1/14/91

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-38___

January 9, 1991

Ms. Maryanne Hruby
Executive Director, LCRAR
55 State Office Building
St. Paul, Minnesota 55155

Dear Ms. Hruby:

Pursuant to Minnesota Statutes, section 14.131, enclosed is a statement of need and reasonableness relating to Surveillance and Utilization Review of Medical Assistance Services, Minnesota Rules, parts 9505.2160 to 9505.2245.

If you have any questions on the statement of need and reasonableness, please do not hesitate to contact me at 297-4301.

Sincerely,

Eleanor Weber

Eleanor Weber
Rulemaker

Encl.

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

In the Matter of Proposed Rule Amendments
of the Department of Human Services
Relating to Surveillance and Utilization
Review of Medical Assistance Service
Providers and Recipients, Minnesota Rules,
Parts 9505.2160 to 9505.2245

STATEMENT OF NEED
AND REASONABLENESS

Introduction

Minnesota Rules, parts 9505.2160 to 9505.2245 are proposed by the Department of Human Services (department) as amendments to existing rules, parts 9505.1750 to 9505.2150 which govern surveillance and utilization review standards and procedures used by the department to: (1) monitor compliance with medical assistance program requirements, (2) identify fraud, theft, or abuse by medical assistance recipients or providers, (3) establish administrative and legal sanctions in cases of fraud, theft, or abuse, and (4) investigate and monitor compliance with federal and state laws and regulations related to the medical assistance program. The proposed rules continue the present provisions for administrative sanctions and monetary recoveries from providers and recipients. In addition to revising certain standards and procedures, the proposed amendments will clarify, reorganize, and technically revise the present rules.

The rules also apply to certain other programs related to the provision of health services. These other programs are general assistance medical care, consolidated chemical dependency treatment, children's health plan, catastrophic

health expense protection program, and home and community-based services under a waiver from the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services.

The medical assistance program in Minnesota is a joint federal-state program that implements Title XIX of the Social Security Act by providing for the medical needs of low income or disabled persons. (See United States Code, title 42, section 1396a, et seq., hereafter referred to as 42 USC 1396a, et seq.) In compliance with the requirements of Title 42, Code of Federal Regulations, section 431.10 (42 CFR 431.10), the Department of Human Services has been designated as the state agency to supervise the administration of the state's medical assistance program and to adopt rules that must be followed in administering the State plan. The State Plan is the department's comprehensive plan to administer, supervise, and monitor the program according to the federal requirements.

42 CFR 456.3 requires the state medicaid agency (the department) to implement a statewide surveillance program "to safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments." See also 42 CFR 455.13.

Correspondingly Minnesota Statutes, section 256B.04, subdivision 10 requires the department to establish rules to identify and investigate suspected medical assistance fraud, theft, abuse, and determine the medical necessity of the services rendered. Minnesota Statutes, section 256B.04, subdivision 15 requires the department to establish "on a statewide basis a new program to safeguard against unnecessary or inappropriate use of medical assistance services, against

excess payments....." Minnesota Statutes, section 256B.04, subdivision 10 also requires the department to establish by rule the general criteria and procedures for identifying and investigating suspected medical assistance fraud, theft, and abuse. Minnesota Statutes, section 256B.04, subdivision 2 requires the department to make uniform rules for implementing the medical assistance program. Minnesota Statutes, section 256B.04, subdivision 4 requires the department to cooperate with the federal government in any reasonable manner as may be necessary to obtain federal financial participation.

Minnesota Statutes, section 256B.064 authorizes the commissioner to terminate payments, obtain monetary recovery, and impose sanctions against vendors of medical care in cases of fraud, theft, or abuse and certain other prohibited conduct described in subdivision 1a of the section.

The Surveillance and Utilization Review Section (SURS) of the Health Care Support Division of the Department represents the post-payment review or enforcement activity of the Minnesota Medical Assistance Program. The section was organized in 1975.

SURS uses a sophisticated computer profiling system and referrals from a variety of sources to identify providers and recipients requiring in-depth investigation. The investigative process draws upon the training and experience of criminal investigators, nurses, auditors, and medical consultants to determine if a particular practice is potentially fraudulent or abusive or if services rendered were medically necessary.

Surveillance and utilization review is a federally mandated function. 42 USC sections 1396a(a)(4), 1396b(i)(2), and 1396h and Title 42, Code of Federal Regulations, Part 455, Subpart A [42 CFR 455(A)] require the State plan to provide for the identification, investigation, and referral of suspected fraud

and abuse cases. Rules were promulgated under the Administrative Procedures Act on September 28, 1981. Originally referred to as Rule 64, the rules were renumbered some years later as parts 9505.1750 to 9505.2150.

On the average in the period 1984 to 1990, SURS opened 750 cases annually. About 40% of those cases led to the issuance of formal Notices of Agency Action, which sought to recover overpayments of MA funds or to impose sanctions. Approximately 5 to 6% of these Notices proposed the imposition of administrative sanctions, however almost all Notices issued by SURS sought recovery of overpayment. (Generally, when a sanction is proposed, a monetary recovery is also sought.) The following is a list of total MA payments recovered, by year, for the fiscal years 1984 through 1990.

FY 84	$300,000 (approx.)
FY 85	$833,775
FY 86	$810,803
FY 87	$1,045,485
FY 88	$1,088,778
FY 89	$1,733,291
FY 90	$3,395, 286

SURS does not maintain a categorical record of the reasons for these overpayments. However, experience has shown that the vast majority of actions to recover overpayments are based on abusive or erroneous billing practices by MA providers. Most frequently, an overpayment occurs because a provider has submitted claims to the program with incorrect or missing procedure codes and code modifiers. The second most common basis for recovery of MA payment is the provider's failure to maintain documentation to support the service billed to the program. On occasion, but much less often, recovery must be made for duplicate

billing of services or for billing of services that are not medically necessary. Beginning in fiscal year 1984, SURS began referring cases of alleged fraud and theft to the Medicaid Fraud Control Unit (MFCU). That unit began operation on July 1, 1983, the beginning of the 1984 fiscal year. The following is a list of the number of referrals by SURS, by year, for fiscal years 1984 through 1990:

FY 84	14
FY 85	6
FY 86	9
FY 87	26
FY 88	12
FY 89	8
FY 90	9

To date, there have been 29 convictions for theft or fraud arising from these referrals. Following these convictions, SURS has proceeded with actions to sanction the convicted provider and, if necessary, recover any funds not returned through restitution. At least 90% of SURS sanction actions are the result of criminal convictions or loss of licensure. On very rare occasions, SURS has sought to impose sanctions for repeated, egregious abusive practices.

Currently, SURS has a staff complement of 25, seventeen of whom are investigators. The remaining staff include provider enrollment specialists, supervisors, secretaries, and legal specialists. Staffing has been at this level since the 1983 legislative session when SURS had an increase of seven positions. During the 1990 legislative session, five more investigator positions were funded. It is expected that SURS recoveries will be significantly enhanced with the increase of staff.

SMALL BUSINESS CONCERNS

In preparing these rules, the Department also considered the requirements of Minnesota Statutes, section 14.115 but believed that these rules come within the exemption given in section 14.115, subdivison 7 (c) because the providers affected by this rule are service businesses regulated by government bodies, for standards and costs, such as nursing homes, long-term care facilities, hospitals and providers of medical care. In part, this belief is based on Minnesota Statutes, section 146.01 which states:

> The term "practicing healing" or "practice of healing" shall mean and include any person who shall in any manner for any fee, gift, compensation, or reward, or in expectation thereof, engage in, or hold out to the public as being engaged in, the practice of medicine or surgery, the practice of osteopathy, the practice of chiropractic, the practice of any legalized method of healing, or the diagnosis, analysis, treatment, correction, or cure of any disease, injury, defect, deformity, infirmity, ailment, or affliction of human beings, or any condition or conditions incident to a pregnancy or childbirth, or examination into the fact condition or cause of human health or disease, or who shall, for any fee, gift, compensation, or reward, or in expectation thereof, suggest, recommend, or prescribe any medicine or any form of treatment, correction, or cure thereof; also any person or persons, individually or collectively, who maintains an office for the reception, examination, diagnosis, or treatment of any person for any disease, injury, defect, deformity, or informity of body or mind, or who attaches the title of doctor or physician, surgeon, specialist, M.D., M.B., D.O., D.C., or any other word, abbreviation, or title to the person's name indicating, or designed to indicate, that the person is engaged in the practice of healing.

Thus, a person "practicing healing" as defined above is considered to be involved in the practice of a health service that constitutes medical care.

Support for the department's belief that the providers affected by these rules are medical providers is drawn from the licensing requirements for these occupations under Minnesota law. These providers must meet professional standards set by their respective licensing boards. They include physicians, nurses, pyschologists, pharmacists, dentists, physical therapists, and chiropractors. Professional standards for physicians are regulated by the Board

of Medical Examiners under Minnesota Statutes, section 147.01; for nurses by the Board of Nursing under Minnesota Statutes, section 148.181; for pyschologists by the Board of Psychology under Minnesota Statutes, section 148.90; for dentists by the Board of Dentistry under Minnesota Statutes, section 150.A06, subdivision 1; for physical therapists by the Board of Medical Examiners under Minnesota Statutes, section 148.70, for pharmacists by the Board of Pharmacy under Minnesota Statutes, section 151.06.

Another group of providers affected by these rules are long-term care facilities which provide nursing care to persons who are unable to live in their own homes. Minnesota Statutes, section 144A.02 requires long term care homes to be licensed by the Commissioner of Health. Acute care facilities, hospitals, are another group of health service providers that are affected by these rules. Minnesota Statutes, sections 144.50 to 144.56 requires a hospital to be licensed by the commissioner of health and sets the standards for licensure.

Parts 9505.2160 to 9505.2245 must be read in conjunction with parts 9505.0170 to 9505.0475 which establish the standards to receive payment for health services provided to medical assistance recipients. Payments to medical assistance providers are regulated under part 9505.0445 which establishes rates for all medical assistance providers.Additionally Minnesota Statutes, sections 256B.03, subdivision 1, 256B.04, subdivison 12, and 256B.05, subdivision 3 specify that medical assistance providers of covered services are subject to limits on the amount paid for covered services.

However, in the event that these rules are not exempt under subdivison 7(c), the department has considered the methods listed in subdivison 2 of section 14.115 for reducing the impact of the rule on small businesses. In considering those

methods, the department was mindful of the need to comply with extensive federal and state requirements applicable to the medical assistance program. As stated above, medical assistance is a federal program established under 42 USC 1396a, et seq. Title XIX and its implementing regulations specify the program standards and limitations and reporting requirements with which a state must comply to obtain federal financial participation in paying the costs of the program. Minnesota Statutes, section 256B.04, subdivision 4 requires the department to cooperate with the federal government "in any reasonable manner as may be necessary to qualify for federal aid in connection with medical assistance program, including the making of such reports in such form and containing such information as the department of health, education, and welfare may, from time to time, require, and comply with such provisions as such department may, from time to time, find necessary to assure the correctness and verifications of such reports." Minnesota Statutes, section 256B.04, subdivison 2 requires the department to "make uniform rules, not inconsistent with law,....to the end that the medical assistance program may be uniformly administered throughout the state..." 42 CFR 431.50 (b)(1) requires a state medical assistance plan to provide that "the plan will be in operation statewide....under equitable standards for....administration that are mandatory throughout the State." Similarly, 42 CFR 433.33 requires the state medical assistance plan to assure that "individuals in similar circumstances will be equitably treated throughout the State." Thus, in addressing the concerns of Minnesota Statutes, section 14.115, subdivison 2, it is necessary and reasonable to review requirements of federal law and regulations about program standards and reporting requirements. Clause (a) of subdivision 2 of Minnesota Statutes, section 14.115 requires consideration of "the establishment of less stringent compliance or reporting

requirments for small business." 42 USC 1396a(a)(10)(B) of the Social Security Act requires the amount, duration, and scope of medical assistance to be the same for all persons receiving services under 42 USC 1396a(a)(10)(A). 42 USC 1396a(a)(19) of the Social Security Act requires medical assistance to provide services "in a manner consistent with simplicity of administration and the best interests of the recipients."

Clause (b) of subdivision 2 of Minnesota Statutes, section 14.115 requires consideration of "the establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses." Clause (c) of subdivision 2 of Minnesota Statutes, section 14.115 requires consideration of "the consolidation of compliance or reporting requirements for small businesses." Because of their similarity, the provisions of these clauses were considered together.

42 USC 1396a(a)(27) of the Social Security Act requires every person or institution providing medical assistance services to keep such records as are necessary to fully disclose the extent of the services provided to recipients and to furnish the state or federal government any information required about payments for services. These reporting requirements are minimum standards applicable to all providers of the same services and are not based on how much medical assistance business the provider does. Thus, it is necessary and reasonable to set uniform administrative standards for the medical assistance program and reporting requirements.

Clause (d) of subdivision 2 of Minnesota Statutes, section 14.115 requires consideration of "the establishment of performance standards for small businesses to replace design or operational standards required in the rule."

42 USC 1396a(a)(30)(A) requires the state to assure that medical assistance

payments are consistent with quality of care and to provide methods and procedures related to utilization review of the services toward this end. This requirement ties the medical assistance program to stringent compliance in regard to quality of care and does not permit the state to establish different levels of quality of care according to the size of a provider's business. Additionally licensure standards with which the providers must comply to obtain and retain their licenses set uniform standards applicable to all license holders without regard to the size of the license holder's business.

Clause (e) of subdivision 2 of Minnesota Statutes, section 14.115 requires consideration of "the exemption of small businesses from any or all requirements of the rule."

42 USC 1396a(a)(10)B requires the amount, duration, and scope of medical assistance to be the same for all persons receiving services under (10)A. Minnesota Statutes, section 256B.04, subdivision 2 requires the department to "make uniform rules....to the end that the medical assistance system may be uniformly administered throughout the state,..." The program and reporting standards in these rules have been accepted by the advisory committee as consistent with the prevailing standard among health care providers. No member of the advisory committee suggested having more than a single set of standards.

Thus, the department believes it would be unreasonable and contrary to federal and state laws and regulations to modify the proposed rule to establish less stringent compliance or reporting standards, deadlines, simplified requirements, or exemptions in response to clauses (a) to (c) and (e) of Minnesota Statutes, section 14.115, subdivision 2.

It should be noted that the department in its Notice of Public Hearing has

invited anyone who may be affected as a small business to speak to their concerns at the public hearing.

Finally, in regard to the requirement of Minnesota Statutes, section 14.115, subdivision 4, the department has notified the following professional organizations of a possible effect of these rules on their members and requested them to inform their members about the opportunity to address the concerns of small businesses at the public hearing. The organizations so notified are: Minnesota Medical Association; Minnesota Hospital Association; Minnesota Nurses Association; Minnesota Dental Association; Minnesota Psychological Association; Minnesota State Pharmaceutical Association; and Care Providers of Minnesota.

OTHER HEALTH CARE PROGRAMS

The statutory authority to promulgate rules governing the identification and investigation of suspected fraud, theft, or abuse in the Catastrophic Health Protection Program (CHEPP) is found in Minnesota Statutes, section 62E.54, subdivision 1 (d.) Minnesota Statutes, section 62E.54, subdivision 1 (d) requires that the rules relating to sanctions under CHEPP be consistent with the provisions of section 256B.064, subdivisions 1a to 2.

Minnesota Statutes, section 256D.03, subdivision 7 (b) requires the commissioner to establish surveillance and utilization review procedures for general assistance medical care services "that conform to those established for the medical assistance program pursuant to chapter 256B, including general criteria and procedures for the identification of suspected fraud, theft, abuse, ..." and certain other actions. Subdivision 7(b) further states that the rules relating to sanctions in the general assistance medical care program shall be consistent with Minnesota Statutes, section 256B.064, subdivisions 1a and 2.

Minnesota Statutes, section 256.936, subdivision 2 authorizes the commissioner to adopt rules related to the provision of children's health services. Subdivision 1 (c) of section 256.936 defines children's health services as health services reimbursed under Minnesota Statutes, Chapter 256B that are provided to children who are not eligible for medical assistance, general assistance medical care, or other third party health coverage and who have gross family incomes that are equal to or less than 185 percent of the federal poverty guidelines. Minnesota Statutes, section 256.936, subdivision 1 (d) requires reimbursement under this section to be "at the same rates and conditions established for medical assistance." Minnesota Statutes, section 256B.04, subdivision 2 requires the commissioner to "make uniform rules, not inconsistent with law, for carrying out and enforcing [the medical assistance program] in an efficient, economical, and impartial manner" so that the program "may be administered uniformly throughout the state..." Using the same procedures and standards for surveillance and utilization review as medical assistance is consistent with the requirements of Minnesota Statutes, section 256.936, subdivision 1 (d).

The consolidated chemical dependency treatment program is established under Minnesota Statutes, section 254B.03 to provide chemical dependency treatment to chemically dependent persons including certain persons eligible for medical assistance and general assistance medical care. Because some persons receiving chemical dependency treatment are medical assistance or general assistance medical care recipients, the surveillance and utilization review procedures and standards applicable to those two public assistance programs apply to them and their service providers. Having a single set of standards and procedures applicable to all participants in a publicly funded program such as the consolidated chemcial dependency treatment program is consistent with

administrative efficiency and equity and avoids possible confusion.

Medical assistance eligibility is required to receive home and community-based services under a waiver from HCFA. Minnesota Statutes, section 256B.04, subdivision 2 requires the commissioner to administer the medical assistance program uniformly throughout the state. As discussed above, having a surveillance and utilization review program is a requirement to obtain federal financial particpation. See Minnesota Statutes, section 256B.04, subdivision 4 and 42 CFR 455.13 and 456.3. Using the same standards and procedures of utilization and surveillance review and control for persons who receive home and community-based services under a waiver is consistent with the cited federal regulations and with Minnesota Statutes, section 256B.04, subdivision 2.

ADVISORY COMMITTEE

The department established an advisory committee to assist the department in reviewing the present rule and the proposed amendments. The committee met three times between November 1989 and March 1990. Members of the committee included health care service providers, representatives of professional organizations, county representatives, and representatives of health care consumers. See Attachment A for the list of committee members. All comments received were reviewed and considered by the department as the proposed amendments were drafted.

The department does not intend to present expert witnesses to testify on behalf of the department at the hearing.

GENERAL COMMENT

As stated in the Introduction, parts 9505.2160 to 9505.2245 include much material found in the existing rules, parts 9505.1780 to 9505.2150, that is continued without substantive change but has been restructured or technically revised to clarify its meaning and conform to rule writing standards. Therefore, the Statement of Need and Reasonableness will differentiate between new program requirements proposed in parts 9505.2160 to 9505.2245 and those that remain the same as the existing rule or have only undergone grammatical or technical changes. The SNR will cross reference the existing rule provisions which are being retained either without substantive change or with grammatical or technical changes only.

9505.2160 SCOPE AND APPLICABILITY

Subpart 1. Scope This part is necessary to specify the scope of the rules, the health care programs to which they apply, and the Minnesota rules and federal regulations that are related to these rules. It is reasonable to inform affected persons so they will know where to find applicable standards and how to comply. It also is reasonable to inform the reader of what the rule encompasses because the information assists the reader. See also pages 1 and 2 for a discussion of the programs to which parts 9505.2160 to 9505.2245 apply.

Subp. 2. Applicability. This part is necessary and reasonable because it informs readers.

9505.2165 DEFINITIONS

Subpart 1. Scope. This subpart identifies the rule parts to which the definitions in part 9505.2165 apply. The definitions are necessary to clarify the meaning of certain terms used in parts 9505.2160 to 9505.2245 and thus

establish a standard. The subpart also is necessary to clarify that terms defined in part 9505.0175 apply to parts 9505.2160 to 9505.2245 as these definitions establish standards applicable to provider services eligible for medical assistance payment. Using the definitions from the rule setting the service standards is reasonable because both rules apply to the medical assistance program and a single set of definitions avoids duplication of language and possible confusion about the required standards.

Subp. 2. Abuse. Minnesota Statutes, section 256B.04, subdivision 10 requires the department to "establish by rule general criteria and procedures for the identification and prompt investigation of suspected medical assistance .....abuse..." Minnesota Statutes, section 256B.064, subdivision 1a establishes the authority of the commissioner to seek monetary recovery and impose sanctions against vendors of medical care in cases of abuse related to the provision of medical assistance services. Thus, a definition is necessary to clarify the meaning of the term.

The term "abuse" is defined in the present rule, part 9505.1750, subpart 2, as "a pattern of practice by a provider, or a pattern of health care utilization by a recipient which is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary cost to the programs, or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health care." The definition in items A to J goes on to specify the conditions which characterize abuse.

The substance of the proposed definition is basically unchanged from that in the present rule, part 9505.1750, subpart 2.

42 CFR 455.2 and 42 CFR 1002.2 define "abuse" as "provider practices that are inconsistent with sound fiscal, business, or medical practices and result in

unnecessary cost to the Medicaid [medical assistance] program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program." Proposed subpart 2 has deleted the term "pattern" from the definition in order to be consistent with the quoted definitions in the federal regulations. Furthermore, Minnesota Statutes, section 256B.064, subdivision 1c states that "patterns need not be proven as a precondition to monetary recovery for false claims, duplicate claims, claims for services not medically necessary or false statements." It is reasonable for a rule to be consistent with federal regulations as such consistency is a condition for receiving federal financial participation as required under Minnesota Statutes, section 256B.04, subdivision 4. The term "pattern" is unnecessary since the characteristics of the definition "abuse" require, in instances where a practice might be the result of error, more than one occurrence of the inappropriate practice to take place before it becomes an abusive practice. The definition "abuse" allows for error. See also part 9505.2215, subpart 1, item A which allows the commissioner to seek monetary recovery for error on the part of provider, department, or local agency.

The proposed definition is divided into two items to clarify its applicability to providers and to recipients in a manner consistent with the federal regulations. Item A defines abuse as related to providers.

Subitem (1) is similar to item A of present rule part 9505.1750, subpart 2; subitem (2) is similar to item B; subitems (3) and (4) are similar to item C. Subitem (5) defines abuse to include the submission of claims for health services that do not comply with part 9505.0210 and, if applicable, part 9505.0215. Part 9505.0210 establishes the general requirements that a health service must meet

to receive medical assistance payment. Part 9505.0215 states additional requirements applicable to health services provided to Minnesota residents by a provider located outside of Minnesota. Parts 9505.0210 and 9505.0215 were adopted pursuant to Minnesota Statutes, section 256B.04, subdivision 2 which requires the department to administer the medical assistance program. For a provider to submit claims contrary to these requirements threatens the integrity of the program and should be treated as an abusive practice. Providers have signed agreements which specify compliance with all laws and regulations related to medical assistance as a condition of continued participation. See part 9505.0195, subpart 2, application to participate (as a medical assistance provider), and subpart 5, duration of provider agreement. Expecting provider compliance with program rules is reasonable as providers have the opportunity to be aware of the requirement and of the consequences of failure to comply.

Subitem (6) is similar to item G of the present rule, part 9505.1750, subpart 2; subitem (7) is similar to item D of part 9505.1750; and subitem (8), to item E.

Subitem (9) defines abuse to include the provider's failure to disclose or make available to the department the recipient's health service records or the provider's financial records as required under these proposed rules in part 9505.2180. A provider's financial record and a recipient's health service record contain information the department needs to determine compliance with medical assistance rules and protect the integrity of the program. Minnesota Statutes, section 256B.064, subdivision 1a requires vendors of medical care to "grant the state agency [the department] access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients." 42 CFR 431.107 (b) (1) requires providers to turn over to the department "any records necessary to disclose the extent of services the provider

furnishes to recipients." 42 CFR 431.107 (b)(2) requires providers to furnish this information to the State on request. This information is found in the recipient's health service records and in the provider's financial records. Part 9505.2175 specifies the information a provider must enter in a recipient's health record. Access to these records is necessary for the department's determination of the provider's compliance with program rules. Therefore, the provider's failure to produce these records is contrary to state laws and state and federal regulations. 42 CFR 455.100 requires providers' disclosure of ownership and control information. This information is in the providers' financial records. See part 9505.2180, subpart 1, item G. It is reasonable to define as abuse the provider's failure to produce or provide access to records because the failure violates laws and rules related to medical assistance participation and makes it impossible for the department to carry out its responsibility to monitor the provision of medical assistance services.

Subitem (10) defines one type of abuse to be the failure to properly report duplicate payments from third parties for covered services to recipients. Minnesota Statutes, section 256B.37, subdivision 5 requires the use of private third party payers to the fullest extent before medical assistance may make a supplemental payment. Minnesota Statutes, section 256B.37, subdivision 5 also specifies that "the combined total amount paid [adding together the payment from the private third party source and the supplemental medical assistance payment] must not exceed the amount payable under medical assistance in the absence of other coverage." Also see part 9505.0070, which requires the use of third party coverage before medical assistance payment is made available on the recipient's behalf and holds the provider responsible for billing the third party. Thus, a provider's failure to report payments made by a third party payer will clearly

result in unnecessary costs or duplicate payments. Minnesota Statutes, section 256B.04, subdivision 15 requires the department to safeguard against unnecessary costs and duplicate payments. Minnesota Statutes, sections 256B.04, subdivision 10 and 256B.064, subdivision 1a, read together, require the department to identify and investigate false statements of material facts by a provider for the purpose of obtaining greater compensation than that to which the provider is legally entitled. Therefore, subitem (10) is reasonable because it is consistent with the statutory and regulatory requirements applicable to claims for medical assistance payments and to the department's obligation to safeguard against duplicate payments for a health service.

Subitem (11) defines one type of abuse to be the provider's failure to obtain information and assignment of benefits as required under part 9505.0070 or to bill Medicare as required under part 9505.0440. It is reasonable to expect providers to comply with medical assistance rules because, by entering into a performance agreement with the department, providers have agreed to comply with all federal and state statutes and rules related to the medical assistance program.

Subitem (12) states that the provider's failure to keep financial records as required under part 9505.2180 constitutes abuse. Minnesota Statutes, section 256B.064, subdivision 1a requires providers to allow the state to access "all records necessary to disclose the extent of the services provided to program recipients." Part 9505.0195 requires a provider to comply with the terms of participation set out in the provider agreement between the provider and the department. In the agreement, providers agree to maintain "records which fully disclose the extent of benefits provided to individuals under these programs." (See Attachment B.) Therefore, defining abuse to include the provider's failure

to keep required records is reasonable because the provider has failed to carry out an obligation and thereby has violated the provider agreement.

Subitem (13) states that abuse includes the submission or causing the submission of false information to obtain prior authorization, inpatient hospital admission certification, or a second surgical opinion. Prior authorization under parts 9505.5000 to 9505.5030, inpatient hospital admission certification under parts 9505.0500 to 9505.0540, and second surgical opinion under part 9505.5035 are three programs assisting the department to comply with the requirement of Minnesota Statutes, section 256B.04, subdivision 15 to "safeguard against unnecessary or inappropriate use of medical assistance services, against excess payments, against unnecessary or inappropriate hospital admissions or lengths of stay..." The rules specify the information the provider must submit and the criteria the department will use in determining whether a service is necessary and appropriate for a specific recipient's condition. If the department receives false information about the recipient's condition, the department will not have a way to accurately determine whether the service is necessary and appropriate for the recipient and thus may be unable to comply with the statutory requirement of subdivision 15. Thus the provider's failure hurts the integrity of the program and also is a violation of the provider's agreement to comply with the federal and state laws and rules related to medical assistance. Additionally, Minnesota Statutes, section 256B.064, subdivision 1a allows the commissioner to seek monetary recovery from a provider who submits false statements of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled. For these reasons, it is reasonable to define as abuse the submission or causing the submission of false information.

Subitem (14) states that abuse includes submitting a false or fraudulent

application for provider status. 42 CFR 1002.203a requires the department to establish "administrative procedures which enable the [department] to exclude from Medicaid [medical assistance] reimbursement a provider who it determines has (1) knowingly and willfully made or caused to make any false statement or misrepresentation of material fact in claiming, or use in determining the right to payment under Medicaid." The department relies on the accuracy of the provider's application to determine whether an applicant is eligible to be a medical assistance provider. Included among the required information are questions related to the applicant's licensure. (See Minnesota Statutes, section 256B.02, subdivision 7 which defines "vendor of medical care" in the medical assistance program as "any person or persons furnishing, within the scope of the vendor's respective license, any or all of the following goods or services.....") Falsifying such information in an application could result in a vendor of medical care receiving medical assistance payment to which a vendor was not entitled. Thus, it is reasonable to define submission of a false or fraudulent application for provider status as abuse because the definition is consistent with the federal regulation requiring exclusion of such a provider. Subitem (15) states that abuse includes a provider's continuation of an abusive practice after receiving a warning to cease. The department, at times, becomes aware that providers' practices are not in compliance with federal or state rules or statutes, sometimes as a result of amendments to the statutes or rules, and sends written warnings to the providers requesting them to correct the erroneous practice. The practice usually does not warrant the imposition of sanctions or monetary recovery. It is merely a practice the department wants corrected. However, if the request is ignored, then the practice becomes abusive. Thus, the definition is reasonable because the provider has been warned of the incorrect

practice but has not complied with the request to cease and be in compliance with federal and state rules and statutes.

Subitem (16) states that requesting or receiving payment from a recipient for a covered service is an abuse. 42 CFR 447.15 states that only providers who agree to accept, as payment in full, the amounts paid by medical assistance plus any deductible, coinsurance or copayment required of the recipient are eligible to participate. Part 9505.0225 prohibits providers from requesting or receiving payment from a recipient or from attempting to collect from a recipient for a covered service unless a copayment is authorized or the recipient has incurred a spenddown obligation. If a provider does solicit, charge, or receive payments from a recipient other than those specified in the federal and state regulations, then the provider has violated the program rules. The performance agreement between the provider and the department has informed the provider of the obligation to comply with program rules. Therefore, the definition is reasonable because a violation of program rules is an abusive practice.

Subitem (17) defines abuse to include payment by a provider of program funds to a vendor suspended or terminated from the program. 42 CFR 455.2 states, "[e]xclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid." 42 CFR 455.2 states, "[s]uspension means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State or local court will not be reimbursed under Medicaid." Proposed part 9505.2235, subpart 1 specifically states that "(N)o payments shall be made to a vendor, either directly or indirectly, for services provided under a program from which the vendor has been suspended or terminated." It is necessary to make payment of program funds by a provider to a terminated

or suspended vendor an abusive practice to protect the integrity of the program. When a vendor is suspended or terminated, the provider agreement between the State and the vendor is cancelled. Therefore, the vendor should not benefit from the program. Thus, it is reasonable to make payment by a provider of program funds to a vendor suspended or terminated from program participation an abuse because the payment is contrary to the intent of the prohibition stated in the federal regulations and violates the integrity of the program.

Subitem (18) defines abuse to include billing a program for services after entering into an agreement with a third party payer to accept the third party's payment as payment in full. Medical assistance is only required to pay a provider for services when there is a legal obligation to pay. Minnesota Statutes, section 256B.37, subdivision 5 states "(M)edical assistance must not make supplemental payment for covered services rendered by a vendor who participates or contracts with a health coverage plan if the plan requires the vendor to accept the plan's payment as payment in full." Providers enter into health coverage plans voluntarily. They are expected to be aware of the terms of their participation in the third party payer's plan and in medical assistance. Thus, the definition is reasonable because the provider has the opportunity to be informed and medical assistance is prohibited from supplementing agreements to the benefit of the provider and third party payer.

Item B defines abuse as related to recipients. The item is reasonable as it is consistent with the requirement of Minnesota Statutes, section 256B.04, subdivision 15 to safeguard against unnecessary or inappropriate use of medical assistance services and against excess payments.

Subitem (1) is reasonable because it is consistent with Minnesota Statutes, section 256B.04, subdivision 15. It clarifies the definition and is similar to

the present definition in part 9505.1750, subpart 2, item I but does not retain the term "knowingly". Whether a person acts "knowingly" is a difficult standard to prove and is usually applied to criminal cases. The rule merely defines activities that are abusive to the program and carries with it a lower standard of proof. 42 CFR 455.2 defines abuse as "recipient practices that result in unnecessary cost to the Medicaid Program." The federal regulations do not require proof that the recipient acted knowingly. Equipment and supplies are being added to the provision as an added protection against the unnecessary expenditure of medical assistance funds as required by Minnesota Statutes, section 256B.04, subdivision 15 and 42 CFR 456.3. The definition is reasonable as it is consistent with federal regulations and state statutes and protects public funds.

Subitem (2) is reasonable because it is consistent with Minnesota Statutes, section 256B.04, subdivision 15 and with the present definition in part 9505.1750, item J. A recipient may have a complex medical condition that requires opinions from practitioners of different specialties to obtain a full diagnosis or complete treatment recommendations. Also, some conditions require second opinions before a recommended surgery is eligible for medical assistance payment. Although these opinions are related to the recipient's same health condition, they are necessary either to comply with a program requirement or to assure that the recipient receives appropriate and necessary covered services. School-age children who have individualized education plans (IEPs) may receive some health services in school during the school day. The student's IEP is developed by a team that includes teaching staff and therapists and includes all educational and health services that a student needs to receive during school hours. The plan specifies the type, scope, and frequency of each service. A

student receiving health services under an IEP may also require additional health services from other providers outside of the school day. Examples of services that may be necessary both during the school day and at home are gastrostomy feedings and physical therapies. See Minnesota Statutes, section 256B.0625, subdivision 26 about the provision of IEP services as covered services. Thus, it would be unreasonable to define services such as IEP services and additional opinions that are medically necessary or required by a program, as duplicate services.

Subitem (3) defines as abuse a recipient's continuation of an abusive practice after receiving a written warning to cease the conduct. The department has the practice of sending recipients warning letters if the department has evidence that the recipient might be overutilizing medical assistance services but the evidence is not sufficient to warrant the recipient's sanction. The warning letter is a preliminary means of informing the recipient about the recipient's inappropriate use of program services and the consequences of continuing the inappropriate use, and thereby of encouraging the recipient's compliance. This practice is consistent with the recommendation of the Legislative Auditor in the August 1988 report "Medicaid: Prepayment and Post-payment Review Follow-up Study." The definition is reasonable because the recipient is expected to comply with medical assistance rules , has been informed of the compliance requirement, has been warned of the consequence of failure to comply, and thus can make an informed choice. The subitem is consistent with the requirement to safeguard against unnecessary or inappropriate use of medical assistance services as specified in Minnesota Statutes, section 256B.04, subdivision 15.

Subitem (4) defines as abuse the altering or duplicating of the medical (assistance) identification card. A medical identification card is issued by the

medical assistance program to a person that a county has determined eligible according to the requirements of part 9505.0010 to 9505.0150. The card gives the names of the eligible person or persons, the period of eligibility, and the restrictions, if any, placed on the person's or persons' access to services. The recipient's county of service issues the initial medical identification card to the recipient. Subsequent cards are issued by the department or, in the case of a recipient participating in a prepaid health plan (PPHP), by the PPHP. See part 9505.0145. No other entity is authorized to issue a card or to change the information on a card. It is reasonable to define altering or duplicating the card as abuse because such alteration or duplication is contrary to medical assistance rules and would change the eligibility determination made according to the rules by the agency authorized to do so. Also see part 9505.0131 which specifies the consequences incurred by a person who wrongfully obtains assistance.

Subitem (5) defines as abuse the use of a medical identification card that belongs to another person. The SNR of subitem (4) discussed the determination of eligibility to receive medical assistance, the issuance of a medical identification card, and the consequences of wrongfully obtaining assistance. Using another person's medical assistance card is clearly an example of wrongfully obtaining assistance. Therefore, it is reasonable to define such a practice as abuse because wrongfully obtaining assistance may result in unnecessary cost to the Medicaid program. See the definitions of abuse and fraud in 42 CFR 455.2. Also see the definition of "wrongfully obtaining assistance" in part 9505.0015, subpart 49 which establishes a standard applicable to medical assistance recipients.

Subitem (6) defines as abuse the circumstance in which a recipient permits an

unauthorized individual to use the recipient's card to obtain a health service for which medical assistance is billed. This item clarifies item H of present part 9505.1750, subpart 2, which states "(t)he recipient permitting use of his/her medical identification card by any unauthorized individual for the purpose of obtaining health care through any of the programs." As discussed above in Subitem (5), use of another person's medical identification card consitutes wrongfully obtaining assistance. Thus, defining as recipient abuse the circumstance in which a recipient uses a medical identification to assist an unauthorized person to obtain a health service is reasonable because the act assists a person to wrongfully obtain assistance. See 42 CFR 455.2 and part 9505.0010, subpart 49 which defines "wrongfully obtaining assistance" in regard to eligibility to receive medical assistance.

Subitem (7) defines duplicating or altering prescriptions as abuse. Minnesota Statutes, section 151.37, specifies that only a licensed practitioner may prescribe medication. Under the medical assistance program such a practitioner is a physician, a dentist, osteopath, or podiatrist. Part 9505.0340, subpart 3 specifies that medical assistance payment is limited to prescribed drugs that are dispensed in the quantity specifed in the prescription. 42 CFR 455.2 defines fraud as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or another person." Thus, it is reasonable to define the practice of altering or duplicating a prescription as an abuse as such a practice is contrary to statutory standards about who is qualified to prescribe and can be assumed to arise from the person's desire to obtain an unauthorized benefit for himself or another person. The definition also is consistent with the requirement of Minnesota Statutes, section 256B.04, subdivison 15 to safeguard against

unnecessary and inappropriate use of medical assistance services.

Subitem (8) defines as abuse misrepresenting material facts as to physical symptoms to obtain medical assistance services. Minnesota Statutes, subdivision 15 requires the department to safeguard against unnecessary or inappropriate use of medical assistance services. A person's diagnosis and appropriate treatment depend in part on the person's accuracy in reporting his physical or mental symptoms to the provider. If the person misrepresents the facts, the person's condition might be misdiagnosed and the treatment might be inappropriate or unnecessary. Therefore, this subitem is reasonable because it is consistent with the statutory requirement of safeguarding against unnecessary or inappropriate use of medical assistance services. It also is consistent with the prohibition of wrongfully obtaining assistance in part 9505.0130.

Subitems (9), (10), and (11) are consistent with the prohibition of wrongfully obtaining assistance in part 9505.0130. Each subitem describes the act of furnishing false or incorrect information from a slightly different viewpoint. All the subitems are necessary to ensure that it cannot be successfully argued that such an act is not abuse.

Subpart 3. Federal share. Proposed rule, part 9505.2231, subpart 3 authorizes the commissioner to recover the federal share from a provider when it is due and owing to the federal government. It is necessary to define the term "federal share" to clarify its meaning. The definition is consistent with 42 CFR 400.203. Consistency with federal regulations is reasonable because it ensures compliance with Minnesota Statutes, section 256B.04, subdivision 4 in regard to obtaining federal financial participation. It should be noted that the terms "federal share" and "federal financial participation" can be used interchangeably.

Subpart 4. Fraud. Proposed rule, part 9505.2160 defines the scope of parts

9505.2160 to 9505.2245 as "governing procedures to be used by the department in the identification and investigation of fraud..." A definition of "fraud" is necessary to clarify its meaning and set a standard for providers and recipients. It is reasonable to use the statutory definition because it ensures the rules' consistency with the statutes.

Subpart 5. Health service. "Health service" is a term used throughout parts 9505.2160 to 9505.2245 and all other rules governing the medical assistance program. A definition is necessary to clarify its meaning and set a standard. Part 9505.0175, subpart 14 defines the term as it applies to providers eligible for medical assistance payment for health services. Defining the term by citing the definition found in the rule establishing the medical assistance provider standards is reasonable because it ensures consistency in the administration of medical assistance program rules.

Subpart 6. Health service record. "Health service record" is a term used in these rules. A definition is necessary to clarify its meaning. The definition is the same as that found in the present rule, part 9505.1750, subpart 5 except that the term "health care record" has been modified to "health service record". "Health service record" is the term used in parts 9505.0170 to 9505.0475, which establish the conditions to be eligible to receive medical assistance payment as a provider of health services. The modification is reasonable because it assures consistency between two sets of rules establishing standards for the same program, the medical assistance program.

Subpart 7. Primary care case manager. "Primary care case manager" is a term used in these rules. A definition is necessary to clarify its meaning. The primary care case manager has the responsibilities toward a recipient's care that are specified in the definition. Minnesota Statutes, section 256B.04,

subdivision 15, clause (4) authorizes the commissioner to "select providers to provide case management services to recipients who use health care services inappropriately." The primary care case manager may be either a physician or a group of physicians and may be employed by or under contract to the department. The Physician's Current Procedural Terminology, Fourth Edition (CPT-4) defines physician case management. (It should be noted that many national medical specialty societies, state medical associations, health insurance organizations, and independent physicians contributed to the CPT-4 which lists descriptive terms and identifies codes for reporting medical services and procedures performed by physicians. See attachment C for a listing of contributors.) The definition is reasonable because it is consistent with a current standard of medical practice. See the definition of physician case management on page Medicine/59 of the CPT-4. Thus, the definition is reasonable because it informs affected persons of the responsibilities of the primary care case manager and of who is responsible for designating the case manager.

Subpart 8. Program. "Program is a term used in these rules. A definition is necessary to clarify its meaning. The definition contains the programs listed in the present rule, part 9505.1750, subpart 10 and also the additional programs that are paid for from medical assistance funds which have been authorized by statute and implemented after the present rule was adopted. These programs are the children's health plan, consolidated chemical dependency program, and home and community-based services under a waiver from HCFA. The modification is reasonable as it informs affected persons of the programs paid for through medical assistance funds and therefore subject to these rules.

Subpart 9. "Provider" is a term used in these rules and other rules establishing standards applicable to the medical assistance program. The term

as defined in part 9505.0175, subpart 38 is applicable to all medical assistance related rules. The definition is reasonable as it informs affected persons and ensures consistency among rules affecting the medical assistance program and its service providers.

Subpart 10. Recipient. "Recipient" is a term used in these rules and other rules establishing standards applicable to the medical assistance program. A definition is necessary to clarify its meaning. The definition includes the elements found in the present definition in part 9505.1750, subpart 12, but it has been expanded through the use of the word "program" to include all persons who are eligible to receive services under a program. See the definition of "program" in subpart 8 above. The expanded definition is reasonable because it includes all eligible persons who are and whose services are subject to the provisions of these rules.

Subpart 11. Restriction. "Restriction" is a term used in these rules. A definition is necessary to clarify its meaning.

Item A. Under the present rules, parts 9505.1750 to 9505.2150, the department could either suspend a provider from a program or allow a provider to stay in a program. 42 CFR 431.54 (f) allows a State agency to "restrict the provider through suspension or otherwise, from participating in the Medicaid program for a reasonable period of time" and thus allows the department more flexibility in sanctioning a provider than the present rule does. The proposed definition of restriction allows the department flexibility in sanctioning a provider by means of limiting the scope of the health services for which a provider may receive payment through a program. At times, full suspension is too harsh a sanction yet no suspension is not adequate. With restriction the provider can be prevented from participating in the program in areas where the provider has significantly

abused the program or has consistently engaged in practices that are not medically necessary. For example, a physician is an adequate or good provider in all areas of his or her practice except he or she consistently overprescribes narcotic drugs for recipients. Restriction of the physician would allow the department to keep the provider enrolled but would prohibit that physician from prescribing narcotic drugs for recipients. Thus the definition is reasonable because it imposes the sanction of limiting the health services for which a provider may receive payment, it is consistent with the federal regulation, and provides the department flexibility in protecting the integrity of the program.

Item B. Sometimes a recipient may use program services in ways that are inappropriate to the recipient's health service needs and the mandate of Minnesota Statutes, section 256B.04, subdivision 15 which requires the department to safeguard against unnecessary and inappropriate use of medical assistance services. For example, a recipient who does have health service needs may inappropriately obtain many prescriptions of the same medication from several physicians who are unaware that the recipient has already seen other physicians for the same purpose. Thus the recipient obtains an unnecessary amount of medication. The recipient is eligible for the program and has health needs that require program services but has abused the program by obtaining unnecessary prescriptions. Restricting the recipient's ability to obtain health services is consistent with safeguarding against unnecessary and inappropriate services and yet protects the recipient's eligibility to receive necessary services. The restriction may be applied by requiring the recipient to use a designated provider or by limiting the recipient to services which the department authorizes before they are provided (prior authorization.) Thus the definition is reasonable as it assures the recipient will receive needed health services but

meets the requirement of safeguarding against unnecessary or inappropriate use of services. Item B is consistent with the provisions of 42 CFR 431.54 (e) which permits the department to restrict a recipient for a reasonable period of time if the department finds the recipient has used medical assistance services or items "at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State...." It also is reasonable to limit the restriction to a period not to exceed 24 months because such a period balances the department's responsibility to impose a penalty for abuse and the recipient's freedom of choice of provider. See part 9505.0190 and 42 CFR 431.51 about choice of provider. It is reasonable to indicate the restriction on the recipient's medical identification card because the information informs the provider about a limitation on program payment for services to the recipient.

Subpart 12. Suspending participation or suspension. The present rule defines "suspending participation" in part 9505.1750, subpart 16. Proposed subpart 12 is the same as and continues the definition found in the present rule. Suspending participation is a sanction applied to a provider who has been shown to abuse a program. The term "suspension" is an abbreviation. The use of an abbreviation is reasonable because it shortens the rules. The definition is consistent with 42 CFR 431.54 (f), 42 CFR 455.2, and 42 CFR 1002.2.

Subpart 13. Suspending payments. The present rule defines "suspension of payments" in part 9505.1750, subpart 17. Proposed subpart 13 is the same as and continues the definition found in the present rule. Suspension of payments is a form of sanction applied to a provider who has been shown to abuse a program. The definition is consistent with the intent of 42 CFR 455.16 (2) and 42 CFR 1002.2.

Subpart 14. Terminating participation. The present rule defines "terminating participation" in part 9505.1750, subpart 18. Proposed subpart 14 is the same as and continues the definition found in the present rule. Terminating participation is a form of sanction applied to a provider who has been shown to have committed abuse, fraud or theft related to a program. The definition is consistent with the intent of 42 CFR 455.16 (2).

Subpart 15. Theft. Theft is a term used in these rules. A definition is necessary to clarify its meaning. Minnesota Statutes, section 609.52, subdivision 2, clause (3)(c) defines theft in relation to medical assistance claims for payment and reimbursement. The definition is reasonable as it informs affected persons of the statutory definition of the term.

Subpart 16. Third party payer. "Third party payer" is a term used in these rules. A definition is necessary to clarify its meaning. It is defined for the medical assistance program in part 9505.0015, subpart 46. (It should be noted that part 9505.0175, subpart 48 which applies to providers eligible for medical assistance payment defines "thrid party payer" by reference to part 9505.0015, subpart 46.) It is reasonable to use the definition applicable to the medical assistance program which is one of the programs governed by parts 9505.2160 to 9505.2245 in order to assure consistency among rules setting standards for the same program and thereby to avoid confusion among affected persons. However, the definition in part 9505.0015, subpart 46 specifically excludes Medicare as a third party payer. Part 9505.0440 requires certain providers to bill Medicare before billing medical assistance if the recipient is Medicare eligible and the recipient's services are covered by Medicare. Medicare thus is a third party payer and it is reasonable to include Medicare in the definition of the term.

Subpart 17. Withholding payments. The present rule defines "withholding of

payments" in part 9505.1750, subpart 20. Proposed subpart 17 is the same as and continues the definition found in the present rule. Withholding payments is a method of recovering money to which the provider was not entitled because of provider error or provider abuse, theft, or fraud. The definition is consistent with 42 CFR 455.16.

9505.2170 BULLETINS, MANUALS, AND FORMS RELATED TO PROGRAM.

Subpart 1. Department issuance. The subpart is necessary to clarify a responsibility of the commissioner. The present rule in part 9505.2170 states that the department "will issue instructional bulletins, manual materials, and forms to assist others in complying with parts 9505.1750 to 9505.2150." The proposed rule clarifies this provision to require that the bulletins, manuals, and forms must be consistent with parts 9505.2160 to 9505.2245 and needed to "assist providers, local agencies, and recipients in complying with" these and other rules of the programs. The proposed rule clarifies the relationship between the materials prescribed by the commissioner and these rules. By clarifying this relationship, the rule avoids the possibility of arbitrary and capricious actions about the prescribed materials. Thus the subpart is reasonable as it limits the materials to those based on the rule and informs affected persons of the basis for the materials. The revision is not substantive but for purposes of clarification.

Subpart 2. Provider compliance. This subpart is necessary to specify the provider's obligation to comply with the procedures and forms issued according to subpart 1. Minnesota Statutes, section 256B.04, subdivision 10 requires the department to establish "procedures related to the identification and prompt investigation of suspected...fraud, theft, abuse, presentment of false or

duplicate claims...." Minnesota Statutes, section 256B.04, subdivision 2 requires the commissioner to administer the medical assistance system "uniformly throughout the state." See also Minnesota Statutes, section 256D.04, clause (2) in regard to the commissioner's duties to administer the general assistance medical care program. It is reasonable to have a uniform standard applicable to all programs under these rules in order to avoid confusion among providers who furnish services under more than one of the programs. The subpart is consistent with the statutes cited in this paragraph.

9505.2175 HEALTH SERVICE RECORDS.

Subpart 1. Documentation required. This subpart is necessary to establish the obligation of the provider to document the health services provided to the recipient. This subpart is a technical revision of the present rule, part 9505.1800, subpart 1. The revision does not change the substance of the present rule. It should be noted that the term "health services" as defined in part 9505.2165, subpart 5 includes medical and all other health services. Therefore, this part uses the term health service records.

Subpart 2. Required standards for health service records. 42 CFR 431.107 (b)(1) requires a provider to "keep any records necessary to disclose the extent of services the provider furnishes to recipients." This subpart is necessary to establish the standards for the providers' records. Proposed subpart 2 totally reorganizes the present rule, part 9505.1800, subparts 2 and 3, items A and B. The revision does not change the substance of the present rule. Item C clarifies that each entry must contain the date on which it is made. Item C adds the new requirement that the record must show the length of time spent with the recipient if the amount paid for the service depends on the time spent with the recipient.

Certain medical assistance payments, such as those for case management services, are based on service units consisting of a certain number of minutes. Thus, the new requirement is reasonable because it facilitates accurate billings and provides an audit trail. The requirement is consistent with 42 CFR 431.107 (b)(1) which requires providers to "keep any records necessary to disclose the extent of services the provider furnishes to recipients." Subitem C(4) continues the requirement that the person from whom the recipient received the service must sign the record. "Counter signatures" were required in the present rule. However the proposed rule clarifies the requirement by specifying the person required to countersign. Items D to K of the present rule, part 9505.1800, subpart 3 are continued in proposed subpart 2, items D to H with technical revisions and clarifications. Item G has been clarified to include all of the relevant terms used to describe a recipient's treatment plan in the various applicable rules. Proposed item I of subpart 2 is in the present rule, part 9505.1810, subpart 2, item B, subitem (1).

Subpart 3. Requirements for pharmacy service records. 42 CFR 431.107 (b)(1) requires a provider to "keep any records necessary to disclose the extent of services the provider furnishes to recipients." This proposed subpart is necessary to establish record requirements for pharmacy services provided to recipients through a program. Pharmacy service records differ in content from other health service records and must comply with certain regulatory standards. The standards are established in Minnesota Rules, part 6800.3110 which specifies the patient profile record system that a pharmacy must maintain for persons for whom it dispenses prescriptions and Minnesota Rules, part 6800.3950 which sets the standards applicable to the use of electronic data processing equipment in maintaining the required records. The proposed subpart 3 requires pharmacy

service providers to comply not only with the requirements of subparts 1 and 2 but also with the standards of the Board of Pharmacy. The requirements are reasonable because they ensure consistency with the rules of the Board of Pharmacy and because they do not impose an added burden on the pharmacy service providers. It should be noted that the proposed subpart 3 requires the pharmacy service provider to keep a record that is "a hard copy made at the time of the request for service and .... kept for a period of five years." The ease with which electronic data can be changed defeats the purpose of records providing an audit trail. Thus requiring a hard copy is reasonable because it protects the integrity of the program and provides an audit trail. The five year record retention requirement is consistent with proposed part 9505.2190, subpart 1 and with present part 9505.1850.

Subpart 4. Requirements for medical transportation service records. This subpart is necessary to set standards applicable to records of medical transportation services.

Item A which requires a service record of the origin, destination and distance traveled is reasonable because it provides an audit trail for the claim for service payment which is based in part on the distance traveled. It should be noted that item A is a clarification of subitem C(2) of subpart 2 of the present rule part 9505.1810 which requires "trip tickets".

Item B. There are two types of medical transportation; specialized and life support, which consists of advanced or basic or life support. The type of transportation affects the amount of the medical assistance payment. Therefore a revision of the present rule is necessary to require a record of the type of transportation because 42 CFR 431.107 (b)(1) requires providers to "keep any records necessary to disclose the extent of services the provider furnishes to

recipients." Therefore, item B is consistent with the federal regulatory requirement about recordkeeping.

Subitem C(1) of the present rule is continued in proposed item C which includes technical changes to clarify the requirement and to ensure consistency with provider service standards found in part 9505.0315, subpart 1, items A and F.

Subpart 5. Requirements for medical supplies and equipment. The present rule contains record requirements applicable to suppliers of medical equipment and non-durable supplies in part 9505.1810, subpart 2, item D. Proposed subpart 5 clarifies the language of the present rule's requirements and incorporates in item A provider services standards that are found in parts 9505.0210 and 9505.0310 which were adopted in November 1988. It is reasonable to require that the record include evidence that the service meet the service standards because medical assistance payment is available only for services that meet the standard and the record provides an audit trail. See Minnesota Statutes, section 256B.04, subdivision 12. Item B of proposed subpart 5 clarifies the present requirement of "prescription" by including "order". Use of the term "prescription" may imply a physician's prescription whereas the rules intend a broader meaning that includes orders from providers other than physicians. 42 CFR 431.107 (b)(1) requires the provider to "keep any records necessary to disclose the extent of the services the provider furnishes to recipients." Requiring the provider to keep a record of the name and amount of the medical supply or equipment provided for the recipient is reasonable as this information is necessary to disclose what has been provided to the recipient and provides an audit trail.

9505.2180 FINANCIAL RECORDS.

Subpart 1. Financial records required of providers. This subpart is necessary

to establish a standard for financial records to be kept by program service providers. The present requirements are in part 9505.1820, subparts 1 and 2. Proposed subpart 1 combines the requirements of subparts 1 and 2 of the present rule, part 9505.1820. Proposed subpart 1 continues present requirements and makes technical changes in proposed items A to D.

Item E is a new requirement. Patient appointment books and supervision schedules are evidence about who receives and provides health services. This evidence may be used as a comparison with services that the provider has actually billed to a program and may be helpful in detecting discrepancies. 42 CFR 431.107 (b)(1) requires providers to "keep any records necessary to disclose the extent of the services the provider furnishes to recipients." Therefore, item E is reasonable because it assists in determining the extent of the services furnished to recipients. Furthermore, specifying patient appointment books and supervision schedules as required records is reasonable because this information is routinely compiled during the course of the providers' business and thus the requirement does not place an additional burden on the providers.

Item F clarifies one requirement of item E of the present rule, part 9505.1820, subpart 2, evidence of claims for reimbursement. A billing transmittal form is the document used to bill the medical assistance program. It is reasonable to clarify the rule to inform affected persons and assist their compliance.

Item G is a new requirement. 42 CFR 455.100 (a) requires states to require "disclosure by providers and fiscal agents of ownership and control information." Minnesota Statutes, section 256B.04, subdivision 4 requires the department 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...." Therefore, item G is necessary and reasonable because it assists

the state to cooperate with the federal government and receive federal financial participation in paying for medical assistance program services.

Item H is a new requirement. Past and present staff members of a provider's services are the persons who perform the services and keep the health service and financial records. The information from their records may provide additional evidence about the provider's services to recipients. The department's SURS unit often uses employee records during the course of an investigation and considers these records to be financial records. The requirement is reasonable because it protects the integrity of the programs and provides an audit trail. It is consistent with the requirement of Minnesota Statutes, section 256B.064, subdivision 1a that vendors of medical care "grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients." The employee records provide the department a means to access current and past employees in order to interview them for purposes of verifying the extent of services provided to program recipients. Furthermore, access to employee records would assist the department in determining whether a suspended provider was using the provider number of a participating provider in order to receive medical assistance payments, a practice prohibited by 42 CFR 455.2. See also proposed part 9505.2235, subpart 1 which is consistent with the federal prohibition. Thus, the requirement is reasonable because it is consistent with state law and federal regulation. Five years is the period of record retention required under the present rule. See part 9505.1850 and the SNR of part 9505.2190, subpart 1, Record retention required; general.

Subpart 2. Additional financial records rquired for long-term care facilities. This proposed subpart continues the substantive requirements of subpart 3 of the

present rule, part 9505.1820, but makes technical and clarifying revisions. Part 9505.0425 sets the medical assistance payment eligibility standards that must be met by long-term care providers in regard to records of the recipients' resident funds accounts. Including this information is reasonable because it informs affected persons and assists compliance.

9505.2185 ACCESS TO RECORDS.

Subpart 1. Recipient's consent to access. Minnesota Statutes, section 256B.27, subdivision 4 states, "A person determined to be eligible for medical assistance shall be deemed to have authorized the commissioner of human services in writing to examine, for the investigative purposes identified in subdivision 3, all personal medical records developed while receiving medical assistance." Minnesota Statutes, section 256B.27, subdivision 3 specifies that the investigative purposes are " whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which is duplicative, erroneous, or false in whole or in part, or which results in the vendor obtaining greater compensation than the vendor is legally entitled to; or (b) the medical care was medically necessary." This subpart is necessary to establish the authority of the commissioner to access the recipient's health service records and the related financial records under a program for the investigative purposes required under parts 9505.2160 to 9505.2245. The subpart is consistent with Minnesota Statutes, section 256B.27, subdivisions 3 and 4. It is reasonable because it informs affected persons. Under contract law, the person signing the contract if he or she has reached the age of majority is presumed competent unless it is later proved otherwise.

Subpart 2. Department access to provider records. See part 9505.1830 of the

present rule. Except for the phrase "unless the provider waives notice", the requirements of proposed subpart 2 are the same as those of the present rule. The language has been revised for purposes of clarification and simplification. It is the department practice that an investigator who finishes an audit earlier than anticipated call another provider in the same locale for permission to begin an audit there. This practice is reasonable as it is administratively efficient and also protects the provider as the provider may give or refuse permission.

9505.2190 RETENTION OF RECORDS.

Subpart 1. Retention required; general. See part 9505.1850 of the present rule. This subpart is necessary to establish a standard length of time for a provider's retention of health service and financial records. Retaining records for five years, a long-standing requirement in the medical assistance program, is the present requirement. It is necessary to clarify when the five year period begins to toll in order to avoid confusion and inform affected persons. Under part 9505.0450, a medical assistance provider must submit a claim for payment no later than 12 months after the date of service to the recipient unless the certain exceptions apply. Thus, it is reasonable to set the beginning date as the date of the billing because that is the time of an act leading to the provider's direct involvement with the medical assistance program.

The provision permitting microfilming records is found in the present rule, part 9505.1850 which has been modified for purposes of clarification in proposed subpart 1. Paper records accumulated over time fill up space that may be needed for other purposes. Thus it is reasonable to permit the provider to store the required records in a way that uses space more effectively. Microfilmed records occupy a minimum of space and are easily accessible for an audit.

Subpart 2. Record retention after provider withdrawal. See present rule, part 9505.1870. Proposed subpart 2 continues the substance of the present rule but makes technical changes to simplify the language and place it within the context applicable to the retention of all provider records.

Subpart 3. Record retention under change of ownership. See present rule, part 9505.1860. Proposed subpart 3 continues the substance of the present rule but makes technical changes to simplify the language and place it within the context applicable to the retention of all provider records.

Subpart 4. Record retention in contested cases. A provider who is sanctioned as a result of an investigation that substantiated abuse, theft, or fraud by the provider has the right to a contested case hearing pursuant to Minnesota Statutes, sections 14.57 to 14.62. The provider's health service and financial records are sources of evidence or potential evidence that may be necessary to the decision on the contested case. Therefore, it is necessary to assure that the records are available until the contested case is resolved. The case may be resolved within the five year retention period applicable to all records or the case may continue for a longer period. Therefore, it is reasonable to require the retention of the provider's health service and financial records for the longer of the duration of the contested case proceedings or the five year period required under subpart 1 because the requirement prevents the destruction of records that may be necessary to the proceedings.

9505.2195 COPYING RECORDS.

See present rule, part 9505.1840 which specifies the authority of the department to photocopy or otherwise duplicate, at its own expense, provider health service and financial records. The proposed part continues the substance of this

provision but makes technical changes in its language and structure consistent with the rest of the proposed rules. Additionally, the proposed part requires a provider who fails to allow the department to use the department's equipment to photocopy the provider's records to furnish copies to the department at the provider's own expense. Many investigations require that a large number of records be examined over a long period of time. If a provider failed to allow the department to duplicate records on the provider's premises and at the department's expense, it might be necessary to assign a department staff member to work at the provider's office over an extended period of time or to make repeated trips to the provider's office. These circumstances might result in unreasonable expense to the department and also might be disruptive to the provider's office staff who have responsibilities for record maintenance. Therefore, requiring the provider, who fails to permit the department to copy records, to provide the records at the provider's expense is reasonable because the provider as a condition of program participation has agreed to make records available to the department and the provider has a choice of whether to incur a possible disruption and copying expense or to let the department copy the records at its own expense. Providing the requested copies within two weeks after the department's request is reasonable because it balances the department's need to receive the material in a timely manner and the provider's additional workload in copying the records.

9505.2200 IDENTIFICATION AND INVESTIGATION OF SUSPECTED FRAUD AND ABUSE

Part 9505.1900 of the present rule specifies the investigative duties of the department and possible postinvestigation actions to be taken by the department in matters of suspected fraud and abuse by providers. Parts 9505.1890, 9505.2070, and 9505.2080 of the present rule specify the parallel duties and

actions in matter of suspected fraud and abuse by recipients. Proposed part 9505.2200 continues the present requirements and brings them together in one part as the investigative procedures and possible postinvestigation actions are similar. This part is necessary to set the standards applicable to identification and investigation of suspected fraud and abuse. This part is a technical change from the present rule that clarifies the present rule through better organization of applicable standards.

Subpart 1. Department investigation. This subpart is derived from present part 9505.1980, subpart 1, part 9505.1900, subpart 1 and part 9505.2070, subpart 1. This subpart is reasonable as it removes the duplicative language of the present rule parts. The activities of fraud, theft, and abuse which the department is authorized to identify are defined in part 9505.2165. See 42 CFR 1002.1 which sets forth the requirements placed on the state for the prevention of fraud and abuse and protecting the integrity of the medical assistance program. See also Minnesota Statutes, section 256B.04, subdivision 10 which requires the department to identify and investigate suspected fraud, theft, or abuse by a vendor of medical care.

Subpart 2. Contacts to obtain information. This subpart specifies part of the procedure of identification and investigation required under subpart 1. A standard is necessary to comply with Minnesota Statutes, section 256B.04, subdivision 10. See present rule, part 9505.1890, subpart 2 which lists the sources of information that the department is authorized to use in its investigation. See also present rule, part 9505.2070, subpart 2. The authorization to contact the entities and persons specified in items A to I is reasonable because these sources have information related to providers' and recipients' activities in providing and obtaining health services. Contact with

professional associations and review organizations will provide the department information about current community standards of practice and is consistent with the requirement of Minnesota Statutes, section 256B.04, subdivision 15 of safeguarding against unnecessary or inappropriate use of medical assistance services. See also present part 9505.2070, subpart 3 about consultation with a review organization in assessing the question of medical necessity. The proposed subpart is consistent with 42 CFR 1002.203 (b) which states the sources an agency may use in determining if services were excessive or of unacceptable quality.

Subpart 3. Activities included in department's investigation. This subpart continues the specification of procedures of identification and investigation as required by Minnesota Statutes, section 256B.04, subdivision 10. Present rule, part 9505.1900, subpart 2 specifies the activities that may be included in an investigation. Proposed item A corresponds to present item A; proposed item B to present item E; proposed item C to present item F; proposed item D to present items B and C; proposed item E to present item D; proposed item E to present item D; proposed item G, which refers to parts of the present medical assistance rule that sets the criteria for determining medical necessity and appropriateness of health services, to present item G. Proposed item F is consistent with the requirements of Minnesota Statutes, section 256B.04, subdivision 15 which requires the commissioner to consult with a professional services (peer review mechanism) advisory group in the determination of whether services are reasonable and necessary. See also present parts 9505.1890, subpart 3, and 9505.2080, subpart 3, which require consultation with a review organization or other provider advisory committee appointed by the commissioner.

Subpart 4. Determination of investigation. When an investigation is completed, the information obtained in the investigation is used to draw conclusions related

to the investigated circumstances. The outcomes specified in proposed items A to C are the three reasonable conclusions that may be drawn from the facts found in the investigation. It is necessary to specify the procedure to be followed when the investigation is completed to comply with Minnesota Statutes, section 256B.04, subdivision 10. See present parts 9505.1900, subpart 3 and 9505.2080. Thus the proposed subpart continues requirements of the present rule.

Subpart 5. Postinvestigation action. Several parts of the present rule specify the actions an agency may take upon its documentation of fraud, theft, or abuse in connection with health care services under medical assistance. These parts include 9505.1900, subpart 3, 9505.1910, 9505.1920, and 9505.1970 in the case of providers and part 9505.2100 in the case of recipients. Proposed subpart 5 brings these actions together in one part and thus clarifies the rules. Clarification of the rule is reasonable as it eliminates duplication and reduces the likelihood of confusion and misunderstanding. Item D of proposed subpart 5 is a new provision. It has been the department's procedure to refer cases to other regulatory agencies when the determinations of the department's investigation support such action as appropriate. Examples of other regulatory agencies are licensing bodies such as the Board of Medical Examiners in the case of physicians, the Board of Social Work in the case of licensed independent clinical social workers, and the Board of Psychology which licenses psychologists. These agencies need to be informed about actions of persons subject to their licensure requirements if the persons have committed acts that violate the Boards' professional standards of practice. Adding the language to the rule is necessary and reasonable because it informs recipients and providers of a possible action by the department. Referral to the appropriate state licensing board is consistent with Minnesota Statutes, section 256B.064,

subdivision 1b. A warning, item F, is a reasonable postinvestigation action because it affords a recipient or provider notice of a practice that is potentially in violation of program laws or regulations and thereby provides the person an opportunity to correct the usuage pattern in time to avert the imposition of a more serious sanction.

9505.2205 COMMISSIONER TO DECIDE IMPOSITION OF SANCTION

This part is necessary to specify who will impose the sanction against a provider or a recipient and the criteria for determining which sanction. Standards are necessary to assure uniform implementation and avoid arbitrary imposition of penalties. The present rules contain similar provisions in part 9505.1990 in regard to sanctions of a provider. Proposed items A to D contain no substantive changes from the present rules but do have technical changes. 42 CFR 431.54 (e) permits the department to impose restrictions on a recipient. The proposed part adds language in the introductory sentences and in item C to apply the criteria for determining sanctions to recipients. Item E is a new provision. 42 CFR 431.54 requires the department, when it restricts a recipient, to assure "that the recipient has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality." A recipient's local trade area is the area in which the recipient customarily obtains needed goods and services. See the definition of "local trade area" in part 9505.0175, subpart 22. However, the department recognizes that not all medically necessary services are available in all trade areas of Minnesota. Thus it is reasonable to require consideration of the recipient's local trade area and access to medically necessary services within the local trade area to assure that the restriction will not interfere with the recipient's ability to access medically necessary services. The relationship between a recipient and his or her

physician may be a very personal and confidential one because of the nature of the information, examinations, and consultations that occur. It is important therefore to consider the recipient's preference of a primary care case manager who will be the recipient's primary physician so that the recipient will feel comfortable in discussing his or her medical problems with the primary care case manager. Consideration of the recipient's preference also is consistent with the requirement of part 9505.0190 about the recipient's right to choose. See also 42 CFR 431.51 which addresses free choice of provider subject to certain restrictions.

9505.2210 IMPOSITION OF ADMINISTRATIVE SANCTIONS

Subpart 1. Authority to impose administrative sanctions. This subpart is necessary to clarify the conditions under which the commissioner is authorized to impose administrative sanctions against a recipient or provider. The substance of this subpart is that of present parts 9505.1930, 9505.1970, and 9505.2210. The practices specified in items B and C of the present part 9505.1930 are included in the definition of "abuse" in proposed part 9505.2165, subpart 2. The proposed language simplifies the rule by removing unnecessary words and ensures consistency with the definitions. The revisions are only for technical purposes. The authority for the imposition of sanctions against vendors is found in Minnesota Statutes, section 256B.064.

Subp. 2. Nature of administrative sanction. This subpart is necessary to establish the actions that the commissioner may impose as administrative sanctions of providers and recipients.

Item A specifies the sanctions that the commissioner may impose on a provider for conduct specified in subpart 1. The subitems of this item continue permissible sanctions under the present rule as follows: subitem (1) is found in present

part 9505.1970, item B; subitem (2) is in present part 9505.1970, item C; subitem (3) is now in part 9505.1970, item D; subitem (4) is now in part 9505.1970, item E. (It should be noted that item A of present part 9505.1970 is now contained in proposed part 9505.2200, subpart 5, item E.) Subitem (5) which is not found in the present rule permits the commissioner to require the provider's attendance at provider education sessions. These sessions would be designed to explain and answer questions about the requirements of the rules and regulations related to provider participation in the medical assistance program. This sanction is reasonable as the session would directly inform a provider of provider obligations under medical assistance and thereby assist the provider to comply. Subitems (6), (7), and (8) permit the commissioner to restrict a provider's participation in some manner while at the same time continuing to be eligible to receive medical assistance payment as long as the provider meets certain conditions. These subitems are consistent with 42 CFR 431.54 (f) which states that "the agency may restrict the provider through suspension or otherwise....." Thus, subitem (6) is a new provision that is designed to enable the provider's continued participation in the medical assistance program and at the same time to monitor the provider's compliance. Prior authorization permits the department to review the provider's documentation of the medical necessity and appropriatenesss of the recipient's health service before the service is provided. If the department finds the service is necessary and appropriate, then delivery of the service is authorized and medical assistance payment is assured. If the documentation is incomplete, the department may request additional information and upon its receipt will make a decision. If the service is not medically necessary or appropriate, then the department will refuse to agree to pay for the service from medical assistance funds. See part 9505.0175, subpart

37 and parts 9505.5010 to 9505.5030 for standards applicable to prior authorization. Requiring prior authorization is reasonable because it balances the opportunity for a provider to continue to participate in the program and the department's obligations under Minnesota Statutes, section 256B.04, subdivision 15 and 42 CFR 1002.1 of protecting program integrity. The subitem also is reasonable as it prevents overpayments for unnecessary or inappropriate services. Furthermore, sanctioning a provider by requiring prior authorization is cost effective as the review takes place before the service is provided and medical assistance payment is made. Thus the department does not have to incur the expense of recovering overpayments from an abusive provider.

Subitem (7) is similar to subitem (6) except that the review takes place after the service is provided but before payment occurs. The subitem is reasonable as it is cost effective.

Subitem (8) permits the commissioner to restrict the provider's participation. It is consistent with 42 CFR 431.54 (f) which states that "the agency may restrict the provider, through suspension or otherwise." It is designed to provide the commissioner means to comply with the requirements of assuring that services are medically necessary (Minnesota Statutes, section 256B.04, subdivision 15) and at the same time to adjust the restriction to the provider's circumstances. An example of such a restriction would be a limitation on a provider's prescription of drugs that are funded under medical assistance if the provider has been determined to be abusive in prescribing.

Item B specifies the sanctions to be imposed on recipients who have been identified as using services inappropriately. This subpart is consistent with the provisions of Minnesota Statutes, section 256B.04, subdivision 15 which

requires the state to "safeguard against unnecessary or inappropriate use of medical assistance services." Subitem B (1), referral of the recipient for health counseling to correct inappropriate or dangerous use of health care services, is reasonable as the counseling will inform the recipient of the appropriate ways to access and use medical assistance services and, thus, offer the recipient an opportunity to comply. Restriction, subitem B (2), is consistent with the provisions of 42 CFR 431.54 (e) and is in the present rule, part 9505.2100, item E. Referral to the appropriate adult or child protection agency, subitem B(3) is consistent with the requirements of Minnesota Statutes, sections 626.556 and 626.557. The referral is reasonable in instances where the recipient's abuse of health services may have endangered his or her own health and safety because the referral will assure compliance with the statutory reporting requirements of sections 626.556 and 626.557.

Subpart 3. Emergency health services excepted from restrictions. This proposed subpart sets forth a new requirement. It is necessary to inform providers and recipients of a requirement of 42 CFR 431.54 (e) (3) which states that "the restrictions [placed on a recipient] will not apply to emergency services furnished to the recipient." The provision is consistent with federal regulations as required under Minnesota Statutes, section 256B.04, subdivision 4 in regard to maximizing federal financial participation. Requiring documentation of the emergency circumstance is necessary to assure compliance with program rules and to provide evidence of the circumstances. It is reasonable to allow recipients free access to emergency services needed to meet the emergency because the serious nature of the emergency requires immediate treatment. The requirement does not add an additional recordkeeping burden for

the provider as proposed part 9505.2175 requires all the recipient's health services to be documented in the recipient's health service records. Furthermore, requiring the documentation to be submitted with the claim for payment is reasonable because it permits the department to review the circumstances and determine if payment based on an emergency is justified. It also prevents overpayments from occurring.

9505.2215 MONETARY RECOVERY

This proposed part combines and reorganizes requirements now contained in parts 9505.1910, 9505.1920, 9505.1950, and 9505.2100. It also makes technical changes.

Subpart 1. Authority to seek monetary recovery. Minnesota Statutes, section 256B.064 authorizes the commissioner to seek monetary recovery from vendors of medical care for certain specified acts including fraud, theft, abuse , and the provision of services that were not medically necessary. This subpart is necessary to set the standard and inform affected persons. Item A of this subpart is consistent with part 9505.0465 and with Minnesota Statutes, section 256B.064, subdivision 1a in regard to intentional error on the part of the provider for the purpose of obtaining greater compensation than that to which the provider is legally entitled. A payment that is obtained through the provider's unintentional error is a payment outside the scope of the State plan. The provider is not entitled to such a payment and, if the federal audit disclosed it, the federal authorities would seek to recover the federal portion of such a payment from the state. Therefore, it is reasonable that the department recover the payment resulting from the provider's unintentional error as the department should have the right to recover the amount the federal government holds it responsible for. Such a recovery is not a punitive action but merely the

correction of an error. See also Minnesota Statutes, section 256B.0641 in regard to recovery of overpayments.

Item B authorizes the commissioner to seek monetary recovery from a recipient. See Minnesota Rules, part 9505.0130, subpart 4 in regard to medical assistance wrongfully obtained by a recipient and the recovery of the amount of the assistance. A medical assistance payment for services that a recipient has wrongfully obtained is a payment outside the scope of the State plan. The recipient is not entitled to such services and, if the federal audit disclosed it, the federal authorities would seek to recover the federal portion of such a payment from the state. Therefore, it is reasonable that the department should have a right to recover the payment from medical assistance funds for those services as the federal government holds the state responsible. As discussed above for item A, seeking recovery in the case of the recipient's error is not a punitive action but is reasonable to correct the error and to conform to the requirements of the State plan.

Subpart 2. Methods of monetary recovery. This subpart is necessary to specify the methods the commissioner may use in seeking monetary recovery. Items A to D are the same as the methods authorized in present part 9505.1950. See also present part 9505.2100, item C pertaining to the "recovery from recipients , to the extent permitted by law all amounts incorrectly paid by the programs". Item E permits the commissioner to request Medicare to withhold payments pending recovery of money under subpart 1. The present rule does not contain this provision. The provision is necessary in order to assure recovery of medical assistance funds in some instances. Section 1885 of the Social Security Act authorizes the Health Care Financing Administration of the United States Department of Health and Human Services (HCFA) to withhold Medicare payments to

a medical assistance provider in order to recover medical assistance overpayments to the provider. 42 CFR 447.31 specifies the procedures the department must use to request recovery of medical assistance overpayments through Medicare. The item is consistent with 42 CFR 447.31. It should be noted that one of the procedural requirements is the availability of an appeal process to protect the provider's due process rights. Proposed part 9505.2230 provides a provider an appeal process.

Subpart 3. Interest charges on monetary recovery. This subpart is necessary to set the standard for interest charges on money owed to the department as a result of an action under subpart 1. Minnesota Statutes, section 256B.064, subdivision 1c allows the commissioner to "charge interest on money to be recovered if the recovery is to be made by installment payments or debits. The interest charged shall be the rate established by the commissioner of revenue under section 270.75." This subpart is consistent with Minnesota Statutes, section 256B.064, subdivision 1c.

9505.2220 USE OF RANDOM SAMPLE EXTRAPOLATION IN MONETARY RECOVERY.

Subpart 1. Authorization. The determination that the department has erroneously paid money to a provider may be based on a pattern of activity during a period in which the provider provided services to a large number of recipients. Analyzing all the provider's records related to the services could be a lengthy, time consuming task. The present rule, in part 9505.1960, has a standard procedure for extrapolating the amount of the monetary recovery the department is authorized to make in the event of a determination of erroneous payments to the provider. Proposed subpart 1 continues the use of this standard, extrapolation of the amount from systematic random samples of claims submitted by the provider and paid by a program or programs. Proposed subpart 1 is

necessary to establish a uniform procedure. Systematic random sampling is a statistical technique accepted by statisticians and researchers as a method that, within certain limits, gives an acceptable measurement of an unknown statistic. See W. Cochran, Sampling Techniques which is cited in subpart 3 for a discussion of reliable methods of sampling a population. The population to be sampled for purposes of determining a monetary recovery is the set of health services provided by the provider during the specific interval under investigation. Using a sampling technique is reasonable as it balances the need for a reliable determination of the amount to be recovered and the need to use available staff resources in a cost effective manner.

Subpart 2. Sampling method. This subpart is necessary to establish criteria for determining when to use sampling and extrapolation. This statistical technique is only valid when the size of the population is large enough to minimize the possibility of extreme values skewing the numerical outcome. The reliability of a sample is expressed in terms of confidence level, which is a predetermined mathematical value based on the size of the population and the variance within the population. Proposed items A and B are the same as the present criteria applied to determine when a sample can be used with confidence in the reliability of the outcome. In both circumstances, the population from which the sample is drawn is of sufficient size to assure the required level of confidence, 95 percent, can be met. Item C of the present rule, claims totaling $2,000 or more, is not in the proposed rule as inflation occuring since item C was adopted has negated the meaningfulness of this amount. The department would not today have a case representing services to 50 or more recipients or 1,000 or more claims for an amount less than $2,000.

Subpart 3. Sampling method. Subpart 3 is necessary to specify the method for

drawing the sample from which to extrapolate the amount of money to be recovered. This subpart has no substantial changes from the present sampling method specified in subpart 3 of part 9505.1960. The proposed subpart does clarify the language. Item A relates the selection of the sample to the likelihood that every sample of the same size is equally likely to be selected. This concept is valid as a systematic random sample follows a controlled selection process affecting the whole sample. Item B is reasonable because the department's authority to recover money is related to its investigation and identification of moneys erroneously paid for certain services and for a specified period. Item C refers only to the text by W. Cochran as the department uses only the statistical procedures in Cochran but does not use those in Survey Sampling, by L. Kish, which is cited in the present rule. Therefore, it is reasonable that the rule be consistent with the text containing the procedures that the department actually uses so that affected persons are accurately informed. Item D continues the present confidence level of 95 percent. A 95 percent confidence level means that an audit of all records of claims for payment for like services in the same interval would result in a recovery amount within five percent of the extrapolated amount. Or to express the confidence level in another way, 5 percent of the time it is expected that the actual value would lie outside the extrapolated amount determined from the sample. Thus it is reasonable to specify that the department will recover the extrapolated amount less the five percent factor as this adjustment acknowledges the variation due to chance alone.

It should be noted that subparts 4, 5, and 6 of the present rule, part 9505.1960 are not replicated in proposed part 9505.2220 as their provisions are stated elsewhere. Thus, the provider's due process rights are protected under the

appeal provisions specified in proposed part 9505.2245 and the requirements for the notice of agency action, including how the agency determined the dollar amount to be recovered, are set forth in part 9505.2230.

9505.2225 SUSPENSION OF PROVIDER CONVICTED OF CRIME RELATED TO MEDICARE OR MEDICAL ASSISTANCE.

Minnesota Rules, part 9505.0475 establishes procedures and standards for the department's actions in regard to a provider who is convicted of a crime related to Medicare or medical assistance. Proposed part 9505.2225 is necessary to inform affected persons and to ensure consistency among the rules affecting the same program or programs. Including the information in proposed part 9505.2225 is reasonable because making the information available reduces the likelihood of misunderstanding.

9505.2230 NOTICE OF AGENCY ACTION.

The proposed part combines the standards applicable to notices to recipients and notices to providers which are found in the present rules, parts 9505.2110 and 9505.1980.

Subpart 1. Required written notice. This subpart sets the standards about notices to providers and recipients if the department is seeking a monetary recovery or imposing an administrative sanction. A required written notice is a provision of the present rules. The requirement is reasonable because a written notice provides evidence that the person receiving the notice has had the opportunity to become informed and because it reduces the likelihood of misunderstanding. Requiring the notice to go by first class mail is a reasonable requirement because first class mail customarily is handled and received more

quickly than third and fourth class mail and certified mail.

A provider has the right to appeal within a specified time limit that begins to run on the date the notice was mailed to the provider. See part 9505.2245. If the provider does not appeal within the specified time period, the department has the right to recover the amount of the overpayment without a hearing. It is reasonable to require the department to place an affidavit of the mailing in the record as the affidavit is evidence of the mailing date and the person to whom and the address to which the mail was sent.

The substance of items A to F is found in the present rules, parts 9505.1980, subpart 2, items A to F and 9505.2110, items A to F. Requiring this information to be in the notice is reasonable as it informs recipients and providers.

Subpart 2. Effective date of recovery or sanction. This subpart specifies the effective date of the proposed monetary recovery or sanction. A standard is necessary to comply with the requirement of Minnesota Statutes, section 256B.04, subdivision 2 of administering the medical assistance program statewide in a uniform manner. The proposed subpart sets the date of recovery as the first day after the last day available for a provider's request as provided in statute. See Minnesota Statutes, section 256B.0643, which applies to vendor requests for contested case proceedings. Thus, the proposed subpart is consistent with the statutory standard applicable to notice to providers. See part 9505.2245, subpart 2 and its SNR.

Minnesota Statutes, section 256.045, subdivision 3 sets a period of 30 days (or 90 days if good cause for delay is shown) for a recipient's appeal of a state agency action. Thus, the 30 day period for a recipient is reasonable because it is consistent with the statute establishing a recipient's right to appeal.

Subpart 3. Effect of department's administrative determination. This subpart

is a new provision that sets a standard for the effective date of the department's administrative determination. A standard is necessary to inform affected persons and to comply with the requirement of Minnesota Statutes, section 256B.04, subdivision 2 to administer the medical assistance program in a uniform manner. It is reasonable that, when the interval ends without an appeal being received by the department, the department's determination take effect as the requirement balances the need of the department to close the case in a timely manner and the due process rights of the provider or recipient.

9505.2231 SUSPENSION OR WITHHOLDING OF PAYMENTS TO PROVIDERS BEFORE APPEAL.

This part authorizes the commissioner to suspend or withhold payments to a provider at the time the department notifies the provider as required under part 9505.2230 and before the expiration of the interval for the provider's possible appeal. The part is necessary to set the standards for when the commissioner is authorized to take such an action.

Subpart 1. Grounds for suspension or withholding.

Present part 9505.2050 establishes the grounds which justify the commissioner's withholding or suspending a provider's payments. Proposed part 9505.2231, subpart 1, items A to C are substantively the same as items A to C of the present part 9505.2050.

Item D. Minnesota Statutes, section 256B.064, subdivision 2 authorizes the commissioner to suspend or reduce payment to a vendor of medical care without prior notice and an opportunity for a hearing "if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program." Item D is necessary and reasonable because it informs affected persons of circumstances under which the commissioner may withhold or suspend payment and ensures consistency with the statute referenced within it. See subpart 2 which

incorporates the statutory exception to withholding or suspending before notice and, if the provider so requests, a hearing.

Subpart 2. Exception to prehearing suspension or withholding. As stated in the SNR of subpart 1, Minnesota Statutes, section 256B.064, subdivision 2, specifies that the commissioner may not suspend or reduce payment to a nursing home or convalescent care facility before the provider has an opportunity for a hearing. Proposed subpart 2 is necessary and reasonable because it is consistent with Minnesota Statutes, section 256B.064, subdivision 2 and informs affected persons. Similar language is found in the present rule, part 9505.1980, subpart 3.

Subpart 3. Federal share. Minnesota Statutes, section 256B.0641, subdivision 1 requires the commissioner to recover the federal share of an overpayment to a provider using the schedule of payments required by the federal government. Subpart 3 is necessary and reasonable because it informs affected persons of the statutory requirement placed on the commissioner.

9505.2235 SUSPENSION OR TERMINATION OF PROVIDER PARTICIPATION.

Subpart 1. Effect of suspension or termination as provider. 42 CFR 1002, Subpart B sets federal requirements related to the exclusion and suspension of providers for fraud and abuse. 42 CFR 1002.207 specifies that the department "must not make payment under Medicaid for items or services furnished by a provider who has been excluded from the Medicaid program in accordance with 42 CFR 1002.203" and further states that "FFP is not available in payment under any State plan for services furnished by a provider who has been excluded from the Medicaid program." (See 42 CFR 1002.200, about the state plan requirement. It should be noted that the term "exclusion" is consistent with and has the same effect as the term "terminating participation", which is defined in part 9505.2165, subpart 14.)

42 CFR 1002.213 states that the department "must not make any payment under the plan for services furnished directly by, or under the supervision of, a suspended party during the period of the suspension." This subpart is necessary and reasonable because it is consistent with the federal regulations, informs affected persons, and complies with Minnesota Statutes, section 256B.04, subdivision 4 about cooperating with the federal government in any reasonable manner necessary to obtain federal participation. The language clarifies the present rule, part 9505.2000 but is substantively the same. The clarification of the proposed subpart is that the provider agreement of a vendor who is under suspension or terminated from participation is void. The clarification is reasonable as a vendor who is under suspension or is terminated from participation incurs this sanction because the vendor violated a condition of the provider agreement, that is compliance with program rules and regulations.

This clarification is necessary to state, in an unmistakable manner, the effect of the suspension or termination on the vendor. The clarification is reasonable because it informs affected persons and thereby reduces the likelihood of confusion and misunderstanding.

Subpart 2. Reinstatement of vendor as provider. This subpart adds new provisions not in the present rule. 42 CFR 1002.230 to 1002.234 provide the reinstatement procedures applicable to a vendor who has been suspended or terminated from participation in the medical assistance program. 42 CFR 1002.232 (a) states the requirements that apply to reinstatement after exclusion "if a State affords reinstatement opportunity to those parties." 42 CFR 1002.232 (c) states that the excluded party may submit a request for reinstatement any time after the date specified in the notice of exclusion. See also 42 CFR 1002.207 (c) which addresses the duration of an exclusion. This subpart is necessary to

establish a uniform procedure for the reinstatement of a vendor and inform affected vendors about when reinstatement is possible and the criteria that they must meet to be reinstated. The subpart is reasonable as it complies with the requirements of 42 CFR 1002.230 to 1002.236 and through this compliance makes payments to reinstated providers eligible for federal financial participation as prescribed in Minnesota Statutes, section 256B.04, subdivision 4.

Subpart 3. Prohibited submission of vendor's claims. This subpart continues language in present rule, part 9505.2010. This subpart is necessary to inform affected persons. It is reasonable to prohibit suspended or terminated vendors from submitting claims for payment during their periods of suspension or termination because such claims are not eligible for payment under a program. The review and subsequent rejection of such claims would be administratively inefficent and contrary to operation of the medical assistance program in a cost effective manner as required under Minnesota Statutes, section 256B.04, subdivision 2. It is reasonable to authorize the department to recover money paid to a vendor for a service provided after the vendor's suspension or termination as the vendor is prohibited from receiving medical assistance payments during the period of suspension or termination amd should not benefit from the program. The recovery of the funds reasonably protects the integrity of the program. See 42 CFR 455.2 which defines suspension as "items or services furnished by a specified provider who has been convicted of a program-related offense....will not be reimbursed under Medicaid." See also 42 CFR 455.2 which defines exclusion as "items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid." See also subpart 1 above and 42 CFR 1002.207 and 42 CFR 1002.213. It also is reasonable to permit the department to impose administrative sanctions against

an entity that knowingly submits a payment claim for a service provided after the effective date of the termination or suspension as such a submission falls within the definition of abuse. See the definition of "abuse" in part 9505.2165, subpart 2, item A, the introductory paragraph and subitem (3) and part 9505.2210, subpart 1 for the administrative sanctions that may be imposed for abuse. However, 42 CFR 1002.213 (b) does permit the suspended or terminated vendor to receive payment for services provided before the effective date of the determination or suspension. Thus this subpart is consistent with federal regulations related to the prohibition of payment for a provider's services that are provided during the period of a provider's suspension or termination.

9505.2236 RESTRICTION OF PROVIDER PARTICIPATION.

Subpart 1. Effect of restriction on a provider. Proposed part 9505.2210, subpart 2 states that the commissioner may impose the administrative sanction of restricting a provider's participation in a program. Proposed part 9505.2236, subpart 1 specifies the effect of such a restriction. Subpart 1 is necessary to set a uniform standard and to inform affected persons. The proposed subpart adds language which is not found in the present rule. Amending the provider agreement to include the restriction is reasonable and necessary as the written provider agreement specifying the conditions agreed to by both the provider and the department affords the provider an opportunity to understand the terms of participation and to choose to comply. See part 9505.0195, subparts 1 and 5. It is reasonable to prohibit the restricted provider from submitting a claim for payment for services specified in the notice of action as the prohibition protects the integrity of the program, assures the provider will not benefit from payments to which he or she is not entitled, and is administratively efficient. It also is reasonable to permit payment to be made for services provided before

the effective date of the restriction as the provider rendered those service in good faith of receiving payment. See the SNR of part 9505.2210, subpart 2, item A, subitem (8) and 42 CFR 431.54 f.

Subpart 2. Reinstatement of restricted provider. This proposed subpart is necessary to set the standard for reinstating a provider whose participation is restricted. Restriction of a provider affords the provider an opportunity to demonstrate willingness to comply with the provider agreement and the department an opportunity to monitor the provider's compliance. Restriction prohibits the provider from full participation in the program but allows the provider to participate on a limited basis which is monitored by the department. It is an administrative sanction which is not as stringent a sanction as either suspension or termination and which the department may apply in cases of a less serious nature. 42 CFR 1002.230 to 1002.234 permits the department to reinstate a provider who has been terminated or suspended because of abuse or fraud and sets criteria for determining when to grant reinstatement. Thus it is reasonable to provide for lifting a restriction and a return to full participation in the case of a provider who has demonstrated a willingness and ability to comply with the participation requirements of part 9505.0195 and the federal regulations.

Subpart 3. Prohibited submission of restricted provider's claims. This proposed subpart is similar to the prohibition in part 9505.2235, subpart 3 which applies to suspended or terminated providers. This subpart is necessary to set a standard. It is reasonable to apply the same standard to the submission of claims for payment for the services of all providers who are no longer eligible to receive program payments for some or all services because a single standard avoids confusion, is administratively efficient, and complies with the requirement of Minnesota Statutes, section 256B.04, subdivision 2 to administer

the medical assistance program statewide in a uniform manner.

9505.2240 NOTICE TO THIRD PARTIES ABOUT DEPARTMENT ACTIONS FOLLOWING INVESTIGATION.

Subpart 1. Notice about providers. The requirements of subpart 1 and 2 are new provisions that are not in the present rules. Subpart 1 is necessary to comply with 42 CFR 431.54 (f)(3) which requires the department to notify HCFA and also give the public a general notice when the department restricts a provider (through suspension or otherwise.) 42 CFR 1002.206 requires the department to notify the Office of the Inspector General (OIG) of the United States Department of Health and Human Services, HCFA, the public, and, as appropriate, recipients, professional review organizations, providers and organization, medical societies and other professional organizations, state licensing boards and affected state and local agencies and organizations, and Medicare carriers and intermediaries. Thus, items A and B are reasonable because they require the department to act in a manner that assures compliance with the federal notification requirements. Item B requires the notice to the general public to be in a general circulation newspaper in the provider's local trade area. Publication in such a newspaper is reasonable because this newspaper is the one most likely to be read by persons who live in the area, are most likely to receive services in the area, and thus may be directly affected by the department's sanction of the provider. Requiring the notice to include the provider's service type, the action taken, and the effective date or dates is reasonable to fully inform affected persons and reduce the likelihood of misunderstanding.

Subpart 2. Information and notice about recipients. This subpart is necessary to notify the recipient's primary care case manager about a recipient who is ineligible for certain services and whose service costs will not be paid through

program payment funds. The recipient's primary care case manager has the responsibility for the recipient's direct care and also for coordinating, controlling access to, initiating, or supervising other health services needed by the recipient. See the definition of primary care case manager in part 9505.2165, subaprt 7a. Thus notice to the recipient's primary care case manager is necessary and reasonable because the information assists the primary care case manager to carry out his or her responsibilities. Because the primary care case manager is responsible for coordinating and controlling access to the other health services needed by the recipient, it is reasonable to require the information to include a list of providers to whom the recipient is restricted so that the primary care case manager will be able to carry out these responsibilities. Thus, this subpart benefits providers as they have the opportunity to be informed about the restriction, to be aware of the recipient's services that are eligible for program payment, and to determine what services, if any, they will provide to the restricted recipient. The notice also is a means of enforcing the recipient's restriction as the primary care case manager must act in accordance with the restriction. Requiring the notice to state the beginning and ending dates of the recipient's restriction is reasonable because the recipient's primary care case manager needs the information to carry out his or her responsibilities about the recipient's access to services.

9505.2245 APPEAL OF DEPARTMENT ACTION.

This part clarifies and restates the appeal provisions found in the present rule, part 9505.2150.

Subpart 1. Provider's right to appeal. Item A states the information that must be included in an appeal request. Subitems (1) to (3) are necessary to prevent arbitrary and capricious appeals and to assure that the department has

information about the provider's reason for the appeal. The department often receives appeals that do not state why or what the provider is appealing. The department needs the required information so that staff can review the case and be prepared to respond in the hearing. Without the required information, the department may be unable to respond at the hearing and the hearing may be delayed to the disadvantage of the provider. Additionally, a review of the information may disclose facts in favor of the provider that the department had not been aware of and that may lead to a resolution of the dispute without a hearing. Therefore, it is reasonable to require the information specified in subitems (1) to (3) because the information will assist the department's review and a timely resolution of the dispute. Requiring the name and address of a contact person (subitem (4)) is reasonable because the information will identify the person who is authorized to be the spokesperson for the provider. Subitems (1) to (5) are consistent with the information required by Minnesota Statutes, section 256B.0643.

Item B. Currently, Minnesota Statutes, section 256B.0643 specifies the period of timeliness for filing an appeal. This item allows for flexibility if the statutory appeal deadline is amended. See part 9505.2230, subpart 2 and its SNR. Including the item is reasonable because it informs affected persons.

Subpart 2. Recipient's right to appeal. Minnesota Statutes, section 256.045 specifies the recipient's right to appeal if the recipient's services are "suspended , reduced, terminated, or claimed to have been incorrectly paid." Restriction of a recipient under part 9505.2210, item B, subitem (2) limits the recipient's access to services and thus reduces the services available to a recipient. See also part 9505.2165, subpart 11, item B which defines restriction of a recipient. This subpart is necessary to inform affected persons. The

subpart is reasonable because it is consistent with Minnesota Statutes, section 256.045.

EXPERT WITNESSES

The department does not plan to present expert witnesses to testify at the public hearing on behalf of the proposed rules.

Dated: December 1, 1990

ANN WYNIA

Commissioner of Human Services