.E.'s Report
Approving agency action

✓ Agency's Findings of Fact combined w/ Order Adopting

N/A LCRAR Report or agency Affidavit

Certificate of Board's Resolution Adopting Rules

Order Approving Incorporation by Reference

Statement of Need and Reasonableness

✓ Petition for Adoption of a Rule

✓ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

✓ Certificate of Compliance w/Rulemaking Procedures

N/A Affidavit of Mailing Notice of Submission to Attorney General

✓ Notice of Submission to the Attorney General

✓ 42 CFR 432, 433, 435 and 436 - pages from Federal Register dated 11.12.85

SF-00006-03

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO: LEONARD W. LEVINE
Commissioner of Human Services

ATTN: PATRICIA A. SONNENBERG
Special Assistant Attorney General

DATE: 4/28/86

FROM: J. MICHAEL MILES JMM
Assistant Attorney General

PHONE: 296-6555

SUBJECT: In the Matter of the Proposed Adoption of the Department of Human Services' Rule Governing Third-Party Liability for Health Services to Medical Assistance Recipients and Medical Assistance Assignment of Rights

The above-referenced rule has been approved as to its legality by the Attorney General on April 25, 1986.

Enclosed is the agency's copy of the approved rule. This office has already filed two copies of the approved rule with the Secretary of State, who will forward one copy to the Revisor of Statutes. The fourth copy is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submission or comments received by the agency and any extra copies of documents which the agency submitted to the Attorney General.

In order for a permanent rule without a hearing to become effective, your agency must publish a notice of adoption in the State Register in accordance with Minn. Stat. § 14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. § 14.34.

If you have any questions in this regard, please contact me.

JMM:pmf

Enclosures

cc: Maryanne Hruby
Executive Director
Legislative Commission to Review
Administrative Rules

Duane Harves
Chief Administrative Law Judge
Office of Administrative Hearings

RR1265

AG copy

Department of Human Services

Adopted Emergency Rule Relating to Medical Assistance Assignment of Rights to Benefits from Liable Third Party Payers and Establishment of Paternity

Rule as Adopted, Emergency

9505.0212 [Emergency] ASSIGNMENT OF RIGHTS.

Subpart 1. **Definitions.** The terms used in subparts 1 to 6 have the meanings given them in items A to F.

A. "Assignment" or "assignment of benefits" means the written authorization by a person or the person's authorized representative, a policyholder, or other authorized individual to transfer to another individual, entity, or agency his or her rights or the rights of his or her dependents to medical support or other third party payments.

B. "Authorized representative" means an individual authorized by the medical assistance applicant or recipient to apply for medical assistance or perform duties required of the FFp.18 applicant or recipient by parts 9500.0760 to 9500.0860 on behalf of the applicant or recipient.

C. "Department" means the Minnesota Department of Human Services.

D. "Local agency" means a county or multi-county agency that is authorized under Minnesota Statutes, sections 393.01, subdivision 7 and 393.07, subdivision 2, as the agency responsible for determining eligibility for the medical assistance program.

E. "Person" means an individual applying for or receiving benefits under the medical assistance program authorized by Minnesota Statutes, chapter 256B including individuals eligible for medical assistance because of eligibility for aid to families with dependent children and Minnesota supplemental assistance.

F. "Third party payer" means an individual, entity,

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agency, or government program, that has a probable liability to pay all or part of the costs of a recipient's health services. Examples are an insurance company, health maintenance organization, CHAMPUS, workers' compensation, and potential defendants in legal actions arising out of unintentional or intentional torts.

Subp. 2. **Notification to local agency.** A person or the person's authorized representative shall notify the local agency of the availability of third party payer coverage at the time of application, at the time of an eligibility redetermination, and within ten days of a change in potential coverage.

Subp. 3. **Assignment of benefits.** All legally able medical assistance applicants and recipients shall assign to the department their rights and the rights of their dependent children to benefits from liable third party payers. Any applicant or recipient who refuses to assign to the department his or her own rights or those of any other ~~individual~~ person for whom he or she can legally make an assignment shall be found ineligible for medical assistance. ~~An individual~~ A person who is otherwise eligible for medical assistance shall not have his ~~to~~ or her eligibility denied or delayed because he or she cannot legally assign his or her own rights and the individual legally able to make the assignment refuses to assign the rights ~~or to cooperate~~.

FFp.18 FFp.19 FFp.19

Subp. 4. **Cooperation in establishing paternity and obtaining medical support.** Except as provided in subparts 5 and 6, a person must cooperate with the department and local agency in establishing paternity of an eligible child and in obtaining medical care support and payments for himself or herself and any other person for whom he or she can legally assign rights. Cooperation includes providing the local agency or the department with information, appearing at a state or local office to provide information or evidence relevant to the case, appearing as a witness at a court or other proceeding, paying to the local agency or the department any medical support or medical care funds received that are covered in the

FFp.19 FFp.19 FFp.17

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assignment, ~~provide~~ providing information or ~~attest~~ attesting to lack of information under penalty of perjury, and taking other reasonable steps to establish paternity and obtain medical support. The person who fails to cooperate in establishing paternity ~~and~~ or obtaining medical support shall be ineligible for medical assistance. The person who is otherwise eligible for medical assistance shall not have his or her eligibility denied because his or her caretaker refuses to cooperate.

Subp. 5. **Good cause exemption from the requirement to cooperate in establishing paternity ~~and~~ or obtaining medical care support for children.** Before requiring ~~a person~~ an individual to cooperate in establishing paternity ~~and~~ or obtaining medical care support for children, a local agency shall notify the ~~person~~ individual that he or she may claim a good cause exemption from ~~cooperating with~~ the requirements of subpart 4 at the time of application or at any subsequent time. When ~~a person~~ an individual submits a good cause claim in writing, the local agency must stop action related to obtaining medical care support and payments. The ~~person~~ individual shall submit corroborative evidence of a good cause claim to the local agency within 20 days of submitting the claim.

A. Good cause exists when:

(1) a child for whom ~~child~~ medical support ~~enforcement~~ is sought was conceived as the result of incest or rape;

(2) legal proceedings for the adoption of a dependent child are pending before a court of competent jurisdiction; or

(3) the person is receiving services from a licensed adoption agency to determine whether to keep the child or relinquish the child for adoption, and the services have not been provided for longer than three months.

B. Good cause exists when the ~~person~~ individual documents that his or her cooperation would not be in the best interest of the dependent child because the cooperation could result in:

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(1) physical harm to the child;

(2) emotional impairment of the child which would substantially affect the child's functioning; or

(3) physical harm to or emotional impairment of the ~~person~~ individual which would substantially affect the ~~person's~~ individual's functioning and reduce the ~~person's~~ individual's ability to adequately care for the child. FF p. 18

C. The local agency shall help ~~a person~~ an individual who has difficulty getting the evidence to support a good cause claim. When a local agency requires additional evidence to make a determination on the claim for good cause, the local agency shall notify the ~~person~~ individual that additional evidence is required, explain why the additional evidence is required, identify what form this evidence might take, and specify an additional period that will be allowed to obtain it. FF p. 18 FF p. 18

D. A local agency shall determine whether good cause exists by comparing the good cause claim of the ~~person~~ individual to sufficiency of the evidence. FF p. 18

E. ~~Once~~ When a local agency determines that ~~a person has~~ good cause exists, the exemption from cooperation under subpart 4 must remain in effect for the period the child remains eligible under that application, except for subitems (1) to (4). FFℓ FFℓ

(1) A good cause exemption allowed because a child was conceived as the result of incest or rape must continue until a subsequent acknowledgement of paternity or an application for adoption by a second parent is submitted for that child.

(2) A good cause exemption allowed because of adoption proceedings must be issued for a fixed period of time based on the expected time required to complete adoption proceedings. The exemption must be extended when the required time is longer than was anticipated and must stop when adoption proceedings are discontinued or completed.

(3) A good cause exemption allowed because of adoption counseling must last no more than three months from the time the counseling began.

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(4) A good cause exemption must be allowed under subsequent applications without additional evidence when the factors which led to the exemption continue to exist. A good cause exemption allowed under item B must end when the factors which led to allowing the exemption have changed.

F. A good cause exemption which has been allowed by a local agency for a person must be honored by the local agency in the county of residence when the person moves into that county, until the factors which led to allowing the exemption change.

G. When a local agency denies a claim for a good cause exemption and resumes its enforcement action, FFSm, the local agency shall require the ~~person~~ individual FFp.18 to submit additional evidence in support of a later claim for a good cause exemption before the local agency ~~stops acting~~ can again stop action FFSm to enforce ~~child~~ medical FFp.17 support under subpart 4.

H. Following a determination that ~~a person~~ an FFp.18 individual has good cause for refusing to cooperate, a local agency shall take no further action to enforce ~~child~~ medical FFp.17 support until the good cause exemption ends according to item E.

Subp. 6. **Good cause exemption from the requirement to cooperate in obtaining medical care support ~~and~~ or payments for other ~~individuals~~ persons.** FFSn FFSn Before requiring ~~a person~~ an FFp.18 individual to cooperate in obtaining medical care support ~~and~~ or payments for other ~~individuals~~ persons not covered by subpart 5, FFSn a local agency shall notify the ~~person~~ individual FFp.18 that he or she may claim a good cause exemption from ~~cooperating with~~ the requirements of subpart 4 at the time of application or at any subsequent time. When ~~a person~~ an individual FFp.18 submits a good cause claim in writing, the ~~person~~ individual FFp.18 shall submit corroborative evidence of the good cause claim to the local agency within 20 days of submitting the claim. The local agency must send the claim and the corroborative evidence to the department and must stop action related to obtaining medical care support and payments.

A. Good cause exists when cooperation is against the best interests of the individual or other person to whom medical

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assistance is being furnished because it is anticipated that cooperation will result in reprisal against and cause physical or emotional harm to the individual or other person.

B. The local agency shall help ~~a person~~ an individual FF18 who has difficulty getting the evidence to support a good cause claim. When a local agency or the department requires additional evidence to make a determination on the claim for good cause, the local agency or department shall notify the ~~person~~ individual FF18 that additional evidence is required, explain why the additional evidence is required, identify what form this evidence might take, and specify an additional period that will be allowed to obtain it.

C. The department shall determine whether good cause exists by comparing the good cause claim of the person to sufficiency of the evidence.

D. ~~Once~~ When FF5o the department determines that ~~a person has~~ good cause exists FF5o, the exemption from cooperation under subpart 4 must remain in effect for the period the person remains eligible under that application. A good cause exemption must be allowed under subsequent applications without additional evidence when the factors which led to the exemption continue to exist. A good cause exemption allowed under this subpart must end when the factors which led to allowing the exemption have changed.

E. When the department denies a claim for a good cause exemption and enforcement action resumes, ~~the department shall continue to enforce medical care support and payment requirements unless~~ the ~~person submits~~ individual must submit additional evidence in support of ~~a~~ any later claim for a good cause exemption before the department or local agency ~~stops~~ can again stop acting to obtain medical care support ~~and~~ or payments under subpart 4. FF5p.

F. Following a determination that ~~a person~~ an FF18 individual has good cause for refusing to cooperate, a local agency and the department shall take no further action to obtain medical care support ~~and payment~~ or payments FF5q until the good

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cause exemption ends under item D.

REPEALER. Minnesota Rules, part 9500.0820, subpart 6 is repealed.

APPROVED IN THE
REVISOR OF STATUTES
OFFICE BY:

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
APR 28 1986
Joan Anderson Growe
Secretary of State
9:36 AM

APPROVED AS TO FORM AND LEGALITY.

4/25 1986

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY _____
ASSISTANT ATTORNEY GENERAL

Department of Human Services

AG copy.

Adopted Emergency Rule Relating to Medical Assistance and Third Party Payer Liability

Rule as Adopted, Emergency

9505.0211 [Emergency] THIRD PARTY PAYER LIABILITY.

Subpart 1. **Definitions.** The terms used in subparts 1 to 9 have the meanings given them.

A. "Assignment" or "assignment of benefits" means the written authorization by a person or the person's authorized representative, a policyholder, or other authorized individual to transfer to another individual, entity, or agency his or her rights or the rights of his or her dependents to medical support or other third party payments.

B. "Authorized representative" means an individual authorized by the medical assistance applicant or recipient to apply for medical assistance or perform duties required of the applicant or recipient by parts 9500.0760 to 9500.0860 on behalf of the applicant or recipient.

C. "Person" means an individual applying for or receiving benefits under the medical assistance program authorized by Minnesota Statutes, chapter 256B including individuals eligible for medical assistance because of eligibility for aid to families with dependent children and Minnesota supplemental assistance.

D. "Provider" means a vendor as specified in Minnesota Statutes, section 256B.02, subdivision 7, that has signed an agreement approved by the department for the provision of health services to a recipient.

E. "Third party payer" means a person, entity, agency, or government program, other than Medicare or the medical assistance program, that has a probable liability to pay all or part of the costs of a recipient's health services. Examples are an insurance company, health maintenance

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organization, CHAMPUS, workers' compensation, and potential defendants in legal actions arising out of unintentional or intentional torts.

Subp. 2. **Third party payer; primary coverage.** A third party payer who is liable to pay all or part of the cost of a health service provided to a medical assistance applicant or recipient shall be the primary payer. The third party payer's coverage of or liability for a health service provided to a medical assistance applicant or recipient shall be utilized to the fullest extent available before a medical assistance payment is made on the recipient's behalf.

Subp. 3. **Provider responsibility to obtain information and assignment of benefits.** The provider shall obtain information about the recipient's potential health service coverage by a third party payer from the recipient, from the recipient's responsible relative, or from the remittance advice provided by the department upon rejection of a claim because of the department's identification of a potential third party payer. Further, the provider ~~shall be responsible to~~ may (FF 11) obtain an assignment of benefits from the recipient, policyholder, or other authorized individual or representative. In the case of a dependent child insured under a policy held by a parent or other individual who does not have custody of the child, the provider ~~shall~~ may (FF 11) obtain the assignment from the individual who has custody of the child. For purposes of this subpart, "responsible relative" means the spouse of a medical assistance recipient or applicant or the parent of a child under age 18 who is a medical assistance recipient or applicant.

Subp. 4. **Provider billing; third party.** When a provider is informed by a recipient, the recipient's responsible relative, a local agency, or the department that the recipient has health service coverage by a third party payer, the provider shall bill the third party payer before seeking medical assistance payment for the health service.

Subp. 5. **Provider billing; department.** Except as in subpart 7, the provider shall not submit a claim for medical

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assistance payment until receiving from the third party payer either a payment, a partial payment, or a notice that the claim has been denied. A provider may submit a claim for medical assistance payment for the difference between the amount paid by the third party and the amount payable by medical assistance in the absence of other coverage. However, no medical assistance payment will be made to a provider under contract with a private health coverage plan when the private health coverage plan calls for the provider to accept the plan's payment as payment in full. The provider who submits a claim for medical assistance payment by the department after a third party payer has paid part of the claim or denied the claim shall submit with the claim the additional information or records required by the department to document the reason for the partial payment or denial.

Subp. 6. **Time limit for submission of claims.** A provider must submit claims to the department according to the 12-month billing requirement in part 9500.1080, subpart 2.

Subp. 7. **Provider billing; third party failure to respond.** A provider who has not received either a payment or denial notice from a third party payer within 90 days after submitting the claim for payment may bill the medical assistance program. The provider shall submit to the department, no later than 12 months after the date of service to the recipient, a copy of the original claim to the third party payer, documentation of two further attempts to contact the third party payer, and any written communication the provider has received from the third party payer.

Subp. 8. **Recovery of payments to recipients.** Notwithstanding the provisions of part 9500.1080, subpart 1, a provider ~~must~~ may bill a recipient to recover the amount of a payment received by a recipient from a third party payer. The department is liable only to the extent that the amount payable by medical assistance exceeds the third party liability.

Subp. 9. **Exclusion from third party payer billing requirements.** The department will exclude from third party

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payer billing requirements those health services for which the probable existence of liability cannot be determined or for which the third party payer billing is not cost effective to the department. Providers are not required to bill third party payers for: } FFp. 15

A. Prescription drugs and medical supplies under major medical expense insurance which provides protection against extraordinary medical expenses that would otherwise create a serious financial hardship. This exclusion does not apply to pharmacy only insurance and private health maintenance organization plans (HMOs).

B. Early periodic screening diagnosis and treatment (EPSDT) claims except when the person is covered by a private health maintenance organization plan (HMO).

C. Claims for which the submitted charge is less than $5. For purposes of this item, "claim" means a single line on the pharmacy and medical supply invoice of the department and the total of all lines on other invoice forms of the department.

D. Personal care attendant services provided by unlicensed personnel.

E. Day activity center (DAC) services.

F. Waivered services billed to the department by the local agency.

G. Health service bills for an individual recipient approved by the department because facts presented by the provider and the local agency demonstrate that third party payer billing is not cost effective to the department.

H. Other health services for which the Health Care Financing Administration (HCFA) has granted the state a waiver. The department will implement any waiver approved by HCFA or discontinue any waiver withdrawn by HCFA within 60 days after the department's receipt of the notice from HCFA. } FFp. 15

APPLICABILITY. Part 9505.0211 [Emergency] supercedes any inconsistent provision of part 9500.0940.

APPROVED IN THE
REVISOR OF STATUTES
OFFICE BY:

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
APR 28 1986
Joan Anderson Growe
Secretary of State
9:35 AM

APPROVED AS TO FORM AND LEGALITY

4/25 19 86

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY _____
ASSISTANT ATTORNEY GENERAL

Department of Human Services

Proposed Emergency Rule Relating to Medical Assistance and Third Party Payer Liability

Rule as Proposed, Emergency (all new material)

9505.0211 [Emergency] THIRD PARTY PAYER LIABILITY.

Subpart 1. **Definitions.** The terms used in subparts 1 to 9 have the meanings given them.

A. "Assignment" or "assignment of benefits" means the written authorization by a person or the person's authorized representative, a policyholder, or other authorized individual to transfer to another individual, entity, or agency his or her rights or the rights of his or her dependents to medical support or other third party payments.

B. "Authorized representative" means an individual authorized by the medical assistance applicant or recipient to apply for medical assistance or perform duties required of the recipient by parts 9500.0760 to 9500.0860 on behalf of the applicant or recipient.

C. "Person" means an individual applying for or receiving benefits under the medical assistance program authorized by Minnesota Statutes, chapter 256B including individuals eligible for medical assistance because of eligibility for aid to families with dependent children and Minnesota supplemental assistance.

D. "Provider" means a vendor as specified in Minnesota Statutes, section 256B.02, subdivision 7, that has signed an agreement approved by the department for the provision of health services to a recipient.

E. "Third party payer" means a person, entity, agency, or government program, other than Medicare or the medical assistance program, that has a probable liability to pay all or part of the costs of a recipient's health services. Examples are an insurance company, health maintenance

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organization, CHAMPUS, workers' compensation, and potential defendants in legal actions arising out of unintentional or intentional torts.

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Subp. 3. **Provider responsibility to obtain information and assignment of benefits.** The provider shall obtain information about the recipient's potential health service coverage by a third party payer from the recipient, from the recipient's responsible relative, or from the remittance advice provided by the department upon rejection of a claim because of the department's identification of a potential third party payer. Further, the provider shall be responsible to obtain an assignment of benefits from the recipient, policyholder, or other authorized individual or representative. In the case of a dependent child insured under a policy held by a parent or other individual who does not have custody of the child, the provider shall obtain the assignment from the individual who has custody of the child. For purposes of this subpart, "responsible relative" means the spouse of a medical assistance recipient or applicant or the parent of a child under age 18 who is a medical assistance recipient or applicant.

Subp. 4. **Provider billing; third party.** When a provider is informed by a recipient, the recipient's responsible relative, a local agency, or the department that the recipient has health service coverage by a third party payer, the provider shall bill the third party payer before seeking medical assistance payment for the health service.

Subp. 5. **Provider billing; department.** Except as in subpart 7, the provider shall not submit a claim for medical

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assistance payment until receiving from the third party payer either a payment, a partial payment, or a notice that the claim has been denied. A provider may submit a claim for medical assistance payment for the difference between the amount paid by the third party and the amount payable by medical assistance in the absence of other coverage. However, no medical assistance payment will be made to a provider under contract with a private health coverage plan when the private health coverage plan calls for the provider to accept the plan's payment as payment in full. The provider who submits a claim for medical assistance payment by the department after a third party payer has paid part of the claim or denied the claim shall submit with the claim the additional information or records required by the department to document the reason for the partial payment or denial.

Subp. 6. **Time limit for submission of claims.** A provider must submit claims to the department according to the 12-month billing requirement in part 9500.1080, subpart 2.

Subp. 7. **Provider billing; third party failure to respond.** A provider who has not received either a payment or denial notice from a third party payer within 90 days after submitting the claim for payment may bill the medical assistance program. The provider shall submit to the department, no later than 12 months after the date of service to the recipient, a copy of the original claim to the third party payer, documentation of two further attempts to contact the third party payer, and any written communication the provider has received from the third party payer.

Subp. 8. **Recovery of payments to recipients.** Notwithstanding the provisions of part 9500.1080, subpart 1, a provider must bill a recipient to recover the amount of a payment received by a recipient from a third party payer. The department is liable only to the extent that the amount payable by medical assistance exceeds the third party liability.

Subp. 9. **Exclusion from third party payer billing requirements.** The department will exclude from third party

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payer billing requirements those health services for which the probable existence of liability cannot be determined or the third party payer billing is not cost effective to the department. Providers are not required to bill third party payers for:

A. Prescription drugs and medical supplies under major medical expense insurance which provides protection against extraordinary medical expenses that would otherwise create a serious financial hardship. This exclusion does not apply to pharmacy only insurance and private health maintenance organization plans (HMOs).

B. Early periodic screening diagnosis and treatment (EPSDT) claims except when the person is covered by a private health maintenance organization plan (HMO).

C. Claims for which the submitted charge is less than $5. For purposes of this item, "claim" means a single line on the pharmacy and medical supply invoice of the department and the total of all lines on other invoice forms of the department.

D. Personal care attendant services provided by unlicensed personnel.

E. Day activity center (DAC) services.

F. Waivered services billed to the department by the local agency.

G. Health service bills for an individual recipient approved by the department because facts presented by the provider and the local agency demonstrate that third party payer billing is not cost effective to the department.

H. Other health services for which the Health Care Financing Administration (HCFA) has granted the state a waiver. The department will implement any waiver approved or withdrawn by HCFA within 60 days after the department's receipt of the notice from HCFA.

APPLICABILITY. Part 9505.0211 [Emergency] supercedes any inconsistent provision of part 9500.0940.

APPROVED BY THE REVISOR OF STATUTES OFFICE BY:

OFFICE OF THE REVISOR OF STATUTES

Proposed Rule

RD891

Agency: Department of Human Services

Division:

Agency Contact: Eleanor Weber

Minnesota Rules: Parts 9505.0211 [Emergency]

Title: Proposed Emergency Rule Relating to Medical Assistance and Third Party Payer Liability

Type of Rules: Emergency

Incorporations by Reference: None

Steven C. Cross
Revisor of Statutes

Susan E. Quayle
Assistant Revisor
Phone: 296-0956
Date: February 12, 1986

Department of Human Services

Proposed Emergency Rule Relating to Medical Assistance Assignment of Rights to Benefits from Liable Third Party Payers and Establishment of Paternity

Rule as Proposed, Emergency (all new material)

9505.0212 [Emergency] ASSIGNMENT OF RIGHTS.

Subpart 1. **Definitions.** The terms used in subparts 1 to 6 have the meanings given them in items A to F.

A. "Assignment" or "assignment of benefits" means the written authorization by a person or the person's authorized representative, a policyholder, or other authorized individual to transfer to another individual, entity, or agency his or her rights or the rights of his or her dependents to medical support or other third party payments.

B. "Authorized representative" means an individual authorized by the medical assistance applicant or recipient to apply for medical assistance or perform duties required of the recipient by parts 9500.0760 to 9500.0860 on behalf of the applicant or recipient.

C. "Department" means the Minnesota Department of Human Services.

D. "Local agency" means a county or multi-county agency that is authorized under Minnesota Statutes, sections 393.01, subdivision 7 and 393.07, subdivision 2, as the agency responsible for determining eligibility for the medical assistance program.

E. "Person" means an individual applying for or receiving benefits under the medical assistance program authorized by Minnesota Statutes, chapter 256B including individuals eligible for medical assistance because of eligibility for aid to families with dependent children and Minnesota supplemental assistance.

F. "Third party payer" means an individual, entity,

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agency, or government program, that has a probable liability to pay all or part of the costs of a recipient's health services. Examples are an insurance company, health maintenance organization, CHAMPUS, workers' compensation, and potential defendants in legal actions arising out of unintentional or intentional torts.

Subp. 2. **Notification to local agency.** A person or the person's authorized representative shall notify the local agency of the availability of third party payer coverage at the time of application, at the time of an eligibility redetermination, and within ten days of a change in potential coverage.

Subp. 3. **Assignment of benefits.** All legally able medical assistance applicants and recipients shall assign to the department their rights and the rights of their dependent children to benefits from liable third party payers. Any applicant or recipient who refuses to assign to the department his or her own rights or those of any other individual for whom he or she can legally make an assignment shall be found ineligible for medical assistance. An individual who is otherwise eligible for medical assistance shall not have his to her eligibility denied or delayed because he or she cannot legally assign his or her own rights and the individual legally able to make the assignment refuses to assign the rights or to cooperate.

Subp. 4. **Cooperation in establishing paternity and obtaining medical support.** Except as provided in subparts 5 and 6, a person must cooperate with the department and local agency in establishing paternity of an eligible child and in obtaining medical care support and payments for himself or herself and any other person for whom he or she can legally assign rights. Cooperation includes providing the local agency with information, appearing at a state or local office to provide information or evidence relevant to the case, appearing as a witness at a court or other proceeding, paying to the local agency any support or medical care funds received that are covered in the assignment, provide information or attest to lack

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of information under penalty of perjury, and other reasonable steps to establish support. The person who fails to cooperate in establishing paternity and obtaining medical support shall be ineligible for medical assistance.

Subp. 5. **Good cause exemption from the requirement to cooperate in establishing paternity and obtaining medical care support for children.** Before requiring a person to cooperate in establishing paternity and obtaining medical care support for children, a local agency shall notify the person that she may claim a good cause exemption from cooperating with the requirements of subpart 4 at the time of application or at any subsequent time. When a person submits a good cause claim in writing, the local agency must stop action related to obtaining medical care support and payments. The person shall submit corroborative evidence of a good cause claim to the local agency within 20 days of submitting the claim.

A. Good cause exists when:

(1) a child for whom child support enforcement is sought was conceived as the result of incest or rape;

(2) legal proceedings for the adoption of a dependent child are pending before a court of competent jurisdiction; or

(3) the person is receiving services from a licensed adoption agency to determine whether to keep the child or relinquish the child for adoption, and the services have not been provided for longer than three months.

B. Good cause exists when the person documents that her cooperation would not be in the best interest of the dependent child because the cooperation could result in:

(1) physical harm to the child;

(2) emotional impairment of the child which would substantially affect the child's functioning; or

(3) physical harm to or emotional impairment of the person which would substantially affect the person's functioning and reduce the person's ability to adequately care for the child.

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C. The local agency shall help a person who has difficulty getting the evidence to support a good cause claim. When a local agency requires additional evidence to make a determination on the claim for good cause, the local agency shall notify the person that additional evidence is required, explain why the additional evidence is required, identify what form this evidence might take, and specify an additional period that will be allowed to obtain it.

D. A local agency shall determine whether good cause exists by comparing the good cause claim of the person to sufficiency of the evidence.

E. Once a local agency determines that a person has good cause, the exemption from cooperation under subpart 4 must remain in effect for the period the child remains eligible under that application, except for subitems (1) to (4).

(1) A good cause exemption allowed because a child was conceived as the result of incest or rape must continue until a subsequent acknowledgement of paternity or an application for adoption by a second parent is submitted for that child.

(2) A good cause exemption allowed because of adoption proceedings must be issued for a fixed period of time based on the expected time required to complete adoption proceedings. The exemption must be extended when the required time is longer than was anticipated and must stop when adoption proceedings are discontinued or completed.

(3) A good cause exemption allowed because of adoption counseling must last no more than three months from the time the counseling began.

(4) A good cause exemption must be allowed under subsequent applications without additional evidence when the factors which led to the exemption continue to exist. A good cause exemption allowed under item B must end when the factors which led to allowing the exemption have changed.

F. A good cause exemption which has been allowed by a local agency for a person must be honored by the local agency in

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the county of residence when the person moves into that county, until the factors which led to allowing the exemption change.

G. When a local agency denies a claim for a good cause exemption, the local agency shall require the person to submit additional evidence in support of a later claim for a good cause exemption before the local agency stops acting to enforce child support under subpart 4.

H. Following a determination that a person has good cause for refusing to cooperate, a local agency shall take no further action to enforce child support until the good cause exemption ends according to item E.

Subp. 6. **Good cause exemption from the requirement to cooperate in obtaining medical care support and payments for other individuals.** Before requiring a person to cooperate in obtaining medical care support and payments for other individuals, a local agency shall notify the person that he or she may claim a good cause exemption from cooperating with the requirements of subpart 4 at the time of application or at any subsequent time. When a person submits a good cause claim in writing, the person shall submit corroborative evidence of the good cause claim to the local agency within 20 days of submitting the claim. The local agency must send the claim and the corroborative evidence to the department and must stop action related to obtaining medical care support and payments.

A. Good cause exists when cooperation is against the best interests of the individual or other person to whom medical assistance is being furnished because it is anticipated that cooperation will result in reprisal against and cause physical or emotional harm to the individual or other person.

B. The local agency shall help a person who has difficulty getting the evidence to support a good cause claim. When a local agency or the department requires additional evidence to make a determination on the claim for good cause, the local agency or department shall notify the person that additional evidence is required, explain why the additional evidence is required, identify what form this evidence might

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take, and specify an additional period that will be allowed to obtain it.

C. The department shall determine whether good cause exists by comparing the good cause claim of the person to sufficiency of the evidence.

D. Once the department determines that a person has good cause, the exemption from cooperation under subpart 4 must remain in effect for the period the person remains eligible under that application. A good cause exemption must be allowed under subsequent applications without additional evidence when the factors which led to the exemption continue to exist. A good cause exemption allowed under this subpart must end when the factors which led to allowing the exemption have changed.

E. When the department denies a claim for good cause exemption, the department shall continue to enforce medical care support and payment requirements unless the person submits additional evidence in support of a later claim for a good cause exemption before the department or local agency stops acting to obtain medical care support and payments under subpart 4.

F. Following a determination that a person has good cause for refusing to cooperate, a local agency and the department shall take no further action to obtain medical care support and payment until the good cause exemption ends under item D.

REPEALER. Minnesota Rules, part 9500.0820, subpart 6 is repealed.

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OFFICE OF THE REVISOR OF STATUTES

Proposed Rule

RD908

Agency: Department of Human Services

Division:

Agency Contact: Eleanor Weber

Minnesota Rules: Part 9505.0212 [Emergency]

Title: Proposed Emergency Rule Relating to Medical Assistance Assignment of Rights to Benefits from Liable Third Party Payers and Establishment of Paternity

Type of Rules: Emergency

Incorporations by Reference: None

Steven C. Cross
Revisor of Statutes

Susan E. Quayle
Assistant Revisor
Phone: 296-0956
Date: February 13, 1986

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of the Emergency Rules of the State Department of Human Services Governing Third Party Payer Liability, Assignment of Benefits, and Establishment of Paternity Under the Medical Assistance Program	FINDINGS OF FACT CONCLUSIONS, AND ORDER ADOPTING EMERGENCY RULES

Notice of the Commissioner's proposed adoption of the above-entitled emergency rules was published in the State Register on March 3, 1986 and was sent by United States mail to all persons on the list maintained by the agency pursuant to Minnesota Statutes, section 14.30 on February 26, 1986.

All persons were given the opportunity to submit written comment on the rule for at least 25 days after notice of proposed rulemaking. No requests for notice of submission to the Attorney General were received by the department. The Commissioner has considered the comments received and makes the following findings:

Minnesota Statutes, section 256B.04, subdivision 2 gives the Commissioner authority to adopt rules in regard to the medical assistance program. Minnesota Statutes, section 14.29, subdivision 1 states, "When an agency is directed by statute, federal law or court order to adopt.....a rule in a manner that does not allow for compliance with sections 14.14 to 14.28,.....the agency shall adopt emergency rules in accordance with sections 14.29 to 14.36." Federal regulations, 42 CFR 433.139,42 CFR 433.137, 42 CFR 433.145, and 42 CFR 435.064 specify that the department must carry out certain measures with regard to collecting from third party payers the cost of health services furnished to medical assistance recipients, that the department must require applicants and recipients as a condition of eligibility to assign any rights to medical support or other payments for medical care to the department, and, additionally, that the department must require applicants and recipients to cooperate with the department in establishing paternity and obtaining support and other payments. The regulations require the department to implement these provisions by May 12, 1986. It is necessary that the department meet the deadline of May 12, 1986 in order to comply with Minnesota Statutes, section 256B.04, subdivision 4 which imposes on the department the obligation to cooperate with the federal government "in any reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program.....". The Commissioner, therefore, finds it necessary and reasonable to propose these emergency rules to comply with federal and statutory requirements. Moreover, the Commissioner finds it necessary and reasonable to use the procedure applicable to emergency rulemaking because the period between publication of the requirements and the effective date set by the federal government was not long enough to carry out all requirements necessary to adopt a permanent rule. (See the attached copy of the cited federal regulations.)

Part 9505.0211, pages 1 to 4, specifies a health service provider's obligation to obtain information from recipients, their authorized representatives, or responsible relatives about third parties which have a probable liability to pay all or part of a recipient's health care costs. This part furthermore specifies the provider's obligation to bill a potentially liable third party payer before seeking medical assistance payment for health services.

1. One commentator, Mr. Steven Chies, President, North Cities Health Care, Inc., expressed concern about the application of the proposed rules to a nursing home's liability for tort claims resulting from an accident to a resident within the nursing home. Although the Commissioner has considered the comment, he finds that the proposed rule should be applied to all probable third party payers and will not provide an exception for nursing homes. Moreover, the nursing home's probable liability for an accident must be established before it or its liability insurance carrier can be billed. Finally, the department believes that the cost of injuries resulting from negligent actions should be borne by the negligent party and not by the state.

2. Ms. Susan Voigt, Minnesota Association of Health Care Facilities, (MAHCF), requested that the department provide forms that a long-term facility may use to record third party payer information. The department has considered the suggestion and will make forms available upon request in implementing the rule.

3. Mr. Vern Silvernale, Minnesota Hospital Association (MHA), expressed the belief that the proposed rule will place an additional administrative burden on the hospital provider. The Commissioner does not agree with Mr. Silvernale's comments. The department promulgated Minnesota Rule, part 9500.1130, (also known as Rule 54), governing medical assistance payment rates for hospital services to recipients. Rule 54 became effective August 1, 1985. Subpart 12 of that rule states, " A hospital may not submit a claim to the department until a final determination of the recipient's eligibility for potential third party payment has been made by the hospital. Any and all available third party benefits must be exhausted prior to billing medical assistance....." (emphasis added). The Commissioner finds that Rule 54 already prohibits hospital providers from billing the medical assistance program before all third party benefits are exhausted. The proposed emergency rule, therefore, will not increase their obligation.

4. One commentator, Mr. Larin Anderson, Indian Health Board of Minneapolis, suggested that the Medical Assistance card contain "the name, address [of the insurance carrier], and the dates of eligibility [of the recipient for third party coverage.]" Mr. Anderson further requested that the rule allow third party payers billed by a provider to bill the difference to the Department of Human Services as Medicare currently does. The department considered Mr. Anderson's suggestions and investigated to determine their feasibility. The Commissioner finds that the MA cards are too small to contain the requested information. Furthermore, the department has no authority to require the third party payer to bill the department for the difference between its payment and the bill submitted to it by the provider.

5. One commentator, Mr. Anderson opposed the requirement that health service providers bill third party payers before submitting claims to the medical assistance program. Under recently enacted federal regulations at 42 CFR 433.139 the medical assistance program can not pay for a medical service if probable third party liability exists.

6. One commentator, Ms. Martha Gisselquist, Assistant Director, Ebenezer Community Services suggested the requirement to bill third parties before submitting claims to the department be waived when from past experience the provider believes the third party will not pay for a medical service. The Commissioner rejects the comment. Under 42 CFR 433.139 medical assistance can not pay if probable third party liability exists. If the department has information that the service might be covered by a third party, it must reject the provider's claim. The department believes the provider should bill all probable third party payers because the provider may be wrong about what the third party will cover. If the provider is wrong, the department could be subject to a federal penalty under 42 USC s1396b(u). Therefore, the commissioner finds that requiring health care providers to bill all probable third party payers is reasonable and necessary.

Subpart 1, item E, page 1, lines 31 to 35 and page 2, lines 1 to 3, of the proposed rule defines the term "third party payer".

7. Ms. Deborah Glass, Minnesota Medical Association, suggested the deletion of the word " probable" from line 33. The department considered Ms. Glass's suggestion but believes that the deletion would be inconsistent with federal regulations at 42 CFR 433.139 (b)(1). Although the extent of liability is sometimes not clearly known, submitting a claim when probable liability to a third party payer exists could result in the acknowledgement of liability or information on the extent of the liability. Therefore, the Commissioner finds including the word "probable" in the definition of third party payer is reasonable and necessary. The Commissioner desires to retain item E as published.

Subpart 3, page 2, lines 12 to 28, of the proposed rule sets out the provider's responsibility to obtain information about the recipient's potential health service coverage by a third party payer and an assignment of benefits.

8. and 9. Mr. Silvernale commented that it would be advantageous for providers to have some authority to require medical assistance patients to give an assignment of benefits. Furthermore, R. C. Dunn, Financial Consultant, Health Central System, suggested that it's the responsibility of the patient rather than the provider to process commercial insurance claims. The department has considered these comments. Under Minnesota Statutes, section 256B.06, subd. 1 (14) and 42 CFR 433.135, the department has the authority to require that third party benefits on behalf of a recipient be assigned to the department by the policyholder. The department does not have clear statutory authority to transfer its assignment of benefits to a provider or require recipients to assign benefits to a provider. Nevertheless, the department believes many providers routinely obtain assignments from their patients and file commercial insurance claims. Therefore, the Commissioner does not accept these suggestions and desires to retain the subpart as published.

10.and 11. Mr. Silvernale also suggested that line 13 be amended by inserting "attempt to" after "shall" and that line 19 be amended by inserting "attempt" after "responsible." Concerning the amendment of line 13, the department believes the providers should obtain the information so they can meet their obligation to bill the appropriate third parties. Under federal law, providers can only bill medical assistance for amounts for which third parties are not liable. Therefore, the Commissioner desires to retain line 13 as proposed. Regardless of whether the provider obtains an assignment of benefits from the recipient, the department will only be responsible for the difference between a lower third party payment and a higher medical assistance rate. It is, therefore, to the provider's advantage to obtain a benefit assignment. The Commissioner, however, accepts the comment that providers may not be able to obtain an assignment from an uncooperative patient. The Commissioner therefore proposes to amend line 19 by deleting "shall be responsible to" and inserting "may" before "obtain'. Furthermore, the Commissioner proposes a similar amendment in line 24, that is, the deletion of "shall" and the insertion of "may", so that the requirements of this subpart are consistent for all affected individuals.

12. One commentator, Ms. Glass, requested that the department amend the rule to make clear that the assignment of benefits is "a permanent assignment of benefits for all health services rendered by that provider to the recipient." The department has carefully considered the request. This provision does not require the provider to obtain an assignment every time the recipient receives care or services. The provider has discretion in wording the assignment. Therefore, the Commissioner believes a provider may choose to obtain a permanent assignment under this provision. Thus, the Commissioner desires to retain the provision as published.

13. Ms. Voigt requested amendments to this subpart that would make counties rather than providers responsible for obtaining information about third party coverage and that would require counties to obtain an assignment from each recipient and to transfer its assignment directly to the provider. The county does obtain, and provide the department with information on third party coverage. The Commissioner finds, however, that it would be an unreasonable administrative burden and not cost efficient to require every county to notify all MA providers of the information they obtained. Neither the department nor the county knows which provider a recipient will choose. Under the MA program, a recipient has the right to free choice of a provider. It is estimated that there are over 20,000 providers in Minnesota. To the extent that providers can not gather the information, the department will make the information available upon the remittance advice. Moreover the county does not have clear statutory authority to transfer its assignment directly to the provider. Therefore, the Commissioner does not accept the request and desires to retain the rule as published with the addition of the amendments proposed by the Commissioner under comments 10 and 11.

14. Ms. Glass requested the amendment of lines 13 to 18 so that a provider would be responsible to review the medical asistance identification card but would be responsible to obtain information about third party liability only if the card indicated such coverage existed. Ms. Glass also requested an amendment to subpart 4 (page 2, lines 29 to 34) which would make subpart 4 consistent with the requested amendment of lines 13 to 18. The commentator is suggesting that providers may not have to look any further than the medical assistance identification card to fulfill their obligations under these rules. The Commissioner does not

believe reliance on the identification card is sufficient compliance. There is always a chance that the information on the card presented by the recipient is inaccurate. For example, a recipient may not have given the department accurate information or the recipient may be showing a card that does not have the most recent information. Many providers require private pay patients to supply insurance and other third party payer information. The Commissioner believes it is no more burdensome to obtain this information from recipients than from private pay patients. Therefore, the Commissioner does not accept the request and desires to retain the subparts as published with the addition of the amendments proposed by the Commissioner under comments 10 and 11.

Subpart 4, page 2, lines 29 to 34, of the proposed rule specifies that the provider must bill the third party payer before seeking medical assistance payment for the health service when the provider has information that the recipient has third party coverage.

15. Ms. Voigt suggested amendment of this subpart in her letter of December 18, 1985 to permit providers simultaneously to bill the third party and the department for their respective shares of the medical bill. The Commissioner finds that efficiency and economy will be served if providers do not bill the department until they receive an actual determination of the amount the third party will pay. When a third party payment or denial is received, the limits of the third party's liability are generally established. Simultaneous billing would cause extra work for both providers and the department when adjustments are necessary because a third party paid more or less than the provider's initial

calculation. Even though this provision may cause a short delay in payment to the provider, it will reduce the administrative burden to the provider and the department. In addition, the provider will be able to bill the department 90 days after billing the third party payer. (See also comment 16.) Therefore, the Commissioner does not accept Ms. Voigt suggestion and desires to retain the subpart as published.

Subparts 4 and 5, page 2, lines 29 to 36 and page 3, lines 1 to 15, of the proposed rule specifies the obligation of the provider to bill the third party payer before seeking medical assistance payment and certain methods related to claims submitted to the department.

16. Mr. Silvernale expressed the hospitals' concerns about the additional delay in processing bills as a results of these provisions. Furthermore, he suggested resolving the problem of submitting information by using the form UB-82 to validate the third party denial. Although the department is aware of the bill processing problem, it can not adopt Mr. Silvernale's suggestion. The rule as published affords the provider the opportunity to keep written notes about contacts or efforts to contact the third party payer in the case of a third party who routinely does not formally notify a provider about claim disposition. The form UB-82 can not be used to validate the third party denials. UB-82 is a standard form used to process claims for payment of institutional health care services. Users include Medicare, medical assistance, and Blue Cross/Blue Shield. A provider billing one of these users must complete a separate UB-82 form for each recipient and enter the appropriate codes for and dates of services given to the recipient. Except when benefits are exhausted or terminated, the form does not have codes that identify the reasons for the denial of the claim. Thus, form UB-82 does not contain the information necessary to verify the denial. Therefore, the Commissioner does not accept Mr. Silvernale's suggestion and desires to retain subparts 4 and 5 as published.

Subpart 5, page 2 lines 35 and 36 and page 3, lines 1 to 15, of the proposed rule specifies submittal requirements that the provider must meet, including additional information and submission only after receiving a payment lower than the medical assistance rate, a partial payment, or a denial.

17. and 18. Two commentators, Messrs. Silvernale and Dunn, were concerned about the additional information this subpart requires providers to submit to document denials and partial payments. The department has carefully considered their comments. Other states such as Washington, Ohio, Illinois, Michigan, Massachusetts, Texas, and New Jersey have successfully used the requirement the department desires to adopt. Some states which do not have this documentation requirement, for example, Pennsylvania, call the insurance carrier of every denied claim in order to obtain the additional information. The department lacks the resources to adopt that procedure. The Commissioner finds that the information required by this rule insures that all third party resources are used to the fullest extent and provides evidence for federal auditors that the federal requirements of 42 CFR 433.139 are satisfied. The requirement is similar to that extensively used by insurance carriers when coordinating benefits. The department will review these suggestions again before a permanent rule is proposed. Therefore, the Commissioner does not accept the suggestion to amend and desires to retain the subpart as published.

19. Mr. Anderson suggested the department require insurance companies to furnish certain information which this provision requires providers to obtain or attempt to obtain before billing medical assistance. The Commissioner finds that he does not have clear authority to impose requirements on insurance carriers. Therefore, the Commissioner does not accept the suggestion and desires to retain the subpart as published.

20. One commentator, Ms. Glass, requesting deletion of the words "or records" from line 13 of page 3, asked the department to reconsider the requirement that all claims submitted on paper be backed by paper documentation. She expressed the opinion that providers submitting paper claims should not be held to a more difficult verification process than providers submitting electronic claims. Although paper documentation is being waived in the case of claims submitted electronically by the provider, the department is requiring providers to put the required documentation directly on the electronic medium. Thus, the department does not believe the documentation required for paper claims is more difficult or burdensome than that required for claims on tape. Furthermore, other states such as Washington and Michigan, which have had extensive experience with cost avoidance, have found that such records or documents are necessary to substantiate the third party's denial. Therefore the Commissioner does not accept the request and desires to retain the subpart as published.

Subpart 6, page 3, lines 16 to 18, of the proposed rule, specifies a 12-month billing requirement.

21. One commentator, Mr. Silvernale suggested an amendment that would define the beginning of the 12-month billing period as the end of the 90-day period for failure to respond. The Commissioner finds that the 12-month limit is strictly required by 42 CFR 447.45 (d)(1). Therefore, the Commissioner does not accept the suggestion and desires to retain the provision as published.

Subpart 7, page 3, lines 19 to 28, of the proposed rule, permits a provider who has not received a third party payment or denial notice within 90 days of submitting its claim, to bill the department if the provider submits the bill within the 12-month period set out in subpart 6 and furnishes documentation of efforts made to contact the third party payer.

22. Commentator Silvernale also requested the deletion of the second sentence of this subpart. He questionned the use and value of additional paper in an era of electronic billing and the availability of specific codes to be used on form UB-82. The department has considered this request here and in its finding in regard to subpart 5, comment 14 above. The department will require providers who bill by electronic media to submit narrative entered on the electronic medium to document the reasons a claim was denied or partially paid. Although the methods of submitting the supporting data are not identical for paper and electronic billings, both billing types will have to provide the same data. Michigan in its many years of experience with cost avoidance has not relied on codes alone but has required narrative documentation. The requirement in proposed subpart 7 is similar to Michigan's requirement. Therefore, the Commissioner rejects the request and desires to retain the subpart as published.

Subpart 8, page 3, lines 29 to 34, of the proposed rule states the extent of the department's liability under the medical assistance program and requires a provider to bill a recipient to recover an amount paid by a third party directly to a recipient.

23. One commentator, Mr. Silvernale requested deletion of this subpart. The Commissioner rejects this suggestion. The medical assistance program currently permits a provider to bill a recipient to recover the amount of a payment received by a recipient from a third party payer for the provider's health services. Federal regulations at 42 CFR 433.139 prohibit medical assistance payments to a provider for the amounts for which a third party is liable.No exception is made for instances when the third party pays a recipient who refuses to transmit the payments to the

provider. The medical assistance program will only pay the amount that is the difference between a third party payment and the higher medical assistance rate. However, the department believes that the decision to recover a third party payment directly to a recipient should be made by the provider who treated the recipient. The Commissioner agrees with the commentator that the proposed rule should not require the provider to bill a recipient. Therefore, the Commissioner desires to amend this subpart by deleting "must" in line 31 and inserting "may" before "bill". p.3

Subpart 9., item A, page 4, lines 6 to 11 of the proposed rule provides an exclusion from the third party billing requirement for providers of certain prescription drugs and medical supplies.

24. One commentator, Mr. Donald Dee, Executive Director, Minnesota State Pharmaceutical Association, raised many questions about the implementation of this rule in regard to pharmacies. The department carefully reviewed and considered Mr. Dee's questions and has responded directly to them in a separate letter. (See the copy of the department's response attached to Mr. Dee's letter of comments). As a result of the review, the Commissioner finds the exclusion for pharmacies in this item to be reasonable and necessary. Therefore the Commissioner desires to retain the item as published.

As a result of the department's review of the comments received and the proposed rules, the department has made several minor changes to correct problems of grammar or lack of clarity of the proposed emergency rule, part 9505.0211. Such changes did not change the substance of the rules. These changes are as follows:

Subpart 1, item B, line 18 of page 1, insert after "of the" the words "applicant or";

Subpart 9, line 2 of page 4, insert after "or" the words "for which";

Subpart 9, item H, line 30 of page 4, insert after "approved" the words "by HCFA" and insert after "or" the words "discontinue any waiver".

Part 9505.0212, pages 1 to 6, of the proposed rule specifies that all legally able medical assistance applicants and recipients must assign to the department their rights and the rights of their dependent children to benefits from liable third party payers. The proposed part also requires these persons to cooperate with the department in establishing the paternity of an eligible child and in obtaining medical care support and payments for himself, herself, or any other person for whom he or she can legally assign rights.

1. One commentator, Mr. George J. Steiner, Director, Community Health and Social Services Department of Anoka County, requested clarification of the persons for whom medical support shall be sought. The department believes that Mr. Steiner has raised a question concerning implementation of the rule rather than one concerning the rule's substance. The proposed part requires medical care support and payment to be sought from all absent parents of child recipients. The proposed part is consistent with, and does not extend, the federal regulations, 42 CFR.137, 42 CFR 145, and 42 CFR 604. This part is also consistent with Laws of Minnesota, 1986, Chapter 404, regarding child support.

2. and 3. Mr. Steiner also requested clarification of the phrase " medical support and payments". The department has reviewed the proposed part and agrees that clarification is necessary. The proposed part

applies only to medical support and payments; it does not apply to traditional "child support." Therefore the Commissioner accepts the request to clarify and proposes the following amendments to the rule as published:

Subpart 4, line 35 of page 2, insert after "any" the word "medical"; p.2

Subpart 4, line 2 of page 3, insert after "establish" the phrase "paternity and obtain medical"; p.3

Subpart 5, item A, line 18 of page 3, revise the phrase "child support enforcement" to read "medical support"; p.3

Subpart 5, item G, line 7 of page 5, delete "child" and insert after "enforce" the word "medical" p.5

Subpart 5, item H, line 10 of page 5, delete "child" and insert after "enforce" the word "medical". p.5

4. Finally, Mr. Steiner requested clarification of whether the proposed part requires recipients to use full IV-D services or only requires the establishment of paternity. The proposed rule does not address the question of enforcement efforts that the county must take. These questions will be addressed through a cooperative agreement between the Child Support Enforcement Division and the Health Care Programs Division of the department.

5. As a result of the department's review of the comments received and the proposed rule, the department has made numerous minor changes to correct problems of grammar and lack of clarity. Such changes did not affect the substance of the rule. These changes are as follows:

a. Subpart 3, lines 17 and 19 of page 2, replace "individual " with "person;

b. Subpart 5, lines 7,9,12,14,27,and 34 of page 3; lines 1, 5, and 10 of page 4; lines 4 and 8 of page 5 replace "person" with "individual;and in lines 34 and 35 of page 3, replace"person's"with "individual's";

c. Subpart 6, lines 14,16,19,20,30,and 34 of page 5; replace "person" with "individual";

d. Subpart 6, lines 16 and 20 of page 6, replace "person" with "individual".

Changes a to d clarify the distinction between the word "person" which applies to a specific population which is defined in subpart 1, item E and the word "individual" which applies to the universe.

e. Subpart 1, item B, line 19 of page 1, insert "applicant or" after "of the";

f. Subpart 3, line 20 of page 2, insert "or" in place of "to";

g. Subpart 3, lines 23 and 24 of page 2, place a period after "rights" and delete "or to cooperate.".See j. below;

h. Subpart 4, lines 31 and 35 of page 2, insert "or the department" after "agency";

i. Subpart 4, line 36 of page 2, revise "provide" to "providing" and "attest" to "attesting"; line 1 of page 3, insert "taking" between "and" and "other";; line 3 of page 3, revise "and" to read "or";

j. Subpart 4, line 4 of page 3, after "assistance.", insert "The person who is otherwise eligible for medical assistance shall not have his or her eligibility denied because his or her caretaker refuses to cooperate." See g. above;

k. Subpart 5, lines 6 and 8 of page 3, revise "and" to "or"; line 9 insert "he or" after "that"; line 27, insert "his or" after "that";

l. Subpart 5, item E, line 12 of page 4, revise "Once" to read "When"; delete "a person has"; line 13, insert "exists" after "good cause";

m. Subpart 5, item G, line 4 of page 5, after "exemption" insert "and resumes its enforcement action"; line 6, revise "stops acting" to read "can again stop action";

n. Subpart 6, lines 13 and 15 of page 5, revise "and" to read "or";line 14, after "other", delete "individuals" and insert "persons"; line 16, delete "individuals," and insert in its place "persons not covered by subpart 5,";

o. Subpart 6, item D, line 6 of page 6, replace "Once" with "When";

and delete "a person has"; line 7, insert "exists" after "good cause";

p. Subpart 6, item E, line 14 of page 6, insert "a" between "for" and "good"; line 15, insert "and enforcement action resumes," after "exemption"; lines 15 and 16, delete "the department shall continue to enforce medical care support and payment requirements unless"; insert "must" before "submits" and delete the "s" from "submits"; line 17, replace " a" by the word "any"; line 18, insert "can again" before "stops" and delete "s" from "stops"; line 19, replace "and" with "or"; and

q. Subpart 6, item F, line 23 of page 6, after "support" replace "and" with "or" and add an "s" to "payment".

All comments concerning the proposed emergency rules, parts 9505.0211 and 9505.0212, received within the period allowed by law were considered by the department.

The changes made to the proposed emergency rules, parts 9505.0211 and 9505.0212, are not substantial.

CONCLUSIONS

I hereby conclude that:

1. The Commissioner has statutory authority to promulgate these rules.

2. Proper notice of the department's intent to adopt the proposed above captioned emergency rules was given as required by law, and all interested persons were afforded an opportunity to submit data and views on the proposed emergency rules.

3. All modifications made to the proposed emergency rules are supported by the data and views submitted to the department, and are not substantial changes.

4. The emergency rules, as modified, are necessary and reasonable.

5. Any duplication in these rules of language contained in Minnesota Statutes is crucial to the ability of persons affected by the rules to comprehend their meaning and effect.

6. The department has complied with all applicable provisions of law and rule in the promulgation of these rules.

7. If any finding or part of a finding, above, is properly characterized as a conclusion it is adopted as a conclusion.

NOW, THEREFORE, IT IS ORDERED that the rules identified as parts 9505.0211 (Emergency) and 9505.0212 (Emergency) as modified are adopted this 14th day of April, 1986, pursuant to authority vested in the Commissioner by Minnesota Statutes, sections 14.29, subdivision 1 and 256B.04, subdivision 2.

STATE OF MINNESOTA



LEONARD W. LEVINE

Commissioner of Human Services

OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, an agency, in preparing proposed rules, may seek information or opinion from sources outside the agency. Notices of intent to solicit outside opinion must be published in the *State Register* and all interested persons afforded the opportunity to submit data or views on the subject, either orally or in writing.

The *State Register* also publishes other official notices of state agencies, notices of meetings, and matters of public interest.

Department of Health
Hazardous Substance Injury Compensation Board

Outside Opinion Sought Regarding Proposed Rules Governing Board Practices and Procedures for All Claims and Proposed Rules on Compensable Death Benefits

Minnesota Statutes Sections 115B.25-115B.37 (1985 Supp.) establish a Hazardous Substance Injury Compensation Fund (''Fund'') to be administered by the Hazardous Substance Injury Compensation Board (''Board''). The Fund will provide compensation for certain personal injuries and damage to property which may result from the release of hazardous substances into the environment.

Notice is hereby given that the Board is seeking information or opinions from sources outside the agency in preparing to propose the adoption of the rules governing (a) practice and procedure before the Board, the form and procedure for applications for compensation, and procedures for claims investigations, and (b) death benefits to dependents which are compensable by the Fund. The adoption of the rules is authorized by Minnesota Statutes section 115B.28 and 115B.34, which require the Board to promulgate rules on its operating procedures and on death benefits.

The State Hazardous Substance Injury Compensation Board requests information concerning the subject matter of the rules. Interested persons or groups may submit data or views on the subject matter of concern in writing. Written statements should be addressed to:

Dr. Valentine O'Malley
Deputy Commissioner
Minnesota Department of Health
717 S.E. Delaware Street
Minneapolis, Minnesota 55440

All statements of information and opinions shall be accepted until 30 days after the day this notice appears in the *State Register*. Any written material received by the State Hazardous Substance Injury Compensation Board shall become part of the rulemaking record to be submitted to the Attorney General's Office or Administrative Law Judge in the event that the rules are adopted.

December 20, 1985

Byron E. Starns, Chairperson
Hazardous Substance Injury
Compensation Board

Department of Human Services
Income Maintenance Bureau
Health Care Programs Division

Outside Opinion Sought Concerning Third-Party Liability for Health Services to Medical Assistance Recipients

Notice is hereby given that the Minnesota Department of Human Services is seeking information or opinions from sources outside the agency in preparing an emergency rule to replace Minnesota Rules, Part 9500.0940, Third-Party Liability.

This rule is authorized by Minnesota Statutes, section 256B.04, Subd. 2 in regard to the Medical Assistance Program and by Minnesota Statutes, secton 14.29, Subd. 1 in regard to the amendment of a rule to comply with a federal law, 42 CFR 433.139. The emergency rule governs liability for collection of benefits available to medical assistance recipients, for reimbursement of medical expenses. The proposed changes under the emergency rule will require health service providers to bill third-party payers before submitting claims to the Medical Assistance Program. Third-party coverage shall be primary and shall be exhausted before payment is made by medical assistance.

Public comment was solicited earlier for a proposed amendment to Part 9500.0940 (See *State Register*, Volume 10, Page 1214). Comments received by the Department in response to that notice will be considered as the Department drafts the proposed emergency rule. Persons or groups who commented in response to the earlier solicitation need not repeat those comments unless they wish to amend or elaborate on their original comments. All interested or affected persons or groups are requested to participate. Statements of information and comment may be made orally or in writing. Written statements and comments may be submitted to:

Jan Taylor
Benefit Recovery Section
Health Care Programs Division
Box 64170
St. Paul, MN 55164

Oral statements of information and comments will be received over the telephone at (612) 296-6964 during regular business hours.

Statements of information and comment will be accepted until 4:30 p.m. on February 7, 1986.

Department of Jobs and Training
State Job Training Office

Deadline for Submittal of Petitions for Re-Designation of Service Delivery Areas to Operate Under the Job Training Partnership Act

Notice is hereby given that the State Job Training Office will accept petitions for re-designation of service delivery areas (SDAs) to operate under the Job Training Partnership Act (JTPA) (PL 97-300).

Pursuant to JTPA Sec. 101(c), the Governor may re-designate service delivery areas no more frequently than every two years and such re-designation shall be made not later than 4 months before the beginning of a program year.

Therefore, any unit of general local government or consortium of contiguous units of general local governments seeking service delivery area re-designation under JTPA Sec. 101 must submit formal petitions, signed by the chief-elected official(s), to the State Job Training Office by Monday, February 3, 1986.

To receive a copy of the formal petition package, contact:

Gary S. Denault, Director
State Job Training Office
690 American Center Building
150 East Kellogg Boulevard
St. Paul, Minnesota 55101
(612) 296-8008

Completed petitions should be mailed to the above address no later than Monday, February 3, 1986.

Department of Public Safety
Driver and Vehicle Services Division

Outside Opinion Sought Regarding Proposed Rules Governing Physical and Mental Qualifications on Driver's License—Loss of Consciousness or Voluntary Control

Notice is hereby given that the State Department of Public Safety is seeking information or opinions from sources outside the agency in preparing to amend rules governing the requirements for physician's statement report for persons who have experienced an episode of loss of consciousness or voluntary control. The amendment is limited to Minnesota Rules 7410.2500, Subp. 5, B.

The promulgation of these rules is authorized by Minnesota Statutes sections 171.04; 171.13; 171.14, which permits the agency to require a driver to submit to a physical examination to determine the physical or mental disability of a driver or any other condition that might affect the driver in exercising reasonable and ordinary control over a motor vehicle.

The State Department of Public Safety requests information and comments concerning the subject matter of these rules. The department had previously published a Notice of Intent to Adopt an amendment without public hearing. Those persons who wrote or called the department need not respond again. The requests for public hearing and comments received pursuant to the prior

OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, an agency, in preparing proposed rules, may seek information or opinion from sources outside the agency. Notices of intent to solicit outside opinion must be published in the *State Register* and all interested persons afforded the opportunity to submit data or views on the subject, either orally or in writing.

The *State Register* also publishes other official notices of state agencies, notices of meetings, and matters of public interest.

Department of Commerce

Outside Opinion Sought Regarding Proposed Insurance Funding Agreements Including the Impact of the Rules on Small Business

Notice is hereby given that the Department of Commerce is seeking information or opinions from persons outside the agency in preparing to promulgate new rules governing Insurance Funding Agreements. Promulgation of these rules is authorized by Minnesota Statutes, Sections 45.023 and 61A.276.

Outside opinion is also being solicited as to how these rules will affect small businesses as defined by Minnesota Statutes § 14.115, subdivision 1.

The Department of Commerce requests information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit statements of information or comment orally or in writing to: Richard G. Gomsrud, Department of Commerce, 500 Metro Square Building, St. Paul, MN 55101, (612) 296-5689.

All statements of information and comment shall be accepted until February 21, 1986. Any written material received by the Department of Commerce shall become part of the record in the event that the rules are promulgated.

January 13, 1986

Michael A. Hatch
Commissioner of Commerce

Historical Society

State Review Board Regular Meeting

A meeting of the State Review Board will be held on Thursday, February 20, 1986, at 7:00 p.m. in the Auditorium, Fort Snelling History Center, Fort Snelling, Minnesota.

Department of Human Services
Income Maintenance Bureau
Health Care Programs Division

Outside Opinion Sought Concerning Assignment of Health Insurance and Other Third-Party Benefits by Medical Assistance Applicants or Recipient and of Establishment of Paternity of Minor Child Who Is a Medical Assistance Applicant or Recipient

Notice is hereby given that the Minnesota Department of Human Services is seeking information or opinions from sources outside the agency in preparing an emergency rule to replace Minnesota Rules, Part 9500.0820, subpart 6, Assignment of Benefits.

This rule is authorized by Minnesota Statutes, section 256B.04, Subd. 2 in regard to the Medical Assistance Program and by Minnesota Statutes, section 14.29, Subd. 1 in regard to the amendment of a rule to comply with federal laws, 42 CFR 433.137, 42 CFR 433.145, and 42 CFR 433.148 (see 50 FR 41887 and 50 FR 46652). The emergency rule governs the assignment of health insurance and other third-party benefits available to medical assistance applicants and recipients for the reimbursement of medical expenses and the requirements for cooperation in establishing paternity and obtaining support for the minor child who is a medical assistance applicant or recipient.

All interested or affected persons or groups are requested to participate. Statements of information and comment may be made orally or in writing. Written statements and comments may be submitted to:

Mary Kennedy
Health Care Programs Division
444 Lafayette Road
St. Paul, MN 55101

Oral statements of information and comments will be received over the telephone at 612/297-3200 during regular business hours.

Statements of information and comment will be accepted until 4:30 p.m. on February 7, 1986.

Department of Labor and Industry

Certified Prevailing Wage Rates, February, 1986

On February 1, 1986, the commissioner will certify prevailing wage rates for commercial and highway/heavy construction projects in the following Minnesota Counties: Aitkin, Becker, Beltrami, Carlton, Cass, Clay, Clearwater, Cook, Crow Wing, Hubbard, Itasca, Kittson, Koochiching, Lake, Lake of the Woods, Mahnomen, Marshall, Norman, Ottertail, Pennington, Polk, Red Lake, Roseau, St. Louis, Wadena and Wilkin.

A copy of the determined wage rates for Minnesota counties may be obtained by contacting the State Register and Public Documents Division, 117 University Avenue, St. Paul, Minnesota 55155. The charges for the cost of copying and mailing are $.50 for the first county and $.30 for any subsequent copies of the same or other counties. For all 87 counties the charge is $25.00. A sales tax of 6% must be added to all orders.

A check or money order payable to the State of Minnesota must accompany each request.

Steve Keefe, Commissioner
Department of Labor and Industry

Metropolitan Council

Public Hearing on 1986 Federal Grant Application and 1986-88 Health Systems Plan

The Metropolitan Council and Health Planning Board will hold a public hearing Thursday, February 20, 1986, beginning at 7:00 p.m at the Metropolitan Council Chambers, 300 Metro Square Building, 7th and Robert Streets, St. Paul, Minnesota, on its 1986 federal grant application and the 1986-88 Health Systems Plan. The grant application and revised Health Systems Plan partially fulfill the requirements of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) as amended in 1979 (P.L. 96-79) for continued funding as the designated Health Systems Agency for Minnesota Region V, for which the Metropolitan Council intends to apply by April 2, 1986.

The Health Systems Plan, revised every three years, serves as the region's long range health plan for 1986-1988. It is a detailed statement of policies and policy direction dealing with issues of the area population's health status and with specific health care services directed at the region's health problems. Certain health status and health system goals contained within the plan have been designated priorities for community attention and action within the next three to five years. They deal with prenatal care, the use of alcohol, violence and abuse, and certain hospital and long term care services.

All interested people are encouraged to attend the hearing and offer comments. People may register to speak at the hearing in advance by contacting Carole Peterson at 291-6559. Questions on the draft application or plan should be directed to Malcolm Mitchell at 291-6351 or Carole Peterson at 291-6559. Single copies of the draft application and plan are available free of charge

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Department of Human Services Rules Governing Third-Party Liability for Health Services to Medical Assistance Recipients and Medical Assistance Assignment of Rights, Minnesota Rules, part 9505.0211 and 9505.0212 [EMERGENCY]

ORDER FOR PUBLICATION OF EMERGENCY RULES

IT IS ORDERED this 12th day of February, 1986 that the proposed emergency rules in the above-entitled matter be published in the State Register and that notice of Notice of Intent to Adopt Emergency Rules be given to all persons who have registered their names with the State Department of Human Services for that purpose.

STATE OF MINNESOTA

Commissioner of Human Services

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF DEPARTMENT OF HUMAN SERVICE RULES GOVERNING THIRD-PARTY LIABILITY FOR HEALTH SERVICES TO MEDICAL ASSISTANCE RECIPIENTS AND MEDICAL ASSISTANCE ASSIGNMENT OF RIGHTS, MINNESOTA RULES, PARTS 9505.0211 AND 9505.0212 [EMERGENCY]

NOTICE OF PROPOSED ADOPTION OF EMERGENCY RULE

Notice is hereby given that the State Department of Human Services proposes to adopt the above-entitled emergency rules. The statutory authority to adopt the emergency rules is contained in Minnesota Statutes, section 256B.04, subdivision 2 in regard to the Medical Assistance Program and in Minnesota Statutes, section 14.29, subdivision 1 in regard to the amendment of a rule to comply with a federal law, 42 CFR 433.139, 433.137, 433.145 and 435.604.

All persons have 25 days, or until 4:30 p.m. March 28, 1986 to submit data and views on the proposed emergency rules or any part or subpart of the rules in writing. Any comments must be submitted to:

Jan Taylor
Benefit Recovery Section
Health Care Programs Division
Box 64170
St. Paul, Minnesota 55164
Telephone: 612/296-6964

Minnesota Rules, part 9505.0211 [Emergency] govern liability for collection of benefits available to medical assistance recipients for reimbursement of medical expenses.

Part 9505.0211 [Emergency] will require health service providers to bill third-party payers before submitting claims to the Medical Assistance Program. Third-party coverage shall be primary and shall be exhausted before payment is made by medical assistance. The rule contains the provider's responsibility to obtain information about potential coverage and assignment of benefits, billing requirements, and time limit for submission of claims to the department.

Minnesota Rules, part 9505.0212 [Emergency] requires that all legally able Medical Assistance applicants and recipients shall assign rights to benefits from liable third-party payers to the department. Failure to assign third-party benefits shall result in ineligibility for Medical Assistance. Children who are otherwise eligible shall not have their eligibility delayed or denied because of action of the parent.

Part 9505.0212 [Emergency] also requires that a Medical Assistance applicant or recipient must cooperate with the local agency in establishing paternity of her eligible child and in obtaining medical care support and payments. Cooperation includes providing the local agency with information, appearing at a state or local office, appearing as a witness at a court or other proceeding, paying to the local agencies any support or medical care funds received that are covered by the assignment, or other reasonable steps to establish support. The rule includes criteria to use in establishing whether "good cause" exists in an applicant's or recipient's non-cooperation in the establishment of paternity or in obtaining medical care supports and payments.

A free copy of the proposed rules are available by contacting:

Jan Taylor
Benefit Recovery Section
Health Care Programs Division
Box 64170
St. Paul, Minnesota 55164

The proposed rules may be reviewed at county welfare or human services agencies in the state of Minnesota.

The proposed rules may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed rules as noticed.

Upon adoption of the emergency rules by the agency, the rules as adopted and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rules, must submit the written request to Jan Taylor.

The emergency rules will take effect five working days after approval by the Attorney General and be effective for 180 days. The emergency rules will be continued in effect for an additional 180 days if the agency gives notice of continuation in accordance with Minnesota Statutes, section 14.35.

The Department anticipates that part 9505.0211 [Emergency] will result in increased third-party collections for medical care, thereby reducing public agencies' medical assistance payments.

The administration of part 9505.0212 [Emergency] will result in additional costs to the local county agency. Under IV-D regulations, federal reimbursement for AFDC cases is at 70%. Under the Medical Assistance Program, the county will receive 70% federal reimbursement for certain activities and 50% federal reimbursement for medical support enforcement activities.

During the implementation period, an addition of approximately 3000 cases would result. After the initial start-up, approximately 200 medical assistance paternity cases will be referred to the county IV-D caseworkers monthly. Only a small proportion of the cases will result in "good cause actions" with the remainder resulting in IV-D casework.

If paternity is established, reimbursement of all costs may be required of the defendant as a part of the court decree. As paternity cannot be established in less than one-third of the cases, the potential for reimbursement is great.

The exact fiscal impact of the proposed rule is not determinable due to the many factors involved in paternity actions. The Department estimates that the net fiscal impact on local public bodies as a result of adoption of this rule will be less than $100,000 in either of the first two years following adoption. The increased administrative costs of local public bodies will be offset by increased paternity collections and increased collections from third-party payors due to the assignment of benefits from third-party payors.

A fiscal note explaining the costs of the rule is available from Jan Taylor.

STATE OF MINNESOTA

2-12-86
Date

LEONARD W. LEVINE, Commissioner
Department of Human Services

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED AMENDMENT TO THE DEPARTMENT OF HUMAN SERVICES RULE GOVERNING THIRD-PARTY LIABILITY FOR HEALTH SERVICES TO MEDICAL ASSISTANCE RECIPIENTS AND MEDICAL ASSISTANCE ASSIGNMENT OF RIGHTS, MINNESOTA RULES, PARTS 9505.0211 AND 9505.0212

AFFIDAVIT OF MAILING

Nancy Storelee, being first duly sworn, deposes and says:

That on the 26th day of February, 1986, at the City of St. Paul, County of Ramsey, State of Minnesota, I served the attached Notice of Proposed Adoption of Emergency Rule by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, to all persons and associations who have requested that their names be placed on file with the Department of Human Services for the purpose of receiving notice of hearing by this Department.

Nancy Storelee

Subscribed and sworn to before me

this 28 day of February, 1986.

Louise J. Breidel

LOUISE J. BREIDEL
NOTARY PUBLIC—MINNESOTA
DAKOTA COUNTY
MY COMM. EXP. SEPT. 22, 1990

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED AMENDMENT TO THE DEPARTMENT OF HUMAN SERVICES RULE GOVERNING THIRD-PARTY LIABILITY FOR HEALTH SERVICES TO MEDICAL ASSISTANCE RECIPIENTS AND MEDICAL ASSISTANCE ASSIGNMENTS OF RIGHTS, MINNESOTA RULES, PARTS 9505.0211 AND 9505.0212

AFFIDAVIT OF ADDITIONAL MAILING

Nancy Storelee, being first duly sworn, deposes and says:

That on the 26th day of February, 1986, at the City of St. Paul, County of Ramsey, State of Minnesota, in addition to serving the attached Notice of Proposed Adoption of Emergency Rule to all persons and associations who have requested that their names be placed on file for the purpose of receiving notice of hearing by this Department, I also served the attached notice by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid to all of the agencies that received the Notice of Hearing.

.The 87 Minnesota County Human Services Agencies
.Other Interested Parties (See attached list)

Nancy Storelee

Subscribed and sworn to before me

this 28 day of February, 1986.

Louise J. Breidel

LOUISE J. BREIDEL
NOTARY PUBLIC—MINNESOTA
DAKOTA COUNTY
MY COMM. EXP. SEPT. 22, 1990

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF DEPARTMENT OF HUMAN SERVICE RULES GOVERNING THIRD-PARTY LIABILITY FOR HEALTH SERVICES TO MEDICAL ASSISTANCE RECIPIENTS AND MEDICAL ASSISTANCE ASSIGNMENT OF RIGHTS, MINNESOTA RULES, PARTS 9505.0211 AND 9505.0212 [EMERGENCY]

NOTICE OF PROPOSED ADOPTION OF EMERGENCY RULE

Notice is hereby given that the State Department of Human Services proposes to adopt the above-entitled emergency rules. The statutory authority to adopt the emergency rules is contained in Minnesota Statutes, section 256B.04, subdivision 2 in regard to the Medical Assistance Program and in Minnesota Statutes, section 14.29, subdivision 1 in regard to the amendment of a rule to comply with a federal law, 42 CFR 433.139, 433.137, 433.145 and 435.604.

All persons have 25 days, or until 4:30 p.m. March 28, 1986 to submit data and views on the proposed emergency rules or any part or subpart of the rules in writing. Any comments must be submitted to:

Jan Taylor
Benefit Recovery Section
Health Care Programs Division
Box 64170
St. Paul, Minnesota 55164
Telephone: 612/296-6964

Minnesota Rules, part 9505.0211 [Emergency] govern liability for collection of benefits available to medical assistance recipients for reimbursement of medical expenses.

Part 9505.0211 [Emergency] will require health service providers to bill third-party payers before submitting claims to the Medical Assistance Program. Third-party coverage shall be primary and shall be exhausted before payment is made by medical assistance. The rule contains the provider's responsibility to obtain information about potential coverage and assignment of benefits, billing requirements, and time limit for submission of claims to the department.

Minnesota Rules, part 9505.0212 [Emergency] requires that all legally able Medical Assistance applicants and recipients shall assign rights to benefits from liable third-party payers to the department. Failure to assign third-party benefits shall result in ineligibility for Medical Assistance. Children who are otherwise eligible shall not have their eligibility delayed or denied because of action of the parent.

Part 9505.0212 [Emergency] also requires that a Medical Assistance applicant or recipient must cooperate with the local agency in establishing paternity of her eligible child and in obtaining medical care support and payments. Cooperation includes providing the local agency with information, appearing at a state or local office, appearing as a witness at a court or other proceeding, paying to the local agencies any support or medical care funds received that are covered by the assignment, or other reasonable steps to establish support. The rule includes criteria to use in establishing whether "good cause" exists in an applicant's or recipient's non-cooperation in the establishment of paternity or in obtaining medical care supports and payments.

A free copy of the proposed rules are available by contacting:

Jan Taylor
Benefit Recovery Section
Health Care Programs Division
Box 64170
St. Paul, Minnesota 55164

The proposed rules may be reviewed at county welfare or human services agencies in the state of Minnesota.

The proposed rules may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed rules as noticed.

Upon adoption of the emergency rules by the agency, the rules as adopted and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rules, must submit the written request to Jan Taylor.

The emergency rules will take effect five working days after approval by the Attorney General and be effective for 180 days. The emergency rules will be continued in effect for an additional 180 days if the agency gives notice of continuation in accordance with Minnesota Statutes, section 14.35.

The Department anticipates that part 9505.0211 [Emergency] will result in increased third-party collections for medical care, thereby reducing public agencies' medical assistance payments.

The administration of part 9505.0212 [Emergency] will result in additional costs to the local county agency. Under IV-D regulations, federal reimbursement for AFDC cases is at 70%. Under the Medical Assistance Program, the county will receive 70% federal reimbursement for certain activities and 50% federal reimbursement for medical support enforcement activities.

During the implementation period, an addition of approximately 3000 cases would result. After the initial start-up, approximately 200 medical assistance paternity cases will be referred to the county IV-D caseworkers monthly. Only a small proportion of the cases will result in "good cause actions" with the remainder resulting in IV-D casework.

If paterni[redacted] is established, reimbursement [redacted] all costs may be required of the defendant as a part of the court decree. As paternity cannot be established in less than one-third of the cases, the potential for reimbursement is great.

The exact fiscal impact of the proposed rule is not determinable due to the many factors involved in paternity actions. The Department estimates that the net fiscal impact on local public bodies as a result of adoption of this rule will be less than $100,000 in either of the first two years following adoption. The increased administrative costs of local public bodies will be offset by increased paternity collections and increased collections from third-party payors due to the assignment of benefits from third-party payors.

A fiscal note explaining the costs of the rule is available from Jan Taylor.

STATE OF MINNESOTA

2-12-86
Date

LEONARD W. LEVINE, Commissioner
Department of Human Services

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED AMENDMENT TO THE DEPARTMENT OF HUMAN SERVICES RULE GOVERNING THIRD-PARTY LIABILITY FOR HEALTH SERVICES TO MEDICAL ASSISTANCE RECIPIENTS AND MEDICAL ASSISTANCE ASSIGNMENT OF RIGHTS, MINNESOTA RULES, PARTS 9505.0211 TO 9505.0212 [EMERGENCY]

CERTIFICATE

I hereby certify that the list of persons, associations and other interested groups who have requested, pursuant to Minnesota Statutes, section 14.14, subdivision 1, that their names be placed on file with and maintained by the Department of Human Services for the purpose of receiving Notice of Proposed Adoption of Emergency Rule by this Department is accurate and complete as of 2:00 p.m. this 26th day of February, 1986.

Nancy Stowlee

EMERGENCY RULES

Proposed Emergency Rules
According to Minn. Stat. of 1984, §§ 14.29-14.30, state agencies may propose adoption of emergency rules if: 1) expressly required; 2) authorized by statute; or 3) if the manner permitted by a directive (given by statute, federal law or court order) does not allow for compliance with sections 14.14-14.28. The agency must, however, publish a notice of intent to adopt emergency rules, along with the rules themselves, in the *State Register*. The notice must advise the public:

1) that a free copy of the proposed emergency rule is available upon request from the agency;
2) that notice of the date that the rule is submitted to the attorney general will be mailed to persons requesting notification;
3) that the public has at least 25 days after publication of the proposed emergency rule to submit data and views in writing; and
4) that the emergency rule may be modified if the data and views submitted support such modification.

Adopted Emergency Rules
Emergency rules take effect five working days after approval by the attorney general, and after compliance with Minn. Stat. §§ 14.29-14.365. As soon as possible, emergency rules are published in the *State Register* in the manner provided for in section 14.18.

Emergency rules are effective for the period stated in the notice of intent to adopt emergency rules. This may not exceed 180 days.

Continued/Extended Emergency Rules
Adopted emergency rules may be continued in effect (extended) for an additional 180 days. To do this, the agency must give notice by: 1) publishing notice in the *State Register*; and 2) mailing the same notice to all persons who requested notification on rulemaking. No emergency rule may remain in effect 361 days after its original effective date. At that point, permanent rules adopted according to Minn. Stat. 14.14-14.28 supercede emergency rules.

MINNESOTA RULES AMENDMENTS AND ADDITIONS

(Emergency rules published in this issue)

DEPARTMENT OF PUBLIC WELFARE
(Now HUMAN SERVICES)

9500.0820, s.6 [Emer] (proposed repealer) 1814
9500.0940 [Emer] (proposed supercession) 1814
9505.0211 [Emer] (proposed) 1814
9505.0212 [Emer] (proposed] 1814

SMALL BUSINESS FINANCE AGENCY
(Under ENERGY AND ECONOMIC DEVELOPMENT)

8300.3100-.3106 [Emer] (adopted) 1819

Department of Human Services

Proposed Emergency Rule Relating to Medical Assistance and Third Party Payer Liability; and
Proposed Emergency Rule Relating to Medical Assistance Assignment of Rights to Benefits from Liable Third Party Payers and Establishment of Paternity

Notice of Proposed Adoption of Emergency Rule

Notice is hereby given that the State Department of Human Services proposes to adopt the above-entitled emergency rules. The statutory authority to adopt the emergency rules is contained in Minnesota Statutes, section 256B.04, subdivision 2 in regard to the Medical Assistance Program and in Minnesota Statutes, section 14.29, subdivision 1 in regard to the amendment of a rule to comply with a federal law, 42 CFR 433.139, 433.137, 433.145 and 435.604.

All persons have 25 days, or until 4:30 p.m. March 28, 1986, to submit data and views on the proposed emergency rules or any part or subpart of the rules in writing. Any comments must be submitted to:

Jan Taylor
Benefit Recovery Section
Health Care Programs Division
Box 64170
St. Paul, Minnesota 55164
Telephone: 612/296-6964

Minnesota Rules, part 9505.0211 [Emergency] govern liability for collection of benefits available to medical assistance recipients for reimbursement of medical expenses.

Part 9505.0211 [Emergency] will require health service providers to bill third-party payers before submitting claims to the Medical Assistance Program. Third-party coverage shall be primary and shall be exhausted before payment is made by medical assistance. The rule contains the provider's responsibility to obtain information about potential coverage and assignment of benefits, billing requirements, and time limit for submission of claims to the department.

Minnesota Rules, part 9505.0212 [Emergency] requires that all legally able Medical Assistance applicants and recipients shall assign rights to benefits from liable third-party payers to the department. Failure to assign third-party benefits shall result in ineligibility for Medical Assistance. Children who are otherwise eligible shall not have their eligibility delayed or denied because of action of the parent.

Part 9505.0212 [Emergency] also requires that a Medical Assistance applicant or recipient must cooperate with the local agency in establishing paternity of her eligible child and in obtaining medical care support and payments. Cooperation includes providing the local agency with information, appearing at a state or local office, appearing as a witness at a court or other proceeding, paying to the local agencies any support or medical care funds received that are covered by the assignment, or other reasonable steps to establish support. The rule includes criteria to use in establishing whether "good cause" exists in an applicant's or recipient's non-cooperation in the establishment of paternity or in obtaining medical care supports and payments.

A free copy of the proposed rules are available by contacting:

Jan Taylor
Benefit Recovery Section
Health Care Programs Division
Box 64170
St. Paul, Minnesota 55164

The proposed rules may be reviewed at county welfare or human service agencies in the state of Minnesota.

The proposed rules may be modified if the modifications are supported by data and views and do not result in a substantial change in the proposed rules as noticed.

Upon adoption of the emergency rules by the agency, the rules as adopted and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rules, must submit the written request to Jan Taylor.

The emergency rules will take effect five working days after approval by the Attorney General and be effecrive for 180 days. The emergency rules will be continued in effect for an additional 180 days if the agency gives notice of continuation in accordance with Minnesota Statutes, section 14.35.

The Department anticipates that part 9505.0211 [Emergency] will result in increased third-party collections for medical care, thereby reducing public agencies' medical assistance payments.

The administration of part 9505.0212 [Emergency] will result in additional costs to the local county agency. Under IV-D regulations, federal reimbursement for AFDC cases is at 70%. Under the Medical Assistance Program, the county will receive 70% federal reimbursement for certain activities and 50% federal reimbursement for medical support enforcement activities.

During the implementation period, an addition of approximately 3000 cases would result. After the initial start-up, approximately 200 medical assistance paternity cases will be referred to the county IV-D caseworkers monthly. Only a small proportion of the cases will result in "good cause actions" with the remainder resulting in IV-D casework.

If paternity is established, reimbursement of all costs may be required of the defendant as a part of the court decree. As paternity cannot be established in less than one-third of the cases, the potential for reimbursement is great.

The exact fiscal impact of the proposed rule is not determinable due to the many factors involved in paternity actions. The Department estimates that the net fiscal impact on local public bodies as a result of adoption of this rule will be less than $100,000 in either of the first two years following adoption. The increased administrative costs of local public bodies will be offset by increased paternity collections and increased collections from third-party payors due to the assignment of benefits from third-party payors.

A fiscal note explaining the costs of the rule is available from Jan Taylor.

February 14, 1986

Leonard W. Levine, Commissioner
Department of Human Services

Proposed Emergency Rule Relating to Medical Assistance and Third Party Payer Liability

Rule as Proposed, Emergency (all new material)

9505.0211 [Emergency] THIRD PARTY PAYER LIABILITY.

Subpart 1. **Definitions.** The terms used in subparts 1 to 9 have the meanings given them.

A. "Assignment" or "assignment of benefits" means the written authorization by a person or the person's authorized representative, a policyholder, or other authorized individual to transfer to another individual, entity, or agency his or her rights or the rights of his or her dependents to medical support or other third party payments.

B. "Authorized representative" means an individual authorized by the medical assistance applicant or recipient to apply for medical assistance or perform duties required of the recipient by parts 9500.0760 to 9500.0860 on behalf of the applicant or recipient.

C. "Person" means an individual applying for or receiving benefits under the medical assistance program authorized by Minnesota Statutes, chapter 256B including individuals eligible for medical assistance because of eligibility for aid to families with dependent children and Minnesota supplemental assistance.

D. "Provider" means a vendor as specified in Minnesota Statutes, section 256B.02, subdivision 7, that has signed an agreement approved by the department for the provision of health services to a recipient.

E. "Third party payer" means a person, entity, agency, or government program, other than Medicare or the medical assistance program, that has a probable liability to pay all or part of the costs of a recipient's health services. Examples are an insurance company, health maintenance organization, CHAMPUS, workers' compensation, and potential defendants in legal actions arising out of unintentional or intentional torts.

Subp. 2. **Third party payer; primary coverage.** A third party payer who is liable to pay all or part of the cost of a health service provided to a medical assistance applicant or recipient shall be the primary payer. The third party payer's coverage of or liability for a health service provided to a medical assistance applicant or recipient shall be utilized to the fullest extent available before a medical assistance payment is made on the recipient's behalf.

Subp. 3. **Provider responsibility to obtain information and assignment of benefits.** The provider shall obtain information about the recipient's potential health service coverage by a third party payer from the recipient, from the recipient's responsible relative, or from the remittance advice provided by the department upon rejection of a claim because of the department's identification of a potential third party payer. Further, the provider shall be responsible to obtain an assignment of benefits from the recipient, policyholder, or other authorized individual or representative. In the case of a dependent child insured under a policy held by a parent or other individual who does not have custody of the child, the provider shall obtain the assignment from the individual who has custody of the child. For purposes of this subpart, "responsible relative" means the spouse of a medical assistance recipient or applicant or the parent of a child under age 18 who is a medical assistance recipient or applicant.

Subp. 4. **Provider billing; third party.** When a provider is informed by a recipient, the recipient's responsible relative, a local agency, or the department that the recipient has health service coverage by a third party payer, the provider shall bill the third party payer before seeking medical assistance payment for the health service.

Subp. 5. **Provider billing; department.** Except as in subpart 7, the provider shall not submit a claim for medical assistance payment until receiving from the third party payer either a payment, a partial payment, or a notice that the claim has been denied. A provider may submit a claim for medical assistance payment for the difference between the amount paid by the third party and the amount payable by medical assistance in the absence of other coverage. However, no medical assistance payment will be made to a provider under contract with a private health coverage plan when the private health coverage plan calls for the provider to accept the plan's payment as payment in full. The provider who submits a claim for medical assistance payment by the department after a third party payer has paid part of the claim or denied the claim shall submit with the claim the additional information or records required by the department to document the reason for the partial payment or denial.

Subp. 6. **Time limit for submission of claims.** A provider must submit claims to the department according to the 12-month billing requirement in part 9500.1080, subpart 2.

Subp. 7. **Provider billing; third party failure to respond.** A provider who has not received either a payment or denial notice from a third party payer within 90 days after submitting the claim for payment may bill the medical assistance program. The provider shall submit to the department, no later than 12 months after the date of service to the recipient, a copy of the original claim to the third party payer, documentation of two further attempts to contact the third party payer, and any written communication the provider has received from the third party payer.

Subp. 8. **Recovery of payments to recipients.** Notwithstanding the provisions of part 9500.1080, subpart 1, a provider must bill a

recipient to recover the amount of a payment received by a recipient from a third party payer. The department is liable only to the extent that the amount payable by medical assistance exceeds the third party liability.

Subp. 9. **Exclusion from third party payer billing requirements.** The department will exclude from third party payer billing requirements those health services for which the probable existence of liability cannot be determined or the third party payer billing is not cost effective to the department. Providers are not required to bill third party payers for:

A. Prescription drugs and medical supplies under major medical expense insurance which provides protection against extraordinary medical expenses that would otherwise create a serious financial hardship. This exclusion does not apply to pharmacy only insurance and private health maintenance organization plans (HMOs).

B. Early periodic screening diagnosis and treatment (EPSDT) claims except when the person is covered by a private health maintenance organization plan (HMO).

C. Claims for which the submitted charge is less than $5. For purposes of this item, "claim" means a single line on the pharmacy and medical supply invoice of the department and the total of all lines on other invoice forms of the department.

D. Personal care attendant services provided by unlicensed personnel.

E. Day activity center (DAC) services.

F. Waivered services billed to the department by the local agency.

G. Health service bills for an individual recipient approved by the department because facts presented by the provider and the local agency demonstrate that third party payer billing is not cost effective to the department.

H. Other health services for which the Health Care Financing Administration (HCFA) has granted the state a waiver. The department will implement any waiver approved or withdrawn by HCFA within 60 days after the department's receipt of the notice from HCFA.

APPLICABILITY. Part 9505.0211 [Emergency] supercedes any inconsistent provision of part 9500.0940.

Proposed Emergency Rule Relating to Medical Assistance Assignment of Rights to Benefits from Liable Third Party Payers and Establishment of Paternity

Rule as Proposed, Emergency (all new material)

9505.0212 [Emergency] ASSIGNMENT OF RIGHTS.

Subpart 1. **Definitions.** The terms used in subparts 1 to 6 have the meanings given them in items A to F.

A. "Assignment" or "assignment of benefits" means the written authorization by a person or the person's authorized representative, a policyholder, or other authorized individual to transfer to another individual, entity, or agency his or her rights or the rights of his or her dependents to medical support or other third party payments.

B. "Authorized representative" means an individual authorized by the medical assistance applicant or recipient to apply for medical assistance or perform duties required of the recipient by parts 9500.0760 to 9500.0860 on behalf of the applicant or recipient.

C. "Department" means the Minnesota Department of Human Services.

D. "Local agency" means a county or multi-county agency that is authorized under Minnesota Statutes, sections 393.01, subdivision 7 and 393.07, subdivision 2, as the agency responsible for determining eligibility for the medical assistance program.

E. "Person" means an individual applying for or receiving benefits under the medical assistance program authorized by Minnesota Statutes, chapter 256B including individuals eligible for medical assistance because of eligibility for aid to families with dependent children and Minnesota supplemental assistance.

F. "Third party payer" means an individual, entity, agency, or government program, that has a probable liability to pay all or part of the costs of a recipient's health services. Examples are an insurance company, health maintenance organization, CHAMPUS, workers' compensation, and potential defendants in legal actions arising out of unintentional or intentional torts.

Subp. 2. **Notification to local agency.** A person or the person's authorized representative shall notify the local agency of the availability of third party payer coverage at the time of application, at the time of an eligibility redetermination, and within ten days of a change in potential coverage.

Subp. 3. **Assignment of benefits.** All legally able medical assistance applicants and recipients shall assign to the department their rights and the rights of their dependent children to benefits from liable third party payers. Any applicant or recipient who

refuses to assign to the department his or her own rights or those of any other individual for whom he or she can legally make an assignment shall be found ineligible for medical assistance. An individual who is otherwise eligible for medical assistance shall not have his to her eligibility denied or delayed because he or she cannot legally assign his or her own rights and the individual legally able to make the assignment refuses to assign the rights or to cooperate.

Subp. 4. **Cooperation in establishing paternity and obtaining medical support.** Except as provided in subparts 5 and 6, a person must cooperate with the department and local agency in establishing paternity of an eligible child and in obtaining medical care support and payments for himself or herself and any other person for whom he or she can legally assign rights. Cooperation includes providing the local agency with information, appearing at a state or local office to provide information or evidence relevant to the case, appearing as a witness at a court or other proceeding, paying to the local agency any support or medical care funds received that are covered in the assignment, provide information or attest to lack of information under penalty of perjury, and other reasonable steps to establish support. The person who fails to cooperate in establishing paternity and obtaining medical support shall be ineligible for medical assistance.

Subp. 5. **Good cause exemption from the requirement to cooperate in establishing paternity and obtaining medical care support for children.** Before requiring a person to cooperate in establishing paternity and obtaining medical care support for children, a local agency shall notify the person that she may claim a good cause exemption from cooperating with the requirements of subpart 4 at the time of application or at any subsequent time. When a person submits a good cause claim in writing, the local agency must stop action related to obtaining medical care support and payments. The person shall submit corroborative evidence of a good cause claim to the local agency within 20 days of submitting the claim.

A. Good cause exists when:

(1) a child for whom child support enforcement is sought was conceived as the result of incest or rape;

(2) legal proceedings for the adoption of a dependent child are pending before a court of competent jurisdiction; or

(3) the person is receiving services from a licensed adoption agency to determine whether to keep the child or relinquish the child for adoption, and the services have not been provided for longer than three months.

B. Good cause exists when the person documents that her cooperation would not be in the best interest of the dependent child because the cooperation could result in:

(1) physical harm to the child;

(2) emotional impairment of the child which would substantially affect the child's functioning; or

(3) physical harm to or emotional impairment of the person which would substantially affect the person's functioning and reduce the person's ability to adequately care for the child.

C. The local agency shall help a person who has difficulty getting the evidence to support a good cause claim. When a local agency requires additional evidence to make a determination on the claim for good cause, the local agency shall notify the person that additional evidence is required, explain why the additional evidence is required, identify what form this evidence might take, and specify an additional period that will be allowed to obtain it.

D. A local agency shall determine whether good cause exists by comparing the good cause claim of the person to sufficiency of the evidence.

E. Once a local agency determines that a person has good cause, the exemption from cooperation under subpart 4 must remain in effect for the period the child remains eligible under that application, except for subitems (1) to (4).

(1) A good cause exemption allowed because a child was conceived as the result of incest or rape must continue until a subsequent acknowledgement of paternity or an application for adoption by a second parent is submitted for that child.

(2) A good cause exemption allowed because of adoption proceedings must be issued for a fixed period of time based on the expected time required to complete adoption proceedings. The exemption must be extended when the required time is longer than was anticipated and must stop when adoption proceedings are discontinued or completed.

(3) A good cause exemption allowed because of adoption counseling must last no more than three months from the time the counseling began.

(4) A good cause exemption must be allowed under subsequent applications without additional evidence when the factors which led to the exemption continue to exist. A good cause exemption allowed under item B must end when the factors which led to allowing the exemption have changed.

F. A good cause exemption which has been allowed by a local agency for a person must be honored by the local agency in the county of residence when the person moves into that county, until the factors which led to allowing the exemption change.

G. When a local agency denies a claim for a good cause exemption, the local agency shall require the person to submit

additional evidence in support of a later claim for a good cause exemption before the local agency stops acting to enforce child support under subpart 4.

H. Following a determination that a person has good cause for refusing to cooperate, a local agency shall take no further action to enforce child support until the good cause exemption ends according to item E.

Subp. 6. **Good cause exemption from the requirement to cooperate in obtaining medical care support and payments for other individuals.** Before requiring a person to cooperate in obtaining medical care support and payments for other individuals, a local agency shall notify the person that he or she may claim a good cause exemption from cooperating with the requirements of subpart 4 at the time of application or at any subsequent time. When a person submits a good cause claim in writing, the person shall submit corroborative evidence of the good cause claim to the local agency within 20 days of submitting the claim. The local agency must send the claim and the corroborative evidence to the department and must stop action related to obtaining medical care support and payments.

A. Good cause exists when cooperation is against the best interests of the individual or other person to whom medical assistance is being furnished because it is anticipated that cooperation will result in reprisal against and cause physical or emotional harm to the individual or other person.

B. The local agency shall help a person who has difficulty getting the evidence to support a good cause claim. When a local agency or the department requires additional evidence to make a determination on the claim for good cause, the local agency or department shall notify the person that additional evidence is required, explain why the additional evidence is required, identify what form this evidence might take, and specify an additional period that will be allowed to obtain it.

C. The department shall determine whether good cause exists by comparing the good cause claim of the person to sufficiency of the evidence.

D. Once the department determines that a person has good cause, the exemption from cooperation under subpart 4 must remain in effect for the period the person remains eligible under that application. A good cause exemption must be allowed under subsequent applications without additional evidence when the factors which led to the exemption continue to exist. A good cause exemption allowed under this subpart must end when the factors which led to allowing the exemption have changed.

E. When the department denies a claim for good cause exemption, the department shall continue to enforce medical care support and payment requirements unless the person submits additional evidence in support of a later claim for a good cause exemption before the department or local agency stops acting to obtain medical care support and payments under subpart 4.

F. Following a determination that a person has good cause for refusing to cooperate, a local agency and the department shall take no further action to obtain medical care support and payment until the good cause exemption ends under item D.

REPEALER. Minnesota Rules, part 9500.0820, subpart 6 is repealed.

Energy and Economic Development Department
Energy and Economic Development Authority

Adopted Emergency Rules Relating to Qualified Economic Diversification Projects

The rules proposed and published at *State Register*, Volume 10, Number 25, pages 1331-1334, December 16, 1985 (10 S.R. 1331) are adopted as proposed.

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of the Department of Human Services' Rule Governing Third-Party Liability for Health Services to Medical Assistance Recipients and Medical Assistance Assignment of Rights, Minnesota Rules, Part 9505.0211 and 9505.0212 [Emergency]

DECLARATION OF COUNSEL

I, Patricia Sonnenberg, Special Assistant Attorney General, do hereby declare that I have examined the above-captioned rule, and the supporting rulemaking record, and that, based on my examination, the Administrative Procedure Act and Minnesota Rules, chapter 2000 have been followed. Any exceptions are listed below. For Attorney General billing purposes, the four-digit docket client code is 0888.

4/11/86
Date

Patricia A. Sonnenberg
Special Assistant Attorney General

SUMMARY: This notice identifies provisions in Medicare prospective payment regulations that are affected by enactment of the Emergency Extension Act of 1985. That Act extended through November 14, 1985, the Federal fiscal year 1985 rules for determining amounts of Medicare payment to hospitals under the prospective payment system and the rate-of-increase limits for hospitals excluded from that system.

FOR FURTHER INFORMATION CONTACT: Linda Magno, (301) 594–9343.

SUPPLEMENTARY INFORMATION: On September 30, 1985, Congress passed and the President signed the Emergency Extension Act of 1985 (Pub. L. 99–107). Section 6(a) of Pub. L. 99–107 extended through November 14, 1985 the Medicare payments rates that were in effect on September 30, 1985 for inpatient hospital services. A result of this delay is that certain changes in the rules that govern Medicare payment for inpatient hospital services, which would have become effective on October 1, 1985 for Federal fiscal year 1986, are postponed until November 15, 1985. The changes concern the rules (implementing sections 1886 (b) and (d) of the Social Security Act) for determining the payment rates for hospitals covered by the prospective payment system and the target rates of increase for hospitals excluded from that system.

We are issuing this notice to inform the public that, as a result of the September 30 enactment, revised payment rates and the amendments to 42 CFR 412.116 (f)(2) and (f)(3) (Determination of indirect medical education costs—limits on count of interns and residents) that were originally scheduled to be effective on October 1, 1985 under the September 3, 1985 final rule (50 FR 35646) are now postponed until November 15, 1985. In addition, the postponement mandated by Pub. L. 99–107 affected the following prospective payment regulations in 42 CFR Part 412 (50 FR 12740, March 29, 1985).

- Sections 412.63 (c)(3) and (d)—Federal rates for fiscal years after Federal fiscal year 1985.
- Sections 412.70 (c)(3), (c)(4), (d)(2) and (d)(3)—General description of the determination of transition period payment rates.
- Section 412.73(c)(3)—Determination of the hospital-specific rate.
- Section 412.80(a)(1)(ii)(B)—General provisions concerning payment for outlier cases.
- Section 412.82(c)—Payment for extended length of stay cases (day outliers).

(Secs. 1102, 1871, and 1886 of the Social Security Act; 42 U.S.C. 1302, 1395hh, and 1395ww)

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance Program)

Dated: October 30, 1985.

C. McClain Haddow,

Acting Administrator, Health Care Financing Administration.

[FR Doc. 85-26894 Filed 11-8-85; 8:45 am]

BILLING CODE 4120-01-M

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42 CFR Parts 432, 433, 435, and 436

[BPO-500-F]

Medicaid Program; Third Party Liability for Medical Assistance; FFP Rates for Skilled Professional Medical Personnel and Supporting Staff; and Sources of State Share of Financial Participation

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final regulations.

SUMMARY: These final regulations—

(1) Broaden the scope of services for which a State must collect from third parties the cost of medical assistance furnished to Medicaid recipients, revise the methods of paying claims involving third party liability, and make conforming changes to incorporate a statutory provision that requires the assignment of medical support rights and other third part payments and cooperation in establishing paternity and obtaining support as a condition of eligibility for Medicaid;

(2) Revise and clarify criteria used in determining whether skilled professional medical personnel and directly supporting staff involved in the administration of the Medicaid program qualify for 75 percent Federal matching; and

(3) Clarify policy to permit public and private donations to be used as a State's share of financial participation in the entire Medicaid program, instead of only for training expenditures.

These amendments are a combination of steps to remove unnecessary requirements in our regulations and to include provisions that will improve the administration of the Medicaid program. They also conform the Medicaid regulations to certain provisions of the Deficit Reduction Act of 1984 (Pub. L. 98–369).

EFFECTIVE DATES:

1. The amendments to the regulations relating to Federal financial participation for skilled professional medical personnel and directly supporting staff under §§ 432.2, 432.45, 432.50, and 433.15 are effective on February 10, 1986.

2. The amendments to the regulations relating to the mandatory assignment of medical support rights and other third party payments as a condition of eligibility and to cooperative agreements under §§ 433.135, 433.137(b), 433.145, 433.151, 433.152, 435.804, and 436.804 are effective on December 12, 1985. (In the case of a Medicaid State plan that HCFA determines needs State legislation in order for the plan to comply with the requirements in these amendments, the State will not be held out of compliance before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after July 18, 1984 (the date of enactment of Pub. L. 98–369).)

3. The amendments to the regulations relating to payment of claims involving third party liability under §§ 433.137(a) and 433.139, to general third party liability provisions under §§ 433.136 and 433.148, and to sources of State financial participation under §§ 432.50 and 433.15 are effective on December 12, 1985.

FOR FURTHER INFORMATION CONTACT:

Third Party Liability—Herb Shankroff (301) 594–6710.

Eligibility Conditions—Marinos Svolos (301) 594–9050.

Rate of FFP—David McNally (301) 597–1998.

Sources of State Share of Financial Participation—Sue Kneffey (301) 594–8594.

SUPPLEMENTARY INFORMATION:

General Background

This document makes changes in certain regulations governing the administration of the Medicaid program to: (1) Remove unnecessary requirements in the regulations and include provisions that will improve program administration relating to third party liability, Federal financial participation (FFP) in the cost of compensation and training for skilled professional medical personnel and directly supporting staff, and sources of the State's share of financial participation; and (2) conform the regulations to statutory provisions of section 2367 of the Deficit Reduction Act (Pub. L. 98–369, enacted on July 18, 1984) that require applicants and recipients of Medicaid, as a condition of eligibility, to assign any rights to medical support or other payments for medical care to the Medicaid agency and to cooperate with the State in establishing paternity and obtaining support or other payments and that require States to provide for

entering into cooperative agreements for the enforcement of rights to and collection of third party benefits. These agreements may be with the State child support enforcement (title IV–D) agency, any appropriate agency of any State, and appropriate courts and law enforcement officials. (For purposes of title XIX of the Social Security Act, medical support is the legal obligation, established under a court order or an administrative procedure under State law, of a spouse or absent parent to provide for medical expenses of a Medicaid recipient. This obligation is usually met through purchase of health insurance rather than through direct payment of medical expenses.)

These changes are a result of our ongoing review of the requirements in our regulations and changes to legislation.

On June 4, 1984, we published in the Federal Register (49 FR 23078) a notice of proposed rulemaking that addressed most of the amendments of the Medicaid regulations included in this document. We received 42 comments on the proposed regulations from State welfare and health agencies, a State Medicaid directors' association, medical and health care associations, a hospital, private welfare agencies, citizens' groups, and private citizens. We also held meetings with two State Medicaid advisory groups to obtain comments. A summary of these public comments, our responses, and an explanation of any changes made in these final regulations as a result of the comments are discussed under the section "Summary of Public Comments on Proposed Rules and Department Responses" presented later in this document.

Discussion and Provisions of Final Regulations

Third Party Liability

Section 1902(a)(25) of the Social Security Act requires that State or local Medicaid agencies take all reasonable measures to ascertain the legal liability of third parties to pay for care and services furnished to Medicaid recipients. This section requires the agency to seek reimbursement from a third party to the extent that the party is legally liable for services "arising out of an injury, disease, or disability."

Section 2367 of Pub. L. 98–369 added a new section 1902(a)(45) to the Act to provide, as a Medicaid State plan requirement, for mandatory assignment of rights to payments for medical support and other medical care owed to recipients in accordance with section 1912 of the Social Security Act. Section 2367 also amended section 1912 to require (rather than allow as an option) the State Medicaid plan (1) to provide that, as a condition of eligibility for medical assistance, individuals must assign to the State their rights to any medical support or other payments for medical care and to cooperate with the State in establishing paternity and obtaining third party payments; and (2) to provide for States to enter into cooperative agreements for the enforcement of rights to and collection of third party benefits. These agreements may be with the State child support enforcement (title IV–D) agency, any other appropriate agency of any State, and appropriate courts and law enforcement officials. Section 2367 has a statutory effective date of October 1, 1984. However, in the case of a Medicaid State plan that HCFA determines needs legislation in order for the plan to comply with the statutory requirements, the State will not be held out of compliance before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of Pub. L. 98–369.

Section 1903(o) of the Act prohibits Federal matching of State Medicaid payments if a private insurer would have been liable to pay for the care except that the insurance contract limits or excludes liability when the individual is eligible for Medicaid. Section 1903(d)(2) of the Act provides for consideration of the Federal share of any amounts recovered by a State from a third party for medical assistance as an overpayment to the State, and for appropriate adjustment of the quarterly Medicaid payments made by the Federal Government to the State.

In these final regulations, we have made changes in several areas relating to third party liability:

1. *Broader definitions.* We have broadened the definitions of "third party" and "private insurer" (§ 433.136) to eliminate the effect that they have had of restricting collections to expenditures for services relating to the diagnosis or treatment of an injury, disease, or disability. While the statute mandates collection in these situations, it does not preclude collections of expenditures for other services that are furnished to recipients under a State's Medicaid plan, e.g., prenatal care, well-baby visits, routine physical examinations, etc. We have replaced the phrase "injury, disease, or disability" in the two definitions with a broader phrase that will require States to collect from third parties for the cost of any medical assistance furnished to a recipient under the approved State plan.

2. *Payment of claims involving third party liability.* Current regulations (§ 433.139) provide States with two methods of paying claims that involve third party liability. Under the first method, if the amount of third party liability is established, the agency pays only to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party liability. The second method permits the agency to pay the total amount allowed under the agency's payment schedule and then seek reimbursement from liable third parties. States have flexibility to use either payment method under any circumstance.

Program experience has indicated that, when third party liability is known or there is a reasonable expectation, based on the nature of the claim and type of insurance, that third party payment on a claim will be made, it is more cost effective for the State to pay the claim only to the extent that the agency's payment exceeds the amount of the third party liability. Areas of potential savings from the use of a method of paying claims only to the extent that the agency's payment exceeds the amount of third party payment (sometimes referred to as a "cost avoidance" method) include:

- Administrative savings from using fewer personnel and other resources to administer the filing of claims with third party payers and resulting receivable system;
- Program savings in interest loss because Medicaid program dollars are not outstanding with the providers before the third party payment is received;
- Administrative savings of claim processing costs for those claims that providers submit directly to the third party instead of to Medicaid;
- Program savings from small dollar claims that are not submitted to Medicaid due to the minimal individual amount left over after the third party pays; and
- Program savings because third party payers are more likely to reimburse claims from providers of services rather than Medicaid because assignment of rights problems are diminished.

Under these revised final regulations, which apply to claims involving third party liability that are processed on or after May 12, 1986, we require State agencies to use the cost avoidance method of payment in circumstances in which the agency (during the eligibility, claims processing, medical support collection, or third party recovery processes or any other third party related activity) has established the

probable existence of third party liability at the time the claim is filed, unless a waiver is requested by the State within a specified time and approved by the HCFA Regional Office. (State agency procedures for determining the likelihood of third party liability and subsequent payment may take into account the type of medical expenses and type of insurance involved on a particular claim.) A State may request a waiver of the required cost avoidance method if it is using, as of the publication date of these regulations, the method of paying the entire claim and then seeking reimbursement, and if it submits appropriate documentation that its method is as cost effective as the cost avoidance method to the HFCA Regional Office within 60 days of the publication date of these regulations. The request to have the requirement waived must be approved by the Regional Office. The Regional Office will notify the State of its determination within 30 days of the receipt of a request for a waiver of the requirement. The waiver will be granted for an indefinite period unless othewise specified in the approval notice. A State that is granted a waiver must notify the Regional Office of any event that occurs that changes the cost effectiveness of the approved method. The Regional Office may rescind the waiver at any time that the State's method is no longer as cost effective as the required cost avoidance method. If the waiver is denied or rescinded, the State has 6 months from the date of the denial or rescission notice to implement a cost avoidance method (a time period that is consistent with that allowed other States to come into compliance with the requirements for a cost avoidance method). (The waiver provisions were not included in the proposed rules. They were added in response to public comments.)

We believe that the increased cost savings in administering the provision for partial claims payment outweigh the benefit of permitting the option of full payment with subsequent recovery. States that do not have a cost avoidance method in place as of the publication date of these final regulations and that do not request a waiver of the requirement to use the cost avoidance method are required to either revise their current method or install a cost avoidance method for claims involving third party liability that are processed on or after May 12, 1986.

When the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, a State would pay the entire claim and then seek reimbursement from any liable third party. All States must submit documentation of their methods for paying claims involving third party liability (e.g., cost avoidance, "pay-and-chase") to the HCFA Regional Office by the date on which the requirements in the regulations must be implemented May 12, 1986.

We also have revised the prescribed 30-day time limit for filing claims to recover from liable third parties under § 433.139. We believe it is more appropriate to allow time limits for filing claims for recovery of 60 days from the end of the month in which payment is made or 60 days from the end of the month that the State agency learns of the existence of the liable third party. This change will give States more flexibility. The 60-day limit is consistent with the average time limit under generally accepted insurance practices. (In the proposed regulations, we had originally proposed to delete the time limit. After further analysis, we now believe it is more appropriate to specify a limit that is consistent with generally accepted insurance practices.)

3. *Assignment of medical support rights and cooperative agreements for third party collections.* We have revised §§ 433.137, 433.145, 435.151, 435.604, and 436.604 to conform them to the statutory provisions of Pub. L. 98–369 that require the assignment of medical support rights and other third party payments and cooperation in establishing paternity and seeking support and other payments as a condition of eligibility for Medicaid, and that require States to provide for entering into cooperative agreements for the enforcement of rights to and collection of third party benefits. These agreements may be with the State child support enforcement (title IV–D) agency, any appropriate agency of any State, and appropriate courts and law enforcement officials. (Pub. L. 98–369 was enacted after the issuance of the June 4, 1984 notice of proposed rulemaking. Therefore, these provisions were not included in the proposed rules.) We also have revised § 433.145 to clarify the terms of the assignment by stating that the assignment will be effective only for third party payments for services furnished to recipients that are reimbursed by Medicaid. In addition, we have deleted § 433.149, which specifies that the agency must restore to an individual who has assigned medical care support to Medicaid his future rights to that support after eligibility for Medicaid ends. Since the assignment of rights is not effective for payments for services furnished after Medicaid eligibility ends as stated in the revision of § 433.145, there is no need to cancel the assignment when eligibility is terminated.

We have revised § 433.151 to conform to the language of the statute which requires rather than allows a State plan to provide for entering into cooperative agreements for the enforcement of rights to and collection of third party benefits. We are requiring State Medicaid agencies to have a written agreement or agreements with some appropriate entity. This entity may be the State child support enforcement (title IV–D) agency, any appropriate agency of any State, or appropriate courts and law enforcement officials.

We have revised § 433.152, which contains detailed requirements for the terms of all cooperative agreements between the State Medicaid agency and the State child support enforcement (title IV–D) agency, any appropriate agency of any State, and appropriate courts and law enforcement officials for the enforcement of rights to and collection of third party benefits. The revision incorporates the requirements under section 2367 of Pub. L. 98–369 relating to cooperative agreements and makes other technical changes to allow States more flexibility in developing these agreements. Specifically, we have deleted most of the details on the terms of agreements because we believe that they are too prescriptive. We specify that the State may develop the terms of individual agreements at its own discretion, as agencies may wish to vary slightly the terms of the agreements to account for individual circumstances. We believe they should have that right. We have clarified the provisions of this section to indicate that the specific requirements of the Office of Child Support Enforcement for agreements with title IV–D agencies (45 CFR Part 306) are still applicable. We also have conformed the language relating to reimbursement requirements to make it consistent with provisions of the Child Support Enforcement Amendments of 1984 (Pub. L. 98–378) by specifying that Medicaid will reimburse the title IV–D agency only for the cost of those services necessary for Medicaid collection and medical support activities that are performed beyond the activities required under section 16 of the Child Support Enforcement Amendments of 1984.

Rates of Federal Financial Participation (FFP) for Compensation and Training of Skilled Professional Medical Personnel

Section 1903(a) of the Social Security Act provides for variable Federal matching rates to States for administrative functions under Medicaid. The majority of activities that are necessary for the proper and efficient operation of a State Medicaid plan, including compensation and training for most of the agency's staff, are financed at the FFP rate of 50 percent. However, certain specific costs, such as compensation and training of skilled professional medical personnel and clerical staff directly supporting these personnel, administration of family planning services, and certain functions related to the Medicaid Management Information System (MMIS) are financed at higher FFP rates. Section 1903(a)(2) of the Act provides for Federal matching at 75 percent for compensation and training of skilled professional medical personnel and their directly supporting staff. It also provides for 75 percent FFP for skilled professional medical staff and directly supporting staff of other public agencies with which the Medicaid agency contracts for administration of the medical phases of the Medicaid program.

The intent of these provisions is to encourage State agencies to employ personnel who have the professional medical expertise necessary to develop and administer Medicaid programs that are medically sound as well as administratively efficient. Professional medical knowledge is needed to shape the medical aspects of the program, including the determination of which medical services should be included in a well-balanced medical benefit program, coordination of available medical resources, and establishment of working relationships with the professional medical community. Although the Medicaid agency uses skilled professional *Medicaid* personnel in various capacities, not all of them are skilled professional *medical* personnel whose costs qualify for 75 percent Federal matching.

Over the years, there has been diversity in interpreting and applying the criteria used to determine what types of personnel and job functions qualify for 75 percent FFP as skilled professional medical personnel and directly supporting staff. This has resulted, in some cases, in different matching rates being paid to States for the same types of staff.

The intent of the law is to provide increased FFP for medical staff, not nonmedical staff. This is evidenced in the Senate Finance Committee report that accompanied the 1965 Social Security Amendments (Report of the Committee on Finance to Accompany H.R. 6675, 89th Cong., 1st Sess., S. Rept. No. 404, Pt. 1, June 30, 1965, p. 83). The term "skilled professional medical personnel" is not meant to include nonmedical health professionals, such as public administrators, medical budget directors or analysts, lobbyists, or senior managers of public assistance or Medicaid programs. We recognize that it is necessary to have a variety of nonmedical health professionals and that these personnel may possess an equivalent level of education, work experience, and certification as those in the medical care field. However, the law does not provide for 75 percent Federal matching for these personnel.

"Supporting staff" is defined in the Senate report as "clerical staff." We have interpreted clerical staff to mean secretarial, stenographic, and copying personnel, and file and records clerks that provide direct support to the skilled professional medical personnel. The costs of other subprofessional staff not performing clerical functions are not eligible for 75 percent FFP as "directly supporting staff."

The changes in FFP limitations addressed in this document do not apply to matching rates for States personnel who are involved in the survey and certification of facilities participating in Medicaid. The FFP matching rates for these survey personnel will be addressed in a separate document.

We have revised the regulations relating to 75 percent FFP for skilled professional medical personnel and directly supporting staff, other than State personnel involved in the survey and certification of Medicaid facilities, to clarify which personnel are eligible for the higher matching rate. We have clarified the definitions of "skilled professional medical personnel" and "directly supporting staff." "Skilled professional medical personnel" includes only professionals in the field of medical care. "Directly supporting staff" includes only those clerical job responsibilities that directly support skilled professional medical personnel (§ 432.2).

We also have incorporated in the regulations under § 432.50 the criteria specified below to clarify further which costs for skilled professional medical personnel and directly supporting staff qualify for 75 percent FFP. All applicable criteria must be satisfied to establish whether the personnel and directly supporting staff qualify for increased FFP. These criteria are the same as those in the proposed rules, with the following changes:

- We have further clarified "supporting staff" by including copying staff and file and records clerks (in addition to secretarial and stenographic staff) as clerical staff to make the reference to the term "clerical staff" consistent with the generally accepted definition of the term. We also have referenced these staff as "directly supporting staff" to clarify the level of direct supervision (immediate first-level supervision) required for these staff, as specified in the statute.
- We have provide for recognition of "*2 years or longer* programs leading to academic degrees or certificates in medically related professions" as professional education and training.

1. *Costs must be for activities directly related to the administration of the title XIX program.* FFP at 75 percent is available only for the costs of compensation, travel, and training of skilled professional medical personnel and their directly supporting staff who are involved in activities that are necessary for the proper and efficient *administration* of the Medicaid State plan. Expenditures for the actual furnishing of medical services by skilled professional medical personnel do *not* qualify for Federal matching at 75 percent.

2. *Skilled professional medical personnel must have professional education and training in a medical field.* Skilled professional medical personnel are required to have education and training at a professional level in the field of medical care or appropriate medical practice before FFP can be claimed at 75 percent.

The Social Security Amendments of 1965 which created the Medicare and Medicaid programs did not define "professional medical personnel." However, the Senate Finance report which accompanied the legislation, cited earlier, states that the "staff will include physicians, medical administrators, medical social work personnel, and other specialized personnel necessary to assure an adequate number of persons to do a quality job. * * *."

All examples of skilled professional medical personnel given in the Congressional Committee report and in existing regulations have one element in common: All indicate that these staff have education and training at a professional level in the field of medical care or apropriate medical practice.

"Education and training at a professional level" means the

completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This may be demonstrated by possession of a medical license or certificate issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the aministration, direction, or implementation of the Medicaid program will *not* be considered the equivalent of professional training in a field of medical care.

3. *Professional medical expertise must be necessary to fulfill the responsibilities of the skilled professional medical personnel's position.* The intent of section 1903(a)(2) of the Act is to ensure the intergrity of the many diverse medical aspects of the Medicaid program by providing an incentive to State agencies to employ skilled professional medical personnel with respect to those medically-related program activities. The law did not intend to provide 75 percent FFP merely to any staff person who has qualifying medical education and training and experience, without regard to his actual responsibilities. Rather, the function performed by the skilled professional medical personnel must be one that requires that level of medical expertise in order to be performed effectively. Consequently, 75 percent FFP is only available for those positions that require professional medical knowledge and skills, as evidenced by position descriptions, job announcements, or job classifications.

Examples of functions that would meet these criteria include, but are not limited to, the following:

- Acting as a liaison on the medical aspects of the program with providers of services and other agencies that provide medical care.
- Furnishing expert medical opinions for the adjudication of administrative appeals.
- Reviewing complex physician billings.
- Providing technical assistance and drug abuse screening on pharmacy billings.
- Participating in medical review or independent professional review team activities.
- Assessing the necessity for and adequacy of medical care and services provided, as in utilization review.
- Assessing, through case management activities, the necessity for and adequacy of medical care and services required by individual recipients.

It should be noted that none of the functions listed above includes the provision of medical care and services. Provision of medical care and services would always be considered medical assistance rather than administration.

When the function of skilled professional medical personnel is the application of administrative practices and procedures unrelated to the specialized field of medical care and requires no skilled medical training, the costs are matched at 50 percent FFP. For example, the costs of a physician in charge of an accounting operation are eligible for FFP only at 50 percent.

4. *An employer-employee relationship must exist between the State agency and the skilled professional medical personnel and directly supporting staff.* As evidenced by the statutory language and legislative history of section 1903(a)(2), the 75 percent FFP rate is applicable to costs of specific personnel and staff of the Medicaid agency or any other public agency. We have consistently interpreted this provision to authorize the 75 percent FFP rate only for personnel who are employed by the agency. Therefore, in most cases, FFP at 75 percent is not authorized for contracts with private organizations or independent contractors. There are instances in which the agency contracts for personnel services as a common method of securing the services of skilled professional medical personnel without going through the formalities of merit hiring. If a Medicaid agency claims FFP at 75 percent for these personnel, it must demonstrate that a documented employer-employee relationship exists between them and the Medicaid agency.

It is fundamental to contract law that the substance of a transaction, rather than its form, is controlling. HCFA may conduct an examination of the actual duties performed, responsibilities assumed, and manner of performing the duties and responsibilities that have been established to determine if the facts, including the State's documentation of the employment relationship, indicate the existence of an employer-employee relationship. It is the substantive relationship between the parties under State law that is critical in determining, on a case-by-case basis, whether an employer-employee relationship exists, not the mere existence of a contract.

5. *The directly supporting staff must provide clerical services that are directly necessary for carrying out the professional medical responsibilities and functions of the skilled professional medical personnel.* As stated earlier, "supporting staff" is defined in the congressional report as "clerical staff." "Clerical staff" is interpreted to mean secretarial, stenographic, and copying personnel, and file and records clerks that provide direct support to the skilled professional medical personnel. It does not include the cost of other subprofessional staff not performing clerical functions.

Eligibility for increased FFP for directly supporting staff is based on the concept in the law of "direct support." "Direct support" means the provision of clerical services which are directly necessary to the completion of the professional medical responsibilities and functions of skilled professional medical personnel. There must be documentation showing that the clerical services provided by the supporting staff are directly related and necessary to the execution of the skilled professional medical personnel's responsibilities. In order for the clerical services to be directly related to skilled professional medical personnel's responsibilities, the skilled professional medical personnel must be immediately responsible for the work performed by the clerical staff and must directly supervise (immediate first-level supervision) the supporting staff and the performance of the supporting staff's work.

6. *Skilled professional medical personnel and direclty supporting staff of other public agencies must meet all of the applicable criteria included items 1 through 5 and this must be verified in a written agreement with the Medicaid agency.* Skilled professional medical personnel and directly supporting staff employed by public agencies other than the Medicaid agency (or, in the case of separate program divisions housed within an "umbrella" agency, employed in other than the Medicaid component) often assist the administration of the Medicaid program. FFP at 75 percent is available for the costs of compensation, travel, and training of these personnel and directly supporting staff if there is a written interagency or interagency agreement that specifically demonstrates that non-Medicaid staff and their functions meet all the applicable criteria, and that they assist the Medicaid agency, or the Medicaid agency's skilled professional medical personnel in activities that are directly related to the administration of the Medicaid program."Directly related" means performing duties that are necessary to the operation of the Medicaid program for which the State Administrator of the Medicaid program is accountable. The agreement must outline the activities the other public agency will perform to assist in the administration of the Medicaid program.

7. FFP must be prorated for split functions of skilled professional medical personnel and directly supporting staff. If the skilled professional medical personnel or directly supporting staff time is split among different functions, some of which do not qualify for 75 percent FFP, the skilled professional medical personnel and directly supporting staff costs must be allocated among the various functions. The allocation must be based on either the actual percentage of time spent within each function or another methodology that is approved by HCFA.

Sources of State's Share of Financial Participation

Section 1902(a)(2) of the Social Security Act requires States to share in the cost of medical assistance expenditures, but permits both State and local governments to participate in the financing of the non-Federal portion of the Medicaid program. This section specifies the percentage of the State's share of these costs and requires that this share be sufficient to assure that lack of adequate funds from local sources will not prevent the furnishing of services equal in amount, duration, scope, and quality throughout the State.

As State fiscal budgets have become more austere, State legislatures have looked increasingly to alternative sources for funding a larger portion of the Medicaid program. Questions have arisen regarding the use of public and private donations as sources of State's share of financial participation.

The definition of "State funds" generally used by States means funds over which the State legislature has an unrestricted power of appropriations. Therefore, in order for donations from public or private sources to be considered as the State's share of financial participation in Medicaid, we issued regulations (§ 432.60) for determining when donations ceased being local or private funds and became State funds for purposes of a Federal program. In developing the regulations, we wanted to ensure that the Medicaid agency maintained administrative control and unrestricted power of allocation of all donated funds. Section 432.60 outlines the conditions under which public and private funds may be considered as the State's share of Medicaid expenditures.

At the time the regulations were formulated, there was some concern about potential for abuse. We wanted to prevent donations that could be conditional on some benefit to the donor. For example, we were particularly concerned that a "kickback" situation could result from private donations made by a proprietary organization, such as a long-term care facility or data processing company, in return for Medicaid business. Therefore, the regulations permitted use of public and private funds as the sources of the State's share of financial participation only for one category of costs—training expenditures.

Experience has shown no abuse of public and private funds through conditional donations or kickbacks. Generally donated funds are commingled with all other Medicaid funds under the State agency's administrative control. By limiting the use of donations as State funds only to expenditures for training, the regulations have placed an administrative burden on the States in terms of cost allocation. Furthermore, if a State were to receive donations in an amount greater than its total training expenditures, the excess funds could not be used as the State share of other Medicaid expenditures.

We have revised the requirements under § 432.60 to permit public and private donations to be used as a State's share of financial participation in the entire Medicaid program, rather than just training expenditures. The revision permits States more flexibility in administering their programs and reduces the recordkeeping necessary to relate donated funds exclusively to training expenditures. Section 432.60 is in Part 432—State Personnel Administration of the Code of Federal Regulations. Because the revised requirements are no longer limited to training costs, we have redesignated them as § 433.45 of Part 433—State Fiscal Administration.

Summary of Public Comments on Proposed Rules and Department Responses

Definitions of Private Insurer and Third Party

Comment: Nine commenters supported the broadened definitions. One commenter expressed concern about the absence in the definition of a private insurer of a specific reference to self-insurance that meets the requirements published by the U.S. Department of Labor under title I of the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides for self-insurance health benefit plans through unions and self-funded employer benefit plans in some large publicly and privately owned business entities.

Response: The provision under section 1902(a)(25) of the Social Security Act that requires State Medicaid agencies to seek reimbursement from third parties who are liable to pay for medical care and services to recipients is broad enough to permit a State to seek reimbursement from all forms of insurance. We have not made any additional change in the definition of private insurer because we believe that the specific language under the existing § 433.136 already adequately covers the commenter's concern—"any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans."

Comment: One commenter objected to the effect that the application of the revised definition of third party might have on liability of an elderly spouse if a State implements the requirement for use of the cost avoidance method of paying claims involving known third party liability. The commenter believed that an elderly spouse could be considered a liable third party in determining probable existence of third party liability on a claim, and that this could result in withholding of reimbursement for services provided to an institutionalized spouse.

Response: The revised definition of third party has not changed from the previous definition in relation to the commenter's objection. The revised definition, as well as the previous definition, includes "any individual, entity, or program that is or may be liable to pay all or part. . . ." The only difference in the definition is the scope of services for which collection can be made, which not includes any medical assistance furnished beyond that relating to the diagnosis or treatment of an injury, disease, or disability, such as prenatal care, well-baby visits, routine physical examinations, etc. The approved practices that a State applied under the previous definition of third party may continue under the revised definition. The revised section 433.139 permits States to have the requirement to use the cost avoidance method waived if they are using, as of the publication date of these regulations, the method of paying the entire claim and then seeking reimbursement from any liable third party, if they can document that their method is as cost effective as the cost avoidance method, and if they receive the approval of the HCFA Regional Office.

Payment of Claims Involving Third Party Liability

Comment: While eight commenters generally supported the overall third party liability changes, four of these and six other commenters objected to the requirement that States use the cost avoidance method in paying claims when the agency has established the probable existence of third party liability. They believed that the requirement would not be cost effective for most States and would increase the administrative burden on providers. Three commenters pointed out that States should be allowed the flexibility to make third party collections in a manner most cost-effective for them and suggested that States with "pay-and-chase" methods in place be granted waivers of the requirement to use the cost avoidance method if they can provide evidence that their methods are cost effective.

Response: We have retained the requirement that States use the cost avoidance method because program experience demonstrates that the method is cost effective. Nevertheless, we recognize that there are some State agencies with effective methods of making full payment with subsequent recovery and that an immediate required change to the cost avoidance method would impose on them unnecessary delays and costs because of system changes and implementation time. Therefore, we have revised § 433.139 to permit States to have the requirement to use the cost avoidance method waived if they are using, as of the publication date of these regulations, the method of paying the entire claim and then seeking reimbursement from any liable third party and if they can document that their method is as cost effective as the cost avoidance method. A State's request to have the requirement waived along with documentation of the cost effectiveness of the existing method must be submitted to the HCFA Regional Office within 60 days of the publication date of these final regulations. Administrative costs must be considered in a computation of the cost effectiveness of the State's method before we will waive the requirement for use of the cost avoidance method. A request to have the requirement waived also will not be approved for a State that does not have in place as of the publication date of these final regulations the method of paying the entire claim and then seeking reimbursement from any liable third party. The HCFA Regional Office will make a determination within 30 days of receipt of the request to have the requirement for use of the cost avoidance method waived.

Comment: Two commenters recommended that pharmacy claims involving third party liability be excluded from being paid under the cost avoidance method. They pointed out that these individual claims are usually small dollar amounts and, therefore, the cost of recovery will usually exceed the actual amount of the claim. They asserted that the alternate method of paying the claim and then seeking reimbursement was more practical and just as cost effective. One of these commenters also recommended exclusion of nursing home claims from the cost avoidance method requirement.

Response: As discussed earlier in this document under "Discussion and Provisions of the Regulations: Third Party Liability," under the provision that a State agency must use the cost avoidance method to pay claims involving probable third party liability, we will allow the State agency to use procedures for determining the likelihood of third party liability and subsequent payment that take into account the type of medical expense and type of insurance on a particular claim. These procedures apply to all claims involving third party liability, including pharmacy and nursing home claims. If the State determines that the use of the cost avoidance method is not appropriate for paying a claim using these criteria, the State would have to use the alternate method of paying the claim and then seeking reimbursement. However, the existing regulations at § 433.139(c) (now redesignated as § 433.139(f)) allow a State to terminate or suspend recovery efforts on claims for which it determines that the amount it reasonably expects to recover will be less than the cost of recovery. This section also allows a State to accumulate billings with respect to a particular liable third party (over a specified period of time and in a dollar amount chosen by the State) in making the decision whether to seek recovery of reimbursement. This accumulation of billings could apply to pharmacy claims.

Comment: One commenter who supported the overall third party liability changes suggested that the regulations, particularly § 433.139(c) (now redesignated as § 433.139(f)) relating to suspensions or termination of recovery action, could not be completely applied to liabilities arising in matters of tort or workers' compensation or, if applied, would be counterproductive to effective program operation. The commenter pointed out that relating the pure cost of recovery to the amount of recovery is logical for health insurance but does not apply to non-no fault personal injury claims, and that it is always "cost effective" to seek payment to the full extent in available settlement money. The commenter suggested revised language that would delineate suspension or termination procedures for third party liability arising in contractual situations (typically health insurance) or no-fault cases and those that arise out of tort or workers' compensation.

Response: Section 1902(a)(25) of the Act requires that in cases where legal third party liability is found to exist after medical assistance is furnished to a recipient, and where the amount the State can reasonably expect to recover exceeds the cost of recovery, the State must seek reimbursement to the extent of any liability. This section contains no exceptions, hence all third party resources, including workers' compensation and tort liability, must be pursued to the limit of liability.

Comment: Five commenters objected to the responsibility that the proposed regulations under § 433.139(b) places on a State to predetermine or estimate the amount the third party liability in situations where probable third party liability exists. Two commenters suggested that "probable liability" be clearly defined; otherwise Medicaid agencies will, in most cases, place the burden of this determination on the provider.

Response: The proposed regulations did not include a requirement to pay claims on an estimated basis when probable third party liability is known to exist. Instead, they would have required payment to the extent that the payment under the agency's payment schedule exceeds the expected amount of the third party liability. We have revised the regulations to clarify the procedure under which a State will establish the amount of third party liability. The regulations specify that, if the Medicaid agency has established the probable existence of third party liability (that is, during the eligibility, claims processing, medical support collection, or third party recovery process or any other third party related activity), the State agency must reject the claim and return it to the provider. We interpret probable liability to mean the presence of an indicator in the case record that suggests a possible third party resource that is or may be liable for a recipient's medical expenses. The establishment of third party liability takes place when the State agency receives confirmation from the provider or the third party resource indicating the

extent of liability available. The agency must then pay the claim only to the extent that payment allowed under the agency's payment schedule exceeds the payment of the third party payer.

Comment: Several commenters emphasized that, if the requirement for use of the cost avoidance method is maintained, reasonable timeframes for implementation be allowed.

Response: We realize that States that do not have a cost avoidance method in place will require time to develop the method or modify a current method to comply with these regulations. Therefore, we are applying the requirements to claims involving third party liability that are processed 180 days after the publication of the regulations. We feel that making these requirements effective 180 days after the date of publication provides ample time for States to come into compliance with the requirements. In addition, States have been given previous notice of the proposed requirements through the notice of proposed rulemaking published in the **Federal Register** on June 4, 1984.

Comment: Two commenters objected to the absence in the preamble to the proposed regulations of a quantification of savings as a result of use of the cost avoidance method. They also pointed out that the inflationary impact on providers was not properly addressed.

Response: In this preamble we have listed the areas in which savings should be increased through use of the cost avoidance method. We believe our logic is sound and accurate because the majority of States are now using cost avoidance to some extent. We recognize that there will be some instances in which the function of collecting from third party payers will be transferred to the provider of service and increase its administrative cost. However, in many cases the provider's billing of third party sources will simply be a substitution for its billing of Medicaid.

Assignment of Rights to Benefits

Comment: Two commenters suggested that while the proposed regulations allow a State to require, as a condition of eligibility, that each legally able applicant and recipient assign his rights to medical support or other third party resources to the Medicaid agencies, this requirement cannot be met in those States where Supplemental Security Income (SSI) eligibility is determined by the Social Security Administration (SSA). They pointed out that SSA has made no provisions for applying these regulations to SSI recipients. One of the two commenters suggested that the State has a right to require information concerning possible third party payers as a condition of eligibility and requested revision of the regulations to incorporate this requirement.

Response: The Deficit Reduction Act, which was enacted after we issued the proposed regulations, now requires applicants and recipients to assign their rights to medical support or other third party payments as a condition of Medicaid eligibility. (Sections 1902(a)(44) and 1912 of the Social Security Act.) We have made conforming changes in these final regulations. SSA is also making conforming references to regulations governing SSI eligibility determination under 20 CFR Part 416 and is developing administrative procedures to obtain the applicant's response and signature to assignment of rights during the eligibility process in States where SSA determines Medicaid eligibility.

Cooperative Agreements for Third Party Collections

Comment: Two commenters supported the proposal to delete the detailed requirements for cooperative agreements with title IV–D agencies and other agencies and officials under § 433.152. However, they pointed out that the deletion of the requirement for reimbursement by the State Medicaid agency to title IV–D agencies for services performed has created a discrepancy with child support regulations at 45 CFR Part 306 which require title IV–D agencies to be reimbursed by Medicaid for activities performed under optional cooperative agreements.

Response: We have revised the regulations to specify that the requirements of the Office of Child Support Enforcement under 45 CFR Part 306 are still applicable and to provide that cooperative agreements entered into with a title IV–D agency must specify that the title IV–D agency's reimbursement from the Medicaid agency will be limited to costs of services that are necessary for Medicaid collection and medical support activities that are in addition to those required to be performed by the title IV–D agency under the Child Support Enforcement Amendments of 1984 (Pub. L. 98–378). Section 16 of Pub. L. 98–378 authorizes the Secretary to issue regulations to require title IV–D agencies to petition to include medical support as part of child support orders and to provide for improved information exchange between State IV–D agencies and State Medicaid agencies regarding the availability of health insurance coverage, with reimbursement from the Office of Child Support Enforcement.

We also have revised the regulations to emphasize that the terms of specific cooperative agreements may be developed at the discretion of each agency to account for individual circumstances.

Rates of FFP for Compensation and Training of Skilled Professional Medical Personnel and Directly Supporting Staff

Comment: Ten commenters objected to the more restrictive definition of supporting staff. These commenters recommended that the definition be broadened to include the category of "subprofessional staff" as defined and allowed in current regulations under § 432.2. In addition, these commenters pointed out that the commonly used definition of "clerical personnel" includes copying, file, and records clerks as well as the secretarial and stenographic personnel specified in the proposed regulations. The commenters recommended revising the definition to include all of these types of clerical personnel.

Response: The Senate Finance Committee report that accompanied the 1965 Social Security Amendments, cited earlier, clearly defines "supporting staff" as the "clerical staff directly associated with the professional staff." The legislative intent, as reflected in this report, does not indicate that the costs of other "subprofessional staff" not performing clerical functions are to be eligible for 75 percent FFP as "supporting staff." Therefore, we are unable to accept the commenters' recommendation to broaden the definition of supporting staff to include other nonclerical subprofessional personnel. However, we agree with the commenters that our interpretation of the term "clerical staff" to mean only secretarial and stenographic personnel was unduly restrictive as to the common use and understanding of the term. Therefore, in the final regulations we have broadened our definition of supporting staff to mean secretarial, stenographic, and copying personnel, and file and records clerks that directly support the responsibilities of skilled professional medical personnel.

Comment: Five commenters objected to the requirement that the supporting staff must be directly supervised by the skilled professional medical personnel in order to qualify for 75 percent funding. The commenters suggested that this requirement did not reflect legislative intent and that there should be no requirement that the supporting staff be directly supervised by or

immediately responsible to the skilled professional medical personnel.

Response: The legislative history and the wording in the statute do not support the commenters' objections. The Senate Report (p. 83) refers to the supporting staff for the skilled professional medical personnel as "directly supporting such personnel" and "directly associated with the professional staff." Also, section 1903(a)(2) refers to "staff directly supporting such personnel." The legislative history and the statute consistently indicated that a *direct* relationship must exist between the supporting staff and the skilled professional medical personnel in order for FFP to be allowable at 75 percent. This direct relationship is best evidenced by the supporting staff being directly supervised (immediate first-level supervision) by the skilled professional medical personnel. We note that is the same interpretation we have been applying under the current regulations.

To accept the commenters' recommendation would be contrary to the clear legislative intent of direct support and could result in a situation where a skilled professional medical personnel position headed the Medicaid agency and the entire supporting staff in that agency were claimed at 75 percent FFP. There is no indication that Congress intended to reimburse the entire cadre of supporting staff in the Medicaid agency at 75 percent FFP.

In order to ensure that there will be no misinterpretation, we have specified in this preamble that "directly supervise" means "immediate first-level supervision," and we have clarified in the regulation text that the skilled professional medical personnel must directly supervise the supporting staff *and* the performance of the supporting staff's work. In addition, we have consistently referred to supporting staff as "directly supporting staff" throughout the preamble and the regulation to make the language conform to the statute.

Comment: Nineteen commenters indicated that the regulations would have a negative financial impact on the States, as States would be required to provide additional State funds to make up the loss of Federal funds for those staff currently being funded at 75 percent FFP that would be funded at 50 percent under the proposed regulations. The commenters also indicated that if the States were unable to provide the additional funds, some State staff reductions would result.

Response: We agree with the commenters that the regulations may result in the need for additional State funds for those positions that no longer qualify for 75 percent FFP as skilled professional medical personnel or directly supporting staff. However, the regulations clearly reflect congressional and statutory intent as to what personnel qualify for 75 percent funding and there is no other authority to provide 75 percent funding for these personnel if they do not qualify under these regulations.

It is difficult for us to assess whether or not actual State staff reductions will result from the implementation of these regulations since State staffing and claiming practices and State budgetary constraints vary from State to State. Some States may restructure their staffing patterns to accommodate the changes in these regulations but we do not know what specific State staffing decisions will actually be made.

Comment: Two commenters indicated that the HCFA regional offices were already "retroactively" applying the proposed regulations to current financial management reviews and were reducing funding to the States accordingly.

Response: The application of the proposed regulations before they are duly promulgated as final regulations is improper. However, we know of no instances where disallowances or financial adjustments have been taken against any State using policy changes included in the proposed regulations. Any disallowances issued before the effective date of these final regulations reflect law, regulations, and policy then in effect and States are provided opportunity for an appropriate appeal of a disallowance to the Departmental Grant Appeals Board.

Comment: One commenter objected to the requirement in the proposed regulations that an employer-employee relationship exist between the Medicaid agency and the skilled professional medical personnel. The commenter suggested that individuals under consultant contracts for administrative services automatically be considered State employees for FFP purposes and that such contracts not be reviewed on a case-by-case basis.

Response: We disagree with the commenter since the legislative history of section 1903(a)(2) of the Act clearly requires that 75 Percent FFP is available only for the costs of specific personnel and staff that are *employed* by the Medicaid agency. If the Medicaid agency claims 75 percent FFP for skilled professional medical personnel working for the State agency under contract, it must document the existence of an employer-employee relationship between the Medicaid agency and such personnel.

Comment: Commenters recommended that the regulations be revised to provide that State Medicaid Directors automatically qualify in all instances as skilled professional medical personnel.

Response: We disagree with the commenters' recommendation because there is no support in the statute or in the legislative history to automatically allow *any* personnel, including State Medicaid Directors, to qualify as skilled professional medical personnel. All personnel of State Medicaid agencies, including State Medical Directors, must satisfy the applicable criteria specified in the regulations to establish whether they qualify as skilled professional medical personnel or directly supporting staff before being claimed at 75 percent FFP.

Comment: Twenty-three commenters objected to the fact that the regulations would not allow States to count an individual's on-the-job training and work experience as qualification for the skilled professional medical personnel designation. They believe that this training and experience may be more relevant and important in doing a quality job than the expertise gained through professional education and training before working in a skilled professional medical personnel function. In addition, the commenters recommended that we clarify our meaning of "professional education and training" to provide for 2-year programs that lead to a certificate.

Response: We do not agree entirely with the commenters' statements. We believe that it was clearly the original intent of the skilled professional medical personnel provision in the statute that the enhanced funding for these personnel was to provide an incentive to States to hire personnel who had professional education and training in a *medical* field *before* being claimed at 75 percent FFP. These personnel would then bring this medical expertise to bear on the development and administration of the Medicaid program.

We can find nothing in the original legislation history of this issue that suggests that the Congress intended to encourage the States to hire personnel with various backgrounds who would somehow gain medical expertise on the job and become skilled professional medical personnel. Also, there is no indication that Congress intended to count an individual's on-the-job training and work experience gained in some other job outside the State agency as qualification for the skilled professional medical personnel designation. Therefore, these regulations require that an individual have professional

education and training in a medical field before being claimed as skilled professional medical personnel. However, we have revised the regulations to provide that "professional education and training" means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession."

Comment: Six commenters emphasized that the regulations would have a significant negative impact on the EPSDT program by reducing the level of funding provided for EPSDT personnel and that this action indicates an increasing lack of support for the EPSDT program.

Response: We do not intend for these regulations to have a negative impact on the EPSDT program or any other Medicaid program area, and we want to emphasize our continued strong support of and commitment to the EPSDT program. However, the statute and its legislative history do not automatically provide for enhanced funding for personnel working in special Medicaid program areas such as EPSDT. We believe that these personnel must qualify as skilled professional medical personnel or directly supporting staff as would any other personnel in the Medicaid agency. We believe that the regulations will have minimal effect, if any, on the health-related professionals involved in the planning, implementation, and supervision of the EPDST program. Additionally, we believe that any loss of revenue associated with EPSDT personnel costs that will no longer be matched at 75 percent may be offset by the increased flexibility States have in the EPSDT program under the new EPSDT regulations published on October 31, 1984 (49 FR 43654).

Comment: One commenter recommended that 75 percent funding be available for skilled professional medical personnel used in any position within the Medicaid agency, even if that position does not require medical knowledge and skills. The commenter reasoned that the skilled professional medical personnel can use their medical background in a myriad of situations within the Medicaid agency.

Response: We do not believe that the statute and legislative history support providing 75 percent funding for skilled professional medical personnel employed in positions that do not require the use of professional medical knowledge and skills. Clearly, it was not the intent of Congress to encourage States, for example, to place doctors in charge of accounting units or nurses in charge of computer facilities. Professional medical knowledge is needed to shape the medical aspects of the program and it is the intent of the skilled professional medical personnel funding to encourage States to place such professional medical personnel in jobs where their medical background and expertise would result in Medicaid programs that are medically sound and administratively efficient.

Comment: Thirteen commenters indicated that we were not following congressional intent because we eliminated specific reference to various types of skilled professional medical personnel (e.g., medical administrators, medical social workers) in the regulations. The commenters believe that these types of personnel should be explicitly defined as skilled professional medical personnel in the regulations.

Response: We have removed some references to specific job titles (e.g., medical administrators, medical social workers) in the definition of skilled professional medical personnel because of the varying and sometimes contradictory use of these titles among the States. In some cases, personnel who did not have professional education and training in the field of medical care or appropriate medical practice were simply given a medically-related job title. This resulted in inconsistent and differing claiming practices around the country. We believe that the congressional intent is to provide 75 percent FFP for personnel who have professional education and training in the field of medical care or appropriate medical practice and who are in positions that have duties and responsibilities that require professional medical knowledge and skills without regard to specific job or position title. Therefore, we have minimized reference to specific job titles in the regulations while at the same time providing for "other specialized personnel" who have the required education and training. This will enable us to review the qualifications of each individual on a case-by-case basis without regard to job title. The revision will more closely conform to the original congressional intent and will facilitate more consistent policy application by HCFA and claiming practices among the States.

Sources of State Financial Participation

Comments: Thirteen commenters supported the proposal to permit public and private donations to be used as a State's share of financial participation in any Medicaid program expenditures and not limit their use to training expenditures. One of these commenters pointed out a typographical error in § 433.45(b)(4) (relating to use by Medicaid of donor's facility)—the word "violation" should be "volition".

Response: We have corrected the typographical error in § 433.45(b)(4).

Comment: One commenter suggested that the proposed change as written would preclude a for-profit private organization from participating in Medicaid if it donates funds to the Medicaid agency because a donation could result in the facility not being allowed to treat Medicaid recipients.

Response: Section 433.45(b) of the regulations does not prohibit a for-profit facility from participating in Medicaid. It serves only to define what non-State funds may be considered part of the State's share of financial participation. Our intent is to preclude "kickback situations" that could result from private donations made by proprietary organizations in return for Medicaid business.

Comment: One commenter expressed concern that opportunities for abuse will result if we allow private and public enterprises to make contributions unconditionally to the Medicaid program. The commenter believed that gifts to the State should be restricted to gifts to the whole State and to the State General funds and that gifts to the Medical program should be prohibited.

Response: Donated funds will come under the administrative control of the Medicaid agency. The regulations clearly prohibit the reverting of private funds to the donor's facility or use unless the donor is a nonprofit organization and the Medicaid agency, of its own volition, decides to use the donor's facility. We will be able to identify any major violations of this provision through the HCFA financial management review. The regulations are intended to permit States more flexibility in administering their Medicaid program. Although public and private donations can be used as a State's share of financial participation, we are not mandating the States do this. If a State wishes to continue to use donated funds for training purposes only, this regulation also allows the flexibility to do so.

Waiver of Notice of Proposed Rulemaking

We have not issued a notice of proposed rulemaking on the provisions in these regulations that incorporate the statutory requirement for assignment of medical support payments and other third party payments and cooperation in establishing paternity and obtaining support as a condition of eligibility and the requirement for cooperative agreements between the Medicaid

agency and other agencies for obtaining medical support. These requirements, which were optional provisions under previous legislation, are mandated under the Deficit Reduction Act of 1984. We do not believe that it would be in the best interest of the public of delay these regulations to obtain public comment, as these provisions are mandated by statute and there is little or no leeway in applying the requirements. Revised procedures for implementing some of the previously optional provisions were addressed in the June 1984 NPRM. Comments on these optional provisions have been responded to in these final regulations and these responses are equally applicable even though the optional provisions were made mandatory after issuance of the NPRM. Therefore, we find that there is good cause to waive public rulemaking procedures and issue these requirements as final regulations.

Regulatory Impact Statement

Executive Order 12291

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any major regulations—that is, those that will have an annual effect on the economy of $100 million or more; cause a major increase in costs or prices for consumers, individual industries, government agencies, or geographic regions, or have significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises in domestic or export markets. We have determined that, for the reasons stated below, these regulations do not meet any of the criteria for a major regulation. Therefore, a regulatory impact analysis is not required.

Third Party Liability

As noted earlier, to improve the administration of the Medicaid program we are broadening the scope of services for which a State must collect from third parties the cost of medical assistance furnished to Medicaid recipients. We also are revising the methods of paying claims involving third party liability, and making conforming changes to incorporate a statutory provision that requires the assignment of medical support rights and other third party payments and cooperation in establishing paternity and obtaining support as a condition of eligibility for Medicaid.

We anticipate that implementing these third party liability provisions will increase our ability to recover Medicaid expenditures. We also anticipate that the impact of these regulations will be enhanced through the interactive effects of other third party liability initiatives. We are unable to develop a precise actuarial estimate for these third party liability provisions. We project that these regulations with other third party initiatives will allow recovery of 80 percent of the amounts that are currently uncollected. We believe that between 1.0 percent and 2.5 percent of current Medicaid expenditures could be recovered through better collection practices.

We anticipate that these regulations will account for 25 percent of the combined effects of these regulations and other third party liability initiatives. We have developed the following projection of low and high values of potential Federal savings:

	1986	1987	1988	1989	1990
Low (in millions) [1]	$25	$25	$50	$50	$75
High (in million [1]	50	75	150	150	175

[1] Rounded to nearest $25 million.

Each State's savings, while not readily estimable, would bear the same relationship to the Federal savings that their current Medicaid expenditures bear to total Federal expenditures. Actual State savings will also depend directly on the State's success in recovering third party liability.

FFP For Compensation and Training of Skilled Professional Medical Personnel

We also expect the changes in the definition of skilled professional medical personnel and directly supporting staff to result in program savings on the Federal level. Implementation of these changes will reduce the rate of FFP from 75 percent to 50 percent for many States' skilled professional medical personnel claims, resulting in some additional program expense for affected States. We estimate a program savings of at least $15.8 million in the first full fiscal year that these regulations are effective. These savings will be generated by disallowance of inappropriate State claims for enhanced Federal matching and an expected reduction in the number of personnel and staff for whom 75 percent matching is claimed and allowed.

Specifically, we estimate: (1) Savings of $11 million resulting from the elimination of 75 percent enhanced funding for EPSDT subprofessionals who do not qualify as directly supporting staff; (2) savings of $4.8 million by eliminating the "subprofessional" category of supporting staff and by defining directly supporting staff as only secretarial, stenographic, and copying personnel and file and records clerks that provide direct support to the skilled professional medical personnel; and (3) an inestimable savings generated by not paying 75 percent enhanced funding for skilled professional medical personnel who do not have the required professional education and training in a medical field related to their position in the Medicaid program. These personnel costs would be matched at 50 percent. We anticipate a possible increase in these savings if States no longer claim these staff at 75 percent FFP. However, we cannot provide savings estimates because we do not know what specific decisions States will make.

Sources of State's Share of Financial Participation

We expect little change from current levels of donations to State Medicaid programs as a result of these provisions. To the extent that donations increase, the individual State programs will benefit but we believe that the extent of the incremental increase will not be great enough to benefit affected recipient populations.

Regulatory Flexibility Act of 1980 (Pub. L. 96–354)

The Regulatory Flexibility Act requires us to prepare and publish a regulatory flexibility analysis (RFA) for any regulation that will have a significant impact on a substantial number of small entities. A small entity is a small business, a nonprofit enterprise, or a government jurisdiction (such as a county or township) with a population of less than 50,000. The purpose of the analysis would be to anticiapte the impact and to seek alternatives that would have a less significant effect.

We do not expect the changes in these regulations to affect a substantial number of small entities. We expect large major health insurors and State Medicaid agencies, which are not considered small entities, to be the entities primarily affected. As mentioned above in the discussion of Executive Order 12291, the changes in skilled professional medical personnel will result in a shift to States of a portion of administrative costs that have previously been born by the Federal government.

We also emphasize that the rules on third party liability should have little impact on Medicaid providers. The changes to third party liability rules do not make recipients any more liable to pay for services furnished under a State

plan than they have been in the past. The revised claims payment system will require providers to file claims with third party payers, but this system has proved workable in the States that now use it. Because only 10 to 15 percent of all Medicaid recipients have health insurance, we believe that providers can accommodate the new claims filing requirement with minimal disruption of billing procedures and no reduction in services furnished to Medicaid recipients.

Therefore, we have determined and the Secretary certifies under 5 U.S.C. 605(b), that these final regulations will not have a significant economic impact on a substantial number of small entities.

Paperwork Reduction Act of 1980 (Pub. L. 96–511)

Sections 432.50(d)(2), 433.139, and 433.145 contain information collection requirements that are subject to approval of the Office of Management and Budget (OMB) under the Paperwork Reduction Act. We have submitted a copy of these requirements to OMB for its review and approval. When OMB approval is obtained, we will publish an appropriate notice in the **Federal Register.**

List of Subjects

42 CFR Part 432

Grant-in-Aid program—health, Health Care Financing Administration, Medicaid, Subprofessionals, Training programs, Volunteers.

42 CFR Part 433

Administrative practice and procedure, Assignment of rights, Claims, Contracts (agreements), Cost allocation, Federal financial participation, Federal matching provision, Grant-in-Aid program—health, Mechanized claims processing and information retrieval systems, Medicaid, State fiscal administration, Third party liability.

42 CFR Part 435

Aid to Families with Dependent Children, Aliens, Categorically needy, Contracts (agreements—State plan), Eligibility, Grant-in-Aid program—health, Health facilities, Medicaid, Medically needy, Reporting requirements, Spend-down, Supplemental security income (SSI).

42 CFR Part 436

Aid to Families with Dependent Children, Aliens, Contracts (agreements), Eligibility, Grant-in-Aid program—health, Guam, Health facilities, Medicaid, Puerto Rico, Supplemental security income (SSI), Virgin Islands.

42 CFR Chapter IV is amended as set forth below:

PART 432—STATE PERSONNEL ADMINISTRATION

A. Part 432 is amended as follows:

1. The authority citation for Part 432 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. The table of contents for Subpart C is amended by adding a new § 432.45 and removing § 432.60 to read as follows:

Subpart C—Staffing and Training Expenditures

432.45 Applicability of provisions in subpart.

* * * * *

432.60 [Reserved]

3. Section 432.2 is amended by adding an introductory phase and revising the definition of "skilled professional medical personnel" and "staff of other public agencies", removing the definition of "supporting staff", and adding a new definition of "directly supporting staff" in alphabetical order to read as follows:

§ 432.2 Definitions.

As used in this part—

* * * * *

"Directly supporting staff" means secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that directly support the responsibilities of skilled professional medical personnel, who are directly supervised by the skilled professional medical personnel, and who are in an employer-employee relationship with the Medicaid agency.

* * * * *

"Skilled professional medical personnel" means physicians, dentists, nurses, and other specialized personnel who have professional education and training in the field of medical care or appropriate medical practice and who are in an employer-employee relationship with the Medicaid agency. It does not include other nonmedical health professionals such as public administrators, medical analysts, lobbyists, senior managers or administrators of public assistance programs or the Medicaid program.

"*Staff of other public agencies*" means skilled professional medical personnel and directly supporting staff who are employed in State or local agencies other than the Medicaid agency who perform duties that directly relate to the administration of the Medicaid program.

* * * * *

4. A new § 432.45 is added to Subpart C to read as follows:

§ 432.45 Applicability of provision in subpart.

The rates of FFP specified in this Subpart C do not apply to State personnel who conduct survey activities and certify facilities for participation in Medicaid, as provided for under section 1902(a)(3)(B) of the Act.

5. Section 432.50 is amended by revising paragraphs (b)(1) and (c) and by adding paragraph (d) and paragraph (e) to read as follows:

§ 432.50 FFP: Staffing and training costs.

* * * * *

(b) *Rates of FFP.* (1) For skilled professional medical personnel and directly supporting staff of the Medicaid agency or of other public agencies (as defined in § 432.2), the rate is 75 percent.

* * * * *

(c) *Application of rates.*

(1) FFP is prorated for staff time that is split among functions reimbursed at different rates.

(2) Rates of FFP in excess of 50 percent apply only to those portions of the individual's working time that are spent carrying out duties in the specified areas for which the higher rate is authorized.

(3) The allocation of personnel and staff costs must be based on either the actual percentages of time spent carrying out duties in the specified areas, or another methodology approved by HCFA.

(d) *Other limitations for FFP rate for skilled professional medical personnel and directly supporting staff.*

(1) *Medicaid agency personnel and staff.* The rate of 75 percent FFP is available for skilled professional medical personnel and directly supporting staff of the Medicaid agency if the following criteria, as applicable, are met:

(i) The expenditures are for activities that are directly related to the administration of the Medicaid program, and as such do not include expenditures for medical assistance;

(ii) The skilled professional medical personnel have professional education and training in the field of medical care or appropriate medical practice. "Professional education and training" means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is demonstrated

by possession of a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care.

(iii) The skilled professional medical personnel are in positions that have duties and responsibilities that require those professional medical knowledge and skills.

(iv) A State-documented employer-employee relationship exists between the Medicaid agency and the skilled professional medical personnel and directly supporting staff; and

(v) The directly supporting staff are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the skilled professional medical staff. The skilled professional medical staff must directly supervise the supporting staff and the performance of the supporting staff's work.

(2) *Staff of other public agencies.* The rate of 75 percent FFP is available for staff of other public agencies if the requirements specified in paragraph (d)(1) of this section are met and the public agency has a written agreement with the Medicaid agency to verify that these requirements are met.

(e) *Limitations on FFP rates for staff in mechanized claims processing and information retrieval systems.* The special matching rates for persons working on mechanized claims processing and information retrieval systems (paragraphs (b)(2) and (3) of this section) are applicable only if the design, development and installation, or the operation, have been approved by the Administrator in accordance with Part 433, Subpart C, of this subchapter.

§ 432.60 [Removed and Reserved]

6. Section 432.60 is removed and reserved. (Its content is revised and redesignated as a new § 433.45 under Part 433.)

PART 433—STATE FISCAL ADMINISTRATION

B. Part 433 is amended as follows:

1. The authority citation for Part 433 is revised to read as follows:

Authority: Secs. 1102, 1902(a)(4), 1902(a)(25), 1902(a)(45), 1903(a)(3), 1903(d)(25), 1903(d)(5), 1903(o), 1903(p), 1903(r), and 1912 of the Social Security Act; 42 U.S.C. 1302, 1396a(a)(4), 1396a(a)(25), 1396(a)(45), 1396b(a)(3), 1396b(d)(2), 1396b(d)(5),1396(o), 1396(p), 1396b(r) and 1396k, unless otherwise noted.

2. The table of contents is amended by adding a new § 433.45 to Subpart B, revising the titles of §§ 433.137, 433.145, and 433.151, and removing §433.149 under Subpart D to read as follows:

* * * * *

Subpart B—General Administrative Requirements

* * * * *

Sec.

433.45 Sources of State share of financial participation.

* * * * *

Subpart D—Third Party Liability

* * * * *

433.137 State plan requirements.

* * * * *

433.145 Assignment of rights to benefits—State plan requirements.

* * * * *

433.149 [Removed and reserved]

* * * * *

433.151 Cooperative agreements and incentive payments—State plan requirements.

* * * * *

3. Section 433.15 is amended by revising paragraph (b) (5) to read as follows:

§ 433.15 Rates of FFP for administration.

* * * * *

(b) *Activities and rates.*

* * * * *

(5) Compensation and training of skilled professional medical personnel and staff directly supporting those personnel if the criteria specified in § 432.50 (c) and (d) are met: 75 percent. (Section 1903(a)(2); 42 CFR 432.50(b)(1).)

* * * * *

4. A new § 433.45 is added to read as follows:

§ 433.45 Sources of State share of financial participation.

(a) *Public funds as the State's share.* (1) Public funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (a)(2) and (3) of this section.

(2) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.

(3) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

(b) *Private donated funds as the State's share.* (1) Funds donated from private sources may be considered as the State's share in claiming FFP only if they meet the conditions specified in paragraphs (b)(2) and (3) of this section.

(2) The private funds are transferred to the State or local Medicaid agency and are under its administrative control.

(3) The private funds do not revert to the donor's facility or use unless the donor is a non-profit organization, and the Medicaid agency, of its own volition, decides to use the donor's facility.

(5) Section 433.135 is revised to read as follows:

§ 433.135 Basis and purpose.

This subpart implements sections 1902(a)(25), 1902(a)(45), 1903(d)(2), 1903(o), 1903(p), and 1912 of the Act by setting forth State plan requirements concerning—

(a) The legal liability of third parties to pay for services provided under the plan;

(b) Assignment to the State of an individual's rights to third party payments; and

(c) Cooperative agreements between the Medicaid agency and other entities for obtaining third party payments.

6. Section 433.136 is amended by revising the definitions of "Private insurer" and "Third party" to read as follows:

§ 433.136 Definitions.

For purposes of this subpart—

"Private insurer" means:

(1) Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts);

(2) Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for services included in the State plan; and

(3) Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

"Third party" means any individual entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.

* * * * *

7 Section 433.137 is revised to read as follows:

§ 433.137 State plan requirements.

(a) A State plan must provide that the requirements of §§ 433.138 and 433.139 are met for determining legal liability of third parties to pay for services under the plan and for payment of claims involving third parties.

(b) A State plan must provide that, for medical assistance furnished on or after October 1, 1984—

(1) The requirements of §§ 433.145 through 433.148 are met for assignment of rights to benefits and cooperation with the agency in obtaining medical support or payments; and

(2) The requirements of §§ 433.151 through 433.154 are met for cooperative agreements and incentive payments for third party collections.

8. Section 433.139 is revised to read as follows:

§ 433.139 Payment of claims.

(a) *Basic provisions.* (1) For claims involving third party liability that are processed on or after May 12, 1986, the agency must use the procedures specified in paragraphs (b) through (f) of this section.

(2) The agency must submit documentation of the methods (e.g., cost avoidance, pay and recover later) it uses for payment of claims involving third party liability to the HCFA Regional Office.

(b) *Probable liability is established at the time claim is filed.* Unless the agency has received approval to use an alternative method of payment as specified under paragraph (b)(2) of this section, the agency must pay claims involving probable third party liability as follows:

(1) If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

(2) The agency may pay the full amount allowed under the agency's payment schedule for the claim and then seek reimbursement from any liable third party to the limit of legal liability if it has obtained approval of a waiver of the requirement under paragraph (b)(1) of this section. The waiver must be in accordance with the provisions of paragraph (e) of this section.

(c) *Probable liability is not established or benefits are not available at the time claim is filed.* If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the agency must pay the full amount allowed under the agency's payment schedule.

(d) *Recovery of reimbursement.* If the agency learns of the existence of a liable third party, or benefits become available after a claim is paid, the agency must seek recovery of reimbursement from the third party to the limit of legal liability within 60 days after the end of the month in which payment is made or 60 days after the end of the month it learns of the existence of the liable third party, whichever is earlier, unless it determines that recovery would not be cost effective in accordance with paragraph (f) of this section.

(e) *Waiver of required use of cost avoidance method.* (1) The requirement to use the claims payment method specified under paragraph (b)(1) of this section may be waived if—

(i) The agency is using the method of paying the entire claim and then seeking reimbursement from any liable third party as of November 12, 1985;

(ii) The agency submits adequate documentation that its method is as cost effective as the method required under paragraph (b)(1) of this section to the HCFA Regional Office on or before January 13, 1986 and requests approval of its use (Administrative costs must be considered in the computation of the cost effectiveness of the State's alternative method); and

(iii) The HCFA Regional Office approves the State's request for a waiver of the requirement.

(2) The HCFA Regional Office will review a State's request to have the requirement under paragraph (b)(1) of this section waived and notify the State of its determination within 30 days of receipt of a request. The Regional Office will request additional information from the State, if necessary.

(3) The HCFA Regional Office will grant the waiver for an indefinite period unless it specifies otherwise in the approval notice to the State. A State that is granted a waiver must notify the Regional Office of any event that occurs that changes the cost effectiveness of the approved alternative method. The Regional Office may rescind the waiver at any time that the State's method is no longer as cost effective as the method required under paragraph (b)(1) of this section. If the waiver request is denied or the waiver is rescinded, the State has 6 months from the date of the denial or rescission notice to implement the method required under paragraph (b)(1) of this section.

(f) *Suspension or termination of recovery of reimbursement.* (1) An agency must seek reimbursement from a liable third party on all claims for which it determines that the amount it reasonably expects to recovery will be greater than the cost of recovery. Recovery efforts may be suspended or terminated only if they are not cost effective.

(2) The State plan must specify the threshold amount or other guideline that the agency uses in determining whether to seek recovery of reimbursement from a liable third party, or describe the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

(3) The State plan must also specify the dollar amount or period of time for which it will accumulate billings with respect to a particular liable third party in making the decision whether to seek recovery of reimbursement.

9. Section 433.145 is revised to read as follows:

§ 433.145 Assignment of rights to benefits—State plan requirements.

For medical assistance furnished on or after October 1, 1984—

(a) A State plan must provide that, as a condition of eligibility, each legally able applicant and recipient must assign his rights to medical support or other third party payments to the Medicaid agency and cooperate with the agency in obtaining medical support payments.

(b) A State plan must provide that the requirements for assignments and cooperation in establishing paternity and obtaining support under §§ 433.146 through 433.148 are met.

(c) A State plan must provide that the assignment of rights to benefits obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid.

§ 433.149 [Removed and reserved]

10. Section 433.149 is removed and reserved.

11. Section 433.151 is revised to read as follows:

§ 433.151 Cooperative agreements and incentive payments—State plan requirements.

For medical assistance furnished on or after October 1, 1984—

(a) A State plan must provide for entering into written cooperative

agreements for enforcement of rights to and collection of third party benefits with at least one of the following entities: The State title IV–D agency, any appropriate agency of the State, and appropriate courts and law enforcement officials. The agreements must be in accordance with the provisions of § 433.152.

(b) A State plan must provide that the requirements for making incentive payments and for distributing third party collections specified in §§ 433.153 and 433.154 are met.

12. Section 433.152 is revised to read as follows:

§ 433.152 Requirements for cooperative agreements for third party collections.

(a) Except as specified in paragraph (b) of this section, the State agency may develop the specific terms of cooperative agreements with other agencies as it determines appropriate for individual circumstances.

(b) Agreements with title IV–D agencies must specify that the Medicaid agency will—

(1) Meet the requirements of the Office of Child Support Enforcement for cooperative agreements under 45 CFR Part 306; and

(2) Provide reimbursement to the IV–D agency only for those child support services performed that are not reimbursable by the Office of Child Support Enforcement under title IV–D of the Act and that are necessary for the collection of amounts for the Medicaid program.

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, AND THE NORTHERN MARIANA ISLANDS

C. Part 435, Subpart G, is amended as follows:

1. The authority citation for Part 435 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 435.604 is revised to read as follows:

§ 435.604 Assignment of rights to benefits.

For medical assistance furnished on or after October 1, 1984—

(a) As a condition of eligibility, the agency must require legally able applicants and recipients to assign rights to medical support or other third party payments to the Medicaid agency and to cooperate with the agency in obtaining medical support or payments. (Part 433, Subpart D, contains specific requirements for these assignments.)

(b) The requirements for assignment of rights must be applied uniformly for all groups covered under the plan.

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

D. Part 436, Subpart G is amended as follows:

1. The authority citation for Part 436 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302) unless otherwise noted.

2. Section 436.604 is revised to read as follows:

§ 436.604 Assignment of rights to benefits.

For medical assistance furnished on or after October 1, 1984—

(a) As a condition of eligibility, the agency must require legally able applicants and recipients to assign rights to medical support and other third party payments to the Medicaid agency and to cooperate with the agency in obtaining medical support or payments. (Part 433, Subpart D, contains specific requirements for these assignments.)

(b) The requirements for assignment of rights must be applied uniformly for all groups covered under the plan.

(Catalog of Federal Domestic Assistance Program No. 13.714—Medical Assistance Program)

Dated: March 5, 1985.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: August 2, 1985

Margaret M. Heckler,

Secretary.

[FR Doc. 85–26603 Filed 11–8–85; 8:45 am]

BILLING CODE 4120–01–M

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

49 CFR Ch. V

[Docket No. T84–01; Notice 8]

Final Theft Data; Motor Vehicle Theft Prevention Standard

AGENCY: National Highway Traffic Safety Administration (NHTSA), DOT.

ACTION: Publication of final theft data.

SUMMARY: These data reflect the passenger motor vehicle thefts in 1983 and 1984 that have been provided to this agency by the National Crime Information Center (NCIC). These data have been used by the agency to determine the theft rates for the 130 existing passenger motor vehicle lines manufactured in 1983 and 1984, and to determine the median theft rate for those 130 lines. The lines listed from number 1 to number 65, inclusive, had a theft rate that exceeded the medium theft rate, and will be subject to selection for coverage under the motor vehicle theft prevention standard.

FOR FURTHER INFORMATION CONTACT: Mr. Brian McLaughlin, Office of Market Incentives, NHTSA, Room 5313, 400 Seventh Street, SW., Washington, DC 20590 (202–426–1740).

SUPPLEMENTARY INFORMATION:

Background

Title VI of the Motor Vehicle Information and Cost Savings Act (the Cost Savings Act; 15 U.S.C. 2021 *et seq.*) requires NHTSA to promulgate a vehicle theft prevention standard applicable to high theft car lines. Section 603(a)(1) of the Cost Savings Act (15 U.S.C. 2023(a)(1)) specifies that three types of car lines are high theft lines within the meaning of Title VI. These three types are:

(1) Existing lines that had a theft rate exceeding the median theft rate in 1983 and 1984;

(2) New lines that are likely to have a theft rate exceeding that median theft rate; and

(3) Lines with theft rates below the median theft rate, but which have a majority of major parts interchangeable with lines whose theft rate exceeded or is likely to exceed the median theft rate.

Section 603(b) of the Cost Savings Act explains how the agency is to determine whether existing lines had a theft rate that exceeded the median theft rate in 1983 and 1984. Section 603(b)(3) directs NHTSA to "obtain from the most reliable source or sources accurate and timely theft and recovery data and publish such data for review and comment. To the greatest extent possible, the [NHTSA] shall utilize theft data reported by Federal, State, or local police. After such publication and opportunity for comment, the [NHTSA] shall utilize the theft data to determine the median theft rate under this subsection."

In accordance with the statutory directive, NHTSA published a notice seeking comments on theft data the agency had obtained from the NCIC and the National Automobile Theft Bureau (NATB); 50 FR 18708, May 2, 1985. That notice stated the agency's tentative decision to use the NCIC data to determine the median theft rate for 1983 and 1984 and the theft rates for the 130 existing lines. The agency explained

SF-00006-04

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT : of Human Services

PHONE : 296-2794

DATE : April 10, 1986

TO : Judith Wehrwein

FROM : Bob Hamper BH

SUBJECT : Review of Emergency Rule, Minnesota Rules, parts 9505.0211 to 9505.0212 [Emergency]

Enclosed are the documents required under Minnesota Rules, part 2010.0400 for your review of the above rule.

Please note that we have used the sample Findings of Fact format from your proposed rule.

Eleanor Weber (297-4301) is the rulemaker on this rule and Patricia Sonnenberg (296-7013) is the attorney general for this rule.

If you have any questions, please call Eleanor, Patricia or me.

Thank you.

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